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Dr. Swati Mehta is director of quality and performance and patient experience at Vituity in Emeryville, Calif.

PHOTO BY VITUITY

Hospitalists address patient experience during the pandemic

Adopt strategies to communicate with compassion

By Larry Beresford

A patient's lived experience of being in the hospital is shaped by a variety of factors, according to Minesh Patel, MD, Mid-Atlantic regional medical director for the Tacoma, Wash.-based hospitalist performance company Sound Physicians. Some – but not

all – of these factors are captured in the “patient experience” questions on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey that is sent to randomly selected patients shortly after their discharge from the hospital.

In March 2020, the COVID-19 pandemic caused hospitals to institute quarantining measures and “no visitor”

policies as doctors and other hospital staff donned masks, visors, and other emotionally distancing personal protective equipment (PPE). All of these factors impacted patients' experience as well as their hospitals' HCAHPS scores, Dr. Patel said. And since these policies applied to all hospitalized patients, a patient did not need to have

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SHM, 55 other groups urge health care vax mandate

By Ken Terry

As COVID-19 cases, hospitalizations, and deaths mount again across the country, the Society of Hospital Medicine, the American Medical Association, and 54 other medical and allied health care associations released a joint statement calling on “all health care and long-term care employers” to require their workers to receive the COVID-19 vaccine.

“SHM’s mission is to promote high-quality care for hospitalized patients. As an organization, we support vaccinating health care workers, including hospitalists, to help stop the spread of COVID-19 and the increasingly dominant Delta variant,” said Eric E. Howell, MD, MHM, chief executive officer of SHM. “We aim to uphold the highest standards among hospitalists and other health care providers to help protect our fellow health care professionals, our patients, and our communities.”

The document, issued July 26, covers everyone in health care, Emanuel Ezekiel, MD, PhD, chair of the department of medical ethics and health policy at the University of Pennsylvania, Philadelphia, and the organizer of the joint statement, said in an interview.

That includes not only hospitals, but also physician offices, ambulatory surgery centers, home care agencies, skilled nursing facilities, pharmacies, laboratories, and imaging centers, he said.

The exhortation to get vaccinated also extends to federal and state health care facilities, including those of the military health system – TRICARE and the Department of Veterans Affairs – which instituted a mandate the same day.

The American Hospital Association and other hospital groups recently said they supported hospitals and health systems that required their personnel to get vaccinated. Several dozen health care organizations have already done so, including some of the nation’s largest health systems.

A substantial fraction of U.S. health care workers have not yet gotten vaccinated, although how many are unvaccinated is unclear.

An analysis by WebMD and Medscape Medical News estimated that 25% of hospital workers who had contact with patients were unvaccinated at the end of May.

More than 38% of nursing workers were not fully vaccinated by July 11, according to an analysis of Centers for Medicare & Medicaid Services data by LeadingAge, which was cited by the Washington Post. And more than 40% of nursing home employees have not been fully vaccinated, according to the Centers for Disease Control and Prevention.

The joint statement did not give any indication of how many employees of physician practices have failed to get COVID shots. However, a recent AMA survey shows that 96% of physicians have been fully vaccinated.

The main reason for vaccine mandates, according to the health care associations’ statement, is “the ethical commitment to put patients as well as residents of long-term care facilities first and take all steps necessary to ensure their health and well-being.”

In addition, the statement noted, vaccination can protect health care workers and their families from getting COVID-19.

The statement also pointed out that many health care and long-term care organizations already require vaccinations for influenza, hepatitis B, and pertussis.

Workers who have certain medical conditions should be exempt from the vaccination mandates, the statement added.

While recognizing the “historical mistrust of health care institutions” among some health care workers, the statement said, “We must continue to address workers’ concerns, engage with marginalized populations, and work with trusted messengers to improve vaccine acceptance.”

There has been some skepticism about the legality of requiring health care workers to get vaccinated as a condition of employment, partly because the U.S. Food and Drug Administration had, at press time, not yet fully authorized any of the COVID-19 vaccines.

But in June, a federal judge turned down a legal challenge to Houston Methodist’s vaccination mandate.

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Hospitalist movers and shakers

By Matt Pesyna

Chi-Cheng Huang, MD, SFHM, was recently named one of the



Dr. Huang

Notable Asian/Pacific American Physicians in U.S. History by the American Board of Internal Medicine. May was Asian/Pacific American Heritage Month. Dr.

Huang is the executive medical director and service line director of general medicine and hospital medicine within the Wake Forest Baptist Health System (Winston-Salem, N.C.) and associate professor at Wake Forest School of Medicine.

Dr. Huang is a board-certified hospitalist and pediatrician, and he is the founder of the Bolivian Children Project, a nonprofit organization that focuses on sheltering street children in La Paz and other areas of Bolivia. Dr. Huang was inspired to start the project during a year sabbatical from medical school. He worked at an orphanage and cared for children who were victims of physical abuse. The Bolivian Children Project supports those children, and Dr. Huang's book, *When Invisible Children Sing*, tells their story.

Joshua Lenchus, DO, RPh, SFHM, has been elected president-elect of



Dr. Lenchus

the Florida Medical Association. Upon his inauguration in 2022, it will be the first time in its history that the FMA will have a DO and a hospitalist as its president. Dr.

Lenchus is a hospitalist and chief medical officer at the Broward Health Medical Center in Fort Lauderdale, Fla.

Mark V. Williams, MD, MHM, will join Washington University School of Medicine and BJC HealthCare, both in Saint Louis, as professor and chief for the Division of Hospital Medicine in October 2021. Dr. Williams is currently professor and director of the Center for Health Services Research at the University of Kentucky and chief quality officer at UK HealthCare, both in Lexington.

Dr. Williams was a founding mem-

ber of the Society of Hospital Medicine, one of the first two elected members of the Board of SHM, its former president, founding editor of the Journal of Hospital Medicine, and principal investigator for Project BOOST. He established the first hospi-



Dr. Williams

talist program at a public hospital (Grady Memorial in Atlanta) in 1998, and later became the founding chief of the Division of Hospital Medicine in 2007 at Northwestern University School of Medicine in Chicago. At the University of Kentucky, he established the Center for Health Services Research and the Division of Hospital Medicine in 2014.

At Washington University, Dr. Williams will be tasked with translating the division of hospital medicine's scholarly work, innovation, and research into practice improvement, focusing on developing new systems of health care delivery that are patient centered and cost effective, and provide outstanding value.

Jordan Messler, MD, SFHM, has been named the new chief medical officer at Glytec (Waltham, Mass.), where he has worked as executive director of clinical practice since 2018. Dr.



Dr. Messler

Messler will be tasked with leading strategy and product development while also supporting efforts in quality care, customer relations, and delivery of products.

Glytec provides insulin management software across the care continuum and is touted as the only cloud-based software provider of its kind. Dr. Messler's background includes expertise in glycemic management. In addition, he still works as a hospitalist and medical director at Morton Plant Hospitalist Group (Clearwater, Fla.).

Dr. Messler is a senior fellow with SHM and is physician editor of SHM's blog *The Hospital Leader*.

Tiffani Maycock, DO, recently was named to the Board of Directors for the American Board of Family Medicine. Dr. Maycock is director of the Selma Family Medicine Residency

Program at the University of Alabama at Birmingham, where she is an assistant professor in the department of family medicine.

Dr. Maycock helped create hospitalist services at Vaughan Regional Medical Center (Selma, Ala.) – Selma Family Medicine's primary teaching site – and currently serves as its hospitalist director and on its Medical Executive Committee. She has worked at the facility since 2017.

Preetham Talari, MD, SFHM, has

been named associate chief of quality safety for the Division of Hospital Medicine at the University of Kentucky's UK HealthCare in Lexington. Dr. Talari is an associate professor of internal medicine in the Division of Hospital Medicine at the UK College of Medicine.



Dr. Talari

Over the last decade, Dr. Talari's work in quality, safety, and health care leadership has positioned him as a leader in several UK Healthcare committees and transformation projects. In his role as associate chief, Dr. Talari collaborates with hospital medicine directors, enterprise leadership, and medical education leadership.

Dr. Talari is the president of the Kentucky chapter of SHM and is a member of SHM's Hospital Quality and Patient Safety Committee.

Adrian Paraschiv, MD, FHM, is being recognized by Continental Who's Who as a Trusted Internist and Hospitalist in the field of Medicine in acknowledgment of his commitment to providing quality health care services.



Dr. Paraschiv

Dr. Paraschiv is a board-certified Internist at Garnet Health Medical Center in Middletown, N.Y. He also serves in an administrative capacity as the Garnet Health Doctors Hospitalist Division's Associate Program Director. He is also the Director of Clinical Informatics. Dr. Paraschiv is certified as the Epic physician builder in analytics, information technology, and improved documentation.

DCH Health System (Tuscaloosa, Ala.) recently selected **Capstone Health Services Foundation** (Tuscaloosa) and **IN Compass Health** (Alpharetta, Ga.) as its joint hospitalist service provider for facilities in Northport and Tuscaloosa. Capstone will provide the physicians, while IN Compass will handle staffing management of the hospitalists, as well as day-to-day operations and calculating quality care metrics. The agreement is slated to begin on Oct. 1, 2021, at Northport Medical Center, and on Nov. 1, 2021, at DCH Regional Medical Center.

Capstone is an affiliate of the University of Alabama and oversees University Hospitalist Group, which currently provides hospitalists at DCH Regional Medical Center. Its partnership with IN Compass includes working together in recruiting and hiring physicians for both facilities.

UPMC Kane Medical Center (Kane, Pa.) recently announced the creation of a virtual telemedicine hospitalist program. UPMC Kane is partnering with the UPMC Center for Community Hospitalist Medicine to create this new mode of care.

Telehospitalists will care for UPMC Kane patients using advanced diagnostic technique and high-definition cameras. The physicians will bring expert service to Kane 24 hours per day utilizing physicians and specialists based in Pittsburgh. Those hospitalists will work with local nurse practitioners and support staff and deliver care to Kane patients.

Wake Forest Baptist Health (Winston-Salem, N.C.) has launched a Hospitalist at Home program with hopes of keeping patients safe while also reducing time they spend in the hospital. The telehealth initiative kicked into gear at the start of 2021 and considered the first of its kind in the region.

Patients who qualify for the program establish a plan before they leave the hospital. Wake Forest Baptist Health paramedics makes home visits and conducts care with a hospitalist reviewing the visit virtually. Those appointments continue until the patient does not require monitoring.

The impetus of creating the program was the COVID-19 pandemic; however, Wake Forest said it expects to care for between 75 and 100 patients through Hospitalist at Home at any one time.

Trio of awardees illustrate excellence in SHM chapters

2020 required resiliency, innovation

By Heidi Splete

The Society of Hospital Medicine's annual Chapter Excellence Exemplary Awards have additional meaning this year, in the wake of the persistent challenges faced by the medical profession as a result of the COVID-19 pandemic.

"The Chapter Excellence Award program is an annual rewards program to recognize outstanding work conducted by chapters to carry out the SHM mission locally," Lisa Kroll, associate director of membership at SHM, said in an interview.

The Chapter Excellence Award program is composed of Status Awards (Platinum, Gold, Silver, and Bronze) and Exemplary Awards. "Chapters that receive these awards have demonstrated growth, sustenance, and innovation within their chapter activities," Ms. Kroll said.

For 2020, the Houston Chapter received the Outstanding Chapter of the Year Award, the Hampton Roads (Va.) Chapter received the Resiliency Award, and Amith Skandhan, MD, SFHM, of the Wiregrass Chapter in Alabama, received the Most Engaged Chapter Leader Award.

"SHM members are assigned to a chapter based on their geographical location and are provided opportunities for education and networking through in-person and virtual events, volunteering in a chapter leadership position, and connecting with local hospitalists through the chapter's community in HMX, SHM's online engagement platform," Ms. Kroll said.

The Houston Chapter received the Outstanding Chapter of the Year Award because it "exemplified high performance during 2020," Ms. Kroll said. "During a particularly challenging year for everyone, the chapter was able to rethink how they could make the largest impact for members and expand their audience with the use of virtual meetings, provide incentives for participants, and expand their leadership team."

"The Houston Chapter has been successful in establishing a Houston-wide Resident Interest Group to better involve and provide SHM resources to the residents within the four local internal medicine residency programs who are interested in hospital medicine," Ms. Kroll said. "Additionally, the chapter created its first curriculum to assist residents in knowing more about hospital medicine and how to approach the job search. The Houston Chapter has provided sources of support, both emotionally and professionally, and incorporated comedians and musicians into their web meetings to provide a much-needed break from medical content."

The Resiliency Award is a new SHM award category that goes to one chapter that has gone

"above and beyond" to showcase their ability to withstand and rise above hardships, as well as to successfully adapt and position the chapter for long-term sustainability and success, according to Ms. Kroll. "The Hampton Roads Chapter received this award for the 2020 year. Some of the chapter's accomplishments included initiating a provider well-being series."

Ms. Kroll noted that the Hampton Roads Chapter thrived by trying new approaches and ideas to bring hospitalists together across a wide region, such as by utilizing the virtual format to provide more specialized outreach to providers and recognize hospitalists' contributions to the broader community.

The Most Engaged Chapter Leader Award was given to Alabama-based hospitalist Dr. Skandhan, who "has demonstrated how he goes above and beyond to grow and sustain the Wiregrass Chapter of SHM and continues to carry out the SHM mission," Ms. Kroll said.

Dr. Skandhan's accomplishments in 2020 include inviting four Alabama state representatives and three Alabama state senators to participate in a case discussion with Wiregrass Chapter leaders; creating and moderating a weekly check-in platform for the Alabama state hospital-medicine program directors' forum through the Wiregrass Chapter – a project that enabled him to encourage the sharing of information between hospital medicine program directors; and working with the other Wiregrass Chapter leaders to launch a poster competition on Twitter with more than 80 posters presented.

Hampton Roads Chapter embraces virtual connections

"I believe chapters are one of the best answers to the question: 'What's the value of joining SHM?'" Thomas Miller, MD, FHM, leader of the Hampton Roads Chapter, said in an interview.

"Sharing ideas and experiences with other hospitalist teams in a region, coordinating efforts to improve care, and the personal connection with others in your field are very important for hospitalists," he emphasized. "Chapters are uniquely



The SHM Hampton Roads (Va.) chapter won the 2020 Resiliency Award, one of the Chapter Excellence Exemplary Awards given by SHM.

positioned to do just that. Recognizing individual chapters is a great way to highlight these benefits and to promote new ideas – which other chapters can incorporate into their future plans."

The Hampton Roads Chapter demonstrated its resiliency in many ways during the challenging year of 2020, Dr. Miller said.

"We love our in-person meetings," he emphasized. "When 2020 took that away from us, we tried to make the most of the situation by embracing the reduced overhead of the virtual format to offer more specialized outreach programs, such as 'Cultural Context Matters: How Race and Culture Impact Health Outcomes' and 'Critical Care: Impact of Immigration Policy on U.S. Healthcare.'" The critical care and immigration program "was a great outreach to our many international physicians who have faced special struggles during COVID; it not only highlighted these issues to other hospitalists, but to the broader community, since it was a joint meeting with our local World Affairs Council," he added.

Dr. Miller also was impressed with the resiliency of other chapter members, such as vice president Gwendolyn Williams, MD, "who put together a provider well-being series, 'Hospitalist Well Being & Support in Times of Crisis.'" He expressed further appreciation for the multiple chapter members who supported the chapter's virtual resident abstract/poster competition.

"Despite the limitations imposed by 2020, we have used unique approaches that have held together a strong core group while broadening outreach to new providers in our region through programs like those described," said Dr. Miller. "At the same time, we have promoted hospital medicine to the broader community through a joint program, increased social media presence, and achieved cover articles in Hampton Roads Physician about hospital medicine and a 'Heroes of COVID' story featuring chapter members. We also continued our effort to add value by providing ready access to the newly state-mandated CME with 'Opiate Prescribing in the 21st Century.'"

"In a time when even family and close friends struggled to maintain connection, we found ways to offer that to our hospitalist teams, at the same time experimenting with new tools that we can put to use long after COVID is gone," Dr. Miller added.

Houston Chapter supports residents, provides levity

"As a medical community, we hope that the award recognition brings more attention to the issues for which our chapter advocates," Jeffrey W. Chen, MD, of the Houston Chapter and a hospitalist at Memorial Hermann Hospital Texas Medical Center, said in an interview.

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SHM's Center for Quality Improvement to partner on NIH grant

The Society of Hospital Medicine has announced that its award-winning Center for Quality Improvement will partner on the National Institutes of Health's National, Heart, Lung, and Blood Institute study, "The SIP Study: Simultaneously Implementing Pathways for Improving Asthma, Pneumonia, and Bronchiolitis Care for Hospitalized Children" (NIH R61HL157804). The core objectives of the planned 5-year study are to identify and test practical, sustainable strategies for implementing a multi-condition clinical pathway intervention for children hospitalized with asthma, pneumonia, or bronchiolitis in community hospitals.

Under the leadership of principal

investigator Sunitha Kaiser, MD, MSc, a pediatric hospitalist at the University of California, San Francisco, the study will employ rigorous implementation science methods and SHM's mentored implementation model.

"The lessons learned from this study could inform improved care delivery strategies for the millions of children hospitalized with respiratory illnesses across the U.S. each year," said Jenna Goldstein, chief of strategic partnerships at SHM and director of SHM's Center for Quality Improvement.

The team will recruit a diverse group of community hospitals in partnership with SHM, the Value in Inpatient Pediatrics Network

(within the American Academy of Pediatrics), the Pediatric Research in Inpatient Settings Network, America's Hospital Essentials, and the National Improvement Partnership Network. In collaboration with these national organizations and the participating hospitals, the team seeks to realize the following aims:

- **Aim 1 (Preimplementation).** Identify barriers and facilitators of implementing a multicondition pathway intervention and refine the intervention for community hospitals.
- **Aim 2a.** Determine the effects of the intervention, compared with control via chart reviews of children hospitalized with asthma, pneumonia, or bronchiolitis.
- **Aim 2b.** Determine if the core im-

plementation strategies (audit and feedback, electronic order sets, Plan-Do-Study-Act cycles) are associated with clinicians' guideline adoption.

"SHM's Center for Quality Improvement is a recognized partner in facilitating process and culture change in the hospital to improve outcomes for patients," said Eric E. Howell, MD, MHM, chief executive officer of SHM. "SHM is committed to supporting quality-improvement research, and we look forward to contributing to improved care for hospitalized pediatric patients through this study and beyond."

To learn more about SHM's Center for Quality Improvement, visit hospitalmedicine.org/qi.

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"We hope that it encourages more residents to pursue hospital medicine, and encourages early-career hospitalists to get plugged in to the incredible opportunities our chapter offers," he said. "We are so incredibly honored that the Society of Hospital Medicine has recognized the decade of work that has gone on to get to where we are now. We started with one officer, and we have worked so hard to grow and expand over the years so we can help support our fellow hospitalists across the city and state.



Dr. Chen

"We are excited about what our chapter has been able to achieve," said Dr. Chen.

"We united the four internal medicine residencies around Houston and created a Houston-wide Hospitalist Interest Group to support residents, providing them the resources they need to be successful in pursuing a career in hospital medicine. We also are proud of the support we provided this year to our early-career hospitalists, helping them navigate the transitions and stay up to date in topics relevant to hospital medicine. We held our biggest abstract competition yet, and held a virtual research showcase to celebrate the incredible clinical advancements still happening during the midst of the pandemic.

"It was certainly a tough and challenging year for all chapters, but despite us not being able to hold the in-person dinners that our members love so much, we were proud that we were able to have such a big year," said Dr. Chen. "We were thankful for the physicians who led our COVID-19 talks, which provided an opportunity for hospitalists across Houston to collaborate and share ideas on which treatments and therapies were working well for their patients. During such a difficult year, we also hosted our first wellness

events, including a comedian and band to bring some light during tough times."

Strong leader propels team efforts

"The Chapter Exemplary Awards Program is important because it encourages higher performance while increasing membership engagement and retaining talent," said Dr. Skandhan, of Southeast Health Medical Center in Dothan, Ala., and winner of the Most Engaged Chapter Leader award. "Being recognized as the most engaged chapter leader is an honor, especially given the national and international presence of SHM.

"Success is achieved through the help and support of your peers and mentors, and I am fortunate to have found them through this organization," said Dr. Skandhan. "This award brings attention to the fantastic work done by the engaged membership and leadership of the Wiregrass Chapter. This recognition makes me proud to be part of a team that prides itself on improving the quality health and well-being of the patients, providers, and public through innovation and collaboration; this is a testament to their work."

Dr. Skandhan's activities as a chapter leader included visiting health care facilities in the rural Southeastern United States. "I slowly began to learn how small towns and their economies tied into a health system, how invested the health care providers were toward their communities, and how health care disparities existed between the rural and urban populations," he explained. "When the COVID-19 pandemic hit, I worried about these hospitals and their providers. COVID-19 was a new disease with limited understanding of the virus, treatment options, and prevention protocols." To help smaller hospitals, the Wiregrass Chapter created a weekly check-in for hospital medicine program directors in the state of Alabama, he said.

"We would start the meeting with each participant reporting the total number of cases, ventilator usage, COVID-19 deaths, and one policy change they did that week to address a pressing issue," Dr. Skandhan said. "Over time the meetings helped address common challenges and were a source of physician well-being."

In addition, Dr. Skandhan and his chapter colleagues were concerned that academics were taking a back seat to the pandemic, so they rose to the challenge by designing a Twitter-based poster competition using judges from across the country. "This project was led by one of our chapter leaders, Dr. Arash Velayati of Southeast Health Medical Center," said Dr. Skandhan. The contest included 82 posters, and the participants were able to showcase their work to a large, virtual audience.

Dr. Skandhan and colleagues also decided to partner with religious leaders in their community to help combat the spread of misinformation about COVID-19. "We teamed with the Southern Alabama Baptist Association and Interfaith Council to educate these religious leaders on the issues around COVID-19," and addressed topics including masking and social distancing, and provided resources for religious leaders to tackle misinformation in their communities, he said.

"As chapter leaders, we need to learn to think outside the box," Dr. Skandhan emphasized. "We can affect health care quality when we strive to solve more significant problems by bringing people together, brainstorming, and collaborating. SHM and chapter-level engagement provide us with that opportunity. "Hospitalists are often affected by the downstream effects of limited preventive care addressing chronic illnesses. Therefore, we have to strive to see the bigger picture. As we make changes at our local institutions and chapter levels, we will start seeing the improvement we hope to see in the care of our patients and our communities."

Survey Insights

Mean leadership

The differences between the mean and median of leadership data

By Romil Chadha, MD, MPH, SFHM

Let me apologize for misleading all of you; this is not an article about malignant physician leaders; instead, it goes over the numbers and trends uncovered by the 2020 *State of Hospital Medicine* report (SoHM).¹ The hospital medicine leader ends up doing many tasks like planning, growth, collaboration, finance, recruiting, scheduling, onboarding, coaching, and most near and dear to our hearts, putting out the fires and conflict resolution.

Ratio of leadership FTE to physician hospitalists FTE

If my pun has already put you off, you can avoid reading the rest of the piece and go to the 2020 SoHM to look at pages 52 (Table 3.7c), 121 (Table 4.7c), and 166 (Table 5.7c). It has a newly added table (3.7c), and it is phenomenal; it is the ratio of leadership full-time equivalent to physician hospitalists FTE. As an avid user of SoHM, I always ended up doing a makeshift calculation to “guesstimate” this number. Now we have it calculated for us and the ultimate revelation lies in its narrow range across all groups. We might differ by region, employment type, academics, teaching, or size, but this range is relatively narrow.

The median ratio of leadership FTE to total FTE lies between 2% and 5% in pediatric groups and between 3% and 6% for most adult groups. The only two outliers are on the adult side, with less than 5 FTE and multistate management companies. The higher median for the less than 5 FTE group size is understandable because of the small number of hospitalist FTEs that the leader's time must be spread over. Even a small amount of dedicated leadership time will result in a high ratio of leader time to hospitalist clinical time if the group is very small.

The multistate management company is probably a result of multiple layers of physician leadership (for example, regional medical directors) and travel-related time adjustments. Still, it raises the question of why the local leadership is not developed to decrease the leadership cost and better access.

Another helpful pattern is the decrease in standard deviation with the increase in group size. The hospital medicine leaders and CEOs of the hospital need to watch this number closely; any extremes on high or low side would be indicators for a deep dive in leadership structure and health.

Total number and total dedicated FTE for all physician leaders

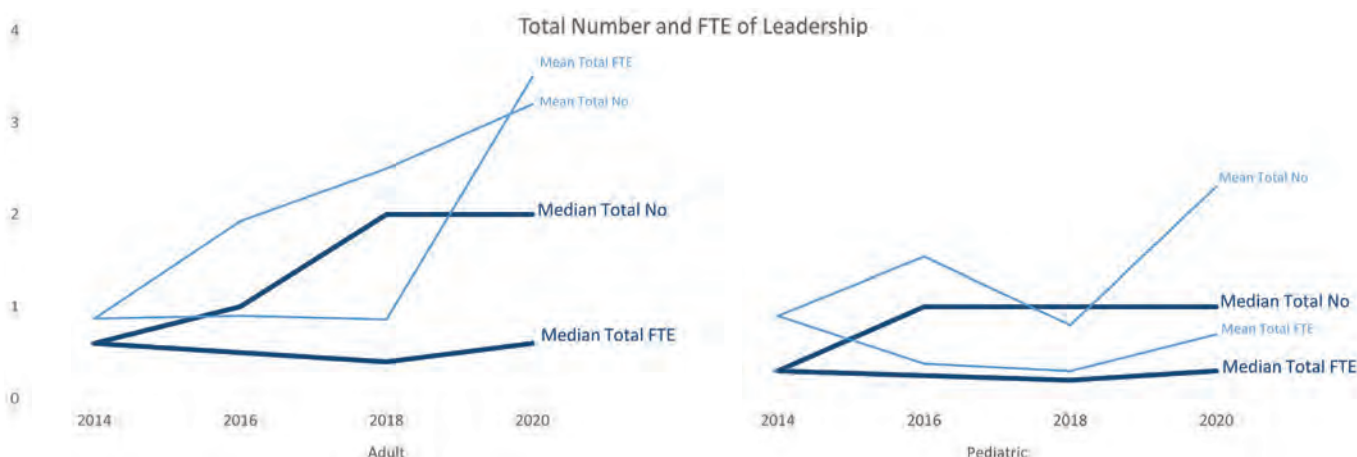
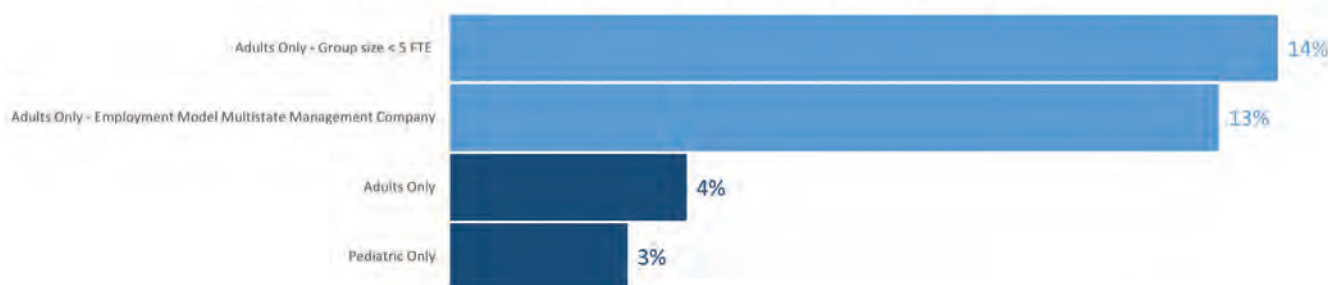
Once we start seeing the differences between the mean and median of leadership data, we can see the median is relatively static while the mean has increased year after year and took a big jump in the 2020 SoHM. The chart below shows trends for the number of individuals in leadership positions (“Total No” and total FTEs allocated to leadership (“Total FTE”) over the last several surveys. The data are heavily skewed toward



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Median - Ratio of Leadership FTE to Physician Hospitalists FTE



2020 SHM STATE OF HOSPITAL MEDICINE REPORT

the right (positive); so, it makes sense to use the median in this case rather than mean. A few factors could explain the right skew of data.

- Large groups of 30 or more hospitalists are increasing, and so is their leadership need.
- There is more recognition of the need for dedicated leadership individuals and FTE.
- The leadership is getting less concentrated among just one or a few leaders.
- Outliers on the high side.
- Lower bounds of 0 or 0.1 FTE.

Highest-ranked leader dedicated FTE and premium compensation

Another pleasing trend is an increase in dedicated FTE for the highest-paid leader. Like any skill-set development, leadership requires the investment of deliberate practice, financial acumen, negotiation skills, and increased vulnerability. Time helps way more in developing these skill sets than money. SoHM trends show increase in dedicated FTE for the highest physician leader over the years and static premium compensation.

At last, we can say median leadership is always better than “mean” leadership in skewed data. Every group needs leadership, and SoHM offers a nice window into trends in leadership amongst many practice groups. It is a valuable resource for every group.

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Future Hospitalist

Embedding diversity, equity, inclusion, and justice in hospital medicine

A road map for success

By Andrew Delapenha, MD, MPH; Flora Kisuule, MD, MPH; Shannon K. Martin, MD, MS; Eileen Barrett, MD, MPH

The language of equality in America's founding was never truly embraced, resulting in a painful legacy of slavery, racial injustice, and gender inequality inherited by all generations. However, for as long as America has fallen short of this unfulfilled promise, individuals have dedicated their lives to the tireless work of correcting injustice. Although the process has been painstakingly slow, our nation has incrementally inched toward the promised vision of equality, and these efforts continue today. With increased attention to social justice movements such as #MeToo and Black Lives Matter, our collective social consciousness may be finally waking up to the systemic injustices embedded into our fundamental institutions.

Medicine is not immune to these injustices. Persistent underrepresentation of women and minorities remains in medical school faculty and the broader physician workforce, and the same inequities exist in hospital medicine.¹⁻⁶ The report by the Association of American Medical Colleges on diversity in medicine highlights the impact widespread implicit and explicit bias has on creating exclusionary environments, exemplified by research demonstrating lower promotion rates in non-White faculty.^{7,8} The report calls us, as physicians, to a broader mission: "Focusing solely on increasing compositional diversity along the academic continuum is insufficient. To effectively enact institutional change at academic medical centers ... leaders must focus their efforts on developing inclusive, equity-minded environments."⁷

We have a clear moral imperative to correct these shortcomings for our profession and our patients. It is incumbent on our institutions and hospital medicine groups to embark on the necessary process of systemic institutional change to address inequality and justice within our field.

A road map for DEI and justice in hospital medicine

The policies and biases allowing

these inequities to persist have existed for decades, and superficial efforts will not bring sufficient change. Our institutions require new building blocks from which the foundation of a wholly inclusive and equal system of practice can be constructed. Encouragingly, some institutions and hospital medicine groups have taken steps to modernize their practices. We offer examples and suggestions of concrete practices to begin this journey, organizing these efforts into three broad categories:

1. Recruitment and retention
2. Scholarship, mentorship, and sponsorship
3. Community engagement and partnership.

Recruitment and retention

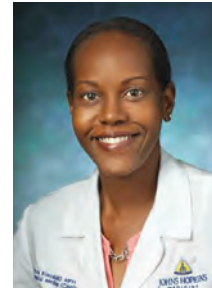
Improving equity and inclusion begins with recruitment. Search and hiring committees should be assembled intentionally, with gender balance, and ideally with diversity or equity experts invited to join. All members should receive unconscious bias training. For example, the University of Colorado utilizes a toolkit to ensure appropriate steps are followed in the recruitment process, including predetermined candidate selection criteria that are ranked in advance.

Job descriptions should be reviewed by a diversity expert, ensuring unbiased and ungendered language within written text. Advertisements should be wide-reaching, and the committee should consider asking applicants for a diversity statement. Interviews should include a variety of interviewers and interview types (e.g., 1:1, group). Letters of recommendation deserve special scrutiny; letters for women and minorities may be at risk of being shorter and less record focused, and may be subject to less professional respect, such as use of first names over honorifics or titles.

Once candidates are hired, institutions and HMGs should prioritize developing strategies to improve retention of a diverse workforce. This includes special attention to workplace culture, and thoughtfully striving for cultural intelligence within the group. Some examples may include developing affinity



Dr. Delapenha



Dr. Kisuule



Dr. Martin



Dr. Barrett

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groups, such as underrepresented in medicine (UIM), women in medicine (WIM), or LGBTQ+ groups. Affinity groups provide a safe space for members and allies to support and uplift each other. Institutional and HMG leaders must educate themselves and their members on the importance of language (see table, p. 9), and the more insidious forms of bias and discrimination that adversely affect workplace culture. Microinsults and microinvalidations, for example, can hurt and result in failure to recruit or turnover.

Conducting exit interviews when any hospitalist leaves is important to learn how to improve, but holding "stay" interviews is mission critical. Stay interviews are an opportunity for HMG leaders to proactively understand why hospitalists stay, and what can be done to create more inclusive and equitable environments to retain them. This process creates psychological safety that brings challenges to the fore to be addressed, and spotlights best practices to be maintained and scaled.

Scholarship, mentorship, and sponsorship

Women and minorities are known to be over-mentored and under-sponsored. Sponsorship is defined by Ayyala et al. as "active support by someone appropriately placed in the organization who has significant influence on decision making processes or structures and who is advocating for the career advancement of an individual and recommends them for leadership roles, awards, or high-profile speaking

opportunities."⁹ While the goal of mentorship is professional development, sponsorship emphasizes professional advancement. Deliberate steps to both mentor and then sponsor diverse hospitalists and future hospitalists (including trainees) are important to ensure equity.

More inclusive HMGs can be bolstered by prioritizing peer education on the professional imperative that we have a diverse workforce and equitable, just workplaces. Academic institutions may use existing structures such as grand rounds to provide education on these crucial topics, and all HMGs can host journal clubs and professional development sessions on leadership competencies that foster inclusion and equity. Sessions coordinated by women and minorities are also a form of justice, by helping overcome barriers to career advancement. Diverse faculty presenting in educational venues will result in content that is relevant to more audience members and will exemplify that leaders and experts are of all races, ethnicities, genders, ages, and abilities.

Groups should prioritize mentoring trainees and early-career hospitalists on scholarly projects that examine equity in opportunities of care, which signals that this science is valued as much as basic research. When used to demonstrate areas needing improvement, these projects can drive meaningful change. Even projects as straightforward as studying diversity in conference presenters, disparities in adherence to guidelines, or quality improvement projects on how race is portrayed in

the medical record can be powerful tools in advancing equity.

A key part of mentoring is training hospitalists and future hospitalists in how to be an upstander, as in how to intervene when a peer or patient is affected by bias, harassment, or discrimination. Receiving such training can prepare hospitalists for these nearly inevitable experiences and receiving training during usual work hours communicates that this is a valuable and necessary professional competency.

Community engagement and partnership

Institutions and HMGs should deliberately work to promote community engagement and partnership within their groups. Beyond promoting health equity, community engagement fosters inclusivity by allowing community members to share their ideas and give recommendations to the institutions that serve them.

There is a growing body of literature that demonstrates how disadvantages by individual and neighborhood-level socioeconomic status (SES) contribute to disparities in specific disease conditions.^{10,11} Strategies to narrow the gap in SES disadvantages may help reduce race-related health disparities. Institutions that engage the community and develop programs to promote health equity can do so through bidirectional exchange of knowledge and mutual benefit.

An institution-specific example is Medicine for the Greater Good at Johns Hopkins. The founders of this program wrote, “health is not synonymous with medicine. To truly care for our patients and their communities, health care professionals must understand how to deliver equitable health care that meets the needs of the diverse populations we care for. The mission of Medicine for the Greater Good is to promote health and wellness beyond the confines of the hospital through an interactive and engaging partnership with the community ...” Community engagement also provides an opportunity for growing the cultural intelligence of institutions and HMGs.

Tools for advancing comprehensive change – Repurposing PDSA cycles

Whether institutions and HMGs are at the beginning of their journey or further along in the work of reducing disparities, having a systematic approach for implementing and refining policies and procedures can cultivate more inclusive and equitable environments. Thankfully,

hospitalists are already equipped with the fundamental tools needed to advance change across their institutions – QI processes in the form of Plan-Do-Study-Act (PDSA) cycles.

They allow a continuous cycle of successful incremental change based on direct evidence and experience. Any efforts to deconstruct systematic bias within our organizations must also be a continual process. Our female colleagues and colleagues of color need our institutions to engage unceasingly to bring about the equality they deserve. To that end, PDSA cycles are an apt tool to utilize in this work as they can naturally function in a never-ending process of improvement.

With PDSA as a model, we envision a cycle with steps that are intentionally purposed to fit the needs of equitable institutional change: Target-Engage-Assess-Modify. These modifications ensure that stakeholders (i.e., those that unequal practices and policies affect

the most) are engaged early and remain involved throughout the cycle (for a PDSA graphic, see the online version of this article at the-hospitalist.org).

As hospitalists, we have significant work ahead to ensure that we develop and maintain a diverse, equitable, and inclusive workforce. This work to bring change will not be easy and will require a considerable investment of time and resources. However, with the strategies and tools that we have outlined, our institutions and HMGs can start the change needed in our profession for our patients and the workforce. In doing so, we can all be accomplices in the fight to achieve racial and gender equity, and social justice.

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Foundational Terminology	
Term	Definition
Accomplice(s)	An individual/group that is complicit, through action, in the struggle to advance social equity and justice for marginalized groups with a focus on deconstructing systemic barriers that lead to oppression. Not to be confused with the term ally.
Ally	An individual who is willing to support marginalized individuals/groups but often only when little personal (professional, social, economic, etc.) risk is involved.
Anti-Racism	Purposeful action taken against racist behaviors, systemic racism, and the oppression of marginalized groups.
Cultural Intelligence (CQ)	The ability to distinguish between behaviors that are common to all human beings, common to a culture, and unique to an individual.
Diversity	The condition of having or being composed of different elements.
Diversity Statement	Statements from applicants highlighting what kind of diversity their prior experiences will bring to the institution.
Equity	The commitment to fair treatment, opportunity, and advancement of all people through the identification and elimination of barriers that hinder full and equal participation in society.
Inclusion	A relation between two classes that exists when all members of the first are also members of the second.
Justice	The morally right and fair treatment of people.
Microaggressions	The subtle, intentional, and unintentional behaviors that communicate some sort of bias. Microassaults, microinsults, and microinvalidations are types of microaggressions.
Microassault	Explicit and conscious communication with the intent to hurt (e.g., name calling such as colored).
Microinsult	Subtle and often unconscious communication that demeans a person's racial heritage or identity; no intent to hurt (e.g., an African being complimented for speaking English well).
Microinvalidations	Communication that subtly exclude or undermines the thoughts, feelings, and experiences of an individual or group of people (e.g., An African American being told they were being overly sensitive about a comment they found racist).

DR. DELAENVA, DR. KISUUE, DR. MARTIN, AND DR. BARRETT

As common respiratory viruses resurface, children are at serious risk

By Jaleesa Baulkman

Younger children may be vulnerable to the reemergence of common respiratory viruses such as influenza and respiratory syncytial virus (RSV) as COVID-19 restrictions wane, experts say. The impact could be detrimental.

The COVID-19 pandemic and the implementation of preventative measures such as social distancing, travel restrictions, mask use, and sheltering in place, reduced the transmission of respiratory viruses, according to the Centers for Disease Control and Prevention. However, because older infants and toddlers have not been exposed to these bugs during the pandemic, they are vulnerable to suffering severe viral infections.

“[We’ve] been in the honeymoon for 18 months,” said Christopher J. Harrison, MD, professor of pediatrics and pediatric infectious diseases at Children’s Mercy Hospitals and Clinics in Kansas City, Mo. “We are going to be coming out of the honeymoon and the children who didn’t get sick are going to start packing 2 years’ worth of infections into the next 9 months so there’s going to be twice as many as would be normal.”

The CDC issued a health advisory in June for parts of the southern United States, such as Texas, the Carolinas, and Oklahoma, encouraging broader testing for RSV – a virus that usually causes mild, cold-like symptoms and is the most common cause of bronchiolitis and pneumonia in children – among those who test negative for COVID-19. Virtually all children get an RSV infection by the time they are 2 years old, according to the CDC.

In previous years, RSV usually spread during

the fall and spring seasons and usually peaked late December to mid-February. However, there’s been an offseason spike in the common illness this year, with nearly 2,000 confirmed cases each week of July.

Richard J. Webby, PhD, of the infectious diseases department at St. Jude Children’s Research Hospital, Memphis, said that, although RSV transmits more easily during the winter, the virus is able to thrive during this summer because many children have limited immunity and are more vulnerable to catching the virus than before. Population immunity normally limits a virus to circulating under its most favorable conditions, which is usually the winter. However, because there are a few more “susceptible hosts,” it gives the virus the ability to spread during a time when it typically would not.

“Now we have a wider range of susceptible kids because they haven’t had that exposure over the past 18 months,” said Dr. Webby, who is on the World Health Organization’s Influenza Vaccine Composition Advisory Team. “It gives the virus more chances to transmit during conditions that are less favorable.”

Dr. Harrison said that, if children continue to take preventative measures such as wearing masks and sanitizing, they can delay catching the RSV – which can be severe in infants and young children – until they’re older and symptoms won’t be as severe.

“The swelling that these viruses cause in the trachea and the bronchial tubes is much bigger in proportion to the overall size of the tubes, so it takes less swelling to clog up the trachea or bronchial tube for the 9-month-old than it does of a 9-year-old,” Dr. Harrison said. “So if a 9-year-old

was to get RSV, they’re not going to have nearly the same amount of symptoms as the 9-month-old.

Dr. Harrison said delaying RSV in children was never an option before because it’s a virus that’s almost impossible to avoid.

“Hopefully, the mask means that if you get exposed, instead of getting a million virus particles from your classmate or your playmate, you may only get a couple thousand,” Dr. Harrison explained. “And maybe that’s enough that you can fight it off or it may be small enough that you get a mild infection instead of a severe infection.”

A summer surge of RSV has also occurred in Australia. A study published in *Clinical Infectious Diseases* (2020 Sep 24. doi: 10.1093/cid/ciaa1475) found that Western Australia saw a 98% reduction in RSV cases. This suggests that COVID-19 restrictions also delayed the RSV season.

Dr. Webby said the lapse in preventive measures against COVID-19 may also affect this upcoming flu season. Usually, around 10%-30% of the population gets infected with the flu each year, but that hasn’t happened the past couple of seasons, he said.

Although a severe influenza season rebound this winter is a possibility, Australia continues to experience a historically low flu season. Dr. Harrison, who said the northern hemisphere looks at what’s happening in Australia and the rest of the “southern half of the world because their influenza season is during our summer,” hopes this is an indication that the northern hemisphere will also experience a mild season.

However, there’s no indication of how this upcoming flu season will hit the United States and there isn’t any guidance on what could happen because these historically low levels of respiratory viruses have never happened before, Dr. Webby explained.



Dr. Harrison

Bronchitis the leader at putting children in the hospital

By Richard Franki

MDedge News

More children admitted to hospitals in 2018 had acute bronchitis than any other diagnosis, according to a recent report from the Agency for Healthcare Research and Quality.

About 7% (99,000) of the 1.47 million nonmaternal, nonneonatal hospital stays in children aged 0-17 years involved a primary diagnosis of acute bronchitis in 2018, representing the leading cause of admissions in boys (154.7 stays per 100,000 population) and the second-leading diagnosis in girls (113.1 stays per 100,000), Kimberly W. McDermott, PhD, and Marc Roemer, MS, said in a statistical brief.

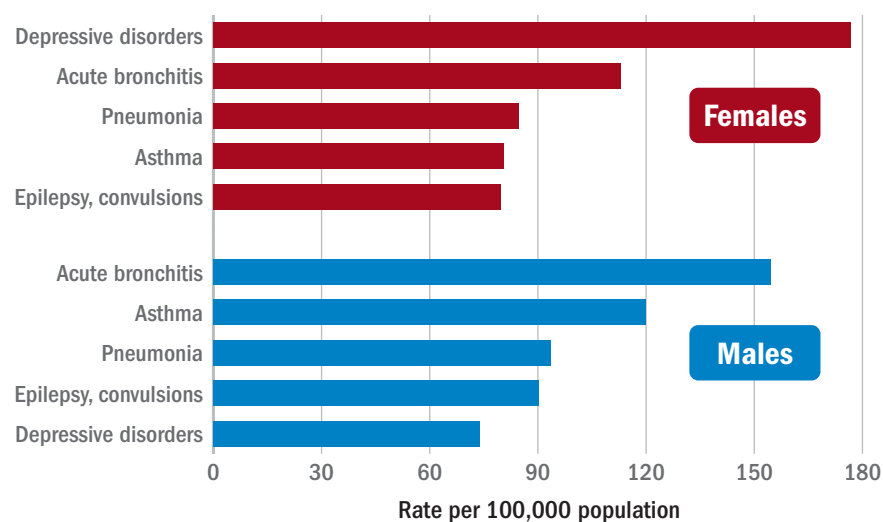
Depressive disorders were the

most common primary diagnosis in girls, with a rate of 176.7 stays per 100,000, and the second-leading diagnosis overall, although the rate was less than half that (74.0 per 100,000) in boys. Two other respiratory conditions, asthma and pneumonia, were among the top five for both girls and boys, as was epilepsy, they reported.

The combined rate for all diagnoses was slightly higher for boys, 2,051 per 100,000 vs. 1,922 for girls, based on data from the National Inpatient Sample.

“Identifying the most frequent primary conditions for which patients are admitted to the hospital is important to the implementation and improvement of health care delivery, quality initiatives, and health policy,” said Dr. McDermott, IBM Watson Health.

Top five principal diagnoses for inpatient stays, ages 0-17 years



Note: Based on 2018 National Inpatient Sample data for nonneonatal, nonmaternal admissions.

Source: Agency for Healthcare Research and Quality

Early heparin treatment linked to lower COVID-19 mortality

By Tara Haelle

Early treatment with low-molecular-weight heparin (LMWH) reduces the risk for death in patients with COVID-19, a retrospective cohort study shows.

Heparin could reduce the risk for blood clots, Andrea De Vito, MD, of the unit of infectious diseases at the University of Sassari (Italy) said during his online presentation of the findings at the 31st European Congress of Clinical Microbiology & Infectious Diseases.

“Several studies try to describe the role played by coagulopathies in COVID-19 death,” but the mechanism causing them is still unclear, Dr. De Vito explained.

Some guidelines have suggested heparin as a treatment for hospitalized COVID-19 patients, but few have looked at nonhospitalized patients. In fact, the National Institutes of Health discourages the use of heparin in nonhospitalized

COVID-19 patients, and guidance for the home care of COVID-19 patients from the World Health Organization doesn't mention heparin treatment at all, he said.

To examine the benefits of early heparin – whether administered at home or in the hospital – Dr. De Vito and colleagues looked at a cohort of older adults with COVID-19 who were evaluated or treated at an Italian university hospital.

“Some patients were hospitalized immediately after symptoms onset; other people preferred to call their general practitioner and started the treatment at home,” Dr. De Vito said. “Other people were hospitalized for worsening of symptoms later in the course of the disease.”

Of the 734 patients, 296 received heparin within 5 days of the onset of symptoms or a positive COVID-19 test. Of the remaining 438 patients, 196 received LMWH treatment later during the disease course, and the rest never received LMWH.

All patients who received early

heparin were treated with LMWH 4,000 IU, or 6,000 IU if their body mass index was above 30 kg/m². This was reduced to 2,000 IU if estimated glomerular filtration rate (eGFR) dropped below 30 mL/min. None of the patients had previously received heparin.

Median age was slightly younger for patients who received early heparin than for those who did not (76.8 vs. 78.5 years).

Other demographic characteristics, such as sex and body mass index, were similar in the two groups, as were rates of comorbidities, such as hypertension, cardiovascular disease, diabetes, chronic obstructive pulmonary disease, kidney disease, and neurologic conditions. Also similar were the frequency of symptoms (such as fever, cough, and shortness of breath) and rates of treatment with remdesivir or steroids.

Rates of hospital admission were not significantly different between patients who received early heparin and those who did not (65% vs.

61%). There was also no significant difference in use of a venturi mask (35% vs. 28%), noninvasive ventilation (13% vs. 14%), or intubation (5% vs. 8%).

However, rates of death were significantly lower in patients who received early heparin than in those who did not (13% vs. 25%; $P < .0001$).

There was a trend toward shorter hospital stays for patients treated with early heparin, but the difference was not significant (median, 10 vs. 13 days; $P = .08$).

Researchers also conducted a separate analysis of 219 COVID-19 patients who received LMWH at home, regardless of when during their disease course they received it. These patients were significantly less likely to be hospitalized than were patients who did not receive LMWH at home (odds ratio, 0.2; $P < .0001$).

Comparatively, early heparin treatment had a greater effect on the risk for death and the risk for hospitalization than did other factors.

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Ivonne Marie Peña, MD
SHM Member - 6 years

“Reflecting over the past decade of practicing medicine, I have a great appreciation for the immense responsibility and influence our words and actions carry. It is our duty to create an environment centered around empathy. Empathic listening allows us to learn about our patients and understand the key events that led to their hospitalization. In Puerto Rico, we value hospitality, respect, and empathy in an unrushed spirit. Patients are immediately receptive to a clinician who genuinely listens to their concerns. Being present for patients has always felt organic.”

– Ivonne Marie Peña, MD

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Patient experience

Continued from page 1

COVID-19 to experience many of the same restrictions imposed by the pandemic.

“A lot of the care hospitalists provide involves touch, sitting down, and looking at the patient eye to eye, on the same level,” said Dr. Patel, a practicing hospitalist at Frederick (Md.) Health Hospital. “That had to take a back seat to infection control.”

Meanwhile, lengths of stay were longer for patients with COVID-19, who were often very sick and alone in their hospital rooms for prolonged periods, sometimes on mechanical ventilation, isolated without the support of their families. Health care providers tried to minimize time spent at the bedside because of viral exposure risks. Nobody really knew how to treat patients’ severe respiratory distress, especially at first. “So we basically threw the kitchen sink at it, following the evolving [Centers for Disease Control and Prevention] guidelines, and hoped it would work,” he explained.

“When we saw our patient experience scores plummeting across the division, we said, ‘This is not good.’ We could see that we weren’t spending as much time at the bedside, and our patients were lonely and scared.” There was also greater fragmentation of care, all of which impacted patients’ experience in partnering hospitals.

Dr. Patel and his team spearheaded a number of processes across their partner hospitals to help patients and their families get the information they needed and understand what was happening during their treatment. “At that moment, real-time feedback was essential,” he explained. “We implemented the TED protocol – Teach back, Empathy, and ‘Double-backing,’ which means spending a shorter visit on morning rounds but going back to the patient’s bedside for a second daily visit at the end of the shift, thereby establishing a second touch point.” Teach back is a strategy of asking patients to repeat back in their own words what they understood the doctor to be saying about their care.

The group developed ID buttons – called “Suttons” or Sound Buttons – with a larger picture of the doctor’s smiling face pinned to their medical gowns. The hospitalists started scheduling Zoom calls with families from the ICU rooms of COVID-19 patients. “We employ clinical performance nurses as collaborative influencers. They visit patients’ bedsides and work with staff on improving patient experience,” Dr. Patel said. “And we printed thank-you cards with the doctor’s name, photo, and an individualized message for their patients.” Together these techniques measurably improved patient experience scores across partnering hospitals.

What is patient experience?

Evaluated by the Agency for Healthcare Research and Quality and endorsed by the National Quality Forum, HCAHPS hospital quality surveys ask patients (or their family members, who may be the ones completing the survey) 29 well-tested questions about the recent hospital stay and how they experienced it. Nineteen of those questions explore critical aspects of the patient’s experience

in areas such as communication, responsiveness of staff, information about their diagnosis, medications, and discharge – and if they would recommend the hospital to others.

Surveys can be done by mail, phone, or interactive voice recognition and are offered in seven different languages. They can be administered by the hospital itself or by an approved survey vendor. They are sent between 48 hours and 6 weeks after the patient’s hospital discharge.

Nationwide results from HCAHPS survey have been published since 2008 in a searchable, comparable format on the consumer-focused government website Hospital Compare (<https://tinyurl.com/8dhr8b7m>). The data have been used in a value-based incentive purchasing program since 2012. Hospital Compare also incorporates measures of quality such as mortality, readmission, and hospital-acquired infection rates as well as process measures such as how well facilities provide recommended care.

Starting in 2016, overall hospital quality has been encapsulated in a Star rating, which summarizes a variety of measures across seven areas of quality into a single number from one to five for each hospital. One of those seven areas is patient experience.

Hospitals may choose to ask additional questions of their own along with the HCAHPS survey, to gather additional, actionable quality data for internal purposes. Internal surveys with results closer to real time, instead of the months-to-years lag in posting HCAHPS scores, enable the hospital to respond to issues that emerge.

It’s not just the scores

“A lot of leaders in the hospital business will tell you ‘It’s not about the scores,’” Dr. Patel related. “But you need scores to tell how your practice is doing. It’s a testament to the kind of care you are providing as a hospital medicine program. These are important questions: Did your doctor listen to you, communicate in ways you understood, and treat you with courtesy?” Scores are scores, he said, but more importantly, are patients getting the information they need? Do they understand what’s going on in their care?

“You have to look at the scores and ask, what can we do differently to impact patient experience? What are we doing wrong? What can we do better? If the scores as a collective experience of hospitalized patients are plummeting, it must mean they’re not feeling good about the care they are receiving, and not recognizing what we’re trying to do for them.”



Hospitalists at Frederick (Md.) Health Hospital created “thank you” cards that they gave to patients at the end of their stays.

Declining HCAHPS scores last year could easily be explained by what was going on with COVID-19, Dr. Patel said. “But we want our patient experience to be seamless. We have to put ourselves in the patient’s shoes. For them, it’s about whether they felt they were treated well or not. We had to reinvent ourselves and find new ways to compensate for the limitations imposed by the pandemic,” he said.

“We also recognized that our No. 1 job as a group is to take care of our doctors, so that they can take care of their patients. We provided quarantine pay, implemented a buddy system for doctors, used CME dollars to pay for COVID education, and if they felt ill, we said they needed to stay home, while we paid their shift anyway,” he said. “When you do that kind of thing and engage them in your mission, frontline hospitalists can help to improve quality of care, decrease costs, and increase patient safety.”

A sacred encounter

For Sarah Richards, MD, a hospitalist with Nebraska Medicine in Omaha, what happens in the hospital room between the hospitalist and the patient is a sacred encounter.

“It’s about relationship and trust,” she said, noting that it’s hard to capture all of that in survey data. It might be better expressed in words: “‘How are things going for you?’ To me, that’s the real patient experience. When I talk with physicians about patient experience, I start with why this matters.

We know, for example, that when patients trust us, they are more likely to engage with their care and adhere to the treatment plan.”

Dr. Richards said standard hospital quality surveys can be a blunt tool. The HCAHPS survey, conducted around a week after the hospitalization, has a low response rate, and returns are not representative of the demographic served in the hospital. “The inpatient data are not always helpful, but this is what we have to work with. One choice hospitals have is for the leadership to choose not to use the data for individual bonuses, recognition, or discipline, since the questions ask patients about the care they received collectively from all of their doctors,” she said.

But as hospitalists have worked longer shifts under more stress while wearing PPE – which makes it harder to communicate with their patients – there is a dynamic that has emerged, which deserves more study. “I think doctors gave it their all in the pandemic. I’m a hospitalist, and people told me I’m a hero. But did that change my impact at work (on patient experience)?” she said.

Dr. Richards sits on SHM’s Patient Experience Special Interest Group (SIG), which was tasked with providing tools to help mitigate the effects of the pandemic. These include a fact sheet, “Communication Tips for 5 Common Conundrums in the COVID-19 Pandemic” (<https://tinyurl.com/dakvbtza>), and a downloadable pocket

Continued on following page

Tachycardia may be distinct marker for long COVID

By Marcia Frellick

Tachycardia is commonly reported in patients with post-acute COVID-19 syndrome (PACS), also known as long COVID, authors report in a new article. The researchers say tachycardia syndrome should be considered a distinct phenotype.

The study by Marcus Ståhlberg, MD, PhD, of Karolinska University Hospital, Stockholm, and colleagues was published online in *The American Journal of Medicine* (2021. doi: 10.1016/j.amjmed.2021.07.004).

Dr. Ståhlberg said that, although

much attention has been paid to cases of clotting and perimyocarditis in patients after COVID, little attention has been paid to tachycardia, despite case reports that show palpitations are a common complaint.

“We have diagnosed a large number of patients with postural orthostatic tachycardia syndrome [POTS] and other forms of COVID-related tachycardia at our post-COVID outpatient clinic at Karolinska University Hospital and wanted to highlight this phenomenon,” he said.

Between 25% and 50% of patients at the clinic report tachycardia and/or palpitations that last 12 weeks or

longer, the authors report.

“Systematic investigations suggest that 9% of post-acute COVID-19 syndrome patients report palpitations at six months,” the authors write.

The findings also shed light on potential tests and treatments, he said.

“Physicians should be liberal in performing a basic cardiological workup, including an ECG, echocardiography, and Holter ECG monitoring in patients complaining of palpitations and/or chest pain,” Dr. Ståhlberg said.

“If orthostatic intolerance is also reported – such as vertigo, nausea, dyspnea – suspicion of POTS should

be raised and a head-up tilt test or at least an active standing test should be performed,” he said.

If POTS is confirmed, he said, patients should be offered a heart rate-lowering drug, such as low-dose propranolol or ivabradine. Compression garments, increased fluid intake, and a structured rehabilitation program also help.

Researchers think the mechanism underlying the tachycardia is autoimmune and that primary SARS-CoV-2 infections trigger formation of autoantibodies that can activate receptors regulating blood pressure and heart rate.

Continued from previous page

card (<https://tinyurl.com/22b2xrze>) called “The 5 Rs of Cultural Humility.”

Also on the SIG is Mark Rudolph, MD, SFHM, Sound Physicians’ chief experience officer, whose job title reflects a growing, systematic attention to patient experience in U.S. hospitals. “Most clinicians are familiar with the surveys and the results of those surveys,” he said. “People in our field can get frustrated with the surveys, and have a lot to say about the quality of the scores themselves – what is actually being measured. Is the patient upset because the coffee was cold, or due to a bad clinical experience? Is it about the care they received from the hospitalist, or the physical setting of the hospital?”



Dr. Rudolph

Doing the right thing

To be a patient hospitalized with an acute illness is a form of suffering, Dr. Rudolph said. “We know patient experience in the hospital since March of 2020 has been frightening and horrible. These people are as sick as can be. Everything about the experience is horrible. Every effort you can make to reduce that suffering is important. If you are a patient in the hospital and don’t know what’s happening to you, that’s terrifying.”

He encourages hospitalists to look beyond the scores or the idea that they are just trying to improve their scores. “Look instead at the actual content of the questions around communication. The competencies addressed in the survey questions – listening and explaining things clearly, for example – are effective guides for patient experience improvement efforts. You can be confident you’re doing the right thing for the patient by focusing on these skills, even if you don’t see immediate changes in survey scores.”

Hospitals that did not allow visitors had worse clinical outcomes and patient experience ratings, and recent research confirms that, when family visitors are not allowed, outcomes are worse in areas such as patient ratings of medical staff re-

sponsiveness, fall rates, and sepsis rates.¹ “None of that should be surprising. Not having family present just ups the ante. Any hospital patients could benefit from an advocate sitting next to them, helping them to the bathroom, and keeping them from falling out of bed,” Dr. Rudolph said.

“In the past year, we have placed a premium on communicating with these patients with kindness and compassion, to help them understand what’s happening to them,” he said. Out of necessity, hospitals have had to rejigger their processes, which has led to more efficient and better care, although the jury is still out on whether that will persist post pandemic.

Communicating with compassion

Swati Mehta, MD, a hospitalist at Sequoia Hospital in Redwood City, Calif., and director of quality and performance and patient experience at Vituity, a physician-owned and -led multispecialty partnership, said COVID-19 was a wake-up call for hospitalists. There have been successful models for enhancing hospitalized patients’ experience, but it took the challenges of COVID-19 for many hospitalists to adopt them.

“Early in 2020, our data analysis showed emerging positive trends, reflecting our patients’ appreciation for what doctors were doing in the crisis and awareness of the challenges they faced. But after that uptick, global measures and national data showed drops for health care organizations and providers. Patients’ expectations were not being met. We needed to respond and meet patients where they were at. We needed to do things differently,” she said.

Keeping patients well informed and treating them with respect are paramount – and more important than ever – as reflected in Dr. Mehta’s “6H” model to promote a human connection between doctors and patients.² As chair of SHM’s Patient Experience SIG, she led the creation of COVID-19-specific communication tips for hospitalists based on the 6H model.

“I’m very committed to treating patients with compassion,” she said.

For Vituity, those approaches included making greater use of the hospital at home model for

patients who reported to the emergency department but met certain criteria for discharge. They would be sent home with daily nursing visits and 24-hour virtual access to hospitalists. Vituity hospitalists also worked more closely with emergency departments to provide emergency psychiatric interventions for anxious patients, and with primary care physicians. Patient care navigators helped to enhance transitions of care. In addition, their hospitalist team added personalized pictures over their gowns so patients could see the hospitalists’ faces despite PPE.

Another Vituity innovation was virtual rounding, with iPads in the patient’s room and the physician in another room. “I did telerrounds at our Redwood City hospital with patients with COVID who were very lonely, anxious, and afraid because they couldn’t have family visitors,” Dr. Mehta said. Telerrounds offered greater protection and safety for both providers and patients, reduced the need for PPE, and improved collaboration with the nursing team, primary care providers, and families.

A recent perspective published in the *New England Journal of Medicine* suggests that the Zoom family conference may offer distinct advantages over in-person family conferences.³ It allows for greater participation by primary care clinicians who knew the patient before the current hospitalization and thus might have important contributions to discharge plans.

The pandemic stimulated many hospitals to take a closer look at all areas of their service delivery, Dr. Rudolph concluded. “We’ve made big changes with a lot of fearlessness in a short amount of time, which is not typical for hospitals. We showed that the pace of innovation can be faster if we lower the threshold of risk.”

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Top 10 things to know about the AHA ACLS 2020 updates

Plus, how things differ in a COVID-19 cardiac arrest case

By Jessica Nave Allen, MD, FHM

Here are the most important take-aways from the 2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.¹

1 There were no changes to the 2015 cardiac arrest algorithms.

2 The 2020 adult bradycardia algorithm increased the atropine dose to 1 mg (from 0.5-1 mg) but maintains the same frequency of dosing as every 3-5 minutes with max dose of 3 mg.

3 Epinephrine was reaffirmed. Specifically, give epinephrine as soon as possible in nonshockable rhythms (pulseless electrical activity and asystole). In shockable rhythms (ventricular fibrillation and pulseless ventricular tachycardia), the timing is

less clear but it is reasonable to give the first dose after initial defibrillation attempts have failed. Currently the shockable rhythms algorithm has the first dose of epinephrine given after the second shock.

4 Giving medications intravenously is preferred over intraosseous (IO) cannulation because of some small observational studies that showed worsened outcomes with IO delivery. Try to get an IV if possible, but can still use IO if necessary. Central venous catheters are still not recommended during a code unless no other access can be obtained.

5 Double sequential defibrillation in refractory VF, which is the application of two sets of pads using two defibrillators to provide defibrillation either in rapid succession or at the same time, is not recommended because of lack of evidence.

6 It is reasonable to use physiological parameters such as arterial blood pressure or end-tidal CO₂ (EtCO₂) to monitor CPR quality. Goal EtCO₂ is greater than 10 but ideally greater 20 mm Hg, so if you're not reaching that ideal goal, push harder and/or faster! Of note, to use arterial blood pressure monitoring you must have an arterial line in place and to get adequate EtCO₂ monitoring, the patient must be intubated with an EtCO₂ monitor attached.

7 The need for intubation and the ideal timing are still unknown. The American Heart Association recommends either bag valve mask or an advanced airway.

8 In pregnant patients who develop cardiac arrest, focus on high-quality CPR and relief of aortocaval compression through left lateral uterine displacement while the patient is supine. This means that someone on the team stands on the left side of the patient and cups the uterus, pulling it up and leftward. Alternatively, if standing on the right of the patient, push the uterus left and upward off of the maternal vessels.

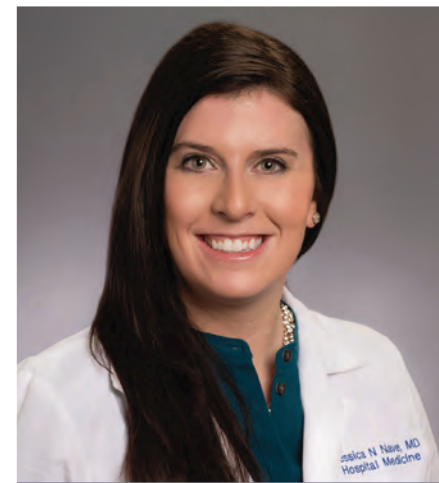
9 AHA released new algorithms for opioid overdose given the current crisis. There is an absence of proven naloxone benefit in cardiac arrest so focus on standard resuscitative efforts and do not wait for effects of naloxone before initiating CPR. However, naloxone is still reasonable to give if overdose is suspected.

10 Clinicians should wait a minimum of 72 hours after return to normothermia before performing multimodal neuroprognostication. This allows for confounding factors (that is, meds) to hopefully be removed for improved accuracy.

Top 5 things that differ in a COVID-19+/PUI cardiac arrest case²

1 Don't adequate personal protective equipment prior to entering the room. This might create a necessary delay in care.

2 Use a high-efficiency particulate air (HEPA) filter on all airway modalities.



Dr. Allen is assistant professor of medicine in the division of hospital medicine at Emory University, Atlanta.

3 Intubate as early as possible by someone highly experienced and place the patient on a ventilator with HEPA filter while undergoing resuscitation. This decreases aerosolization risk.

4 Use a mechanical CPR device if possible. This results in less people needed in the room.

5 If a patient is NOT intubated but is prone when they arrest, safely turn them supine and perform resuscitative effort. If a patient is intubated and prone when they arrest: If unable to safely turn them, place the pads in the AP position and perform compressions over T7-T10 vertebral bodies. Evidence for this is extremely limited but comes from a small pilot study which showed that reverse CPR generated a higher mean arterial pressure, compared with standard resuscitation.³

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DOACs best aspirin after ventricular ablation: STROKE-VT

By Steve Stiles

Catheter ablation has been around a lot longer for ventricular arrhythmia than for atrial fibrillation, but far less is settled about what antithrombotic therapy should follow ventricular ablations, as there have been no big, randomized trials for guidance.

But the evidence base grew stronger this week, and it favors post-procedure treatment with a direct oral anticoagulant (DOAC) over antiplatelet therapy with aspirin for patients undergoing radiofrequency (RF) ablation to treat left ventricular (LV) arrhythmias.

The 30-day risk for ischemic stroke or transient ischemia attack (TIA) was sharply higher for patients who took daily aspirin after RF ablation for ventricular tachycardia (VT) or premature ventricular contractions (PVC) in a multicenter randomized trial.

Those of its 246 patients who received aspirin were also far more likely to show asymptomatic lesions on cerebral MRI scans performed both 24 hours and 30 days after the procedure.

The findings show the importance of DOAC therapy after ventricular ablation procedures, a setting for which there are no evidence-based guidelines, “to mitigate the risk of systemic thromboembolic events,” said Dhannunja Lakkireddy, MD, Kansas City Heart Rhythm Institute, Overland Park. Dr. Lakkireddy spoke at a media presentation on the trial, called STROKE-VT, during the Heart Rhythm Society 2021 Scientific Sessions, held virtually and on-site in Boston.

The risk for stroke and TIA went up in association with several procedural issues, including some that operators might be able to change in order to reach for better outcomes, Dr. Lakkireddy observed.

“Prolonged radiofrequency ablation times, especially in those with low left ventricle ejection fractions, are definitely higher risk,” as are

procedures that involved the retrograde transaortic approach for advancing the ablation catheter, rather than a trans-septal approach.

The retrograde transaortic approach should be avoided in such procedures, “whenever it can be avoided,” said Dr. Lakkireddy, who formally presented STROKE-VT at the HRS sessions and is lead author on its report published about the same time in JACC: Clinical Electrophysiology (2021 Jul 29. doi: 10.1016/j.jacep.2021.07.010).

The trial has limitations, but “it’s a very important study, and I think that this could become our standard of care for managing anticoagulation after VT and PVC left-sided ablations,” Mina K. Chung, MD, Cleveland Clinic, said as an invited discussant after Dr. Lakkireddy’s presentation.

How patients are treated with antithrombotics after ventricular ablations can vary widely, sometimes based on the operator’s “subjective feeling of how extensive the ablation is,” Christine M. Albert, MD, MPH, Cedars-Sinai Medical Center, Los Angeles, not involved in the study, said during the STROKE-VT media briefing.

That’s consistent with the guidelines, which propose oral anticoagulation therapy after more extensive ventricular ablations and antiplatelets when the ablation is more limited – based more on consensus than firm evidence – as described by Jeffrey R. Winterfield, MD, of the Medical University of South Carolina, Charleston, and Usha Tedrow, MD, MSc, of Brigham and Women’s Hospital, Boston, in an accompanying editorial.

“This is really the first randomized trial data, that I know of, that we have on this. So I do think it will be guideline-influencing,” Dr. Albert said.

“This should change practice,” agreed Jonathan P. Piccini, MD, MHS, Duke University, Durham, N.C., also not part of STROKE-VT. “A lot of evidence in the trial is consistent and provides a compelling story, not to mention that, in my opinion, the study probably underestimates the value of DOACs,” he said in an interview.

That’s because patients assigned to DOACs had far longer ablation times, “so their risk was even greater

than in the aspirin arm,” Dr. Piccini said. Ablation times averaged 2,095 seconds in the DOAC group, compared with only 1,708 seconds in the aspirin group, probably because the preponderance of VT over PVC ablations for those getting a DOAC was even greater in the aspirin group.

wasn’t the one related to the core hypothesis. And that was the effect of retrograde access,” Paul A. Friedman, MD, Mayo Clinic, Rochester, Minn., said as an invited discussant after Dr. Lakkireddy’s formal presentation of the trial.

Whether a ventricular ablation is performed using the retrograde

Ventricular ablation outcomes, postprocedure DOAC vs. aspirin

Endpoint	DOAC (n = 123)	Aspirin (n = 123)	P value
Stroke	0	6.5%	.001
TIA	4.9%	17.9%	.001
Asymptomatic cerebral event by MRI	24 hours	12.2%	.03
	30 days	6.5%	.006

Note: Based on data from the randomized controlled STROKE-VT study.

Source: JACC Clin Electrophysiol. 2021 Aug 29. doi: 10.1016/j.jacep.2021.07.010

Of the 246 patients assigned to either aspirin or a DOAC, usually a factor Xa inhibitor, 75% had undergone VT ablation and the remainder ablation for PVCs. Their mean age was 60 years and only 18% were women. None had experienced a cerebrovascular event in the previous 3 months.

The 30-day odds ratio for TIA or ischemic stroke in patients who received aspirin, compared with a DOAC, was 12.6 (95% confidence interval, 4.10-39.11; $P < .001$).

The corresponding OR for asymptomatic cerebral lesions by MRI at 24 hours was 2.15 (95% CI, 1.02-4.54; $P = .04$) and at 30 days was 3.48 (95% CI, 1.38-8.80; $P = .008$).

The rate of stroke or TIA was similar in patients who underwent ablation for VT and for PVCs (14% vs. 16%, respectively; $P = .70$). There were fewer asymptomatic cerebrovascular events by MRI at 24 hours for those undergoing VT ablations (14.7% and 25.8%, respectively; $P = .046$); but difference between rates attenuated by 30 days (11.4% and 14.5%, respectively; $P = .52$).

The OR for TIA or stroke associated with the retrograde transaortic approach, performed in about 40% of the patients, compared with the trans-septal approach in the remainder was 2.60 (95% CI, 1.06-6.37; $P = .04$).

“The study tells us it’s safe and indeed preferable to anticoagulate after an ablation procedure. But the more important finding, perhaps,

transaortic or trans-septal approach often depends on the location of the ablation targets in the left ventricle. But in some cases it’s a matter of operator preference, Dr. Piccini observed.

“There are some situations where, really, it is better to do retrograde aortic, and there are some cases that are better to do trans-septal. But now there’s going to be a higher burden of proof,” he said.

Given the findings of STROKE-VT, operators may need to consider that a ventricular ablation procedure that can be done by the trans-septal route perhaps ought to be consistently done that way.

Dr. Lakkireddy discloses financial relationships with Boston Scientific, Biosense Webster, Janssen Pharmaceuticals, and more. Dr. Chung had “nothing relevant to disclose.” Dr. Piccini discloses receiving honoraria or speaking or consulting fees from Sanofi, Abbott, ARCA Biopharma, Medtronic, Philips, Biotronik, Allergan, LivaNova, and Myokardia; and research in conjunction with Bayer Healthcare, Abbott, Boston Scientific, and Philips. Dr. Friedman discloses conducting research in conjunction with Medtronic and Abbott; holding intellectual property rights with AliveCor, Inference, Medicoool, Eko, and Anumana; and receiving honoraria or speaking or consulting fees from Boston Scientific. Dr. Winterfield and Dr. Tedrow had no disclosures.



Dr. Lakkireddy

Ad hoc hospitalist model evolves during India's COVID surge

Hospital administrators recognize the efficiencies

By Jeff Craven

MDedge News

A year after the start of the COVID-19 pandemic, as the United States was getting a reprieve in new cases from its winter surge, the opposite was happening in the rest of the world. In India, a deadly second wave hit, crippling the health care system in the country for months.

Yugandhar Bhatt, MBBS, MD, a consultant pulmonologist with Yashoda Hospital–Malakpet in Hyderabad, India, told this news organization that someone looking at his hospital before the pandemic – a 400-bed multispecialty care unit



Dr. Odeti

“Even in the U.S. when we started the hospitalist model, it started out of necessity. It’s a combination of creating efficiencies and improving quality. It’s the same thing in India. It’s borne of necessity, but it was [done] at a rapid pace.”

– would see patients being treated for respiratory failure secondary to exacerbation of chronic obstructive pulmonary disease, bronchial asthma, community-acquired pneumonia, and heart failure. About 30-40 patients per day were treated on an outpatient basis, and more than 30 people were admitted as inpatients.

“After [the] COVID-19 surge, our hospital totally divided into COVID and non-COVID [wards], in which COVID patients occupied 70% of [the] total,” he said. About half of COVID-19 patients were in the ICU, with half of those patients requiring supplemental oxygen.

During the first wave in India, which lasted from May to December 2020, 50% of patients who were intubated were discharged. The percentage of extubated patients decreased to 20% in the second wave, Dr. Bhatt said.

The death toll during the second wave of COVID-19 cases was unlike anything India has seen previously. Between March 1 and June 29, 2021, an estimated 19.24 million individuals were newly infected with COVID-19 and 241,206 patients died, according to Our World in Data, a

project of the Global Change Data Lab. When the second wave peaked on May 22, more than 4,000 people were dying each day.

“All hospitals [in India] were treating COVID-19 more than any other acute or chronic disease,” Ramesh Adhikari, MD, MS, SFHM, a hospitalist with Franciscan Health in Lafayette, Ind., said in an interview.

Challenges arose in treating COVID-19 in India that ran counter to how medicine was usually performed. Physicians were seeing more inpatient cases than usual – and more patients in general. The change, Dr. Adhikari said, forced health care providers to think outside the box.

An ‘on-the-fly’ hospitalist model

Patients in India access health care by visiting a hospital or primary health center and then are referred out to consultants – specialist doctors – if needed. While India has universal health coverage, it is a multi-payer system that includes approximately 37% of the population covered under the government plan, a large number of private health care facilities and no caps on cost-sharing for the patient. Initiatives like Rashtriya Swasthya Bima Yojana in 2008 and Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana in 2018 have attempted to close the gap and raise the number of lower-income individuals in India covered under the government plan and reduce out-of-pocket spending. Out-of-pocket payments still consist of about 70% of total health expenditures, according to the Commonwealth Fund.

“There is not much scope for a hospitalist because it’s so cash driven,” Shyam Odeti, MD, MS, SFHM, section chief, hospital medicine, at the Carilion Clinic in Roanoke, Va., said in an interview. “For a hospitalist, there is no urgency in getting

them out of the hospital. There was no need for much efficiency before.”

The first issue during the second wave was figuring out which consultants would care for COVID-19 patients. As there is no dedicated specialty for infectious disease in India, the responsibilities fell to internists and critical care medicine consultants who volunteered. Both are considered small specialties in India. They became “makeshift hos-

quality,” Dr. Odeti said. “It’s the same thing in India. It’s borne of necessity, but it was [done] at a rapid pace.”

Problems with patient flow

The next issue was triaging patients in the hospital based on COVID-19 severity. When the second wave began, hospitals in India ran out of beds and experienced staff shortages like in many countries. But this situation “was unusual for the



Medical staff attend to patients with COVID-19 in the emergency ward at the Holy Family hospital on May 6, 2021, in New Delhi. The country broke a fresh record with more than 412,000 new cases of COVID-19.

pitalists” who learned as they went and became the experts in COVID-19 care, treating their own patients while making themselves available for consultations, Dr. Odeti said.

While no official hospital medicine model in India exists like in the United States, the second COVID-19 surge caused these consultants to begin thinking like hospitalists. Tenets of hospital medicine – like team-based treatment across specialties – arose out of necessity during the crisis. “They were trying to implement a hospitalist model because that’s the only way they could treat COVID-19,” said Dr. Adhikari, an editorial advisory board member for the Hospitalist.

“Even in the U.S. when we started the hospitalist model, it started out of necessity. It’s a combination of creating efficiencies and improving

health system,” according to Dr. Odeti, who is also an editorial board member for the Hospitalist.

“We never had that issue. There were so many patients wanting to come to the hospital, and so there was this rush.” There was no process to triage patients to determine who needed to stay. “Everybody got put into the hospital,” he said.

Once it was determined who would take care of patients with COVID-19, access to supplies became the primary problem, Dr. Adhikari explained. Lack of oxygen, ventilators, and critical medicines like the antiviral drug remdesivir were and continue to be in short supply. “I had friends who [said] they could not admit patients because they were worried if their oxygen supply [went] low in the middle of the night. They will treat the patients who were



Patients who contracted the coronavirus lie in beds while connected to oxygen supplies inside the emergency ward of a COVID-19 hospital on May 3, 2021, in New Delhi.

already admitted versus taking new patients. That had caused problems for the administrators,” Dr. Adhikari added.

It is also a source of additional stress for the physicians. Where patients flow through a hospital medicine model in the United States, a system that might include case managers, social workers, pharmacists, physician advocates, and other professionals to keep a patient’s care on track, the physician is the go-to

In response to the restlessness, irritation, and despair resulting from hospitals closing their doors, “people have shown their frustration by verbally abusing and threatening to physically assault doctors and other health care workers.”

person in India for patient care. While physicians provide access to medications and remain available to a patient’s family, those duties become much harder when caring for a greater number of patients during the pandemic. “That has led to some unrealistic expectations among the patients,” Dr. Adhikari said.

Dr. Bhatt said “more than half” of a physician’s time in India is spent counseling patients on concerns about COVID-19. “Awareness about the disease is limited from the patient and patient’s family perspective, as [there is] too much apprehension toward the nature of [the] disease,” he added. “Theoretical discussions collected from social media” obstruct the physician from executing his or her duties.

Physicians in India have had to

contend with physical violence from patients and individuals on the street, Dr. Adhikari added. Workplace violence was already a concern – for years, the Indian Medical Association has cited a statistic that 75% of doctors in India have experienced violence at work (Indian J Psychiatry. 2019 Apr;61[Suppl 4]:S782-5). But the threat of violence against physicians has sharply increased during the COVID-19 pandemic. Disruptions to daily life through lockdowns “made people fearful, anxious, and sometimes they have found it difficult to access emergency treatment,” according to a letter published by Karthikeyan Iyengar and colleagues in the Postgraduate Medical Journal (2020 Aug 19. doi: 10.1136/postgrad-medj-2020-138496). In response to the restlessness, irritation, and despair resulting from hospitals closing their doors, “people have shown their frustration by verbally abusing and threatening to physically assault doctors and other health care workers,” the authors wrote.

A telemedicine boon in India

Back in the United States, hospitalists with family and friends in India were trying to figure out how to help. Some were working through the day, only to answer calls and WhatsApp messages from loved ones at night. “Everyone knows a physician or someone who’s your colleague, who owns a hospital or runs a hospital, or one of the family members is sick,” Dr. Adhikari said.

These U.S.-based hospitalists were burning the candle at both ends, helping with the pandemic in both countries. Physicians in India were posing questions to U.S. colleagues who they saw as having the most recent evidence for COVID-19 treatment. Out of the 180 physicians he trained with in India, Dr. Odeti said 110 of the physicians were in a large WhatsApp group chat that was con-

stantly exchanging messages and serving as “kind of a friendly support group.”

In Dr. Odeti’s group chat, physicians helped one another find hospital beds for patients who reached out to them. “The first couple of weeks, there was no proper way for people to know where [patients] were based. There was no way to find if this hospital had a bed, so they reached out to any doctors they knew,” he said.

While he said it was emotionally draining, “at the same time, we felt a responsibility toward colleagues in India,” Dr. Odeti said, noting that as COVID-19 cases have decreased in India, the requests have been less frequent.

Because of concerns about traveling to India during the pandemic while on a J-1, H-1B, or other visa with the United States, directly helping friends and family in India seemed out of reach. But many hospitalists of Indian origin instead turned to telemedicine to help their colleagues. Telemedicine had already been steadily growing in India, but was accelerated by the pandemic. The current ratio of doctors to patients in India is 0.62 to 1,000 – lower than recommendations from the

World Health Organization (J Educ Health Promot. 2020;9:190). That makes telemedicine a unique opportunity for one physician in India to reach many patients regardless of location.

Dr. Adhikari said he helped out his colleagues in India by performing consults for their patients. “They were just worried because they did not know where to go, or what to get,” he said. “I was treating more patients in India than I was actually treating here.”

In March 2020, the Indian Ministry of Health and Family Welfare released telemedicine practice guidelines for the country, which relaxed regulations on privacy requirements and has been credited in part for giving telemedicine an additional boost during the pandemic. “That makes it easy for people to reach out but also has its own problems,” Dr. Adhikari said.

Monitoring of milder COVID-19 cases that don’t require hospitalization can be performed by a nurse who calls every few hours to check on a patient, make recommendations, and text treatment plans. “The telemedicine platforms are being adopted really fast,” Dr. Adhikari

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said. “The platforms were built in no time.”

According to NewZoo, a games market data analytics company, India has 345.9 million smartphone users as of 2019 – the second highest number of users in the world after China. Dr. Odeti said he believes telemedicine will be widely adopted.

“In India, they are very proactive in accepting these kinds of methods, so I’m sure they will,” he said. “Governments were trying to do it before the pandemic, because access to care is a problem in India. There are villages which are very, very remote.”

Reversion to old systems

After the peak in late May, new COVID-19 cases in India began to decrease, and the second wave waned on a national level. Hospitals began to get the supplies they needed, beds are available, and patients aren’t as sick as before, according to Dr. Adhikari. The federal government has begun issuing supplies to patients in each state, including COVID-19 vaccines. “The peak for the second wave is gone,” he said.

What remains is a group of physicians trained in how to triage patients and create efficiencies in a

hospital setting. Could those skills be put to use elsewhere in India after the pandemic?

According to Dr. Bhatt, the patient care model is likely to revert to the system that existed before. “Whatever the changes, interims of bed occupancy, cost of ICU will be temporary [and] will change to normal,” he said. “But awareness about masks [and] sanitizing methods will be permanent.”

Dr. Adhikari believes that not utilizing the skills of newly minted hospitalists in India would be a missed opportunity. “This is a silver lining from COVID-19, that hospital medicine plays a vital role in the sickest patients, whether it is in India or the U.S. or anywhere,” he said. “I think the model of hospital medicine should be adopted. It’s not: ‘Should it really be adopted or not?’ It should be. There is a huge potential in doing inpatient coordinated [care], having people dedicated in the hospital.”

There are tangible benefits to creating efficiencies in India’s health system, Dr. Odeti said. Length of stay for sicker patients “was much longer” at 10-14 days during the second wave, compared with the United States, before lowering to around



Health care worker Shama Shaikh, 53, cares for a patient who has COVID-19 in an ICU ward at the government-run St. George hospital on May 27, 2021, in Mumbai, India. The nation has experienced a prolonged and devastating wave of COVID-19 infections.

5 days. “These hospitals right now are learning the efficient ways of doing it: when to send [patients] out, how to send them out, how to [perform] service-based practices, creating processes which were non-existent before.”

While he doesn’t personally believe physicians will adopt a full-fledged hospitalist model unless the payer structure in India changes, “these people are at an advantage with this extra set of skills,” he said. “I think all the knowledge that these people have are going to come in handy.”

Opportunities for growth

Dr. Odeti sees the potential for the hospitalist model to grow in India – if not into its own specialty, then in how critical care consultants handle sicker patients and handoffs.

“The critical care clinician cannot keep the patient from the time they are admitted to the ICU until the discharge, so there will be a need for the transition,” Dr. Odeti said. “In the past, there were not many capabilities in Indian health systems to take care of these extremely sick patients, and now it is evolving. I think that is one more thing that will help.”

Dr. Adhikari said hospital systems in India are beginning to realize how having dedicated hospital physicians could benefit them. In India, “if you’re sick, you go to your doctor, you get treated, and you disappear,” he said. The next time, you may see the same doctor or a completely different doctor. “There’s no system there, so it’s really hard for hospital medicine as such because patients, when they are very sick, they just come to the ER. They’re not followed

by their primary care.”

Anecdotally, Dr. Odeti sees patients already adapting to having access to a physician for asking questions normally answered by primary care physicians. “I think primary care will come into play,” he said. “When I was doing a Zoom

“In India, they are very proactive in accepting these kinds of methods... Governments were trying to do it before the pandemic, because access to care is a problem in India. There are villages which are very...remote.”

call for patients, they were asking me questions about sciatica. I think they are getting comfortable with this technology.”

A hospitalist model could even be applied to specific diseases with a large population of patients. Hospital administrators “have seen this for the first time, how efficient it could be if they had their own hospitalists and actually run it. So that’s the part that has crossed their minds,” Dr. Adhikari said. “How they will apply it going forward, other than during the COVID-19 pandemic, depends on the size of the hospital and the volume of the patients for a particular disease.”

“You can see in certain areas there is large growth for hospital medicine. But to rise to the level of the United States and how we do it, India needs bigger health systems to adopt the model,” Dr. Adhikari said.

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Addressing vaccine hesitancy with patients

Break through with empathy and compassion

By Gwendolyn Williams, MD

The COVID-19 pandemic is a worldwide tragedy. In the beginning there was a lack of personal protective equipment, COVID tests, and support for health care workers and patients. As 2020 came to a close, the world was given a glimpse of hope with the development of a vaccine against the deadly virus. Many world citizens celebrated the scientific accomplishment and began to breathe a sigh of relief that there was an end in sight. However, the development and distribution of the COVID-19 vaccine revealed a new challenge, vaccine hesitancy.

Community members, young healthy people, and even critically ill hospitalized patients who have the fortune of surviving acute illness are hesitant to the COVID-19 vaccine. I recently cared for a critically ill young patient who was intubated for days with status asthmaticus, one of the worst cases I'd ever seen. She was extubated and made a full recovery. Prior to discharge I asked if she wanted the first dose of the COVID-19 vaccine and she said, "No." I was shocked. This was an otherwise healthy 30-something-year-old who was lucky enough to survive without any underlying infection in the setting of severe obstructive lung disease. A coinfection with COVID-19 would be disastrous and increase her mortality. I had a long talk at the bedside and asked the reason for her hesitancy. Her answer left me speechless, "I don't know; I just don't want to." I ultimately convinced her that contracting COVID-19 would be a fate worse than she could imagine, and she agreed to the vaccine prior to discharge. This interaction made me ponder – "why are our patients, friends, and family members hesitant about receiving a lifesaving vaccine, especially when they are aware of how sick they or others can become without it?"

According to the World Health Organization, *vaccine hesitancy* refers to a delay in acceptance or refusal of vaccines despite availability of vaccine services. Vaccine hesitancy is complex and context specific, varying across time, place, and vaccines. It is influenced by factors such as complacency, convenience, and confidence.¹ No vaccine is 100%

effective. However, throughout history, the work of scientists and doctors to create vaccines saved millions of lives and revolutionized global health. Arguably, the single most life-saving innovation in the history of medicine, vaccines have eradicated smallpox, and protected against whooping cough (1914), diphtheria (1926), tetanus (1938), influenza (1945) and mumps (1948), polio (1955), measles (1963), and rubella (1969),

“This past month, when asking patients why they don't want the vaccine, I found many have no real legitimate health-related reason. ... So, how do we get through to the unvaccinated?”

and worldwide vaccination rates increased dramatically thanks to successful global health campaigns.² However, there was a paradox of vaccine success. As terrifying diseases decreased in prevalence, so did the fear of these diseases and their effects – paralysis, brain damage, blindness, and death. This gave birth to a new challenge in modern medicine, vaccine hesitancy – a privilege of first-world nations.

Vaccines saved countless lives and improved health and well-being around the world for decades. However, to prevent the morbidity and mortality associated with vaccine-preventable diseases and their complications, and optimize control of vaccine-preventable diseases in communities, high vaccination rates must be achieved. Enter the COVID-19 pandemic, the creation of the COVID-19 vaccine, and vaccine hesitancy.

The question we ask ourselves as health care providers is "how do we convince the skeptics and those opposed to vaccination to take the vaccine?" The answer is complicated. If you are like me, you've had many conversations with people – friends, patients, family members, who are resistant to the vaccine. Very often the facts are not well received, and those discussions end in argument, high emotions, and broken relationships. With the delta variant of COVID-19 on the rise, spreading ag-

gressively among the unvaccinated, and increased hospitalizations, we foresee the reoccurrence of overwhelmed health systems and a continued death toll.

The new paradox we are faced with is that people choose to believe fiction versus fact, despite the real-life evidence of the severe health effects and increased deaths related to COVID-19. Do these skeptics simply have a cavalier attitude toward not only their own life, but the lives of others? Or, is there something deeper? It is not enough to tell people that the vaccines are proven safe³ and are more widely available than ever. It is not enough to tell people that they can die of COVID-19 – they already know that. Emotional pleas to family members are falling on deaf ears. This past month, when asking patients why they don't want the vaccine, I found many have no real legitimate health-related reason and respond with a simple, "I don't want to." So, how do we get through to the unvaccinated?

A compassionate approach

We navigate these difficult conversations over time with the approach of compassion and empathy, not hostility or bullying. As health care providers, we start by being good empathic listeners. Similar to when we have advance care planning and code status conversations, we cannot enter the dialogue with our intention, beliefs, or formulated goals for that person. We have to listen without judgment to the wide range of reasons why others are reluctant or unwilling to get the vaccine – historical mistrust, political identity, religious reasons, short-term side effects that may cause them to lose a day or two of work – and understand that for each person their reasons are different. The point is to not assume that you know or understand what barriers and beliefs they have toward vaccination, but to meet them at their point of view and listen while keeping your own emotions level and steady.

Identifying the reason for vaccine hesitancy is the first step to getting the unvaccinated closer to vaccination. Ask open-ended questions: "Can you help me understand, what is your hesitancy to the vaccine?"; "What about the vaccine worries you?"; "What have you heard about/



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know about the COVID-19 vaccine?"; or "Can you tell me more about why you feel that way?" As meticulous as it sounds, we have to go back to the basics of patient interviewing.

It is important to remember that this is not a debate and escalation to arguments will certainly backfire. Think about any time you disagreed with someone on a topic. Did criticizing, blaming, and shaming ever convince you to change your beliefs or behaviors? The likely answer is, "No." Avoid the "backfire effect" – which is when giving people facts disproving their "incorrect" beliefs can actually reinforce those beliefs. The more people are confronted with facts at odds with their opinions, the stronger they cling to those opinions. *If you want them to change their mind, you cannot approach the conversation as a debate.* You are having this vaccine discussion to try to meet the other person where they are, understand their position, and talk with them, and not at them, about their concerns.

As leaders in health care, we have to be willing to give up control and lead with empathy. We have to show others that we hear them, believe their concerns, and acknowledge that their beliefs are valid to them as individuals. Even if you disagree, this is not the place to let anger, dis-

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appointment, or resentment take a front seat. This is about balance, and highlighting the autonomy in decision making that the other person has to make a choice. Be humble in these conversations and avoid condescending tones or statements.

We already know that you are a caring health care provider. As hospitalists, we are frontline providers who have seen unnecessary deaths and illness due to COVID-19. You are passionate and motivated because you are committed to your oath to save lives. However, you have to check your own feelings and remember that you are not speaking with an unvaccinated person to make them get vaccinated, but rather to understand their cognitive process and hopefully walk with them down a path that provides them with a clarity of options they truly have. Extend empathy and they will see your motivation is rooted in good-heartedness and a concern for their well-being.

If someone admits to reasons for avoiding vaccination that are not rooted in any fact, then guide them to the best resources. Our health care system recently released a COVID-19 fact versus myth handout called Trust the Facts. This could be the kind of vetted resource you offer. Guide them to accredited websites, such as the World Health Organization, the Center for Disease Control, or their local and state departments of health to help debunk fiction by reviewing it with them. Discuss myths such as, “the vaccine will cause infertility,” “the vaccine will give me COVID,” “the vaccine was rushed and is not safe,” “the vaccine is not needed if I am young and healthy,” “the vaccine has a microchip,” etc. Knowledge is power and disinformation is deadly, but how facts are presented will make the biggest difference in how others receive them, so remember your role is not to argue with these statements, but rather to provide perspective without agreeing or disagreeing.

Respond to their concerns with statements such as, “I hear you. ... It sounds like you are worried/fearful/mistrusting about the side effects/safety/efficacy of the vaccine. ... Can we talk more about that?” Ask them where these concerns come from – the news, social media, an article, word of mouth, friends, or family. Ask them about the information they have and show genuine interest that you want to see it from their perspective. This is the key to compassionate and empathic dialogue –

you relinquish your intentions.

Once you know or unveil their reasons for hesitancy, ask them what they would like to see with regards to COVID-19 and ending the pandemic. Would they like to get back to a new normal, to visit family members, to travel once again, to not have to wear masks and quarantine? What do they want for themselves, their families, communities, the country, or even the world? The goal is to find something in our shared humanity, to connect on a deeper

“If you are a vaccinated health care provider, your words have influence and power, and we are obliged by our positions to have responsibility for the health of our communities. Don't be discouraged.”

level so they start to open up and let down walls, and find something you both see eye-to-eye on. Know your audience and speak to what serves them. To effectively persuade someone to come around to your point of view starts with recognizing the root of the disagreement and trying to overcome it before trying to change the person's mind, understanding both the logic and the emotion that's driving their decision-making.⁴

Building trust

Reminding patients, friends, or family members that their health and well-being means a lot to you can also be a strategy to keeping the conversation open and friend-

ly. Sharing stories as hospitalists caring for many critically ill COVID patients or patients who died alone because of COVID-19, and the trauma you experienced as a health care provider feeling paralyzed by the limitations of modern medicine against the deadly virus, will only serve to humanize you in such an interaction.

Building trust will also increase vaccine willingness. This will require a concerted effort by scientists, doctors, and health care systems to engage with community leaders and members. To address hesitancy, the people we serve have to hear those local, personal, and relatable stories about vaccinations, and how it benefits not just themselves, but others around them in their community. As part of the #VaxUp campaign in Virginia, community and physician leaders shared their stories of hesitancy and motivation surrounding the vaccine. These are real people in the community discussing why getting vaccinated is so important and what helped them make an informed decision. I discussed my own hesitancy and concerns and also tackled a few vaccine myths.

As vaccinated health care workers or community leaders, you are living proof of the benefits of getting the COVID vaccine. Focus on the positives but also be honest. If your second shot gave you fevers, chills, or myalgias, then admit it and share how you overcame these expected reactions. Refocus on the safety of the vaccine and the fact that it is freely available to all people. Maybe the person you are speaking with doesn't know where or how to get an appointment to get vaccinated. Help them find the nearest place to get an appointment and identify barriers they may have in transportation,

or child or senior care to leave home safely to get vaccinated, or physical conditions that are preventing them from receiving the vaccine. Share that being vaccinated protects you from contracting the virus and spreading it to loved ones. Focus on how a fully vaccinated community and country can open up opportunities to heal and connect as a society, spend time with family/friends in another county or state, hold a newborn grandchild, or even travel outside the United States.

There is no guarantee that you will be able to persuade someone to get vaccinated. It's possible the outcome of your conversation will not result in the other person changing their mind in that moment. That doesn't mean that you failed, because you started the dialogue and planted the seed. If you are a vaccinated health care provider, your words have influence and power, and we are obliged by our positions to have responsibility for the health of our communities. Don't be discouraged, as it is through caring, compassionate, respectful, and empathic conversations that your influence will make the most difference in these relationships as you continue to advocate for all human life.

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Mental illness admissions: Among top diagnoses for ages 18-44

Depressive disorders in top 5 for men and women

By Richard Franki

MDedge News

More mental and/or substance use disorders are ranked among the top-five diagnoses for hospitalized men and women aged 18-44 years than for any other age group, according to a recent report from the Agency for Healthcare Research and Quality.

In 2018, schizophrenia spectrum/other psychotic disorder was the leading primary diagnosis for inpatient stays (251.2 per 100,000 population) in men aged 18-44, while depressive disorders were the third-most common (195.0 stays per 100,000) and alcohol-related disorders were fifth at 153.2 per 100,000, Kimberly W. McDermott, PhD, and Marc Roemer, MS, said in an AHRQ statistical brief.

Prevalence was somewhat lower in women aged 18-44 years, with two

mental illnesses appearing among the top five nonmaternal diagnoses: Depressive disorders were second at 222.5 stays per 100,000 and bipolar and related disorders were fourth at 142.0 per 100,000. The leading primary diagnosis in women in 2018

“Administrators can use diagnosis-related information to inform planning and resource allocation, such as optimizing subspecialty services or units for the care of high-priority conditions.”

was septicemia, which was the most common cause overall in the age group at a rate of 279.3 per 100,000, the investigators reported.

There were no mental and/or substance use disorders in the top five primary diagnoses for any of the other adult age groups – 45-64, 65-74, and ≥75 – included in the report. Septicemia was the leading

diagnosis for men in all three groups and for women in two of three (45-64 and ≥75), with osteoarthritis first among women aged 65-74 years, they said.

There was one mental illness among the top five diagnoses for

for all inpatient stays and all ages in 2018 with a rate of 679.5 per 100,000, followed by heart failure (347.9), osteoarthritis (345.5), pneumonia not related to tuberculosis (226.8), and diabetes mellitus (207.8), based on data from the National Inpatient Sample.

Depressive disorders were the most common mental health diagnosis in those admitted to hospitals and the 12th most common diagnosis overall; schizophrenia, in 16th place overall, was the only other mental illness among the top 20, the investigators said.

“This information can help establish national health priorities, initiatives, and action plans,” Dr. McDermott and Mr. Roemer wrote, and “at the hospital level, administrators can use diagnosis-related information to inform planning and resource allocation, such as optimizing subspecialty services or units for the care of high-priority conditions.”

children under age 18 years, as depressive disorders were the most common reason for stays in girls (176.6 per 100,000 population) and the fifth most common for boys (74.0 per 100,000), said Dr. McDermott of IBM Watson Health and Mr. Roemer of AHRQ.

Septicemia was the leading non-maternal, nonneonatal diagnosis

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Key Clinical Question

Should hospitalists use albumin to treat non-SBP infections in patients with cirrhosis?

Caution is advised in patients at risk of pulmonary edema

By Aksharananda Rambachan, MD, MPH

Case

A 56-year-old male with hypertension, alcohol use disorder, stage II chronic kidney disease, and biopsy-proven cirrhosis presents with fever and chills, pyuria, flank pain, and an acute kidney injury concerning for pyelonephritis. Is there a benefit in treating with albumin in addition to guideline-based antibiotics?

Brief overview of the issue

Albumin is a negatively charged human protein produced by the liver. Albumin comprises 50% of plasma protein and over 75% of plasma oncotic pressure.¹ It was first used at Walter Reed Hospital in 1940 and subsequently for burn injuries after the attack on Pearl Harbor in 1941.²

Albumin serves several important physiologic functions including maintaining oncotic pressure, endothelial support, antioxidation, nitrogen oxide scavenging, and buffering and transport of solutes and drugs, including antibiotics. In cirrhosis, albumin is diluted because of sodium and water retention. There is increased redistribution, decreased synthesis by the liver, and impaired albumin molecule binding.³

For patients with liver disease, per the European Association for the Study of the Liver and the American Association for the Study of Liver Diseases, albumin should be administered to prevent postparacentesis circulatory dysfunction after large-volume paracentesis, to prevent renal failure and mortality in the setting of spontaneous bacterial peritonitis (SBP), and in the diagnosis and treatment of hepatorenal syndrome (HRS) type I to potentially improve mortality.^{4,5} Beyond these three guideline-based indications, other uses for albumin for patients with liver disease have been proposed, including treatment of hyponatremia, posttransplant fluid resuscitation, diuretic unresponsive ascites, and long-term management of cirrhosis. There has yet to be strong evidence supporting these

additional indications. However, given the known benefits of albumin in patients with SBP, there has been recent research into treatment of non-SBP infections, including urinary tract infections.

Overview of the data

There have been three randomized controlled trials (RCTs) regarding albumin administration for the treatment of non-SBP infections for hospitalized patients with cirrhosis. All three trials randomized patients to a treatment arm of albumin and antibiotics versus a control group of antibiotics alone. The treatment protocol prescribed 20% albumin with 1.5 g/kg on day 1 and 1.0 g/kg on day 3. The most common infections studied were pneumonia and urinary tract infection. These RCTs found that albumin administration was associated with improved renal and/or circulatory function, but not with a reduction in mortality.

First, there was a single center RCT by Guevara et al. in 2012 of 110 patients with cirrhosis and infection based on SIRS criteria.⁶ The primary outcome was 90-day survival with secondary outcomes of renal failure development; renal function at days 3, 7, and 14; and circulatory function measured by plasma renin, aldosterone, and norepinephrine. Renal function and circulatory function improved in the albumin group, but not mortality. In a multivariable regression analysis, albumin was statistically predictive of survival (hazard ratio, 0.294).

Second, there was a multicenter RCT by Thévenot et al. in 2015 of 193

patients.⁷ The primary outcome was 90-day renal failure and the secondary outcome was 90-day survival. Renal failure was chosen as the primary endpoint because of its association with survival in this patient population. The treatment group had delayed onset of renal failure, but no difference in the development of 90-day renal failure or 90-day mortality rate. Notably, eight patients (8.3%) in the albumin group developed pulmonary edema with two deaths. This led the oversight committee to prematurely terminate the study.

Third and most recently, there was a multicenter RCT by Fernández et al. in 2019 of 118 patients.⁸ The primary outcome was in-hospital mortality, with secondary outcomes of circulatory dysfunction measured by plasma renin concentration, systemic inflammation measured by plasma IL-6 and biomarkers, complications including acute-on-chronic liver failure (ACLF) and nosocomial bacterial infections, and 90-day mortality. Between the albumin and control group, there were no differences in in-hospital mortality (13.1% vs. 10.5%, $P > .66$), inflammation, circulatory dysfunction, or liver severity. However, a significantly higher proportion of patients in the albumin group had resolution of their ACLF (82.3% vs. 33.3%, $P = .003$) and a lower proportion developed nosocomial infections (6.6% vs. 24.6%, $P = .007$). A major weakness of this study was that patients in the albumin group had a higher combined rate of ACLF and kidney dysfunction (44.3% vs. 24.6%, $P = .02$).

Beyond these three randomized controlled trials, there was a study on the long-term administration of albumin for patients with cirrhosis and ascites. Patients who received twice-weekly albumin infusions had a lower 2-year mortality rate and a reduction in the incidence of both SBP and non-SBP infections.⁹ Another long-term study of albumin administration found similar results with greater 18-month survival and fewer non-SBP infections.¹⁰ A trial looking at inflammation in patients without bacterial infections and in biobanked samples from cirrhotic

Key points

- In patients with spontaneous bacterial peritonitis, hepatorenal syndrome, and for large volume paracentesis, albumin improves outcomes and is recommended by guidelines.
- In patients with cirrhosis and a non-SBP infection, there is some evidence that albumin may improve renal and circulatory function.
- Clinicians should be cautious about albumin use in patients at an elevated risk for development of pulmonary edema.

patients with bacterial infections found that treatment with albumin reduced systemic inflammation.¹¹

In summary, the three RCTs looked at comparable patients with cirrhosis and a non-SBP infection and all underwent similar treatment protocols with 20% albumin dosed at 1.5 g/kg on day 1 and 1.0 g/kg on day 3. All studies evaluated mortality in either the primary or secondary outcome, and none found significant differences in mortality between treatment and control groups. Each study also evaluated and found improvement in renal and/or circulatory function. Fernández et al. also found increased resolution of ACLF, fewer nosocomial infections, and reduction in some inflammatory markers. However, all studies had relatively small sample sizes that were underpowered to detect mortality differences. Furthermore, randomization did not lead to well-matched groups, with the treatment group patients in the Fernández study having higher rates of ACLF and kidney dysfunction.

The data suggest that albumin may be beneficial in improving renal and circulatory function. In select patients with ACLF and elevated serum creatinine, albumin treatment may be considered. There has been discussion about the use of albumin preferentially in patients with subdiaphragmatic bacterial infections, most related to increased



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inine, an infectious process associated with progressive renal failure, and is not at an elevated baseline risk of developing pulmonary edema, albumin would be reasonable to administer at 1.5 g/kg on day 1 and 1.0 g/kg on day 3 of hospitalization.

Bottom line

In certain patients with cirrhosis and a non-SBP infection, the use of albumin to help improve renal and circulatory function is reasonable. There is no evidence that albumin will improve mortality and caution is warranted for patients at risk for pulmonary edema.

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Summary of RCTs for use of albumin in patients with cirrhosis and non-SBP infections

Author	Study type	N	Primary outcome	Result of primary outcome (albumin vs. control)	Selected secondary outcomes	Results of secondary outcomes	Other notable findings and comments
Fernandez et al. 2019	Multicenter RCT	118	In-hospital mortality	13.1% vs. 10.5% (P = .66)	Resolution of ACLF	82.3% vs. 33.3% (P = .03)	<ul style="list-style-type: none"> Fewer nosocomial infections in treatment group. Treatment group at baseline had higher rates of ACLF and kidney dysfunction.
Thévenot et al. 2015	Multicenter RCT	193	3-month renal failure	14.3% vs. 13.5% (P = .88)	3-month survival	70.2% vs. 78.3% (P = .16)	<ul style="list-style-type: none"> Onset of renal failure reduced in treatment group (29 vs. 11.7 days; P < .001). 8/96 patients in treatment group developed pulmonary edema with two deaths.
Guevara et al. 2012	Single-center RCT	110	3-month survival	82.6% vs. 80.4% (P = .75)	Creatinine at days 3, 7, 14	Creatinine reduction in albumin group (P < .05)	<ul style="list-style-type: none"> In multivariable regression analysis, albumin treatment was associated with reduced mortality (HR, 0.294; P = .042).

Source: Dr. Rambachan

risk of renal failure such as biliary and urinary tract infections.¹² The authors of these studies also note that albumin may be more beneficial in patients with higher baseline creatinine. Caution is warranted for patients with impaired cardiac function or poor respiratory status given the possibility of pulmonary edema. Finally, the high cost of albumin in many medical centers is a major limitation of this treatment approach.

Application of data to our patient

Our patient has cirrhosis and is acutely presenting with pyelonephritis and acute kidney injury. He has no baseline pulmonary disease or oxygen requirement. His recent transthoracic echocardiogram is reviewed and he has no evidence of cardiac disease.

Because he has an elevated creat-

Additional reading

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Quiz

Which of the following is not a guideline-recommended use of albumin for patients with cirrhosis?

- Treatment of type 1 hepatorenal syndrome
- Treatment of spontaneous bacterial peritonitis
- To correct plasma albumin < 2.5 g/dL in nontransplant patients
- Post large-volume paracentesis

The answer is C. Per the EASL and AASLD, A, B, and D are recommended. There is not strong evidence to support administering albumin to correct low plasma albumin.

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Patients with diabetes more likely to be hospitalized, especially with foot infection

By Liam Davenport

People with diabetes are at increased risk of hospitalization for infection, as well as infection-related mortality, shows a large U.S. study that suggests the risk is even higher in younger and Black individuals.

Michael Fang, PhD, Johns Hopkins University, Baltimore, and colleagues studied more than 12,000 participants in a community cohort study who were followed for an average of 24 years, between 1987-1989 and 2019.

Participants with diabetes faced a 67% increase risk of infection-related hospitalization, compared with those without diabetes.

Of particular note, the risk of hospitalization with foot infection was almost sixfold higher for people with diabetes than those without.

The research, published in *Diabetologia* on Aug. 4 (2021. doi: 10.1007/s00125-021-05522-3), also suggests that diabetes may be associated with a 72% increased risk of infection-related mortality, although the absolute numbers were small.

Dr. Fang explained to this news organization that they focused on infection-related hospitalization and mortality “because these are comprehensively tracked in administrative data and ... are the most severe types of outcomes.”

However, this is probably just the tip of the iceberg, as people with diabetes are “likely at increased risk for milder infection too,” which can have a “significant adverse impact on people’s well-being and quality of life.”

As a result of their findings, the authors call for “broader guidance on infection prevention and management” in people with diabetes. To achieve this, Dr. Fang said, “we need to better understand why diabetes is associated with an increased risk of infection-related complications.”

“One likely factor is glycemic control: Emerging research suggests patients with diabetes with better glycemic control may be at significantly lower risk of infection-related complications.”

He continued that, in younger patients, a factor for worse outcomes could be that “diabetes tends to be more aggressive when it emerges early in life,” while in Black patients “there is research highlighting

Black-White differences in glycemic control, access to care, and beliefs around vaccines.”

Overall, their findings – coupled with recent data showing that diabetes is an important risk factor for adverse outcomes with COVID-19 infection – paint “a common picture,” Dr. Fang said.

“People with diabetes are much more susceptible to infection-related complications, including COVID-related hospitalization and mortality,” which suggests people with diabetes “may need to be especially cautious.”

Adds to existing literature; amputations begin with infections

Robert A. Gabbay, MD, PhD, chief scientific and medical officer for the American Diabetes Association, said the study “does add to the existing literature by having followed a larger number of people over time and linking them to serious complications from infections.”



Dr. Gabbay

“Sadly, we have seen this play out in real-time during the COVID-19 pandemic.”

“One of the sobering bits of data is the significant health disparities that exist in Black Americans and the fact that foot infections remain a significant problem,” he said in an interview.

“Given that amputation rates for [Black Americans] are three times higher than White Americans, amputations begin with infections,” Dr. Gabbay added, noting the ADA “has been taking a strong stand to prevent amputations and address the inequities in health that exist.”

Jamie Hartmann-Boyce, PhD, from the University of Oxford, U.K., who was not involved in the study, commented that diabetes is a “well-known risk factor for worse outcomes from all kinds of infection,” which is why they “are prioritized for flu vaccination every year.”

She told this news organization that the current study “further confirms that people with diabetes are more likely to be hospitalized for infection of any type and most

markedly for foot infection.”

“These new data further highlight the need for public health interventions to prevent type 2 diabetes, and for preventive health care in people with diabetes, including access to diabetes medications and support and to vaccinations to prevent infection,” added Dr. Hartmann-Boyce, who is a senior research fellow in health behaviors.

Diabetes is thought to be associated with susceptibility to infection via mechanisms such as impaired neutrophil functioning and humoral immune responses, and studies have shown a link with both common and rare infections.

However, the authors point out that “most” of those included “small clinical populations and were cross-sectional or had short follow-up.”

Guidelines for diabetes management, they note, also “pay less attention” to infectious diseases than they do to the prevention of micro- and macrovascular complications.

ARIC data mined for infections in those with diabetes

The team analyzed data from the ongoing U.S. community-based Atherosclerosis Risk in Communities (ARIC) study.

The National Heart, Lung, and Blood Institute–sponsored cohort was composed of adults aged 45-64 years from four U.S. communities, recruited between 1987 and 1989 for clinical examinations, medical interviews, and laboratory tests, repeated over five more visits up to 2018-2019.

For the current analysis, the team included 12,739 individuals with a mean age of 54.5 years, of whom 54.3% were female and 24.7% were Black.

Patients were defined as having diabetes if their baseline fasting blood glucose was greater than or equal to 7 mmol/L, or nonfasting glucose was greater than or equal to 11.1 mmol/L, they self-reported a diagnosis of diabetes by a physician, or they were taking glucose-lowering medication at the first study visit. The researchers weren’t able to distinguish between type 1 and type 2 diabetes.

In total, 1,485 individuals had diabetes at baseline. They were more likely to be older, Black, have a low

socioeconomic status, and have worse cardiometabolic health than participants without diabetes.

Over an average follow-up of 23.8 years, there were 4,229 incident hospitalizations for infection, at an overall rate of 15.9 per 1,000 person-years.

Individuals with diabetes at baseline had a higher rate of hospitalizations than those without, at 25.4 per 1,000 person-years versus 15.2 per 1,000 person-years.

After sociodemographic characteristics, socioeconomic status, and cardiometabolic risk factors were considered, this equated to a hazard ratio for hospitalization with any infection of 1.67 ($P < .001$).

The risk of hospitalization for any infection was significantly higher

“People with diabetes are much more susceptible to infection-related complications, including COVID-related hospitalization and mortality.”

for younger patients with diabetes, defined as aged less than 55 years ($P = .005$), and for Black patients ($P < .001$).

While the increased risk was generally consistent across infection types, it was markedly increased for foot infection, at a hazard ratio of 5.99 ($P < .001$).

Overall, there were few deaths due to infection in the study, at just 362. The risk of infection mortality was nevertheless significantly increased in people with diabetes, at an adjusted hazard ratio of 1.72 ($P < .001$).

Dr. Fang has reported being supported by a grant from the National Institutes of Health/National Heart, Lung, and Blood Institute. Dr. Selvin has reported being supported by grants from the National Institutes of Health/National Heart, Lung, and Blood Institute and National Institutes of Health/National Institute of Diabetes and Digestive and Kidney Diseases. Dr. Selvin is an associate editor for *Diabetologia* and had no role in the peer review of the manuscript.



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PHM Fellows

New fellowship, no problem

Using a growth mindset to tackle challenges in a new program

By Daniel Herchline, MD, MSED

Growth mindset is a well-established phenomenon in childhood education that is now starting to appear in health care education literature.¹ This concept emphasizes the capacity of individuals to change and grow through experience and that an individual's basic qualities can be cultivated through hard work, open-mindedness, and help from others.²

Growth mindset opposes the concept of fixed mindset, which implies intelligence or other personal traits are set in stone, unable to be fundamentally changed.² Individuals with fixed mindsets are less adept at coping with perceived failures and critical feedback because they view these as attacks on their own abilities.² This oftentimes leads these individuals to avoid potential challenges and feedback because of fear of being exposed as incompetent or feeling inadequate. Conversely, individuals with a growth mindset embrace challenges and failures as learning opportunities and identify feedback as a critical element of growth.² These individuals maintain a sense of resilience in the face of adversity and strive to become lifelong learners.

As the field of pediatric hospital medicine (PHM) continues to rapidly evolve, so too does the landscape of PHM fellowships. New programs are opening at a torrid pace to accommodate the increasing demand of residents looking to enter the field with new subspecialty accreditation. Most first-year PHM fellows in established programs enter with a clear precedent to follow, set forth by fellows who have come before them. For PHM fellows in new programs, however, there is often no beaten path to follow.

Entering fellowship as a first-year PHM fellow in a new program and blazing one's own trail can be intriguing and exhilarating given the unique opportunities available. However, the potential challenges for both fellows and program directors during this transition cannot be understated. The role of new PHM fellows within the institutional framework may initially be unclear

to others, which can lead to ambiguous expectations and disruptions to normal workflows. Furthermore, assessing and evaluating new fellows may prove difficult as a result of these unclear expectations and general uncertainties. Using the growth mindset can help both PHM fellows and program directors take a deliberate approach to the challenges and uncertainty that may accompany the creation of a new fellowship program.

One of the challenges new PHM fellows may encounter lies within the structure of the care team. Resident and medical student learners may express consternation that the new fellow role may limit their own autonomy. In addition, finding the right balance of autonomy and supervision between the attending-fellow dyad may prove to be difficult. However, using the growth mindset may allow fellows to see the inherent benefits of this new role.

Fellows should seize the opportunity to discuss the nuances and differing approaches to difficult clinical questions, managing a team and interpersonal dynamics, and balancing clinical and nonclinical responsibilities with an experienced supervising clinician, issues that are often less pressing as a resident. The fellow role also affords the opportunity to more carefully observe different clinical styles of practice to subsequently shape one's own preferred style.

Finally, fellows should employ a growth mindset to optimize clinical time by discussing expectations with involved stakeholders prior to rotations and explicitly identifying goals for feedback and improvement. Program directors can also help stakeholders including faculty, residency programs, medical schools, and other health care professionals on the clinical teams prepare for this transition by providing expectations for the fellow role and by soliciting questions and feedback before and after fellows begin.

One of the key tenets of the growth mindset is actively seeking out constructive feedback and learning from failures to grow and improve. This can be a particularly useful practice for fellows during the course of their scholarly pursuits in clinical research, quality im-

provement, and medical education. From initial stages of idea development through the final steps of manuscript submission and peer review, fellows will undoubtedly navigate a plethora of challenges and setbacks along the way. Program directors and other core faculty members can promote a growth mindset culture by honestly discussing their own challenges and failures in career endeavors in addition to giving thoughtful constructive feedback.

Fellows should routinely practice explicitly identifying knowledge and skills gaps that represent areas for potential improvement. But perhaps most importantly, fellows must strive to see all feedback and perceived failures not as personal affronts or as commentaries on personal abilities, but rather as opportunities to strengthen their scholarly products and gain valuable experience for future endeavors.

Not all learners will come equipped with a growth mindset. So, what can fellows and program directors in new programs do to develop this practice and mitigate some of the inevitable uncertainty? To begin, program directors should think about how to create cultures of growth and development, as the fixed and growth mindsets are not just limited to individuals.³ Program directors can strive to augment this process by committing to solicit feedback for themselves and acknowledging their own vulnerabilities and perceived weaknesses.

Fellows must have early, honest discussions with program directors and other stakeholders about expectations and goals. Program directors should consider creating lists of "must meet" individuals within the institution that can help fellows begin to carve out their roles in the clinical, educational, and research realms. Deliberately crafting a mentorship team that will encourage a commitment to growth and improvement is critical. Seeking out growth feedback, particularly in areas that prove challenging, should become common practice for fellows from the onset.

Most importantly, fellows should reframe uncertainty as opportunity for growth and progression. Seeing oneself as a work in progress



Dr. Herchline is a pediatric hospitalist at Cincinnati Children's Hospital Medical Center and recent fellow graduate of the Children's Hospital of Philadelphia. During fellowship, he completed a master's degree in medical education at the University of Pennsylvania. His academic interests include graduate medical education, interprofessional collaboration and teamwork, and quality improvement.

provides a new perspective that prioritizes learning and emphasizes improvement potential.

Embodying this approach requires patience and practice. Being part of a newly created fellowship represents an opportunity to learn from personal challenges rather than leaning on the precedent set by previous fellows. And although fellows will often face uncertainty as a part of the novelty within a new program, they can ultimately succeed by practicing the principles of Dweck's Growth Mindset: embracing challenges and failure as learning experiences, seeking out feedback, and pursuing the opportunities among ambiguity.

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CEO Corner

Never prouder to be a hospitalist

By Eric E. Howell, MD, MHM

I have been a proud hospitalist for more than 20 years, and yet I have never been prouder to be a hospitalist than now. The pandemic has been brutal, killing more than 620,000 Americans as of this writing. It has stretched the health care system, its doctors, nurses, and other providers to the limit. Yet we will get through it, we are getting through it, and hospitalists deserve a huge portion of the credit.

According to the Centers for Disease Control and Prevention, there have been over 2.5 million COVID-19 hospitalizations. In my home state of Maryland, between two-thirds and three-quarters of hospitalized COVID patients are cared for on general medical floors, the domain of hospitalists. When hospitals needed COVID units, hospitalists stepped up to design and staff them. When our ICU colleagues needed support, especially in those early dark days, hospitalists stepped in. When our outpatient colleagues were called into the hospital, hospitalists were there to help them on board. When the House of Medicine was in chaos because of COVID-19, hospitalists ran toward that fire. Our previous 20+ years of collective experience made us the ideal specialty to manage the inpatient challenges over the last 18 months.

- Need a new clinical schedule by Sunday? Check.
- Need help with new clinical protocols? Check.

- Need to help other colleagues? Check.
- Need to reprogram the EMR? Check.
- Need a new way to teach residents and students on the wards? Check.
- Need a whole new unit – no, wait – a new hospital wing? No, scratch that – a whole new COVID hospital in a few weeks? Check. (I personally did that last one at the Baltimore Convention Center!)

For me and many hospitalists like me, it is as if the last 20 years were prep work for the pandemic.

Here at SHM, we know the pandemic is hard work – exhausting, even. SHM has been actively focused on supporting hospitalists during this crisis so that hospitalists can focus on patients. Early in the pandemic, SHM quickly pivoted to supply hospitalists with COVID-19 resources in their fight against the coronavirus. Numerous COVID-19 webinars, a COVID addendum to the *State of Hospital Medicine* Report, and a dedicated COVID issue of the *Journal of Hospital Medicine* were early and successful information dissemination strategies.

As the world – and hospitalists – dug in for a multiyear pandemic, SHM continued to advance the care of patients by opening our library of educational content for free to anyone. Our Public Policy Committee was active around both COVID-19– and hospitalist-related topics: immigration, telehealth, well-being, and

financial impacts, to name a few.

As the pandemic slogged on, our Wellbeing Task Force came up with innovative support measures, including a check-in guide for hospitalists and fellow health care workers and dedicated wellness sessions complete with a licensed therapist for members. All the while, despite the restrictions and hurdles the pandemic has thrown our way, SHM members keep meeting and collaborating through virtual chapter events, committee work, Special Interest Groups, and our annual conference, SHM Converge. Thank you to the countless members who donated their time to SHM, so that SHM could support hospitalists and their patients.

For the past few months, we have been slowly transitioning into a new phase of the pandemic. The medical miracles that are the COVID-19 vaccines have made that possible. Don't get me wrong; as I write, the Delta variant has a tight grip on the nation, and "breakthrough" infections of the fully vaccinated are making headlines. What data are available show that the vaccinated remain extremely well protected from hospitalization and death due to COVID-19. (I'll take a sore throat over those other two any day.) Although I am still careful, masking up indoors and following the most recent CDC guidelines, as someone fully vaccinated, I am reasonably comfortable traveling again. In August, I went to the Atlanta and Baltimore Chapter meetings, both held in person. I was able to interact personally with fellow, masked-up hospitalists, and it was incredibly rewarding. We still must remain vigilant and do all we can to prevent us from further backtracking and increasing the stress on health care workers around the country; after all, they have sacrificed and continue to sacrifice. Yet, I can't help but remain optimistic that this pandemic will begin to ease, allowing more opportunities for us to rebuild our personal and professional lives.

No matter in what direction the coronavirus takes us, SHM will continue to pivot to meet our members' needs. Looking ahead, we have started planning for more in-person education and networking events. We will continue to actively monitor data to ensure the safety of our members and the patients they



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serve, and will put protocols in place to limit potential spread of the virus at any SHM events as needed.

For those chapters that are able and willing to meet in person safely, SHM is happy to provide the visiting faculty. Our Board of Directors and other SHM leaders are also starting to meet with members in person. With added protection and careful planning, our own Leadership Academy will take place as an in-person event at Amelia Island in Florida this October, where we can learn, network, and even decompress. We also can't wait for SHM Converge 2022 in Nashville, where we hope to reunite with many of you after 2 years of virtual conferences.

Our response to the pandemic, a once-in-a-century crisis where our own safety was at risk, where doing the right thing might mean death or harming loved ones, our response of running into the fire to save lives is truly inspiring. The power of care – for our patients, for our family and friends, and for our hospital medicine community and the community at large – is evident more now than ever.

There have always been good reasons to be proud of being a hospitalist: taking care of the acutely ill, helping hospitals improve, teaching young doctors, and watching my specialty grow by leaps and bounds, to name just a few. But I've never been prouder than I am now.



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