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p12

Dr. Masina Wright aims for equitable care for transgender patients



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IN THE LITERATURE

Mount Sinai

p5

Drs. Siau, Hui, Jordan, Kochar, Reiff-Pasarew, Shenoy, Shinwa, and Epstein's med-lit reviews

KEY CLINICAL QUESTION

Drs. Naidu, Hall, and Gray ask...

p18

What's the best initial management of a pressure injury?

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CONTENT



IN THE NEXT ISSUE...

SHM Converge 2024 session recaps

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Coding Corner: Billing by Time

By Arunab Mehta, MD, MEd, FHM

A 66-year-old man with a history of hypertension was admitted to the hospital with chest pain and shortness of breath. He was found to have an acute pulmonary embolism on CT pulmonary angiography (CTPA), and had a complete blood count, basic metabolic panel, and INR. A chest X-ray was done, and an ultrasound of the legs was ordered. You see him on day two of admission.

You spend five minutes reviewing the labs, CTPA report, and overnight history and physical; four minutes listening to the overnight resident tell you about this patient; five minutes talking about this patient on social-work rounds; 10 minutes speaking to and examining the patient; 10 mins (throughout the day) talking to the nurse about heparinized partial prothrombin time orders and intravenous-line-related issues; and 15 minutes writing your note and putting in orders. You speak to the patient's sister for 10 minutes. You also spend 30 minutes coming to the hospital and 40 minutes going home.

What level of billing does this qualify for?

This would qualify for level 3 (99233) level of billing. He would qualify based on the 54 minutes spent on his care that day. Travel time here will not be counted. If



50 minutes is met or exceeded for subsequent visits, it qualifies for level 3 billing. The times for 99232 and 99231 are 35 and 25 minutes, respectively. Times for 99221, 99222, and 99223 are 40, 55, and 75 minutes, respectively. Times for 99234, 99235, and 99236 are 45, 70, and 85 minutes, respectively.

Tip

You can choose to bill a patient by time. Preparing to see the patient, obtaining, and reviewing tests, performing a medical examination, counseling and educating the patient and family, ordering tests, medications, and procedures, referring and communicating with other healthcare professionals, documentation, interpreting and communicating test results with the patient and family, and care coordination can be used for billing by time. Remember that travel, teaching, and separately billed activities cannot be counted toward time for billing. ■

Dr. Mehta is the medical director and an assistant professor of medicine at the University of Cincinnati Medical Center in Cincinnati.

From JHM

An estimated 1.6 million transgender adults live in the U.S. Transgender and gender-diverse adults experience social and legal discrimination and this stigma permeates into medical settings.

A 2022 study showed that 48% of transgender individuals had negative healthcare experiences, and 24% delayed seeking care because of fear of discrimination.

Transgender individuals face increased rates of health issues, including psychiatric disorders, suicidal ideation, human immunodeficiency virus infection, cardiovascular diseases, physical violence, and mortality. Within this population, hospitalization rates and the primary reasons for hospitalization are inadequately characterized.

Given the known health disparities that exist for transgender

patients the authors hypothesized that transgender individuals admitted to the hospital would also have higher mortality and resource utilization than cisgender individuals.

This is an excerpt from *Hospitalizations and Transgender Patients in the United States*, written by Keshav Khanijow MD, Scott Wright MD, Helene Hedian MD, and Che Harris MD, published in the *Journal of Hospital Medicine's* April 2024 issue.

Scan the QR code for the full article. ■



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SHM'S DIVERSITY AND INCLUSION STATEMENT

Hospitalists are charged with treating individuals at their most vulnerable moments, when being respected as a whole person is crucial to advancing patients' healing and wellness. Within our workforce, diversity is a strength in all its forms, which helps us learn about the human experience, grow as leaders, and ultimately create a respectful environment for all regardless of age, race, religion, national origin, gender identity, sexual orientation, socioeconomic status, appearance, or ability. To this end, the Society of Hospital Medicine will work to eliminate health disparities for our patients and foster inclusive and equitable cultures across our care teams and institutions with the goal of moving medicine and humanity forward.

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Bridging Healthcare Disparities: A Call to Action for LGBTQIA+ Inclusive Care

Empowering hospitalists through a gender-inclusive care toolkit

By **Gagandeep Dhillon, MD, MBA, Harpreet Grewal, MD, Venkata Buddhavarapu, MD, Ripudaman Munjal, MD, and Rahul Kashyap, MD, MBA, FCCM**

Our first and foremost duty in healthcare is to provide our patients with compassionate and equitable care. Members of the lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual (LGBTQIA+) community often face significant barriers within the healthcare system. Our duty as healthcare practitioners and leaders of healthcare institutions is to address these issues and work toward inclusivity.

Over the years, we have heard heartbreaking stories about the experiences of LGBTQIA+ patients with healthcare providers.¹ LGBTQIA+ individuals often face unique healthcare needs that clinicians overlook due to education gaps and discrimination.² These include improper identification, dismissiveness of gender-identity roles, discrimination with treatment options, and many more. Additionally, the community also exhibits higher rates of substance abuse, suicide, promiscuous sexual behaviors, behavioral health issues, and self-harm.³

These issues illustrate the urgency of taking action to improve inclusive healthcare provision and rectify systemic flaws. In response, we initiated a collaborative project to develop a Gender Inclusive Care Toolkit for Hospitals.⁴ We did this by conducting a rigorous examination of medical journals and interviewing patients and clinicians representing the LGBTQIA+ community to understand how we could better meet the care needs of our patients. We consolidated those insights into resources that could easily be adapted for use in institutions from large academic medical centers to community hospitals and local practices. By tackling these important concerns and offering feasible solutions, we aim to help more healthcare settings provide fairer and more equitable care to everyone.

Despite advances in legal protections and acceptance of the community, there have been barriers to LGBTQIA+ patients receiving equitable and inclusive healthcare. Evidence indicates that LGBTQIA+ individuals are more likely to use tobacco than cisgender heterosexual adults and sexual minority women have been



Dr. Dhillon



Dr. Grewal



Dr. Buddhavarapu



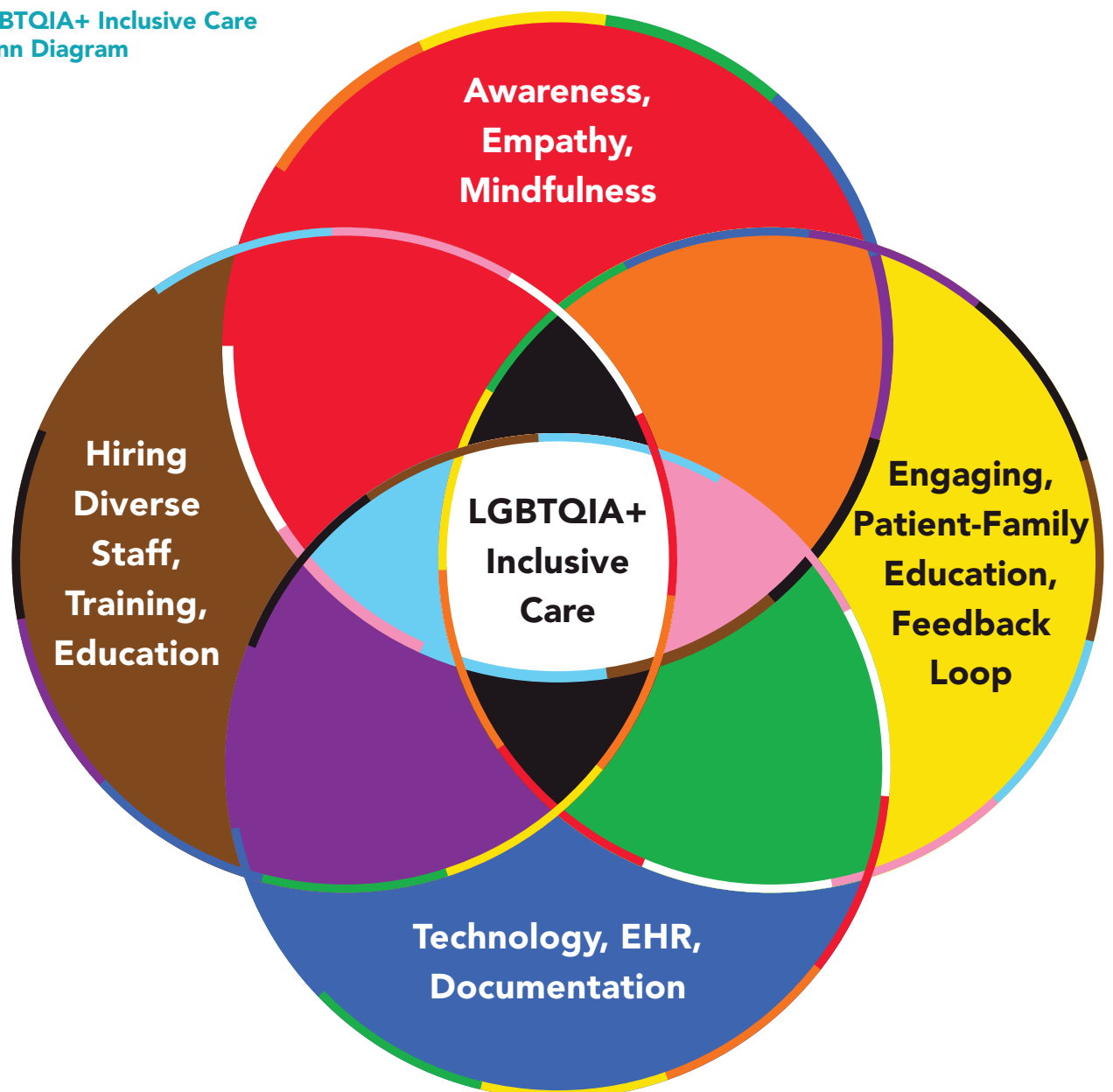
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Dr. Dhillon is an assistant medical director at Adfinitas Health in Hanover, Md., and an adjunct assistant professor and hospitalist at the University of Maryland Baltimore Washington Medical Center in Glen Burnie, Md. Dr. Grewal is a radiologist and an assistant professor at Florida State University College of Medicine in Pensacola, Fla. Dr. Buddhavarapu is a hospitalist at Banner Health's Banner Baywood Medicine Center, Banner Health, in Mesa, Ariz. Dr. Munjal is an adjunct assistant professor in the department of nephrology at Touro University College of Osteopathic Medicine in Vallejo, Calif. Dr. Kashyap is the medical director research at WellSpan Health in York, Pa., and assistant professor of anesthesiology at the Mayo Clinic in Rochester, Minn.

LGBTQIA+ Inclusive Care Venn Diagram



reported as having higher BMI than their heterosexual counterparts.⁵

The toolkit offers a host of resources and guidelines designed to increase awareness of innate biases. The toolkit also provides valuable resources on healthcare disparities experienced by LGBTQIA+ people, equipping healthcare practitioners with

knowledge on recognizing and mitigating unconscious biases to provide compassionate, respectful, culturally competent care. With the toolkit, the goal was to equip healthcare staff with tools for identifying and combating unconscious biases that may negatively impact patient care by providing information on healthcare disparities, collaborating with organizations for resources, and

increasing the training we provide medical and nursing students so that LGBTQIA+ care becomes an essential part of their studies.

Here are a few salient points from the toolkit:

- Empathy and mindfulness can serve as the cornerstones of building trust with patients. Hospitalists working with LGBTQIA+ patients should

adopt an inclusive mindset, employ culturally sensitive terminology, and practice active listening. This ensures a non-judgmental atmosphere that protects privacy while simultaneously creating space for open and honest communications.

- Technology can play an invaluable role in providing better healthcare to members of the LGBTQIA+ community. Electronic health records (EHRs) provide us with a powerful ally in this effort by ensuring the “sexual orientation” and “gender identity” data fields are always readily available within healthcare systems. Every visit is reviewed to ensure EHR entries are culturally sensitive; this allows every aspect of care provided for LGBTQIA+ patients to be tailored specifically.
- Culture-competent healthcare requires meaningful patient engagement throughout the hospitalization. Our aim at every step should be to include patients and family members during their healthcare journey, building open relationships between hospitalist and patient with empathic communication and trust among clinicians and patients alike. Respecting the identities of our patients and using preferred pronouns are

SHM’s CME in LGBTQIA+ Health

SHM offers continuing medical education (CME) content (free for members) developed by the LGBTQIA+ Task Force of the SHM Education Committee.

This series is geared toward physicians, nurse practitioners, and physician assistants practicing hospital medicine.

Objectives include:

- Recognize LGBTQ+ as a social determinant of health.
- Document using language that is consistent with the patient’s sexual orientation and gender identity.
- Recognize that risk scoring systems and laboratory refer-

ence ranges are not validated for transgender patients.

- Described the risk of abruptly stopping gender-affirming hormone therapy.
- Describe best practices for pre-exposure prophylaxis (PreP) therapy while patients are admitted to the hospital.
- Identify methods to advocate for LGBTQ+ patients.
- Apply methods for discussing gender identity, organ inventory, and sexual orientation with patients.
- Courses include:
 - LGBTQ+ Affirming Language and Documentation

- Inpatient Care of Transgender Individuals: Gender Affirming Hormone Therapy
 - LGBTQ+ as a Social Determinant of Health
 - Advocacy for/with LGBTQ+ Persons: Population and Policy
 - PrEP 101: A Hospitalist’s Guide to HIV Pre-Exposure Prophylaxis
- Scan the QR code for more information and registration. ■



powerful yet simple gestures of inclusion that demonstrate our dedication.

- Communication and feedback loops are vital for continuous improvement. By conducting patient-satisfaction and process-improvement surveys after every encounter, we gain invaluable insight into strengths and growth opportunities. Sharing these results with healthcare professionals and administra-

tors promotes accountability while quickly addressing any deficiencies or weaknesses.

- Diversity is not only a goal but also a necessity in the healthcare workforce. We enrich our institutions by actively recruiting and supporting LGBTQIA+ employees. Building trust and communication channels between healthcare professionals and patients is crucial to creating an environment where everyone feels understood and valued.
- Education is at the core of our strategy to reduce healthcare disparities experienced by LGBTQIA+ people. By including training on bias against this community in medical and nursing curricula, future generations will possess the knowledge and skills to provide equal care for everyone. And developing bias-reduction skills among students is vital in creating more inclusive healthcare environments.

This toolkit features practical measures designed to increase empathy and mindfulness among healthcare providers, use technology to better care for LGBTQIA+ patients, include families and patients in decision-making, implement feedback loops and closed communication for continuous improvement, as well as increase diversity within the healthcare workforce. By employing the above measures within their institutions, hospitals can foster more inclusivity in the workplace. Even simple educational techniques, such as attending training sessions on using inclusive language and practices with patients and advocating for institutional resources and support, can create environments where LGBTQIA+ people feel valued, respected, and understood.

LGBTQIA+ patients experience various mental health challenges that include emotional distress,

stigmatization, victimization, discrimination, and barriers to healthcare services.⁶ Although LGBTQIA+ rights have been legalized across numerous nations; they still experience significant mental health challenges that require further attention. The Gender Inclusive Care Toolkit for Hospitals is an important and tangible step toward addressing healthcare disparities and promoting LGBTQIA+ inclusive care. Hospitalists can play an essential role in creating healthcare environments that empower and respect all people through increased awareness of bias, improved patient engagement, technology advances, and commitments to diversity education and training. There is something special and comforting about being part of something bigger, and being around other like-minded individuals who empathize with other communities and groups. Our toolkit can promote this positive culture in a stressful setting and thus significantly improve patient satisfaction. ■

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Icahn School of Medicine at Mount Sinai Medical Research Reviews

By Evan Siau, MD, MPH, FACP, Jennifer Hui, MD, Kevin P. Jordan, MD, Aveena Kochar, MD, Faye Reiff-Pasarew, MD, Shantheri Shenoy, MD, Masih Shinwa, MD, and Jeff Epstein, MD

Icahn School of Medicine at Mount Sinai, New York

IN THIS ISSUE

1. Elevated fibrinogen and D-dimer relative to C-reactive protein linked to cognitive deficits post-COVID-19 hospitalization
2. Frequent PT in hospital increases home discharge for pneumonia patients
3. Liberal transfusion strategy in acute myocardial infarction patients with anemia not shown to significantly reduce recurrent MI or death
4. Limited utility in using NT-proBNP rather than functional capacity to estimate risk of perioperative MACE
5. High-sensitivity versus conventional troponin in assessing PE risk
6. Semaglutide reduces major adverse cardiovascular events by 20% in patients with cardiovascular disease
7. Comparing in-hospital adverse events in elderly postoperative delirium patients: haloperidol versus atypical antipsychotics
8. Hydrocortisone reduces mortality in severe CAP

By Evan Siau, MD, MPH, FACP

1 Elevated fibrinogen and D-dimer relative to C-reactive protein linked to cognitive deficits post-COVID-19 hospitalization

CLINICAL QUESTION: Are acute blood biomarker profiles predictive of cognitive deficits following COVID-19 hospitalizations?

BACKGROUND: Cognitive deficits have been observed in many patients after COVID-19 hospitalizations, with one study showing one in eight patients receiving their first-ever neurological or psychiatric diagnosis within six months after COVID-19. The mechanism remains unknown and it's unclear if specific biomarker profiles can predict cognitive deficits post-COVID-19 hospitalization.



Dr. Siau

STUDY DESIGN: Multicenter, prospective cohort study

SETTING: 83 hospitals across the United Kingdom

SYNOPSIS: This study investigated 1,837 patients from the posthospitalization COVID-19 (PHOSP-COVID) cohort (average age 57.9, 36.6% female) to determine whether blood biomarkers could predict cognitive deficits post-COVID-19 hospitalization.

Six biomarkers were measured upon hospital admission, namely C-reactive protein (CRP), D-dimer, fibrinogen, lymphocyte, neutrophil, and platelet counts. Cognitive assessments, including the Montreal Cognitive Assessment (MoCA) for objective deficits and the Patient Symptom Questionnaire (C-PSQ) for subjective deficits, were conducted at six and 12 months post-hospitalization.

The study found elevated fibrinogen levels relative to CRP were associated with both objective and subjective cognitive deficits (lower MoCA scores and higher C-PSQ scores). Elevated D-dimer relative to CRP was associated with subjective cognitive deficit (higher C-PSQ scores), and signs of occupational impact. These associations were validated in a separate dataset of more than 90 million patients as not attributable to pre-COVID-19 cognitive function. The study's observational nature is a limitation, and while the associations weren't significantly mediated by depression or anxiety, fatigue and dyspnea partly mediated elevated D-dimer levels' association with cognitive deficits.

BOTTOM LINE: Elevated fibrinogen or D-dimer levels relative to CRP are associated with cognitive deficits at six and 12 months post-COVID-19 hospitalization.

CITATION: Taquet M, Skorniewska Z, et al. Acute blood biomarker profiles predict cognitive deficits 6 and 12 months after COVID-19 hospitalization. *Nat Med.* 2023;29(10):2498-508.

2 Frequent PT in hospital increases home discharge for pneumonia patients

CLINICAL QUESTION: Does increased frequency of physical therapy (PT) for hospitalized pneumonia patients affect their discharge to home versus to a post-acute care facility?

BACKGROUND: Each year, one million older adults in the U.S. are hospitalized for pneumonia, with a third eventually discharged to post-acute care facilities. Prior research indicates that early PT has been linked to shorter length of stay (LOS), and frequent PT has been linked to reduced readmission rates. However, the impact of in-hospital PT visit frequency on discharge disposition is not well established.

STUDY DESIGN: Observational cohort study

SETTING: 595 hospitals across the U.S.

SYNOPSIS: The study analyzed 18,886 hospitalized patients, focusing on those receiving PT on the first and fifth days within a five-day window. Exclusion criteria included transfer to or from another acute hospital, intensive care unit stay, and long-term care residents.

Patients had higher home-discharge rates if receiving PT on all five days (+6.1%; 95% confidence interval [CI], 3.5% to 8.6%) or four out of five days (+3.6%; 95% CI, 1.1% to 6.0%) compared to those receiving PT on two out of five days. Lower in-hospital mortality rates were observed in patients receiving PT on all five days and four out of five days (-1.3% and -1.0%, respectively) compared to patients receiving PT on two out of five days. However, no significant association was found between PT frequency and mortality after adjusting for hospital and patient characteristics.

Of note, more-frequent-PT patients were older and more likely to be non-Hispanic and white, with fewer severe illness indicators. The study's limitations, including its observational nature, exclusion of patients receiving no days or one day of PT, and lack of comprehensive clinical data should be noted.

BOTTOM LINE: Increased frequency of PT visits for hospitalized pneumonia patients is associated with a higher likelihood of discharge to home.

CITATION: Young DL, Johnson JK, et al. Association between physical therapy frequency and post-acute care for a national cohort of patients hospitalized with pneumonia. *J Hosp Med.* 2023;18(9):803-11.

Dr. Siau is a hospitalist in the division of hospital medicine at the Mount Sinai Health System and assistant professor of medicine at the Icahn School of Medicine at Mount Sinai in New York.

By Jennifer Hui, MD

3 Liberal transfusion strategy in acute myocardial infarction patients with anemia not shown to significantly reduce recurrent MI or death

CLINICAL QUESTION: What should be the transfusion target for patients hospitalized for myocardial infarction (MI) with anemia?

BACKGROUND: Data on the optimal transfusion target for patients with MI and concurrent anemia are less established than for patients without active ischemia. To date, there have been three randomized trials, involving a total of 820 patients, investigating this issue. The largest of these



Dr. Hui

was a European study with 668 patients and a noninferiority design that found restrictive transfusion (<8 g/dL) to be noninferior to liberal transfusion (≤10 g/dL) for the composite endpoint of death, reinfarction, stroke, and emergency revascularization at 30 days.

STUDY DESIGN: Phase 3, open-label, randomized, controlled trial

SETTING: 144 sites in the U.S., Canada, France, New Zealand, and Australia

SYNOPSIS: A total of 3,506 patients with STEMI or NSTEMI (type 1 or 2) with Hgb <10 g/dL were randomized to a restrictive transfusion strategy (for Hgb <7 to 8 g/dL) or a liberal strategy (Hgb <10 g/dL). Comparing restrictive and liberal transfusion-strategy groups, the composite primary outcome of MI or all-cause death within 30 days occurred in 16.9% versus 14.5% of patients, respectively (Relative Risk, 1.15; P=0.07), while secondary outcomes of death occurred in 9.9% versus 8.3% of patients and recurrent MI in 8.5% versus 7.2% of patients. In subgroup analyses, type 1 MI patients had higher rates of death or MI with restrictive management, an effect not seen for type 2 MI patients. The liberal strategy group had more protocol discontinuations (13.7% versus 2.6%), but only a small, nonsignificant increase in the incidence of heart failure (6.3% versus 5.8%) and other safety outcomes. Limitations include a lack of blinding, and that only the outcome of recurrent MI was centrally adjudicated. There was also heterogeneity in the MI population enrolled, with a majority (55.8%) with demand ischemia.

BOTTOM LINE: In the largest study on transfusion strategies in patients with MI and anemia, no significant difference in rates of recurrent MI or death was found between the restrictive (<7 to 8 g/dL) and liberal (≤10 g/dL) strategy groups, though slightly less favorable outcomes using the restrictive strategy was observed.

CITATION: Carson JL, Brooks MM, et al. Restrictive or liberal transfusion strategy in myocardial infarction and anemia. *N Engl J Med.* 2023;389(26):2446-56.

Dr. Hui is a hospitalist in the division of hospital medicine at the Mount Sinai Health System and assistant professor of medicine at the Icahn School of Medicine at Mount Sinai in New York.

By Kevin P Jordan, MD

4 Limited utility in using NT-proBNP rather than functional capacity to estimate risk of peri-operative MACE

CLINICAL QUESTION: Does adding N-terminal pro-B-type natriuretic peptide (NT-proBNP) to clinical risk scores provide a better estimate of the risk of major adverse cardiac events (MACE) among patients undergoing noncardiac surgery (NCS) than the addition of self-reported functional capacity?



Dr. Jordan

BACKGROUND: Guidelines recommend using functional capacity or B-type natriuretic peptides to guide perioperative management, but limited data compare the performance of these approaches.

STUDY DESIGN: Prospective cohort study

SETTING: 25 hospitals in Europe across 10 countries

SYNOPSIS: 3,597 patients undergoing elevated-risk NCS were enrolled between June 2017 and April 2020. The primary endpoint of in-hospital MACE occurred in 86 patients (2.4%). The addition of NT-proBNP to a clinical risk score model increased discrimination for in-hospital MACE. The discrimination gained from the addition of self-reported functional capacity to the clinical risk score model did not reach statistical significance. The discrimination of the two models (adding NT-proBNP, versus functional capacity, to the clinical risk score) did not significantly differ. Decision analysis demonstrated that models incorporating NT-proBNP offered a net benefit over those using functional capacity measures but found the benefit to be marginal. Study limitations include lack of external validation, possible selection bias due to nonrandomized design, and heterogeneity of the surgical procedures and perioperative management.

BOTTOM LINE: NT-proBNP may improve the estimation of in-hospital MACE risk after NCS but may be no better at doing so than self-reported functional capacity.

CITATION: Buse GL, Larmann J, et al. NT-proBNP or self-reported functional capacity in estimating risk of cardiovascular events after noncardiac surgery. *JAMA Netw Open.* 2023;6(11):e2342527. doi:10.1001/jamanetworkopen.2023.42527

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By Aveena Kochar, MD

5 High-Sensitivity versus conventional troponin in assessing PE risk

CLINICAL QUESTION: Is high-sensitivity cardiac troponin I (hs-cTnI) better at predicting outcomes for hemodynamically stable pulmonary embolism (PE) than conventional cardiac troponin I (cTnI)?



Dr. Kochar

BACKGROUND: Hs-cTnI is more sensitive compared to cTnI, but traditional PE risk scores rely on cTnI.

STUDY DESIGN: Multicenter cohort study

SETTING: 12 hospital emergency departments in Spain

SYNOPSIS: In post-analysis of the PROTECT study of 834 hemodynamically stable PE patients, 139 patients (16.7%) had a positive cTnI versus 264 hs-cTnI patients (31.7%). A complicated course (hemodynamic collapse, recurrent PE, or 30-day mortality) occurred in 62 patients (7.4%; 95% CI, 5.7-9.4). Hs-cTnI as a binary variable was not associated with significantly increased odds of a complicated course (odds ratio [OR], 1.12; (95% CI, 0.65-1.93) as compared to cTnI (OR, 2.84; 95% CI, 1.62-4.98). None of the 125 patients who had elevated hs-cTnI with normal cTnI developed a complicated course.

Using the European Society of Cardiology 2019 risk stratification and cTnI, 247 patients (29.6%) were designated as low-risk. Within this group,

CPAP reduces cardiovascular events

By Aveena Kochar, MD

This meta-analysis evaluated 4,186 outpatients with obstructive sleep apnea and a history of cardiovascular disease and showed those who used continuous positive airway pressure for more than four hours a day (versus not at all) had a reduction in the risk of major adverse cardiac and cerebrovascular events.

CITATION: Sánchez-de-la-Torre M, Gracia-Lavedan E, et al. Adherence to CPAP treatment and the risk of recurrent cardiovascular events: a meta-analysis. *JAMA.* 2023;330(13):1255-65.

Dr. Kochar is a hospitalist in the department of hospital medicine at Mount Sinai Hospital, and an assistant professor of medicine at the Icahn School of Medicine in New York. ■

78 (31.6%) had a positive hs-cTnI, but none had a complicated course.

BOTTOM LINE: In patients with stable PEs, hs-cTnI overestimated the 30-day risk of mortality and did not change risk stratification.

CITATION: Bikdeli B, Muriel A, et al. High-sensitivity vs conventional troponin cutoffs for risk stratification in patients with acute pulmonary embolism. *JAMA Cardiol.* 2024;9(1):64-70.

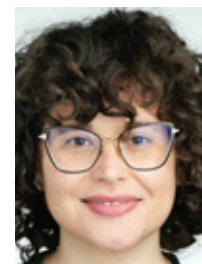
Dr. Kochar is a hospitalist in the department of hospital medicine at Mount Sinai Hospital, and an assistant professor of medicine at the Icahn School of Medicine in New York.

By Faye Reiff-Pasarew, MD

6 Semaglutide reduces major adverse cardiovascular events by 20% in patients with cardiovascular disease

CLINICAL QUESTION: Does semaglutide reduce cardiovascular events in non-diabetics with cardiovascular disease?

BACKGROUND: While glucagon-like peptide-1 (GLP-1) agonists reduce cardiovascular events in diabetics with high cardiovascular risk, it is unknown whether they reduce cardiovascular events in non-diabetic patients with preexisting cardiovascular disease. Weight loss is associated with a reduction in cardiovascular risk, but it is unknown whether GLP-1 agonists confer a benefit beyond weight loss.



Dr. Reiff-Pasarew

STUDY DESIGN: Multicenter, double-blind, randomized, placebo-controlled, trial

SETTING: 804 sites in 41 countries

SYNOPSIS: A total of 17,604 patients over age 45 with a BMI over 27 and a history of cardiovascular disease (myocardial infarction [MI], cerebrovascular accident [CVA], or symptomatic peripheral arterial disease) were randomized to semaglutide 2.4 mg per week versus placebo. Exclusion criteria were diabetes, end-stage renal disease, heart failure, pregnancy, recent cardiovascular event, or planned cardiovascular intervention. Patients were followed for a mean of 40 months. A composite of cardiovascular death, MI, and CVA occurred in 8.0% and 6.5% in

the placebo and semaglutide groups, respectively, with a statistically significant hazard ratio of 0.80. At week 104, those in the semaglutide group lost 9.39% of body weight versus 0.88% in the placebo group. The survival and time to primary endpoint differed between the groups before significant weight loss occurred, suggesting that semaglutide reduces cardiovascular risk beyond its effect on weight loss. Limitations were that the population was 72% male and 84% white. The study was sponsored by Novo Nordisk.

BOTTOM LINE: Semaglutide reduces cardiovascular events and death among overweight or obese non-diabetic patients with cardiovascular disease.

CITATION: Lincoff AM, Brown-Frandsen K, et al. Semaglutide and cardiovascular outcomes in obesity without diabetes. *N Engl J Med.* 2023;389(24):2221-32.

Dr. Reiff-Pasarew is the deputy chief medical officer and associate chief of hospital medicine in the division of hospital medicine at the Mount Sinai Health System, and an associate professor of medicine at the Icahn School of Medicine at Mount Sinai in New York.

By Shantheri Shenoy, MD

7 Comparing in-hospital adverse events in elderly post-operative delirium patients: haloperidol versus atypical antipsychotics

CLINICAL QUESTION: Are in-hospital adverse events worse in post-operative delirium patients treated with haloperidol compared to atypical antipsychotics?



Dr. Shenoy

BACKGROUND: Post-operative delirium is common in the elderly and can lead to prolonged length of stay, institutional discharge, and increased healthcare costs. While non-pharmacological management is preferred, antipsychotics are commonly used in this population. Over the years, the use of haloperidol has declined, and there is a rise in the use of atypical antipsychotics, particularly in the elderly. This retrospective study looked at in-hospital adverse events, including death, cardiac arrhythmia, pneumonia, stroke, and transient ischemic attack in patients treated with haloperidol, olanzapine, quetiapine, and risperidone for postoperative delirium.

STUDY DESIGN: Retrospective cohort study

SETTING: Premier healthcare database which includes 900 hospitals

SYNOPSIS: The study population included patients over the age of 65 undergoing major surgery, as defined by AHRQ procedure classification. Patients who received antipsychotics on or before the day of surgery, had indications for antipsychotics for other diagnoses, or received medications seven days or more after surgery or via parenteral route were excluded. 17,115 patients were analyzed using propensity-score-based overlap weighting. Patients treated with haloperidol were older and had higher medical acuity. The risk of death for patients treated with haloperidol was 3.0% compared to 3.3%, 2.6%, and 2.8% for risperidone, quetiapine, and olanzapine respectively, with no statistically significant difference. The differences in sec-

SHORT TAKES

Universal decolonization in nursing homes reduced risk of hospitalization for infection

By Jeff Epstein, MD

Randomized trial demonstrated that universal decolonization among nursing home residents with chlorhexidine and nasal iodophor significantly reduced rates of hospitalization for infection as well as decreased prevalence of

carriage of multi-drug resistant organisms.

CITATION: Miller LG, McKinnell JA, et al. Decolonization in nursing homes to prevent infection and hospitalization. *N Engl J Med.* 2023;389(19):1766-77.

More frequent use of CTA ordered for suspected pulmonary embolism by ED providers

Retrospective analysis across international emergency departments showed statistically significant increased use of computed tomography angiographies to rule out suspected pulmonary embolism (PE) since 2015. Although the study found this correlated with higher numbers of PE diagnoses, there was also a rising rate of low-risk PEs resulting in outpatient

management.

CITATION: Roussel M, Bloom B, et al. Temporal trends in the use of computed tomographic pulmonary angiography for suspected pulmonary embolism in the emergency department: a retrospective analysis. *Ann Intern Med.* 2023;176(6):761-8.

Supervised walking program during hospitalization reduces discharges to SNF

A randomized trial demonstrated that a supervised walking program significantly reduced rates of discharge to a skilled nursing facility from 13% to 8% among previously community-dwelling adults over the age of 60, but did not significantly impact hospital lengths of stay or inpatient falls.

al. Effects of implementation of a supervised walking program in Veterans Affairs hospitals: a stepped-wedge cluster randomized trial [published correction appears in *Ann Intern Med.* 2023 Oct 17]. *Ann Intern Med.* 2023;176(6):743-50.

Dr. Epstein is a hospitalist in the division of hospital medicine at Mount Sinai Hospital and an assistant professor of medicine at the Icahn School of Medicine at Mount Sinai in New York. ■

CITATION: Hastings SN, Stechuchak KM, et

ondary outcomes, including cardiac arrhythmia, pneumonia, stroke, or transient ischemic attack (TIA) were also not statistically significant.

BOTTOM LINE: The risk of in-hospital death, cardiac arrhythmia, pneumonia, and stroke or TIA was similar in elderly patients treated with haloperidol, olanzapine, risperidone, or quetiapine for post-surgical delirium.

CITATION: Kim DH, Lee SB, et al. Comparative safety analysis of oral antipsychotics for in-hospital adverse clinical events in older adults after major surgery: a nationwide cohort study. *Ann Intern Med.* 2023;176(9):1153-62.

Dr. Shenoy is the associate chief of hospital medicine at Mount Sinai West, and an associate professor of medicine at Icahn School of Medicine at Mount Sinai in New York.

By Masih Shinwa, MD

8 Hydrocortisone reduces mortality in severe CAP

CLINICAL QUESTION: Does early hydrocortisone therapy reduce mortality among patients with severe community-acquired pneumonia (CAP) requiring admission to an intensive care unit (ICU) or intermediate care unit?



Dr. Shinwa

BACKGROUND: Though there have been several small studies favoring the use of glucocorticoids in severe CAP, their data are mixed on mortality benefits. A recent, randomized, controlled trial (RCT) involving 586 patients showed no mortality benefit with the use of methylprednisolone, while a meta-analysis of multiple small RCTs has found mortality benefit from using glucocorticoids in severe CAP.

STUDY DESIGN: Multicenter, double-blind, randomized, controlled trial

SETTING: 31 sites in France

SYNOPSIS: From October 2015 to March 2020, 800 patients diagnosed with severe CAP were randomly assigned to the hydrocortisone group (401 patients) or placebo (399 patients). Patients in the hydrocortisone group received 200 mg per day intravenous hydrocortisone in continuous infusion for four to seven days followed by a taper within 24 hours of meeting eligibility criteria, including admission to an ICU or intermediate care unit. The trial excluded patients with septic shock treated with vasopressors. Antibiotics and other supportive treatments were left to the discretion of the treating team. Adverse events were similar in both groups except for a high incidence of hyperglycemia in the hydrocortisone group. All-cause 28-day mortality was significantly lower in the hydrocortisone group (6.2%) compared to the placebo group (11.9%). The use of invasive ventilation and vasopressors was also lower in the hydrocortisone group at 28 days.

Limitations of the study include a lower mortality rate in the control arm (11.9%) compared to predicted mortality of 27%, suggesting less severe illness in the cohort. Additionally, hydrocortisone was given in continuous infusion rather than bolus dosing.

BOTTOM LINE: Early hydrocortisone therapy reduces 28-day all-cause mortality and the need for mechanical ventilation and vasopressors in severe CAP.

CITATION: Dequin PF, Meziani F, et al. Hydrocortisone in severe community-acquired pneumonia. *N Engl J Med.* 2023;388(21):1931-41.

Dr. Shinwa is an academic hospitalist in the division of hospital medicine at the Mount Sinai Health System, and an assistant professor of medicine at the Icahn School of Medicine at Mount Sinai in New York.

SHM 2024 Awards of Excellence and Junior Investigator Award

SHM's Awards of Excellence Program honors members who've made exceptional contributions to hospital medicine in various categories. Please join *The Hospitalist* and SHM in congratulating the 2024 award winners.

Clinical Leadership for Physicians

Rachel Cyrus, MD, SFHM

Dr. Rachel Cyrus is an associate professor of medicine at Northwestern University's Feinberg School of Medicine in Chicago. Since 2012, she has been the clinical practice director for the division of hospital medicine at Northwestern. As part of her role, she's overseen the expansion of hospitalists from 40 to more than 100 physicians and advanced practice practitioners (APPs) who provide care to 290 complex patients across 12 units daily.



Dr. Cyrus

She has facilitated numerous changes to the physician support and service structure, including the proposal and incorporation of APPs, the creation of staffing buffers, the shift to an admit/rounder model, and the addition of a nurse role to help coordinate discharges. Even with rapid growth, hospitalist engagement scores have remained among the best in the past 20 years.

Dr. Cyrus currently serves as the first hospitalist chief of staff as well as associate chief medical officer for Northwestern Memorial Hospital in Chicago and participates in and leads numerous local quality committees.

Within SHM, she's been a member of the Practice Management Committee since 2017 and is finishing her third year as chair. She's also served as faculty and course co-director for the Practice Management Advanced Learning Courses at SHM Converge.

Clinical Leadership for NPs and PAs

Alexandra Gallant, PA-C

Lexie Gallant graduated from the University of Colorado's Child Health Associate/Physician Assistant Program in Aurora, Colo., and completed a fellowship in hospital medicine before joining the division of hospital medicine as faculty. As one of the lead APPs,

Ms. Gallant has spearheaded discussions around APP promotion and mentorship, aided in the recruitment of numerous APPs and leaders, and assisted with onboarding the institution's rapidly expanding hospitalist program.



Dr. Gallant

Observing the lack of feedback post-training, she developed a division-wide peer-feedback program for physicians and APPs to provide bidirectional feedback on clinical skills. With a strong desire to ensure her teammates thrive in the division, she became co-director of provider experience, where she collaborates with colleagues across the department of medicine on wellness-related initiatives.

She frequently advocates for her fellow hospitalists through practitioner experience rounds, where she discusses clinical and academic work and determines areas in need of improvement. Last year, she was awarded a grant aimed at improving practitioner workspaces for the institution's medical-oncology urgent-care clinic.

Diversity, Equity, and Inclusion Leadership

Areeba Kara, MD, MS

Dr. Areeba Kara was born and raised in Karachi, Pakistan, where she attended medical school at the Aga Khan University. She completed her internal medicine residency at the Indiana University School of Medicine in Indianapolis and joined IU's Health Methodist Hospital as a hospitalist in 2003. She is an associate professor and currently serves as the associate division chief and director of faculty development for the division of general internal medicine and geriatrics.



Dr. Kara

She enjoys the challenges of clinical hospital medicine. Upon seeing missed opportunities for asking and answering research questions in hospital medicine, she sought further training in clinical research methods. Dr. Kara has served roles furthering diversity, equity, inclusion, and justice at local, regional, and national levels, including within graduate medical

education, her division and department, SHM, and the HOMERuN collaborative.

She is also an assistant editor for the *Joint Commission Journal on Quality and Patient Safety*. Dr. Kara believes that hospitalists are uniquely positioned to tackle the complex and difficult issues of unconscious bias and healthcare disparities.

Excellence in Humanitarian Services

C. Nicholas Cuneo, MD, MPH

Dr. C. Nicholas Cuneo is board-certified in internal medicine and pediatrics with a background in refugee health, asylum medicine, and global health education. Dr. Cuneo is currently an assistant professor at the Johns Hopkins University School of Medicine. He works clinically as an attending med-peds hospitalist at Johns Hopkins Hospital and as a primary care physician to immigrant survivors of torture at Esperanza Center, both in Baltimore.



Dr. Cuneo

He is the founding medical director of HEAL Refugee Health & Asylum Collaborative in Baltimore, an organization that expands access to medicolegal, medical, and mental health services to forced migrants seeking refuge in the U.S. He also serves as co-lead of the national Asylum Medicine Training Initiative, which defines and disseminates best practices in the clinical evaluation of survivors of persecution seeking humanitarian protection.

Dr. Cuneo has lived and practiced abroad in diverse settings, including Mexico, Haiti, India, Lebanon, and South Africa. His work with asylum seekers in Baltimore and at the U.S.-Mexico border was the subject of a recent *New England Journal of Medicine* documentary.

He earned his BS at Duke University in Durham, N.C., his medical degree from Johns Hopkins in Baltimore, and his Master of Public Health from Harvard University in Cambridge, Mass. He completed the Harvard combined residency in medicine and pediatrics at Brigham and Women's Hospital and Boston Children's Hospital, both in Boston, and served as Global Health Equity Chief Resident.

Excellence in Research

Robert E. Burke, MD, MS, SFHM

Dr. Robert Burke is a tenured associate professor of medicine and the associate chief for research in the division of general internal medicine and division of hospital medicine at the University of Pennsylvania in Philadelphia. He is also a core investigator in the Center for Health Equity Research and Promotion at the Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center in Philadelphia.



Dr. Burke

Dr. Burke's research seeks to reduce unnecessary hospitalizations and long-term nursing home care for frail older adults. He is leading a Veterans Affairs (VA) implementation science program center seeking to implement evidence-based practices aligned with the Age-Friendly Health System model.

He is the principal investigator of an Agency for Healthcare Research and Quality R01 research project evaluating differences in post-acute care use between Medicare Advantage and fee-for-service beneficiaries, as well as a National Institute on Aging R01 evaluating the intended and unintended effects of the Skilled Nursing Facility Value-Based Purchasing Program. He is also leading a VA R01 intended to help the VA build a high-value, post-acute, care network in skilled nursing facilities.

He has published more than 100 papers in his research area, including publications in the *Journal of the American Medical Association*, *Health Affairs*, and the *Journal of Hospital Medicine*. Dr. Burke matriculated from the Stanford University School of Medicine in Stanford, Calif., and completed his internal medicine residency at Brigham and Women's Hospital in Boston.

Excellence in Teaching

Alfred Paul Burger, MD, MS, SFHM

Dr. Alfred Burger is a professor of medicine and medical education at the Icahn School of Medicine at Mount Sinai and the senior associate



Dr. Burger

program director for the internal medicine residency at Mount Sinai Beth Israel, both in New York.

As a practicing hospitalist, Dr. Burger frequently engages in teaching on the medical floors, focusing on clinical reasoning, high-value care, quality improvement, patient safety, and leadership skills for physicians.

As associate residency director, he restructured morning reports to focus on real-time case presentations with increased emphasis on problem representation and illness script formation. He's instituted and enhanced the quality-improvement curriculum. Dr. Burger also established a high-value care resident committee. His initiation of review sessions for medical conference abstract submissions resulted in a sevenfold increase in abstract acceptances, with more than 700 presentations during his tenure.

During his 20 years as an educator, Dr. Burger has mentored hundreds of physicians who have gone on to successful careers. He has encouraged students and residents to take on academic projects, inspiring residents to develop successful publications, including in the *Journal of Hospital Medicine's* "Things We Do for No Reason" section.

Dr. Burger was an inaugural member of SHM's Physicians in Training Committee and helped pioneer the early-career track at SHM's annual conference. As chair of SHM's Digital Learning Committee, he assisted in the selection of the SHM education app. He is an active member of the SHM Education Committee and will serve as the chair of the Annual Conference Committee and course director for SHM Converge 2026. He also represents SHM on the Alliance for Academic Internal Medicine's Internal Medicine Education Advisory Board.

Excellence in Management of Hospital Medicine

Eduardo Eschenbach

Mr. Eschenbach has charted a professional journey marked by dedication to others and achievement in healthcare administration. Born in Mexico and raised in Guatemala, Mr. Eschenbach moved to Texas for high school and college, earning a BS in microbiology from the University of Texas, in Austin.



Eschenbach

Upon graduation, Mr. Eschenbach played a crucial role in implementing health IT during the initial years of the Affordable Care Act, igniting a passion for

healthcare administration. Before further pursuing this passion, he returned to Guatemala to give back to his childhood community by becoming a math teacher at a small non-profit middle school.

In 2016, Mr. Eschenbach moved to Baltimore, where he earned an MBA in healthcare management from the Johns Hopkins Carey Business School.

This paved the way for his entry into the Johns Hopkins University division of allergy in 2018, followed by the division of hospital medicine in 2020, during the COVID-19 pandemic. During this time, he proved himself as a solutions-oriented leader with a strong desire to help physicians who help heal communities.

Outstanding Service in Hospital Medicine

Steven Deitelzweig, MD, MMM, SFHM

Dr. Steve Deitelzweig is the system chairman for hospital medicine at Ochsner Health System in New Orleans, a role he has held for more than 30 years.



Dr. Deitelzweig

Dr. Deitelzweig founded the hospital medicine department at Ochsner Health and has overseen the development of a group of more than 250 physicians and advanced practice practitioners in a network of more than 20 healthcare facilities.

Following his time as chief resident of the internal medicine residency at Cornell University Medical College at NorthShore University Hospital in Manhasset, N.Y., Dr. Deitelzweig completed hepatology and vascular medicine fellowships at Ochsner. He then continued clinical practice as a hospitalist, starting in 1993, prior to the coining of the term "hospitalist."

Dr. Deitelzweig has a long-standing record of leadership in hospital medicine, including disaster management during Hurricanes Katrina and Gustav in New Orleans. He also led the system through the COVID-19 pandemic.

He was a charter member of SHM. His work with SHM has positively impacted the field, including on the State of Hospital Medicine Survey and as a co-author of *Key Principles and Characteristics of an Effective Hospital Medicine Group*.

He has served as chair of the Practice Management, Practice Analysis, Annual Conference, and Leadership Committees, and was on SHM's Board of Directors for a three-year term.

Dr. Deitelzweig also served as course director and lecturer for Southern Hospital Medicine and is a representative for SHM at the American Medical Association House of Delegates.

Junior Investigator Award

Paula Chatterjee, MD, MPH

Dr. Paula Chatterjee is an assistant professor at the Perelman School of Medicine and director of Health Equity Research at the Leonard Davis Institute of Health Economics at the University of Pennsylvania in Philadelphia. She is a hospitalist and health policy researcher whose work focuses on ensuring the viability of the healthcare safety net for low-income patients. She conducts rigorous empirical work on safety-net hospital financing and quality of care and the role of health policy in mitigating population health disparities.



Dr. Chatterjee

Dr. Chatterjee's research and viewpoints have been featured in the *New England Journal of Med-*

icine, the *Journal of the American Medical Association*, the *Journal of Hospital Medicine*, and the *American Journal of Public Health*. Her work has had important policy impact at both state and national levels.

Dr. Chatterjee has testified for the Pennsylvania House of Representatives Subcommittee on Health on the role of payment policy in ensuring hospital viability and conducted research with state policymakers to measure the administrative burden associated with a Medicaid work requirement.

Her work on safety-net hospital financing has influenced discussions held by the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment & Access Commission, both of which advise Congress on healthcare payment policy.

Dr. Chatterjee completed her residency and chief residency at Brigham and Women's Hospital in Boston. She received her medical degree from Harvard Medical School in Cambridge, Mass., and her Master of Public Health and undergraduate degrees from Yale University in New Haven, Conn. ■

SHM invites you to continue progressing your professional and personal growth at our upcoming selection of virtual, hybrid, and in-person events.



Pediatric Hospital Medicine
August 1-4, 2024
Minneapolis, MN



Adult Hospital Medicine Boot Camp
September 18-22, 2024
Phoenix, AZ



Leadership Academy
October 28-31, 2024
Rancho Palos Verdes, CA



SHM Converge 2025
April 22-25, 2025
Las Vegas, NV

Celebrating the 2023 Chapter Excellence Status Awards Recipients

SHM has five international and 65 U.S. chapters, extending SHM’s reach and providing networking and information at the local level. The chapters and leaders honored here have gone above and beyond and helped advance SHM’s mission of empowering hospitalists to provide exceptional care to hospitalized patients.

2023 Status Awards



PLATINUM CHAPTER EXCELLENCE AWARD

- Atlanta
- Connecticut
- Hampton Roads
- Kansas
- Kentucky
- Long Island
- Los Angeles
- Maryland
- Middle TN
- NC Triangle
- Nebraska
- NYC/ Westchester
- Pittsburgh
- Rocky Mountain
- St. Louis
- Utah



GOLD CHAPTER EXCELLENCE AWARD

- Iowa
- Lake Erie
- Minnesota
- North Florida
- North Jersey
- Pacific Northwest
- Pee Dee
- San Diego



SILVER CHAPTER EXCELLENCE AWARD

- Arizona
- Memphis
- New Hampshire/Vermont
- South Central PA
- Wisconsin



BRONZE CHAPTER EXCELLENCE AWARD

- Delaware
- Maine
- Western Massachusetts

2023 Exemplary Awards



OUTSTANDING CHAPTER OF THE YEAR

Maryland
led by Evelyn Gathecha, MD



OUTSTANDING MEMBERSHIP RECRUITMENT & RETENTION

Utah
led by Linda Venner, MD



RESILIENCY AWARD

Pee Dee
led by Mitchell Nimmich, MD, SFHM



SHINING STAR

North Florida
led by Kaitlin Moran, MD



CHAPTER INITIATIVE FUND AWARD

South Central PA
led by Daniel Fischman, MD



RISING STAR CHAPTER

Sacramento
led by Adrienne Atencio, MD



MOST ENGAGED CHAPTER LEADER

Ali Rafiq, MD
Kansas Chapter



UNsung HERO

Farzana Hoque, MD
St. Louis Chapter

SHM Fellows Class of 2024

The Society of Hospital Medicine is pleased to announce the 2024 class of Masters, Senior Fellows, and Fellows in Hospital Medicine. Congratulations!

Masters in Hospital Medicine

Leonard S. Feldman, MD, FAAP, FACP, MHM
Tara Lagu, MD, MPH, MHM
Jerome C. Siy, MD, MHA, MHM

Senior Fellows

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Nagendra Gupta, MD, FACP, SFHM
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Marcel Parent, MD, CCFP, SFHM
Prince Philip, MD, SFHM
Sandeep Pulimi, MD, SFHM
Catherine E. Rabon, MD, SFHM
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Prabhbir Singh, MD, SFHM
Srinivas Sirimalle, MD, SFHM
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Laura B. Sollenberger, MD, SFHM
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Goutham Talari, MD, FACP, SFHM
Linda M. Venner, MD, FACP, SFHM
Anunta Virapongse, MD, SFHM
Srinivas Vunnam, MD, SFHM
Richard M. Wardrop, MD, FAAP, FACP, PhD, SFHM
Charlie M. Wray, DO, MHS, SFHM

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Harkesh Arora, MD, FHM
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Manogna Maddineni, MD, FHM
Bhanu Maturi, MD, FHM
Lana McGill, MD, FHM
Arunab Mehta, MD, FHM
Sachin Mehta, MD, FHM
Pete Meliagros, MD, FHM
Justin Miller, MD, FHM
Sara Millwee, DNP, APRN, FHM
Kalyan Kumar Reddy Mogili, MD, FHM
Maria-Perez Muoghalu, MBBS, FACP, FHM
Stephanie Murphy, DO, FHM
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ment” surgery or hormones, and “a transgender,” which can be offensive.

“Unfortunately, ICD-10 codes may not have caught up to this and still use some of this offensive terminology in coding,” said Dr. Khanijow, who is also a member of the SHM Diversity, Equity, and Inclusion Committee.

Appropriate terminology would be what the patient states their gender identity is, though commonly “the patient is a trans woman” (or man) is okay, Dr. Dao says. Another example is “The patient identifies as a non-binary individual and uses they/them pronouns.”

Similarly, electronic health records (EHRs) may not have caught up with appropriate terminology and may not have a clear, consistent way to collect pronouns. This means that trans patients may be asked repeatedly for their pronouns, Dr. Dao says.

Deficiencies in education about transgender health basics are common among even well-meaning practitioners, particularly those who graduated before 2015, says Masina Wright, MD (they/them), a locum hospitalist in New Mexico. “Let’s take perioperative medicine, for example,” she said. “For those practicing hospital medicine, have you ever taken a CME course on perioperative management of a transgender woman on gender-affirming hormones? What does the evidence say? Is this discussed in Grand Rounds at your hospital?”



Dr. Wright

Improving transgender care at the administrative level

Although equitable care for transgender patients faces obstacles, there are still initiatives that hospitalists can take to improve care. Here are some strategies to implement at the administrative level.

Aim for a diverse clinical team. “Administrators are high-level people who care about various perspectives and care for different patients. They should be thoughtful in curating their team to have various opinions and diversity,” Dr. Dao said. Having various perspectives increases the chance that someone on the team will be thinking about building trust with different groups of people, including transgender patients.

Advocate for more education about transgender care and LGBTQIA+ care in general. This education can take place at the hospital level (including asking about pronouns) as well as at conferences. SHM has modules on its learning portal that are updated with appropriate documentation and recommended language, and it released a module on transgender healthcare in 2021, Dr. Khanijow says. On a more global level, the World Professional Association for Transgender Health will take place this September in Portugal, Dr. Wright says. There’s also a U.S. Professional Association for Transgender Health every other year, with the last one held in 2023. However, Dr. Wright would like to see trans health integrated into a variety of conferences so it becomes normalized. “Once the appropriate language and basic foundational understanding of gender diversity become just a regular part of the human experience, trans folks can be seen like every other human in the medical system—depoliticized,” they said.

Use EHRs that allow staff to easily list pronouns and remind staff to list those pronouns. “An EHR that easily identifies pronouns/names and actually prints them to a daily list can



prevent damaging misgendering or dead-naming,” Dr. Bishop said. Dead-naming is the use of a name given to someone at birth that they no longer use due to a gender transition.

Participate in DEI committees. This can assist with better care for transgender as well as all other patients. “Hospitalists should collaborate with members of their DEI committees,” Dr. Dao said. “Many DEI committees feel like the ‘minorities’ are there to teach the majority. The truth is that all hospitalists are responsible for the advancement of all people.”

Be a leader and set the tone. “In hospital medicine, a lot of the care is driven by the hospitalist,” Dr. Dao said. “You really set the tone for your team when you’re there. When you have a trans patient, as the leader of the time, you’re setting that positive tone for the patient and making sure [fellow staff] know that the patient is trans and has preferred pronouns.” He also reminds staff of the importance of not misgendering the patient or unnecessarily exposing them. If they have questions about the patient, they can ask a team member or review the chart rather than asking the patient. “Creating a safe environment for your staff to ask you questions has allowed me to have meaningful conversations with my nurses and staff, especially because most intent is that of curiosity rather than of harm,” he said. “Sometimes, it may involve focusing on what everyone can do to best help the patient move forward with their chief health concern.”

Improving transgender care at the patient level

There are also specific approaches and strategies that hospitalists can take directly with transgender patients to improve their care:

Question what biases you might have. “One has to look inward and see if they have any implicit or explicit biases to transgender and gender-diverse individuals,” Dr. Khanijow said. “Are there stereotypes or thoughts that one has about transgender and gender-diverse people? If so, what are those thoughts? Being able to identify these biases is the first step in actively working against them when providing patient care.”

Focus on their chief health concern. Avoid “transgender broken arm syndrome,” Dr. Khanijow cautions.

Aim for equitable care, not just equal care, Dr. Khanijow advises. Because of the prejudice

faced by transgender patients, this may mean taking extra steps to keep these patients safe and comfortable, such as receiving a private room or a room with someone of the same gender identity and setting up reasonable post-discharge follow-up with clinics known for culturally competent care. This also can mean supporting the patient’s identity while they are at the hospital with the use of makeup, prostheses, clothing, or jewelry of their choice. Although hospitalists are bound by local laws, they still can empathize with the patient about how unfair a legal situation might be and try to come up with creative solutions to help patients achieve their goals despite a hostile legal environment, Dr. Khanijow says.

Acknowledge their partners. It’s typical for providers to ask patients if they have a partner to be inclusive, but also be aware that patients may sometimes refer to their partners as their “friends,” Dr. Dao said. “While it’s unnecessary to bully your patient into telling you who is actually with them, it’s important to take a moment and thank them for being there for the patient,” he said. This also includes asking partners what their pronouns are or asking the patient if they can share their partner’s pronouns.

Encourage the use of gender-affirming hormones, PrEP, or other related medications unless there’s a clear contraindication, Dr. Dao says. This is yet another area that’s ripe for more education geared toward hospitalists and other providers. In the 2022 U.S. Transgender Survey, 98% of respondents receiving hormone treatment reported that hormones for their gender identity or transition made them a lot more satisfied (84%) or a little more satisfied (14%) with their life. ■

Vanessa Caceres is a medical writer in Bradenton, Fla.

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Facing the Inevitable: Cyberattacks in Healthcare

How diligence, “old-school” methods, drills, and training can help

By Richard Quinn

Kristian Feterik, MD, MBA, FAMIA, SFHM has been a hospitalist for 20 years, and a board-certified clinical informatician for the last eight years. But the cyberattack on UnitedHealthcare unit Change Healthcare in late February that has continued to reverberate throughout the medical world was like nothing he’d ever seen before.



Dr. Feterik

It was “by far, the largest cyber-attack that has affected our health system,” said Dr. Feterik, whose titles include associate program director for the University of Pittsburgh Medical Center’s Clinical Informatics Fellowship Training Program. “Even though we have multiple electronic health records in UPMC’s 40 hospitals and 800 ambulatory centers, we do have a myriad of bolt-on applications. And as you can imagine, any compromise in the technology stack can lead to a lot of immediate and delayed effects on the patient side.”

Of course, and unfortunately, cyberattacks are nothing new. But the February incident has shone a direct spotlight on the increasing frequency, sophistication, and

danger of the phenomenon in a healthcare landscape increasingly dominated by electronic health records (EHRs) and other digital infrastructure.

The Hospitalist spoke to three experts to survey how practitioners and others can best prepare for the future, despite fear and forecasts for more attacks. What lessons have been learned? What can you do in the event an attack cripples your facility? And how can the specialty best prepare for that eventuality?

Perhaps the main answer to all those questions starts with diligence on personal and institutional levels.

“We really need to make sure all these digital tools we’re using are actually making patient care better,” said Mihir Patel, MD, MPH, FACP, CLHM, SFHM, chair of SHM’s Health Information Technology Special Interest Group. “But let’s say everything goes down because of a cyberattack. In that case, it’s all about what you can do with your core clinical skills. Whether it’s talking to patients, figuring out what’s wrong without EHR, or even just writing things down the old-fashioned way, doctors need to be ready to rely on their training,



Dr. Patel

not just on tech. Over-reliance on technology is a vulnerability.”

What’s the big deal?

The largest worry for physicians, when a cyberattack paralyzes EHRs, medical reconciliation systems, and other processes, is that patient safety could be compromised. That could be because health records are unavailable, prescriptions sent to a pharmacy never arrive, discharge instructions get interrupted, or critical information delivered via health information exchanges freezes along the way.

When such systems go offline during digital disruptions, hospitalists and their staffers typically pivot to hand-written notes, the last vestige of the pre-digital revolution. Such analog processes may seem quaint most of the time, but they provide a vital tool for continuing to deliver care, says Romil Chadha, MD, MBA, MPH, FACP, SFHM, chief medical informatics officer for UK HealthCare at the University of Kentucky in Lexington, Ky.

“I have a theory that is: If a new request comes to us, for everything that happens, people try to find IT solutions,” he said. “Which



Dr. Chadha

is good. It keeps us in business. But at the same time, my ground rule is if you cannot do it on paper, you cannot do it electronically.

“You have to have the proof of concept, the prototype, on paper or in your mind before you can convert an analog thing into digital workflow. Because if you are catching errors in that analog workflow, then you will not be able to build a robust, digital platform.”

Dr. Patel, the medical director of virtual medicine at Ballad Health in eastern Tennessee, as well as chair of the health system’s inpatient clinical informatics council, recalls that during his time as telehospitalist at a CommonSpirit Health hospital, a ransomware attack significantly disrupted his EHR for several days.

“This prevented any remote access to the EHR for chart reviews or placing orders, crucial to a telehospitalist’s workflow,” he said. “We had to revert to a more traditional method of operation, relying on on-site nurses to communicate lab results and receive orders verbally over the phone, completely bypassing the EHR.”

“This severely impacted patient care due to communication breakdowns, delays in diagnosis and treatment, increased administrative workload, risk of errors in medication and prescriptions, potential erosion of patient trust and hospital reputation, and a substantial financial burden on

the healthcare system.”

Dr. Patel says that for hospitalists earlier in their career, working with pen-and-paper can be bewildering, as they’ve grown up, been educated, and worked only in a digital world.

“For someone who’s never had to work without an EHR system during their residency or medical training, facing a situation where it’s not available is a tough wake-up call,” he said. “For people like me, who did part of their residency when EHRs weren’t everywhere, it might be a bit easier to dust off some of those old skills.”

Dr. Patel says one potential way to train physicians on analog backups is to use scheduled breaks, as opposed to waiting for disruptions caused by cyberattacks or other emergent problems. Think of it like fire drills in grade school.

“As a national healthcare community, we aim to minimize disruptions,” he said. “Therefore, we arrange for system downtimes during less busy hours. However, it might be advantageous to conduct these drills during regular activity periods instead. This ensures everyone gains practical experience. It’s akin to performing tornado or fire drills. Organizing these drills when the facility is nearly empty might keep operations smooth, but it doesn’t teach anyone how to act during an actual emergency, does it?”

Dr. Feterik suggests institutions could even have “a downtime manual that should be the essential cybersecurity attack-mitigation procedure. But then do we need a federal or state policy or guideline for downtime procedures at a state or federal level? What do we do as a nation? How do we handle a simultaneous downtime for several health systems?”

What can I do?

The scale of cyberattacks that affect hospitals nationwide can feel too broad to combat from one computer. But that’s not true, information technology (IT) professionals and others constantly preach.

Take something as seemingly simple as passwords, for computers, websites, or phone applications.

“Access should be limited strictly to those who truly need it,” said Dr. Patel.

Also, healthcare practitioners should not assume that their IT staff has already weeded out unsafe missives, so they need to be diligent there as well, the same as any worker with access to a corporate email system.

“Merely by clicking on a link in an email, you could inadvertently open a gateway for unauthorized access to your system,” Dr. Patel said. “It’s crucial to recognize



phishing emails and report them immediately to your cybersecurity team or department. Given the volume of phishing attempts we receive daily in a health system—with perhaps 10,000 to 15,000 employees—consider how long it might take for your cybersecurity team to respond once the threat is identified. Time is of the essence, not just in terms of financial cost, but more importantly, regarding patient care and safety.”

A financial incentive

Another major danger highlighted by the Change Healthcare incident was the impact on billing. Given the fiscal nature of healthcare where services rendered are paid for at a later—sometimes much later—date, anything that paralyzes payment procedures is a problem.

To wit, *The Washington Post* last in March reported that the Centers for Medicare & Medicaid Services “would offer emergency funding to physicians, physical therapists, and other professionals that provide outpatient healthcare, following a cyberattack that crippled

the nation’s largest processor of medical claims and left many organizations in financial distress.”

“On the Medicare side, it’s a good act,” Dr. Feterik said. “However, I have not seen if perhaps this will be followed immediately by other private health insurers. Because I imagine from their perspective, from a business perspective, this can be a liability, as well, to fly blind and say, ‘I’ll trust the fact that you still have the benefits,’ especially if the effect of the attack is lasting for weeks.”

AI: friend or foe?

Dr. Feterik says cyberattacks are even more concerning these days because of the growing prowess and functionality of artificial intelligence (AI) and large language models like ChatGPT.

“Someone just recently demonstrated that they could do audio jacking,” he said. “Just like the way you and I are speaking right now, there can be a so-called ‘man in the middle attack’ where you can essentially take what you say, run it through a large language model, and what I hear on my end

is your voice, but not your words, it’s a text-to-speech generator that is actually altering what you are saying. Unfortunately, I’m a little pessimistic, and I think cyberattacks may get worse in the future.”

Dr. Patel says artificial intelligence cuts both ways. While threats are increased, so is the capacity for privacy or security.

“With predictive analytics, we can foresee cybersecurity threats by analyzing patterns in internet traffic before they even occur,” he said. “This is one of the positive aspects of AI. It enables the automation of monitoring and responses, offering round-the-clock surveillance of healthcare networks and swiftly addressing potential security breaches.”

Dr. Patel adds that using AI to buttress the efforts of IT staff means that the technology can also shut down.

“Used proactively by healthcare systems, it can be a powerful defense,” he said. “We must stay ahead of those who seek to use AI for malicious purposes.” ■

Richard Quinn is a freelance writer in New Jersey.



Chapter Spotlight: Pee Dee

Keeping the momentum going

By Richard Quinn

COVID-19 was brutal on SHM chapters nationwide, immediately forcing events to teleconference technology and eliminating the in-person networking and education that has become a staple of the industry's confabs over the years.

But in the Pee Dee—a section of northeast South Carolina most known for Myrtle Beach—the pandemic was even worse. The already-reeling chapter saw membership at an all-time low and, honestly, had reached a “dead end,” according to Pee Dee chapter president Jilian Sansbury, MD, FACP, CHSE, FHM.



Dr. Sansbury

“We didn't really have the bandwidth to reach out to other places, either in person or virtually, to try to garner new memberships,” said Dr. Sansbury, is the transitional-year program director, internal-medicine associate program director, chair of the department of medicine, and medical director of the Grand Strand Health Education and Simulation Center at Grand Strand Health in Myrtle Beach, S.C. “So, we were kind of just at a stalemate. So, when I took over, my first goal was to get us back into in-person events, or events in general. And we found that after a couple of events, the interest started blooming again.”

One could say that again, as in 2023 the group won both a Gold Chapter Excellence Award and a Resiliency Award.

So, what broke the impasse of getting folks involved?

“In late 2022, I took over as the acting president of our chapter,” Dr. Sansbury said. “We had been involved in in-person events or trying to create more opportunities for networking in our

chapter, and we found through a series of exploratory question-and-answers with the SHM staff, that there was a large area of our chapter that was essentially unreached, untouched... either didn't know SHM existed or hadn't even been approached about membership opportunities.

“We saw a huge opportunity for our leadership group to reach into those areas, find some folks who were interested in becoming members, and then grow those members into future leaders. We created a multi-tiered leadership roster. We had me as the acting president, and we decided to align leaders in each of our major areas. That included Myrtle Beach, Florence, which is about halfway between here and Columbia, and the eastern portion of Columbia.”

Then, it was time for good old-fashioned networking and events. Perhaps unsurprisingly in hindsight, that turned out easier than thought.

“People were craving face-to-face social interaction,” Dr. Sansbury said. “We weren't getting it in our patient interactions. We were masked and covered in gowns and personal protective equipment we had to wear in the hospital. And we weren't really getting it outside of the hospital because either everything was closed, or we were just getting takeout and going home while trying not to get our families sick.”

“So, it wasn't very difficult to get people to come out. They were excited about it and excited about the opportunity to meet up. The first couple of events we had were masked but we were still able to see each other in a social setting and hold meetings. That's what broke the stalemate.”

Now, as is common in chapters moving past purely pandemic scheduling, the Pee Dee chapter thrives with a mix of in-person and virtual accessibility.

“I'm able to offer lots of in-person opportunities for people who might be traveling as locums, as part of their day-to-day work, or movement with their families. We're able to

recruit speakers for these events who are really exciting: people in other leadership roles, people who are doing novel things in hospital medicine, and people whose reach is beyond just our area. Our state is, for the most part, very rural. So, there's a big push toward, ‘How do we reach these rural populations for different issues?’

“For most of our meetings, we also offer a virtual option and continuing medical education. So, in the event that I live in Myrtle Beach and can't drive to Columbia for an event, I can join on Zoom. I can have dinner at home and listen to the speaker. We try to keep it as flexible as possible and offer as many opportunities for engagement as we can.”

The goal for the Pee Dee chapter now is to keep the momentum going. As a member of SHM's Physicians in Training Committee, Dr. Sansbury knows that resting on laurels is a death knell for participation, so she and her board are focused on developing new leaders and on scheduling events, speakers, and content that appeal to a cross-section of members.

“Engagement begets engagement,” she said. “So, if you have folks at your facility who are engaged and love and have passion for the SHM community, they're going to share that. They're going to get other people interested. So, your job as a chapter leader is to find those people and get them involved.”

“Find people who have a little spot of time in their schedule that they can devote to your chapter's growth, and engage them, give them projects, delegate tasks, delegate roles, give them leadership opportunities, have them actually help and participate. We would not be successful without the hard work, joy, and commitment of the members of our chapter's leadership ladder. They make our chapter work, and their excitement is contagious!” ■

Richard Quinn is a freelance writer in New Jersey.

SIG Spotlight: Patient Experience

Moving beyond the metrics to the “why”

By Richard Quinn

Length of stay, work-relative value units, hospital-acquired infections.

There is no shortage of metrics—and their accompanying acronyms—that silo, summarize, and study whether hospitalists are doing their job. But perhaps the most ephemeral—and important—of those measurements is patient experience (PX).

That’s where SHM’s Patient Experience Special Interest Group steps in.

“Having been the medical director of a 40-clinician hospitalist team, I understood earlier on the pain points about how patient experience is perceived in a very negative light,” said SIG chair Swati Mehta, MD, FACP, CPXP, SFHM. “And understandably so, because of how it has been framed historically as being just a data point we need to move. It’s a number. It’s a metric, rather than the right thing to do. Historically, the frame of reference is not a thing I was a fan of, and I wanted to change it. I wanted to find a way to find best practices to network and to understand better than what’s just happening with my own site.

“My passion for patient experience comes from believing it’s the heart of healthcare,” said SIG vice chair Jennifer Colella, MD, FACP. “It’s greater than the sum of the parts. One bad experience can taint even the best efforts to provide sterling care. Patients are unique with different experiences, expectations, and needs. Patient experience is an integral part of patient satisfaction, loyalty, and success for the entire healthcare system.

“Continued capture of market share depends on academic excellence, state-of-the-art facilities, proven continuing advancement in patient outcomes, or mitigation of suffering. Commitment to patient and family support by exceptional people directly and indirectly involved in patient care is a must. There is no substitute for a cohesive team that puts the patient first and shows that they care holistically to make every



Dr. Mehta



Dr. Colella

The 6H model: Human connection with patients

OUR PATIENTS WANT	HELPFUL PHRASES
HEAR my full story	<ul style="list-style-type: none"> • What have I missed? • Anything else? Tell me more. • Is there anything weighing on your mind today?
HEED my worries	<ul style="list-style-type: none"> • What worries you the most today? • What matters most to you in your visit today?
HELP me navigate	<ul style="list-style-type: none"> • Here are the three things we will do today. • Is it okay if I share your plan of care with your (caregiver)? • Here is the number to call for questions about medications/appointments.
Be HONEST with me	<ul style="list-style-type: none"> • I don’t know the answer to your question, but I will find the person who can best help you with that. • I can’t promise the pain will go away completely. I do want you to be comfortable. Here is what we can do now.
HEAL my misunderstanding	<ul style="list-style-type: none"> • I am truly sorry you had to wait so long. You have my undivided attention. • I am sorry you had a poor experience. That was not our intention. Here is what I’ll do
Leave me with HOPE	<ul style="list-style-type: none"> • Together we will get through this. • You have one of our best (nurses/surgeons/docs) today. You are in great hands! • You’re doing so much better! Soon you’ll be able to go home. • We are going to take excellent care of you.

SOURCE: DR. MEHTA

hospital admission the most positive experience possible with efficient and effective appropriate disposition and follow-up. Meeting and exceeding expectations is a cornerstone of success for everyone.”

Dr. Swati, national director of quality and performance for patient experience at Vituity and chair of SHM’s Patient Experience Executive Council, says one of the challenges of improving patient experience is getting hospitalists and others to move beyond seeing it as ticking off a measurement box, and to focus on actually improving a patient’s experience in the hospital.

“For the nerds in us, most docs are science-driven, right? That’s why we went to med school,” she said. “We want to learn the data behind it. We want to know this is the right thing to do, and not just a metric.”

So Dr. Swati points to what she calls the “why behind it,” which has three main pillars.

First, she said, “When we compassionately sit down and communicate better with our patients, study after study has shown that patients adhere more to their medications, their clinical outcomes improve, and they come back less often for unnecessary readmissions, and they really take better care of themselves because they feel like their doc really cares for them.”

Second, a better patient experience makes for a better hospitalist experience.

“Honestly, it’s a very selfish move to be selfless with patients and to really care for our patients,” Dr. Swati said. “We get a kick in our step after a good interaction. We feel good. We feel pumped even if we have five more admissions, we’ll take them on because we just had a good interaction. Knowing very well that the [reverse] is also true... poor interactions can really deflate us. This is the what and why for me.”

The third motivation is financial, personal, and professional.

“If you want to stay in the community you are in, if you don’t want to move, we need job stability, we need security, and we need to really think about not just our clinical role as a hospitalist, but how can I make sure my hospital’s doors are always open?” Dr. Swati said. “That’s all about patient loyalty. Patient’s word of mouth. They come back (and say) ‘Yes, I recommend this hospital,’ and we are going to thrive in our community.”

Dr. Colella, medical director of patient experience at Nebraska Medical Center in Omaha, says it would be “folly to trivialize any aspect of the patient’s experience.”

“Patient experience encompasses the totality of care,” she said. “It ties together all the components that go into a successful healthcare system from the patient’s perspective. You cannot have a first-class hospital system without patients recognizing the importance of every contact at every level over time. This in-

cludes everyone at our facility. Interpersonal relations are part of the patient’s experience, and all components are necessary. All healthcare is a continuum and continuous improvement based upon metrics that are deemed necessary and appropriate will be an ongoing endeavor.”

Dr. Swati boils patient experience down to the 6H model 1 and the three Cs, which is what she highlights whenever she makes presentations on the topic: culture, connect, and correct. Building a team-based approach that values the patient’s experience, connecting with them to make them see that, and then correcting inevitable mistakes.

“Things are going to go south,” Dr. Swati said. “Patients will be in the room for too long. Patients will be waiting too long. They got the wrong medicine. Things will happen in life, just like in healthcare, but how do we correct issues? How do we apologize immediately? How do we do that recovery to gain the patient’s loyalty and forgiveness? If you focus on culture, connection, and correction, I think those are good standards to continue PX.” ■

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What is the Best Initial Management of a Pressure Injury?

By Lakshmi Naidu, MD, Alan Hall, MD, and Adam Gray, MD

Case

A 74-year-old frail man with diabetes mellitus, hypertension, and chronic kidney disease is admitted for severe community-acquired pneumonia. On hospital day four, the nurse reports a new sacral wound. Physical examination demonstrates a 3- by 4-cm oval wound on the sacrum that is pink and with partial-thickness skin loss. What is the best initial management of this suspected pressure injury (PI)?

Hospitalized patients have reduced mobility, which is the most critical risk factor for the development of a PI. In addition, inpatients have a host of other risk factors for hospital-acquired PI (HAPI), including advanced age, frailty, comorbid illness, decreased nutrition, and urinary and bowel incontinence. HAPIs negatively impact patient outcomes, increase length of stay, increase hospitalization costs, and can lead to pain, depression, and social isolation.¹ Pressure injuries are significant health issues and a challenge to caregivers and the healthcare industry. The development of a severe PI is a life-changing sentinel event, and the Center for Medicare and Medicaid Services defines severe HAPI as “never events” and discontinues financial reimbursement when these originate in the hospital.

PIs have long been known to be a marker of poor overall prognosis. The development of a PI in the hospital increases the risk of mortality threefold, although this risk is largely due to the presence of severe coexisting medical comorbidities that likely contributed to the PI.² Annually, it's been estimated the cost of medical errors is over \$17 billion, and PIs are the single most common type of medical error.³ Hospitalist physicians and advanced practice practitioners

should be comfortable with the initial approach to a PI, given hospitalists, as first-line clinicians for many patients who develop PIs, have a significant role and responsibility for the prevention, detection, and treatment of PIs.

Management

Before addressing the management of PIs, it should be emphasized that prevention is the critical first step for at-risk patients. The Braden scale (Figure 1) is the most widely used tool to assess PI risk. This scale consists of six risk categories including sensory perception, moisture, activity, mobility, nutrition, and friction or shear.⁴ Determining the level of risk can help identify the need for pressure-offloading intervention strategies to help prevent PIs.

If a PI develops, hospitalists need to be comfortable performing the initial wound evaluation and staging. This begins by measuring the ulcer dimensions and evaluating the wound bed for the presence of granulation tissue, exudate, necrotic tissue, eschar, tunneling, or signs of infection.¹

Signs of infection can be variable, but patients should be assessed for clues including systemic findings of sepsis such as fever, and localized findings of purulence, surrounding peri-wound erythema, warmth, tenderness, or foul-smelling discharge. Given the challenges in identifying infection in PI, especially in chronic PI, infectious disease consultation should be considered. When performing a PI evaluation, photographs entered into the electronic health record can be helpful for other care team members and monitoring.

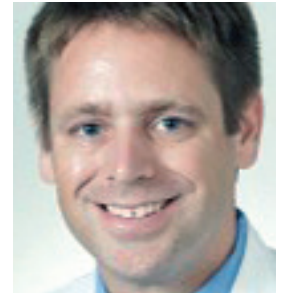
Staging is usually performed using the National Pressure Injury Advisory Panel staging system and is based on the initial wound appearance. Examples of the stages are shown in Figure 2. Stage 1 PIs have non-blanchable erythema with intact skin. Stage 2 PIs have partial-thickness skin loss



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with exposed dermis. Stage 3 PIs have full-thickness skin loss with adipose tissue visible. Stage 4 PIs have full-thickness skin and tissue loss with exposed fascia, muscle, tendon, ligament, cartilage, or bone. Some PIs may be unstageable if the wound bed is obscured by necrotic tissue, slough, or eschar. Deep-tissue PIs consist of persistent, non-blanchable, deep red, maroon, or purple discoloration, often with intact skin or a blood-filled blister.

The treatment of PIs is complex and best performed with a multidisciplinary approach. The mainstays of treatment are addressing the etiology of the injury; pressure redistribution; debridement of non-viable necrotic tissue; maintaining a moist and clean wound-bed environment; and ensuring good nutrition.

In addition to the hospitalist, this often involves the patient's primary nurse, a wound-care nurse specialist and/or a surgeon, a dietician, a physical therapist, and an occupational therapist. The overall medical condition of the patient should be assessed to determine the etiology of the wound as it is critical in wound healing to prevent further injury and address modifiable risk factors.

When initially evaluating possible PIs, hospitalists should consider other potential conditions that may be misdiagnosed as pressure-related, such as moisture-associated skin damage, abscess, burns, skin tears, inflammatory wounds, and malignancies such as squamous cell skin cancer. The clinical history of wound development often provides a clearer understanding of the cause.

There is a significant overlap between the prevention and treatment of pressure injuries, and patients with risk factors should be

managed with pressure offloading on areas with the highest risk for injury, such as the sacrum, heel, and occiput. Hospitalists should monitor skin for medical device-related pressure injuries from oxygen tubing, nasal feeding tubes, and orthopedic devices.

Once a new wound is determined to be a PI, preventive strategies should be continued to minimize further skin breakdown. Patients should be frequently turned and repositioned, generally every two hours. Pressure support surfaces are designed to redistribute tissue load over a wider surface and ease pressure on bony prominences.⁵ These include specialty mattresses, integrated bed systems, and chair cushions. Advanced support surfaces are superior to regular hospital beds for managing pressure injuries.¹ Trapeze bars can be used in a subset of patients to assist patients in repositioning themselves in bed.

Stage 1 PIs are typically covered for barrier protection, often with a foam dressing over pressure points.

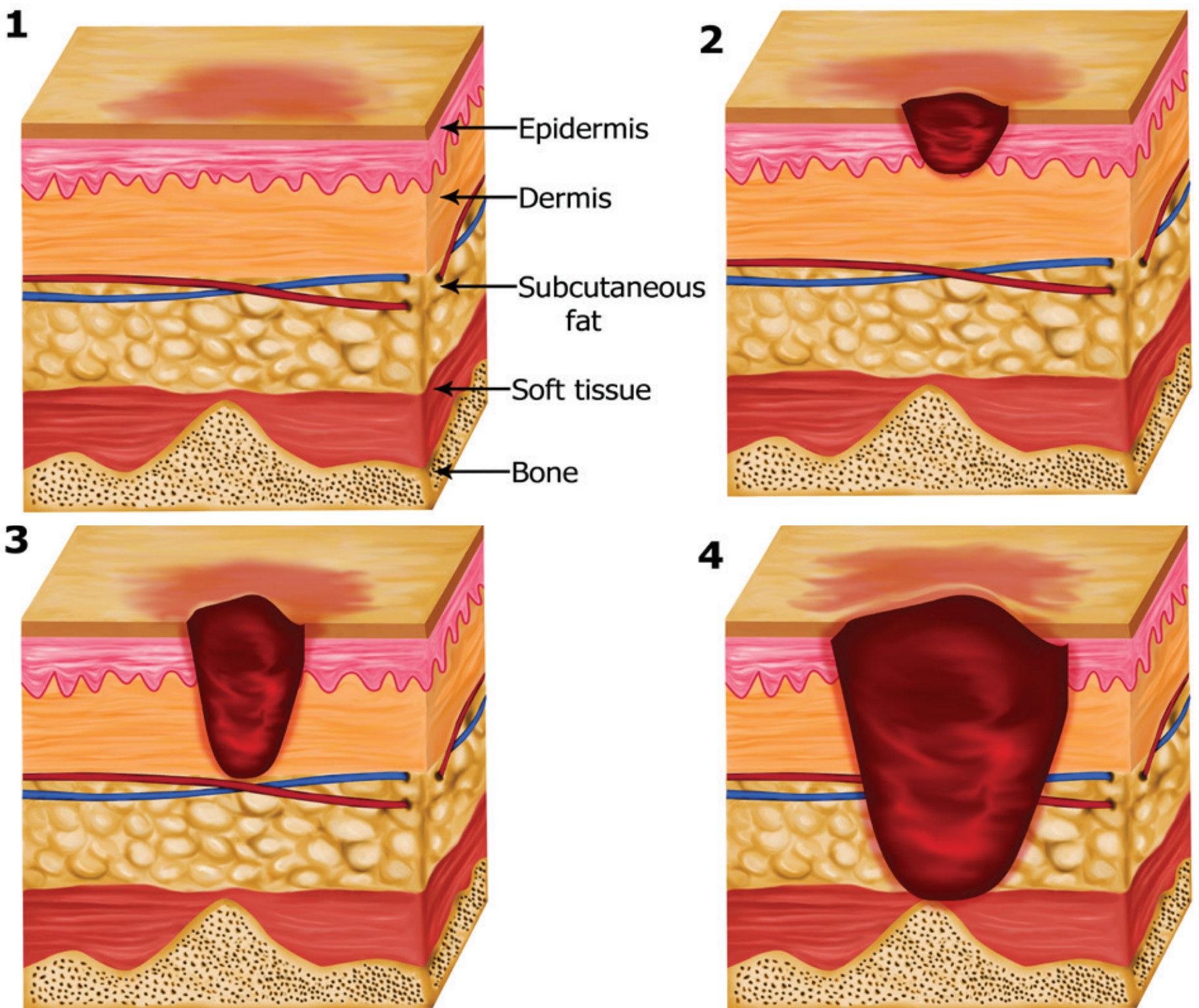
For high-risk patients, foam dressings can also be used over bony prominences including the elbow, heel, sacrum, and occiput. For moisture control, skin-barrier zinc-based cream or no-sting barrier spray adds a layer of protection to the skin, especially if the patient has urinary or stool incontinence. Stage 2 PIs normally require little debridement. In addition to barrier protection and pressure offloading, stage 2 PIs are managed locally with an occlusive or semi-occlusive wound dressing that maintains a moist wound environment.⁵ Using moisturizing cream or ointment can help alleviate dry skin surrounding the wound.

Wound cleansing and debridement create a wound-bed environment optimal for healing. Wound

Key Takeaways

- Hospitalists should assess for risk factors of PI and implement pressure-redistribution preventive strategies in high-risk patients.
- Should a PI develop, hospitalists should perform proper initial wound evaluation including staging and evaluation for necrotic tissue or signs of infection.
- Management involves a multidisciplinary team of nurses, a dietician, physical and occupational therapists, and often a wound care specialist.

FIGURE 2 Stages of Pressure Sores



cleansing is the process of using fluids to remove debris and microorganisms, and to provide better visualization to assess for potential debridement of necrotic tissue.⁵ Debridement is often required for stage 3 or 4 PIs. Debridement removes devitalized tissue, decreases barriers to wound healing, and potentially provides healing stimulatory effects.⁵ Adequate perfusion should be assessed before performing any debridement of the lower extremities. Debridement can be selective where only nonviable tissue is removed, or nonselective where both viable and nonviable tissues may be removed.

There are different methods of debridement. Autolytic debridement uses the body's endogenous enzymes to loosen and liquefy necrotic tissue in the wound bed and is accomplished by using medical-grade Manuka honey, hydrocolloid, hydrogel, or films. Enzymatic or chemical debridement uses topical preparation of enzymes like collagenase (one common brand name is Santyl) that helps break down the devitalized colla-

FIGURE 1 Braden Scale for Risk of Pressure Injury⁴

Low Risk, >18; Mild Risk, 15-18; Moderate Risk, 13-14; High Risk, 10-12; Severe Risk, <10

	1	2	3	4
Sensory Perception	Completely limited	Very limited	Slightly limited	No impairment
Moisture	Constantly moist	Very moist	Occasionally moist	Dry
Activity	Bedfast	Chairfast	Walks occasionally	Walks frequently
Mobility	Completely immobile	Very Limited	Slightly Limited	No Limitation
Nutrition	Very Poor	Probably inadequate	Adequate	Excellent
Shear and Friction	Problem	Potential Problem	No Problem	Not applicable

gen in the wound bed. Mechanical debridement is commonly accomplished with wet-to-dry dressing changes, where removing dried gauze acts as a debriding agent. Deep ulcers often require surgical debridement that can be performed at the bedside or in the operating room, in addition to packing deeper wounds. Other advanced therapies for deep ulcers are wound vacuum devices or skin grafting.

Other, general, care measures are important for all stages of wound

healing. Good nutrition and hydration are essential, as patients with chronic PIs are in a catabolic state and often malnourished. When there is concern for inadequate oral intake, adding targeted nutrition therapy like nutritional supplements can support wound healing by enhancing collagen production. In addition, ensure patients are getting sufficient micronutrients and vitamins C, E, B12, and zinc to support the wound healing process. In addition to nutrition, physical

and occupational therapy can encourage mobility and ambulation. Finally, remember PIs can be painful, debilitating, and life-altering for patients; thus, hospitalists should address our patients' pain and offer psychosocial support.

PIs can lead to multiple clinical complications including wound infection, abscess, osteomyelitis, sepsis, and death. Infected PIs are one of the leading causes of infection in long-term care facilities.⁶ If a PI has extensive necrosis or is close to the

KEY CLINICAL QUESTION

anus, there is an increased risk of contamination with stool, and surgical procedures like debridement, diverting colostomy, and skin grafts may be required to effectively close the wound. Patients with larger or more complicated PIs may require care at long-term acute-care or skilled nursing facilities for wound management, thus increasing healthcare costs and further altering patients' lives by keeping them from their home and their families.

Back to the case

This 74-year-old frail man develops a new sacral wound during his hospitalization that is consistent with a pressure injury. The pink sacral wound with partial-thickness skin loss is consistent with stage 2 PI. Initial wound evaluation should measure the size and depth of the wound, assess for necrotic tissue, and look for clues supporting infection such as purulence or foul-smelling discharge. A picture of the wound loaded into the electronic health record would be helpful for other providers and for monitoring.

The initial management of the PI would first include addressing the etiology of the injury and implementing repositioning strategies to reduce further pressure injuries. Additional supportive measures

should include a multidisciplinary care team that includes nurses, physical and occupational therapists, and a dietician. Care includes dressing changes to maintain a moist environment, optimizing nutrition, and increasing repositioning and mobility.

Bottom line

Management of PIs starts with individualized patient risk assessment, pressure offloading, provider comfort with early identification and staging, and a multidisciplinary care team. ■

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Quiz:



An 82-year-old man is hospitalized for a left femoral neck fracture after a fall. He undergoes operative repair on hospital day three and has a complicated hospital course with further debility and weakness resulting from traumatic rhabdomyolysis. One week into his hospital stay, the patient develops a sacral wound. The wound is 3 cm long, 2 cm wide, 1 cm deep, oval-shaped, and associated with full-thickness skin loss and exposed adipose tissue. No bone or other deeper tissue is seen. There is no surrounding erythema, purulence, necrosis, or eschar. Which of the following is the most likely stage of this pressure injury?

- a. Stage 1
- b. Stage 2
- c. Stage 3
- d. Stage 4
- e. Unstageable

Best Answer: C. Hospitalists need to be comfortable performing the initial evaluation and staging of pressure injuries. This patient had risk factors for a pressure injury and was found to have full-thickness skin loss with exposed adipose tissue over his sacrum. This is most consistent with a stage 3 pressure injury.

Stage 1 pressure injuries have non-blanchable erythema of intact skin. Stage 2 pressure injuries have partial-thickness skin loss with exposed dermis. Stage 4 pressure injuries have full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone. Unstageable pressure injuries are obscured by necrotic tissue, slough, or eschar.



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