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the Hospitalist

Recognized for their mentoring, hospitalists reflect on its importance

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IN THE NEXT ISSUE...
Tackling co-management and more

The Hospitalist Wins 2024 APEX Award for Publication Excellence

The Hospitalist, the official monthly news magazine of the Society of Hospital Medicine (SHM), has won an APEX Award of Excellence in the magazines, journals, and tabloids category for writing for its June 2023 issue.

The 36th-annual Awards for Publication Excellence (APEX) program recognizes excellence in publishing by professional communicators. APEX Awards are based on excellence in graphic design, editorial content, and the ability to achieve overall communication excellence. APEX Awards of Excellence recognize exceptional entries in 100 subcategories.

"*The Hospitalist* allows us to use our collective voice to reach our members and share their perspectives on the issues impacting them the most," said Eric E. Howell, MD, MHM, chief executive officer of SHM. "This honor is a testament to the exceptional quality of our editorial team, contributing writers, and member subject matter experts, and underscores SHM's commitment to providing hospitalists with the resources they need to deliver exceptional care."

There were more than 1,100 entries with 439 Awards of Excellence. *The Hospitalist* was among 10 magazines to receive the Award of Excellence in writing for a single issue. In addition to the 2024 award, *The Hospitalist* has received 11 APEX Awards since its inaugural issue in 1997.

The Hospitalist's June issue celebrated Pride Month with features on LGBTQIA+ Hospitalists Find Their Comfort Zone, and LGBTQIA+ Allyship, and columns about diversity (Everyone Deserves to Belong, and Our SHM Village) in support of SHM's efforts to cultivate an inclusive community for hospitalists and supporting career growth and well-being.

"Our team is always on the lookout for topics that resonate with our audience while ensuring that hospitalists' voices are at the forefront of each article we publish," said Weijen Chang, MD, SFHM, physician editor of *The Hospitalist*. "I am grateful to our team for inspiring us to strive for continued excellence—and to the judges of the APEX Awards for recognizing our commitment to sharing superior content." ■

Accepting Applications for Editorial Positions

The Hospitalist is now accepting applications for the position of pediatrics editor and the newly created position of associate editor.

You should apply if you're an SHM member interested in becoming more involved in guiding the editorial direction of the magazine, communicating with readers through your writing, and ensuring our content is both accurate and relevant. The pediatrics and associate editor terms are for three years. The application deadline is October 15, 2024, followed by a selection process, and interview.

Scan the QR code for more information. ■

From *JHM*

The Editor's Pick from the *Journal of Hospital Medicine* is a perfect match for the September issue of The Hospitalist, Beyond "Who is your mentor?" written by JHM's editor-in-chief, Samir S. Shah, MD, MSCE, MHM. Dr. Shar shares insights on building a cadre of mentors, focusing on the mentoring team and peer mentors. Scan the QR code for the full article. ■

THE Hospitalist®

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The Leadership Course Perfect for Hospitalists

By Kierstin Cates Kennedy, MD, MSHA, FACP, SFHM

About 10 years ago, I'd just landed a new leadership position as director of quality and, whether external or self-induced, I was feeling the pressure. I wanted to succeed in the role and was eager to show the leaders who had trusted me with this title that they'd made the right decision. I wasn't entirely green—I'd completed my master's in health administration three years earlier and a fellowship in quality the year before, but that felt too academic. I needed training that felt immediately applicable. A Google search led me to SHM Leadership Academy. and after reviewing the curriculum, I decided to register. (I'm almost certain that the fact that it was in Hawaii was *not* a factor...almost.)

This meeting not only far exceeded expectations but has proven to be pivotal in my career development! I learned about meta leadership, emotional self-awareness, hospital finances, and how to use these tools to manage up—a skill I desperately needed in my role. More than that was what I learned from fellow attendees. At my table with an OB hospitalist, community hospitalists, an administrator, and a respiratory therapist, we discussed unique approaches to staffing, common challenges, and new ways to look at old problems. The experience was so impactful I took what I'd learned and used it to convince our leadership that we should invest in sending every leader through the series.

The next year, I returned for Mastering Teamwork, but this time with our team of leaders! We learned about building high-functioning teams and establishing trust and psychological safety. Since we'd traveled together, we got to start applying these tools immediately at group dinners, a fun excursion, and in the airport as we traveled home.

This tradition of attending SHM Leadership Academy continues to help us develop effective leaders that have taken on roles within our group and beyond, myself included. Now as course director of SHM Leadership Academy, I devote my energy to ensuring that other hospitalists, APPs, administrators, and other hospital-based clinicians get the tools they need to return to their institutions and lead.

Thanks to attendee feedback, the curriculum has evolved. While some topics and speakers we love remain the same (change management and ugly dogs), we've added content like conflict resolution for leaders and creating inclusive environments for diverse teams. We've also added incredible faculty like Dr. Khaalisha Ajala, who will speak on personal leadership styles, Dr. Kimberly Manning, who will share effective communication skills in leadership positions, and Dr. Jennifer O'Toole, who will explore tools on graceful self-promotion and professional development. Finally, we have added executive coaching to the Capstone course, so every participant will be paired with an executive coach to work with them as they begin leading their Capstone project. These changes are designed to equip attendees with the knowledge and resources needed to be effective leaders within their practices and beyond.

So, if you're interested in becoming a leader, new to a leadership role, or well established in a role, but looking for ways to expand and bolster your effectiveness, register for SHM Leadership Academy. This year, it's in gorgeous Rancho Palos Verdes, Calif., from October 28 to 31. Visit shmleadershipacademy.org and sign up. I can't wait to meet you there! ■

Dr. Kennedy is a clinical associate professor and chief medical officer at the University of Alabama at Birmingham. She is also a member of SHM's Board of Directors.

DRG Downgrades

The clash of medical standards and insurance guidelines

By Thejaswi K. Poonacha, MD, and Lea Chamoun

Clinical coding is a meticulous task that translates patient notes into specific International Classification of Diseases, Tenth Revision (ICD-10) codes, crucial for billing and insurance claims. Coupled with this coding, clinical validation ensures that documented diagnoses correlate with the patient's presenting symptoms, signs, investigations, and treatment. While these processes are foundational for medical billing, they are highly complex and are used by both healthcare centers and insurance companies.

Insurance companies have their own set coding and clinical validation guidelines which are adapted from national guidelines and customized to a very large extent, such that they may deviate from the nationally accepted definitions of disease processes.

This strategic adjustment introduces substantial ambiguity into the clinical validation process and raises concerns about the entities responsible for this function, including artificial intelligence (AI) systems, non-clinical personnel, and outsourced firms.

AI and automation offer the potential to streamline the labor-intensive coding process, yet accurately capturing the complexities of medical diagnoses and treatments remains a challenge. Additionally, these technologies and the non-clinical staff or third-party companies involved in validation are primarily focused on insurance directives, which aim more at controlling costs than at improving patient care or documentation accuracy.

Clinical practice guidelines are developed through a systematic process to ensure they are evidence-based, enabling clinicians to make the best decisions for their patients. Typically, a panel of experts convenes to create these guidelines for diagnosis and treatment. Each author is required to disclose any conflicts of interest, providing transparency about potential biases that could influence the guideline. In addition, the guideline-development process is explicitly outlined for each nationally recognized guideline, including the level of evidence for each recommendation.

In contrast, the process of health insurance guideline development is often less transparent. It is frequently unclear how these guidelines are formulated, who is involved in their development, and whether conflicts of interest exist. This lack of clarity can raise concerns about the objectivity and reliability of insurance guidelines, which is evident in the differences that arise between insurance guidelines and clinical standards.

The divergence between the insurance-driven criteria and the established clinical standards, such as those from the Centers for Medicare and Medicaid Services (CMS), leads to frequent denials of coverage for reasons pertaining to diagnosis-related groups (DRGs), causing significant revenue losses for healthcare practitioners. Among the millions of accounts audited, instances where insurance companies adjust DRGs to increase hospital reimbursement are virtually non-existent. In other words, a fair audit that results in a DRG change that benefits the hospital financially simply does not happen; instead, these audits invariably lead to downgrades, reducing reimbursements rather than increasing them.

This discrepancy emphasizes the need for a harmonized approach that bridges the gap between insurance company guidelines and clinical practice standards. Establishing such alignment is essential, not only for ensuring that clinical validation accurately documents patient care, but also for supporting the financial sustainability of healthcare institutions in a complex and evolving regulatory environment.

Common diagnoses frequently denied and downgraded by insurance companies include the sepsis spectrum (A41), acute kidney injury (N17), acute respiratory failure (J96), severe malnutrition (E43), and type 2 myocardial infarction (I21.A1). Sepsis and respiratory failure are among the most common diagnoses for hospital admissions under inpatient status. Most hospitals have set protocols for the diagnosis and management of such conditions. Not only are such protocols adapted from nationally and internationally published guidelines, but hospitals also include those aspects in their customized protocols due to oversight by regulatory authorities, such as CMS, to ensure timely recognition and intervention are in place.

Dr. Poonacha

Ms. Chamoun

Dr. Poonacha is a staff hospitalist, clinical associate professor of medicine, and medical director of utilization management at the University of Minnesota Medical Center in Minneapolis. Ms. Chamoun graduated from the University of California, Los Angeles with a bachelor's degree in psychobiology and biomedical research. Following an internship in North Africa where she provided psychosocial support to victims of human trafficking, she will be working in Lebanon on health advocacy for refugee communities. Aspiring to become a physician, Ms. Chamoun is also preparing to attend medical school. She is dedicated to advancing healthcare and contributing to the medical community through clinical practice and biomedical research.

The guidelines authored by insurance companies are only for specific diagnoses, and not the entire spectrum of health issues. Some insurance companies, such as United Healthcare (UHC), have a specific document they term a "guideline," which is a partial adaptation of those already published by scientific organizations. These payer documents include only specific diagnostic components of the condition, with minimal aspects related to treatment. Other insurance companies quote published scientific articles as their justification for denial. Denials are largely based on diagnosis and not on the treatment offered, even if the treatment resulted in improvement of the diagnosis that is being denied.

It should be underscored that insurance companies only recognize the diagnosis component of any condition in their guidelines and do not have any comprehensive treatment directives. This renders such a document no longer a guideline. Such a document could be best termed as a rulebook. If the diagnosis lags by one decimal point from a lab value criterion for a specific diagnosis, despite clinical and professional diagnosis by a clinician, and if treatment is offered that results in improvement, it may still not qualify for the relevant DRG, due to strict adherence to this rulebook. The review process will not accommodate any degree of deviation from the rulebook lab values.

A thorough evaluation of sepsis criteria by UHC and Blue Cross Blue Shield indicates that they use the Sepsis-3 guidelines for the diagnosis of sepsis, with strict adherence to the numbers outlined for determination of the minimum Sequential Organ Failure Assessment (SOFA) score for a diagnosis of sepsis. Any deviation from that SOFA score is denied. Furthermore, one insurance company considers the SOFA score only after fluid resuscitation, which is not a part of the originally published Sepsis-3 criteria. If the initial SOFA score met Sepsis-3 criteria, and a subsequent SOFA score after administration of IV fluids and antibiotics resulted in a reduction of that score below the minimum required for diagnosis, it may be denied. Given the variability of interpretation and adoption by different insurance companies, a case of sepsis validated by one company may be invalid for another.

It is important to note that Medicare Advantage (MA) patients must be treated along the guidelines recognized by Medicare. For the diagnosis of sepsis, CMS follows the Sepsis-2 guidelines and expects all participating programs to be in compliance with the sepsis-care bundle. Despite adherence to the sepsis-care bundle, commercial insurance companies covering Medicare patients still refuse to recognize sepsis as a diagnosis if the basis for diagnosis used was Sepsis-2.

The CMS-4201-F rule stipulates that Medicare Advantage plans are obliged to adhere to traditional Medicare coding policies and the nationally standardized ICD-10 and CPT/HCPCS codes, including associated coding guidelines. Yet, major insurance companies continue to deny such accounts despite all levels of appeal, including a direct peer-to-peer meeting with their medical directors. The directors express that they understand the basis for appeal but confirm they are to abide by the rulebook created by the insurance company strictly without exception, despite knowing full well that sepsis is a clinical diagnosis and what the limitations are of applying Sepsis-3 as a blanket criterion. In other words, the authority given to them to deny an account overpowers the clinical authority they have achieved as practitioners, by virtue of training and experience, to question

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the rulebook in a specific context.

A related issue is that the Healthcare Association of New York (HANY) in 2019 determined that it would not recognize UHC's use of Sepsis-3 criteria when reviewing claims to validate sepsis for payment. New York State law defines sepsis by systemic inflammatory response syndrome (SIRS) criteria, otherwise known as Sepsis-2, thus making it mandatory for UHC and other companies to use Sepsis-2 criteria if they are to provide insurance to New York residents.

Similarly to the situation with sepsis, the diagnostic criteria for acute respiratory failure vary from one insurance company to another. One company argues that a patient needs to be consistently on 5 L of oxygen or use a bilevel positive airway pressure machine and have an arterial blood gas test on file with partial oxygen pressure less than 60 mmHg to validate acute respiratory failure. Venous oxygen saturation or indirect measures via pulse oximetry are often not accepted as a surrogate marker of acute respiratory failure. Oftentimes, the criteria for diagnosis change, and it is unclear if the change is communicated to the contracting team or the hospitals. Coders have noticed that the criteria may change for different levels of appeal in the same case.

In the case of severe malnutrition, most insurance companies recognize the Global Leadership Initiative on Malnutrition criteria and not the American Society of Parental and Enteral Nutrition (ASPEN) criteria. Both are nationally and internationally accepted criteria for the diagnosis of malnutrition, with an explicit letter from the U.S. Office of The Inspector General stating that hospitals may use either of the criteria. Despite the argument that ASPEN criteria detect acute malnutrition cases that can be easily detected and treated in a hospital setting, insurance companies refuse to accept them even if treatment is initiated, thereby downgrading the DRG or removing it from the list and recouping the amount relevant to the omitted or downgraded DRG.

As described above, large hospitals and healthcare centers are at the mercy of the oligopoly of select insurance companies to have their work recognized and reimbursed. The burden of additional work involved in appealing the DRG denials initially involves three levels of appeals. With hospitals dedicating a team for this work, and with rapid turnaround of denial-appeal cycles, insurance companies have devised new ways of determining what constitutes an appeal and what does not. One insurance company allows for multiple appeals before determining that all three levels of appeals are exhausted, thereby prolonging both time and the number of appeals required to reach the end result, if the denial is to be upheld. Additionally, it is unclear if the initial appeal letters are reviewed by board-certified physicians, non-physicians, or simply by an automated process. Certainly, the language used in denial letters when the initial denial is upheld points to a possible use of AI. Some insurance companies have a third party involved in validating codes and clinical diagnosis. When all levels of appeals are exhausted with the third party, there is no clear path forward to the next level of appeal with the parent insurance company.

Thus, healthcare institutions are left with the difficult task of defining specific diagnoses due to the risk of denials. Since the survival of healthcare centers is directly related to reimbursement by payers, should medical students and trainee residents learn medicine based on insurance company rulebooks?

This pressing issue underscores the urgent need for regulatory bodies to investigate insurers' rulebooks and their denial-management process. The ideal outcome would be to achieve uniformity for diagnosis and management among insurance companies in line with national and international guidelines. Furthermore, there should be a close relationship between the medical team and the contracting team of healthcare centers so that the language used for diagnostic criteria and treatment is reviewed by the medical team before contracts are signed between the healthcare center and an insurance company.

While it is understood that denials are issued to less than the majority of the accounts submitted, it is certainly a major issue for the hospital industry complex, which is surviving on razor-thin margins. As insurance companies continue to post billions of dollars of profits each quarter, shouldn't a piece of the pie be shared with the hospitals that take care of their beneficiaries, rather than withheld by denying legitimate DRGs? Awareness by medical providers and advocacy by medical organizations should be at the forefront of efforts to ensure that hospitals are paid appropriately. In addition, the concept of clinical documentation integrity should be introduced in medical schools, so that future practitioners understand the critical relationship between clinical documentation and reimbursement. ■

Precision Medicine in Sepsis Diagnosis

Emerging trends and future perspectives

By Sonali Iyer, MD, FACP

Sepsis, a life-threatening syndrome induced by infection, has been a leading cause of hospitalization and death in U.S. healthcare settings and accounts for more hospital admissions and spending than any other condition.[1,2] Early and effective diagnosis and treatment of sepsis, along with prevention, have been a patient-safety focus to improve outcomes and reduce mortality. Unfortunately, sepsis remains a significant challenge within the medical community due to its elusive nature and rapid progression.[2] The heterogeneous presentation of sepsis often impedes efforts for early diagnosis and management.[3]

As a harbinger of the future, precision medicine (or personalized medicine) first came to light in 1999 when specific genetic markers and therapeutics were identified. In 2015, it became a national initiative under the Obama administration and was identified as one of the research priorities by the Surviving Sepsis Campaign in 2023. Precision medicine is an innovative approach tailoring disease prevention and treatment to a patient's genes, environments, and lifestyles.[4] As one size does not fit all, the goal of precision medicine is to target the right treatments to the right patients at the right time. This article aims to review current diagnostic methods and discuss emerging techniques in precision medicine in sepsis diagnosis.

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Dr. Iyer is a hospitalist in internal medicine and an associate clinical professor at UCI Health in Orange, Calif.

Current challenges in sepsis diagnosis

The causal pathogen, infection location, associated organ dysfunction, antimicrobial resistance profiles, and host factors collectively encompass the heterogeneity of sepsis presentation and progression. When the infection source remains unclear, imaging studies, including X-rays, CT scans, MRIs, or ultrasounds, can be instrumental.[5] These factors and the time needed for culture and serology tests contribute to a range of outcomes, necessitating various types and intensities of treatment.[6] This heterogeneity has likely added to the failure of multiple pharmacologic and supportive care interventions in critically ill patients.[7] Additionally, there are limits to current diagnostic methods and definitions (Table 1) making sepsis a challenge to diagnose while potentially exposing some patients to unnecessary antibiotics and care pathways. According to the U.S. Centers for Disease Control (CDC), approximately 30% of the antibiotics administered in the U.S. are unnecessary or suboptimal, causing 2.8 million antibiotic-resistant infections annually and more than 35,000 deaths.[8]

Precision medicine technologies in sepsis diagnosis

Patients with sepsis exhibit a spectrum of dysfunctional responses ranging from an exaggerated hyperinflammatory state to immunoparalysis. Precision medicine examines the patient at the molecular level to provide pinpoint accuracy in diagnosis and treatment. Several emerging technologies have shown the potential to tailor treatments to individual patient characteristics. Multiple "-omics" technologies, sometimes called multi-omics (e.g., epigenomics, transcriptomics, proteomics, metabolomics), combine these methods for diagnosis and management.

Table 1. Sepsis definitions[2,9,10]

Sepsis-2	Definition, which is currently used by the Centers for Medicare and Medicaid Services (CMS) for SEP-1 core measure for early recognition and treatment, focuses on the systemic inflammatory response syndrome (SIRS) in people with suspected or proven infection.
Sepsis-2.5	Definition is unique to different organizations. However, a recently published article characterizes it as: the presence of clinical illness (appearing toxic); an identified or suspected infection; and evidence of organ dysfunction that exceeds expectation for a localized infection, or is external to the site of infection, and is not attributable to another concurrent or chronic condition.
Sepsis-3	Definition is a life-threatening organ dysfunction caused by a dysregulated host response to infection which uses an increase in the validated SOFA score to measure infection-associated organ dysfunction with subsequent mortality.

Genomics

Genomic technologies study the totality of a person's DNA. Though inflammatory biomarkers are elevated in both sepsis and sterile inflammation, variances in gene expression signatures could differentiate between the two entities and improve understanding of disease susceptibility.

An initial study of 11 gene sets showed a mean area under the curve (AUC) of 0.87 to distinguish systemic inflammatory response syndrome (SIRS) due to trauma from SIRS due to sepsis.[11] Of the genes tested, FAM20A+OLAH show good performance with an AUC of 0.9906 and could be used to triage patients rapidly who have suspected severe inflammation, while the CMTM5/CETP/PLA2G7/MIA/MPP3 gene panel could differentiate SIRS from sepsis with an AUC of 0.9758.12 Interestingly, urine can also be used to discern gene expression during early sepsis from inflammatory SIRS, instead of using blood.[13]

The genomics of vasomotor dysregulation in septic shock has been examined. The Vasopressin and Septic Shock Trial identified two single nucleotide polymorphisms (SNPs) with the homozygous genotype of rs28418396 associated with severe adverse events with vasopressor use and the homozygous genotype of *ADRB2* rs1042717 associated with a higher risk of mortality. However, in vitro the administration of low-dose steroids eliminated this genotypic effect.[14,15] Glucocorticoids impact the vascular tone and reduce pro-inflammatory gene transcription. However, SNPs affecting receptor function can have negative impacts on septic patients, though in-vitro use of methylprednisolone overcame this effect.[16] However, there have been no prospective, in-vivo, validation trials to assess therapeutic-regimen adjustments based on SNP information.

Epigenomics

Epigenomics is a rapidly expanding field exploring heritable changes in gene expression due to the environment, allostatic load, and other external factors that do not alter DNA sequencing and could explain the variability in gene expression during sepsis.

Investigations into various microRNAs, an epigenetic marker, indicate their expression is linked to sepsis-associated encephalopathy, acute lung injury, acute kidney injury, and endothelial leakage, suggesting that these could be potential targets for therapeutic development.[17] Exosome mimic therapy, which packages beneficial microRNAs to deliver them to targeted cells in septic patients similar to its use in cancer treatment, is gaining interest.[18]

Transcriptomics

Transcriptomics analyzes and monitors RNA transcription to gain insights into regulatory mechanisms, disease pathways, and therapeutic targets. This field has helped identify several different

sepsis phenotypes and endotypes. Moreover, it is established that gene expression endotypes observed on day one differ from those on day three among half of adult septic patients.[19]

The U.K. Genomic Advances in Sepsis study identified two sepsis response signature (SRS) phenotypes. SRS1 individuals had suppressed immune system response (higher T-cell exhaustion), and have a higher 14-day mortality risk, and SRS2 are those with normal immune system response.[20] However, in the Vasopressin vs Norepinephrine as Initial Therapy in Septic Shock trial, mortality risk increased significantly for SRS2 phenotypes when given steroids compared to SRS1.[21]

The MARS (Molecular Diagnosis and Risk Stratification of Sepsis) Consortium revealed four different molecular endotypes, with MARS1 (*BPGM, TAP2*) having the worst outcome/more immunosuppressed, MARS2 (*GADD45A, PCGF5*) and MARS4 (*IFIT5, GLTSCR2*) exhibiting an exaggerated inflammatory state and MARS3 (*AHNAK, PDCD10*) correlated with better outcomes and appropriate adaptive immune function.[22]

Two recent studies are advancing rapid sepsis diagnosis. The first study categorized suspected sepsis patients into five endotypes based on unique gene expression within two hours of their arrival in the emergency department, showing varying outcomes.[23] The second study introduced a rapid testing system with a one-hour turnaround time, using four host immune markers to diagnose sepsis. It was validated against Sepsis-2 and Sepsis-3 screening tools on ICU patients, demonstrating high predictive value for sepsis diagnosis, although its usefulness for patients with lymphopenia or neutropenia is limited.[24]

Proteomics

By elucidating protein structures, modifications, and interactions, proteomic analyses offer insights into disease mechanisms and potential therapeutic targets.

Through the use of this technology, acute respiratory distress syndrome patients have been classified into two phenotypes: hyperinflammatory (elevated IL-6, IL-8, and sTNFR-1 levels, protein C deficiency, metabolic alkalosis, increased prevalence of shock, thrombocytopenia, and higher vasopressor use); and hypoinflammatory (lower IL-6 and IL-8 levels, normal protein C levels, higher survival rate), which directs the care pathway patients receive regarding positive end-expiratory pressure, the fluid management strategy, and simvastatin use.[25] Also, the reclassification of the Prospective Recombinant Human Activated Protein C Worldwide Evaluation in Severe Sepsis—Shock study population revealed that the hyperinflammatory acute respiratory distress syndrome group had a lower mortality rate with activated protein C administration compared to the hypoinflammatory group.[7]

As some septic patients have a severe hyperinflammatory response, representing a macrophage-activation-like syndrome as indicated by high ferritin levels, the pilot study Personalized Randomized trial Of Validation and restoration of Immune Dysfunction in severE infections and Sepsis (PROVIDE) showed some benefit from anakinra administration to improve Sequential Organ Failure Assessment (SOFA) score at seven days of drug use, though with no benefit in mortality.[26] The ImmunoSep, or Personalised Immunotherapy in Sepsis, trial is a double-blind, multinational, randomized, controlled trial based on the PROVIDE pilot study to investigate the use of biomarkers (ferritin and HLA-DR) and adjunctive immunotherapy (recombinant interferon-gamma and anakinra) to improve outcomes in fulminant hyperinflammation or immunoparalysis sepsis subgroups. This trial may demonstrate a better response with a large study population and longer treatment window.[27]

Metabolomics

Sepsis affects several metabolic and biochemical pathways, and investigating the activation, suppression, and dysregulation of these cycles has the potential to enhance diagnosis, risk stratification, and treatment. Cellular metabolism of amino acids, lipids, and carbohydrates is altered in sepsis, leading to increased oxidative stress. This pattern distinguishes septic patients from those with sterile SIRS and healthy subjects.[28] Metabolomic profiling has also shown promise in sepsis diagnosis, with studies demonstrating that different metabolic fingerprints can be associated with early septic shock diagnosis compared to other types of shock.[29] Elevated levels of 3-hydroxybutyrate, alpha-1-acid glycoprotein, and glycine, along with a decrease in the concentration of citrate and histidine, are potential markers that could facilitate the identification of early-stage sepsis phenotypes.[30]

Microbiome analysis

Changes in the microbiome have been associated with sepsis, suggesting that microbiome analysis could be a valuable tool in sepsis diagnosis. Diet, medications, and environment also impact the health of an individual's microbiome. In septic patients, gut dysbiosis leads to a dysregulated inflammatory response, impaired immunomodulation, organ dysfunction, and altered metabolism due to a rapid and persistent decrease in short-chain fatty acid concentration.[31] Enterococcus species' predominant dysbiosis was positively correlated with increased gene expression related to cell chemotaxis and inflammatory damage.[32] Potential therapeutics targeting microbial function modification may involve select small-molecule inhibition of specific enzymes, harvesting microbial bacteriocins as novel antibiotics, or administering microbial product analogs such as receptor agonists to mimic the beneficial effects of microbiota.[33]

Cytomics

Cytomics studies the immune cell responses to sepsis triggers. Current areas of research include low-density neutrophils, monocyte human leukocyte antigen-DR isotype, and toxic granulocyte production in neutrophils. Low-density neutrophils are present in chronic inflammatory and autoimmune states but are also seen in sepsis. They contribute to a weakened immune response (reduced chemotaxis, phagocytic capacity, and T cell proliferation) and proinflammatory state (increased reactive oxygen species).[34] Reduced or deficient monocyte human leukocyte antigen-DR isotype expression impairs antigen presentation for immune signaling and reduces tumor necrosis factor alpha (TNF α) production.[35] Intensive-care-unit populations with severe deficiencies had higher mortality risk, longer length of stay, and higher risk for secondary infections.[26]

Machine learning

Machine learning algorithms can integrate large volumes of data and identify patterns that might not be apparent to clinicians, thereby aiding in early sepsis diagnosis. Dr. Mihir Patel writes about this on page 9.

Point-of-care testing for biomarkers

Several biomarkers have been used to identify and differentiate patients with sepsis.

Guidelines caution about the risks of false positives and negatives when using procalcitonin (PCT), emphasizing the need for careful interpretation of results in the appropriate clinical context as noted in Table 2.[36,37] Patients on di-

Table 2. Contributing factors to false positive and negative procalcitonin results [36,37,39,40]

FALSE POSITIVE		FALSE NEGATIVE	
Non-infectious	• Cardiac arrest/ shock • Trauma • Surgery • Burns • Cerebral hemorrhage • Pancreatitis • Severe liver disease • Medullary thyroid cancer • Pulmonary neuroendocrine tumor • Kawasaki disease • CKD/ESRD • Acute graft versus host disease • Microangiopathic hemolytic anemia • Veno-occlusive disease	**Atypical infection**	• *Legionella* spp • *Mycoplasma* spp. • *Chlamydia* spp.
Medications	• T cell antibodies • Alemtuzumab	**Localized uncomplicated infection**	• Cellulitis • Tonsillitis • Empyema • Abscess
Non-bacterial infection	• *Candida* spp. • *Aspergillus* spp. • *Plasmodium* spp.		

alysis without an active infection can have a PCT level >0.5.[38] Three separate meta-analyses of PCT for diagnosing sepsis showed a sensitivity range of 77% to 85% and a specificity range of 75% to 83%.[39]

C-reactive protein (CRP) is another biomarker used to assess for sepsis. Levels rise quickly following inflammatory insult, though they are not affected by immunosuppression, chronic kidney disease, end-stage renal disease, or cirrhosis and cannot reliably distinguish between sepsis and SIRS, with a sensitivity of 78% to 80% and specificity of 60% to 61%.[40] A meta-analysis of monocyte distribution width revealed higher sensitivity but lower specificity compared to PCT, with similar sensitivity and specificity compared to CRP.[41] Point-of-care neutrophil CD64 testing in emergency department patients shows promise for ruling in bacterial infections, with a positive predictive value of 1, sensitivity of 0.27, specificity of 1, and negative predictive value of 0.64.[42]

Cell-free DNA techniques have enhanced the care of septic patients by enabling rapid diagnosis of sepsis-causing pathogens along with their antibiotic-resistance profiles compared to standard blood culture methods. A recent proof-of-concept study showed a reduced time to sensitivity of 12 hours to allow for earlier targeted therapy.[43]

Although the concept of precision medicine is often used to classify patients by molecular means, physiologic measurements remain valuable to developing this approach by aiding in patient therapeutic selection criteria due to advances in monitoring, signal processing, and imaging techniques.[44] Vital signs or temperature trajectory can assist in stratifying the risk of septic patients and identifying those who would benefit from balanced fluids.[45,46]

Future perspectives and conclusion

The 2023 White House Office of Science and Technology Policy Report outlined goals to advance precision medicine, including health monitoring, multi-omics, cell therapies, artificial-intelligence–driven drug development, and microbial genome sequencing.[47] Many published studies are limited by research design, focusing on selective biomarkers or pathways and small sample sizes, which restrict their broad application. Additionally, clinical variables and measurable "-omics" must offer actionable information and predictable responses so as to customize care and enhance patient outcomes.[44] The ethical issue of equipoise arises when using biomarker credentials to randomize patients who may be genetically disadvantaged and unable to benefit from the experimental therapy.[44] There are several prospective studies of various patient characteristics and "omics" which are evaluating the feasibility of real-time identification that could influence decision making and assessment of targeted therapies in clinical settings.[27,44,48-51] However, there is a need for integration with a multi-omics approach to capture the complex relationship between different biological systems to have a transformative impact on the understanding and management of sepsis.

Ethical challenges and precautions in applying precision medicine in sepsis should be considered. If the use of predictive biomarkers enhances patient care and outcomes, there are ethical, legal, and social implications involve integrating these diagnostic and therapeutic options responsibly, equitably, and effectively.[52] It is recommended that decisions to apply a precision-medicine approach, like any other test or treatment option, should be guided by the best interests of the patient, scientific evidence, and ethical standards.[53] These considerations, including risks, limitations, and benefits, are inclusive of the physician's ethical responsibility to practice high-value care.[53] Additionally, more inclusive research is needed to ensure the generalizability of specific markers and thresholds for diagnosis and initiation of therapeutics.

In summary, precision medicine accelerates the process of obtaining crucial information about hosts, genes, and microbes from days to just hours, enhancing patient care by customizing treatment. This strategy targets reduced antimicrobial resistance, patient morbidity, and healthcare costs. ■

View the complete list of references online.

Decoding Sepsis: Documenting Sepsis Accurately

By Arunab Mehta, MD, MEd, FHM

A 64-year-old female is admitted to the hospital with pneumonia and started on IV antibiotics. You see her after she has been admitted and start some IV fluids for presumed sepsis. On day two, the patient improves, and you are asked by your institutional coder to clarify whether this patient truly has sepsis and to document it accordingly.

What documentation is necessary for sepsis?

Sepsis can safely be documented using the Sepsis-3 criteria from the third international consensus definitions for sepsis and septic shock

(2016) that requires the acute change in SOFA score of >2 from baseline consequent to a recognized infection. This represents a dysregulated response of organ systems to an infection.

Tip

For clinical validation purposes, your clinical documentation improvement specialist might be looking for documentation that:

- Demonstrates the presence of infection, whether the source is known or unknown
- Has evidence of organ dysfunction demonstrating an increase of two or more points in the SOFA score
- Shows organ dysfunction, usually in more than one organ system (e.g., an elevated creatinine level resulting in a SOFA score of 3 by itself is less supportive of clinically validating sepsis)
- Indicates treatment directed at the underlying source of the sepsis and directed at the clinical consequences of the sepsis (e.g., acute kidney injury, respiratory failure, etc.) ■

Dr. Mehta is the vice-chair of inpatient clinical affairs, medical director, and assistant professor of medicine in the clinical core faculty for program valuation and improvement at the University of Cincinnati Medical Center in Cincinnati.

Table 1. SOFA Criteria

ORGAN SYSTEM, MEASUREMENT	SOFA SCORE 0	1	2	3	4
Respiration PaO_2/FiO_2, mmHg	Normal	<400	<300	<200 (with respiratory support)	<100 (with respiratory support)
Coagulation Platelets $x10^3/mm^3$	Normal	<150	<100	<50	<20
Liver Bilirubin, mg/dL (µmol/l)	Normal	1.2-1.9 (20-32)	2.0-5.9 (33-101)	6.0-11.9 (102-204)	>12.0 (<204)
Cardiovascular Hypotension	Normal	MAP<70 mmHg	Dopamine <5 or dobutamine (any dose)**	Dopamine >5 or epinephrine <0.1 or norepinephrine <0.1	Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1
Central Nervous System Glasgow Coma Score	Normal	13-14	10-12	6-9	<6
Renal Creatinine, mg/dL (µmol/l) or Urine output	Normal	1.2-1.9 (110-170)	2.0-3.4 (171-299)	3.5-4.9 (300-440) or <500 mL/day	>5.0 (>440) Or <200 mL/day

**Adrenergic agents administered for at least 1 hour (doses given are in mcg/kg/min).

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Digital Tools: The New Frontline Against Sepsis

Improving patient outcomes

By Mihir Patel, MD, MPH, FACP, CLHM, SFHM

In the fast-paced world of hospital medicine, digital tools are revolutionizing the battle against sepsis. This life-threatening condition, known for its rapid onset and potentially devastating outcomes, is met with cutting-edge technologies that streamline workflows, improve patient care, and empower hospitalists to deliver timely interventions.

EHRs and clinical decision support systems

At the core of this transformation are electronic health records (EHRs) integrated with clinical decision support systems. These systems continuously analyze patient data, alerting hospitalists to potential sepsis cases in real time. They flag abnormal vital signs, lab results, or specific combinations of symptoms indicative of sepsis. By flagging at-risk patients early and guiding clinicians through sepsis protocols, these tools ensure timely interventions and adherence to best practices. This streamlined workflow reduces the cognitive load on healthcare practitioners, allowing them to focus on patient care. Real-time alerts, guided protocols, and reduced mental burden are key benefits that enhance hospitalist efficiency.[1,2]

AI-powered predictive analytics

The advent of artificial intelligence (AI)-powered predictive analytics introduced an unprecedented level of precision in identifying patients at risk of sepsis. These tools analyze a wide range of data points, including patient history, demographics, and lab results, to predict sepsis risk. For hospitalists, this means being steps ahead, armed with insights drawn from vast datasets that reveal complex, otherwise invisible patterns. These tools enable clinicians to intervene even before traditional symptoms become apparent. This proactive approach not only improves patient outcomes but also optimizes hospitalists' workflow by allocating resources more effectively and prioritizing care where it is needed most. Early detection, resource optimization, and improved outcomes are significant advantages of predictive analytics in sepsis care.[3-7]

Sepsis virtual and remote monitoring

Sepsis virtual and remote monitoring harnesses advanced technology, enabling trained healthcare teams, including remote nurses and clinicians, to oversee patient data and identify early sepsis signs while guiding on-site care through timely interventions. This approach increases adherence to the sepsis bundle—crucial for improving outcomes—by alerting and reminding on-site teams about treatments such as timely antibiotic administration and supporting continuous documentation. Importantly, the remote team could also use video monitoring technology to evaluate patient responsiveness to sepsis treatment, offering an additional layer of oversight. The potential cost savings and expanded access to care that remote monitoring could offer, especially for smaller hospitals or those in underserved areas, are significant. This capability can not only boost compliance with best practices but also support a cycle of continuous improvement and education for on-site staff, thereby elevating the standard of care for patients at risk of sepsis. By integrating technology with expert remote support, this model underscores the transformative potential of digital health in critical-care scenarios, significantly improving sepsis management and patient outcomes.[8-10]

Mobile apps and wearables

Mobile apps and wearable smart sensor patches provide hospitalists with instant access to sepsis protocols, reminders, and decision support tools—all at their fingertips. Real-time monitoring of vital signs through these wearables further enhances the ability to respond to patient changes promptly. These wearables could seamlessly integrate real-time data into a patient's EHR, ensuring that hospitalists have the most up-to-date information. Instant access to treatment protocols, continuous tracking of patient vitals, and increased responsiveness to changes in patient condition are key benefits of these mobile technologies.[11-13]

Data analytics for quality improvement

Data analytics tools empower hospitalists to evaluate their sepsis care strategies and guide quality improvement initiatives. By analyzing outcomes and protocol adherence, these tools can identify areas for improvement and support accreditation, leading to better decision making and a continuous cycle of progress. These tools could help hospitals benchmark their performance against national standards and identify areas for improvement beyond sepsis care. Detailed outcome analysis, monitoring of protocol adherence, and ongoing refinement of sepsis management strategies are essential elements of using data analytics for quality improvement.[14,15,16]

Dr. Patel is the chair of the inpatient clinical informatics council, the medical director of virtual medicine, and a hospitalist at Ballad Health System in Johnson City, Tenn. He is also chair of SHM's Health Information Technology Special Interest Group.

Conclusion

The integration of digital tools in sepsis prediction and treatment can transform hospital medicine. From EHRs and predictive analytics to remote monitoring and mobile apps, these technologies improve the efficiency and effectiveness of hospitalists, ultimately improving patient outcomes in the fight against sepsis. Looking ahead, the potential for future advancements in AI and machine learning promises to further improve sepsis prediction and treatment. ■

View the complete list of references online.

Diverse Mentorship Options Allow a Tailored Approach

Beneficial to mentees, mentors, and healthcare systems

By Lucy Shi, MD

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Dr. Shi is an adult hospitalist, assistant clinical professor, and director of student-run clinics at UC Davis Health in Sacramento, Calif.

Mentorship has been shown to have numerous benefits for mentees such as increasing confidence, mitigating burnout, improving physician retention, and successful career development.[1] According to SHM's State of Hospital Medicine Report, annual hospitalist turnover for both adult and pediatric hospitalists is high. It's been rising, nearly doubling for adult hospitalists, from 6.9% in 2016 to 11.7% in 2023.[2] Although reports vary in the monetary cost of physician turnover, high turnover can have downstream effects on morale, burnout, and group culture, which emphasizes the impact of mentorship for all hospitalists.[3,4] While the importance of mentorship is frequently discussed, it can be difficult for individual hospitalists to navigate the numerous forms of mentorship to find relationships that work for their varied needs.

Informal versus formal

Historically, many mentorship relationships occurred outside of organized programs, where the relationship developed intentionally or organically out of personal connections. To maximize the benefit of informal mentorship, Barrett Fromme, MD, MPHE, professor of pediatrics at the University of Chicago Pritzker School of Medicine in Chicago, emphasizes the need to be intentional about seeking out these relationships. Like many things in life, she points out that "[a great mentor] isn't just going to fall into your lap." For hospitalists who are more advanced in their careers, making connections with other hospitalists nationally can provide mentorship and peer cohorts to navigate the ever-changing hospitalist landscape. These informal mentoring relationships are frequently based on genuine connection and trust without set rules, allowing for increased flexibility for mentors and mentees.


Dr. Fromme

While personal connections are invaluable, informal mentorship may not work for everyone and many groups across the nation have created formal mentorship programs. Julie Schaefer, MD, department chair of hospital medicine at Regions Hospital in St. Paul, Minn., notes, "part of the impetus behind starting our mentorship program was a desire to make mentoring relationships accessible to all. We know that underrepresented groups in medicine are less likely to seek out mentorship on their own. Formal mentorship programming, while it doesn't meet every mentorship need in the department, can help build towards a culture where mentorship is sought, valued, and expected."


Dr. Schaefer

Traditional versus peer

When thinking about mentorship, people traditionally think about a one-on-one interaction between a senior mentor and junior mentee where the senior mentor typically has expertise in an area that the mentee is interested in. However, in hospital medicine, where many hospitalist groups have rapidly expanded in the past 10 years with numerous junior faculty members needing mentorship, traditional mentoring may place increased demands on a small pool of quality senior mentors.

The division of hospital medicine at Emory University is the largest in the nation, with more than 250 hospitalists across multiple sites. Providing faculty development and strong support for potential mentors has helped them expand their pool of mentors to keep up with their rapid growth in junior faculty, says Annie Massart, MD, assistant professor at Emory University School of Medicine in Atlanta. She notes that many hospitalists have significant expertise and wisdom to share, but don't want to be a disservice to more junior faculty. With formal training built into their mentorship program, they are able to help faculty gain skills that allow them to feel comfortable being mentors. Lien Le, MD, MBA, associate chief medical officer at Tampa General Hospital in Tampa, Fla., also recommends thinking outside of the box and looking throughout the department to connect hospitalist mentees with senior faculty outside of the group.


Dr. Massart


Dr. Le

In comparison, peer mentorship is where individuals of similar ages or experience levels are paired together. Because peer mentors are at similar life stages, they frequently face similar work challenges and can provide support and a different perspective. Eric Signoff, MD, FACP, associate professor at the University of California Davis School of Medicine in Sacramento, Calif., notes that "... there's a lot of growth that happens early on as a hospitalist and there is an enormous amount of wisdom that early career hospitalists can provide to their peers." One of the benefits of peer mentorship is that frequently the only experience necessary is the mentor's lived experiences.


Dr. Signoff

One-on-one mentoring

Even after considering the type of mentor, there are different forms of mentorship models to explore. One-on-one mentorship is a traditional model of mentoring that is mentee-focused and frequently personalized to their needs to help them advance in their career. This individualized approach can be powerful, allowing for a deeper focus on the mentee and the formation of a close relationship, but often depends on finding the right mentor-mentee fit. In formal mentorship programs, hospitalist groups typically consider a combination of professional and personal components when creating matches.

While traditionally thought of as a relationship between a senior mentor and a junior mentee, near peers can also engage in effective one-on-one mentorship. At Regions Hospital, they moved to a one-on-one mentorship model for all incoming hospitalists when they had an influx of new hires: They paired new hospitalists with a more experienced peer for their first year with the group. According to Dr. Schaefer, while some of the focus of this relationship can be situational related to the logistics of starting a new job, the near-peer aspect of the partnership allowed for the mentor to create a trusting relationship with their mentee, helping them set career goals and develop leadership skills.

Group mentoring

In comparison, group mentorship involves three or more individuals and can be more powerful in fostering a sense of inclusion and collaborative growth. This can be organized with one or more senior mentors facilitating and guiding the group, helping one mentor reach and impact more mentees in

a shorter amount of time. Dr. Massart shares that group mentorship can also be a more casual introduction to mentorship for some hospitalists who may not feel ready for traditional dyad mentoring. Because her group has multiple practice sites, individual locations facilitate local mentorship groups that focus on site-specific interests and challenges, while also allowing hospitalists to form stronger bonds with their peers.

They also used group mentorship to support their mentors at Emory University, where mentors come together for quarterly calls to discuss mentorship topics, work through difficult scenarios, and learn from their peers. Dr. Massart adds that while more experienced mentors can be sources of wisdom, individuals bring a diversity of backgrounds and perspectives. Having a multi-element structure with group mentorship in addition to a traditional dyad partnership helps them serve the diverse needs of their different faculty.

Situational mentorship

When Dr. Le was a young hospitalist, she felt alone in her journey, which inspired her to develop a robust onboarding mentorship program to give new hires an on-the-job mentor to provide the support they need to successfully transition to joining the group. Not always recognized as mentorship, situational mentorship is typically a short-term relationship surrounding a specific situation. For hospitalist groups, this frequently manifests during the onboarding process for new hires but may also work well to support hospitalists in research and other scholarly activities. This type of mentorship program allows hospitalist groups to select from a larger pool of potential mentors with a limited time commitment. This is also a form of mentorship where Dr. Le thinks that in some programs, advanced care practitioners and physicians could have joint mentorship programs and benefit from shared resources and knowledge.

Speed mentoring

Speed mentoring is a form of mentorship modeled after speed dating, where mentees rotate between mentors for short, focused sessions. Dr. Signoff found that holding a speed-mentoring event was particularly useful to complement their peer-mentoring program and allow hospitalists to engage with a senior mentor in addition to their near-peer mentor. This allows a small group of senior hospitalists with valuable expertise to reach a larger number of junior hospitalists and to create space for impactful mentorship advice without the pressure of long-term relationships or scheduled meetings. He emphasized the value of having a cabinet of mentors rather than relying on just one person and used speed mentoring as a means to help young hospitalists connect with senior faculty across the hospital system.

It can work well to have events organized around a specific theme or topic, such as education or research, which allows mentees to gain different perspectives on that topic as they rotate through various mentors. For those who want to expand their mentorship pool beyond their immediate hospital system, many organizations host speed-mentoring sessions both throughout the year and at national conferences, which is a great avenue to connect with hospitalists across the nation. This can be a way to expand your team of mentors, get perspectives outside of your own institution, and network with leaders across the nation.

Virtual mentoring

With the shift to more virtual meetings and busy schedules, some groups have turned toward virtual mentoring. There are a variety of apps and software that can be used for virtual communication that also expands the reach of mentor pairings beyond the immediate local hospitalist group. This can be an inclusive option for hospitalists who prefer to connect virtually or for hospitalist groups that have multiple practice sites.

Some national organizations have also created virtual mentorship groups. For example, Women in Pediatric Hospital Medicine developed a virtual group-mentorship program for pediatric hospitalists where a group of near peers has facilitated monthly meetings structured around specific topics to help provoke discussion. Having a virtual format allows hospitalists across the nation to form mentorship groups, make meaningful connections, and find a safe space to reflect on institutional challenges.

Creating a mentorship program

The logistics of coordinating a new mentorship program for a hospitalist group can be daunting. However, in addition to supporting individual hospitalists, a formal mentoring program can help hospitalist organizations demonstrate their commitment to faculty development and create a culture where hospitalists feel valued and supported. Dr. Fromme recommends starting by reflecting on your group, optimizing resources, keeping your aims narrow to start, and slowly building with time. For example, peer mentorship may work better for groups with a large cohort of junior hospitalists.

In her current position, Dr. Le can now provide financial support for a position focused on mentorship and professional development for their hospitalist group, but when she started her first mentorship program, she needed to gain support from her section chief. Her recommendation to hospitalists looking to find support from senior leadership is to emphasize the importance and value of a strong mentorship program, particularly the return on investment. Strong mentorship can help hospitalists provide safer care as they transition to a new program as well as improve recruitment of quality physicians.

In addition to the work necessary to build a mentorship program, continued success relies on ongoing programmatic support. Although the mentorship program at Emory University has been present for more than eight years, having someone dedicated to the administration and growth of the mentorship program has allowed them to have continued success, according to Dr. Massart. She emphasizes that there is a tremendous return on investment when a system invests in mentorship, acknowledging that mentorship can improve retention and decrease burnout, as well as help hospitalists find increased success in scholarship and engage in research.

While formal mentorship programs have numerous benefits, it is also important to recognize that they may not be sufficient to meet every need. Mentorship relationships can be transient or longer lasting, but individuals frequently benefit from having a diverse group of mentors who can help them navigate the various aspects of their careers. With an intentional approach to mentorship, casual acquaintances can become strong mentors and formal mentorship programs can ease some of the challenges in exploring potential mentors. ■

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Hospitalist Leaders Reflect on the Importance of Mentorship

Mentors and mentees benefit from cultivating their role to help hospital medicine evolve

By Vanessa Caceres

With hospital medicine a newer specialty, mentorship has an extra special role, say several hospitalist leaders who have spent much of their careers serving as mentors for others. Mentoring helps newer hospitalist leaders to grow and try new experiences, such as research. It also can serve as a guiding light for newer hospitalists struggling to balance work and life obligations or handling certain clinical situations.

Mentoring relationships aren't just for senior and junior hospitalist pairs. They also can form between peer or near-peer hospitalists who may serve in different roles that can mutually nurture each other.

In celebration of Women in Medicine Month, *The Hospitalist* spoke to several leaders who've been recognized for their mentoring.

Jagriti Chadha, MD, MPH, FACP, SFHM

Dr. Chadha is an associate professor of medicine, advanced development director of internal medicine, medical director for physician development in the division of hospital medicine, and associate vice chair for faculty development and advancement in internal medicine at the University of Kentucky in Lexington.

Dr. Chadha

She has served in a variety of faculty and mentorship roles in her 13-plus years at the University of Kentucky. One program she helped start in her department is called WISE, which stands for Women in Internal Medicine Sessions for Empowerment, where they bring in women leaders to talk about how they got to their current role and discuss any current challenges.

One thing Dr. Chadha particularly enjoys is watching her mentees succeed, whether that means getting into a residency program or taking on a leadership position. "It's that giving-back feeling, or feeling like helping the next generation," she said.

Dr. Chadha believes that the newness of hospital medicine makes the role of mentoring even more key. "I feel like it's still a relatively new specialty compared with some of the other specialties, so there aren't as many well-developed pathways. The onus is on us to develop those pathways. Mentorship can help people figure out their career and get promoted," she said.

For hospitalists looking for more guidance on how to mentor or be a mentee, Dr. Chadha recommends "The Mentoring Guide: Helping Mentors and Mentees Succeed."

"We all mentor people, but we probably all need guidance as to how to be good mentors and mentees," she said.

Allison S. DeKosky, MD

Dr. DeKosky is the medical director of UPMC Presbyterian Hospital Medicine, associate program director for quality and patient safety of the internal medicine residency program, and director of the hospitalist track of the ACES General Medicine Fellowship in the UPMC Presbyterian division of general internal medicine, all in Pittsburgh.

Dr. Dekosky

With a first career in health policy and having previously worked in the U.S. Senate, Dr. DeKosky says that medical school was not part of her original plans. However, it became her next step as she began to work with more physicians, patient advocates, and researchers.

"Hospitalists really can serve a critical role for what is next in health care in the U.S.," Dr. DeKosky said. "We have an intimate knowledge of the systems and the intersections of inpatient and outpatient procedures, surgery, post-acute care, rehab, and need for access to primary care and emergency care—all of those things are critical to our work, and that knowledge is central to improving health care delivery."

Cultivating young faculty in the field via education and mentorship will help build the pipeline in hospital medicine, which is smaller than many other specialties. "It's important to make this a sustainable career so we have more senior and seasoned hospitalists to help make the field something that young doctors want to pursue," she said.

Changing to meet the current environment faced by hospitalists is part of a mentor's responsibility as well. "What our hospitalists who are just entering the field are navigating is very different from what we did 10 years ago. We have to evolve with it and make sure that we're meeting our mentees where they are. And we have to be available," she said.

For a mentee's part, reflecting on their own vision, mission, and goals will help them find mentors for each of those areas. "You won't find all of that in one person. Having a diverse set of mentors helps with a diverse set of interests as well," Dr. DeKosky said.

Mirna Giordano, MD, FAAP, FHM

Dr. Giordano is an associate professor of pediatrics at Columbia University Medical Center and the pediatric-critical-care and hospital-medicine-progressive-care units' medical director at NewYork-Presbyterian Morgan Stanley Children's Hospital, both in New York City.

Dr. Giordano

Mentorship can help hospitalists take care of each other, prevent burnout, and learn from each other's mistakes, Dr. Giordano says.

As a pediatric hospitalist for about 20 years, Dr. Giordano has had the chance to mentor in many different ways, including with a small group of female pediatric hospitalists doing surgical co-management. This team eventually joined the larger pediatric hospital medicine team. She also has met with fellows in her role as faculty for some national pediatric hospital medicine meetings.

Dr. Giordano also is involved with PULSE, a mentorship organization for those interested in medical school, and she teaches medical school students and residents. "I am fortunate to see young people in a variety of roles and hopefully contribute in some small ways to their growth."

For those searching for mentors, Dr. Giordano suggests sending an email, approaching people at meetings, or taking part in speed mentoring events. "Following up on the initial contact is the most important step," she said.

She also encourages hospitalists to send some thoughts of gratitude to their mentors and consider whom they may want to mentor themselves in the future. "To think ahead and believe that we could be the force that so many will be grateful for at some point is powerful," she said.

Melinda Kantsiper, MD, FACP

Dr. Kantsiper is an associate professor of clinical medicine at Johns Hopkins School of Medicine, associate vice chair for inpatient quality and safety at Johns Hopkins Bayview Medical Center, and clinical director, division of hospital medicine at Johns Hopkins Bayview Medical Center, all in Baltimore.

Dr. Kantsiper

Dr. Kantsiper's early-career mentors gave her role models to look back on as she's served as a mentor more frequently in her hospitalist career. These mentors "were able to really care about my professional development and my joy in practice and help identify opportunities for me that I would not have found on my own and encourage me to get the building blocks that would allow me to grow and succeed," she said.

For example, with her own mentees, she will let them know about opportunities within SHM or projects that need a research collaborator.

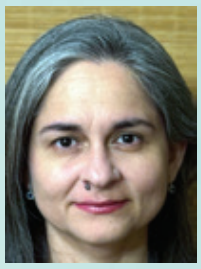
"Having a mentor can keep you from going down dead ends," she said.

For those who are seeking a mentor or mentors but are not part of a formal program, Dr. Kantsiper recommends joining a professional society, such as SHM or the American College of Physicians. The national conferences often provide sessions geared toward early-career physi-

cians, and attendees can meet people from outside their institution. Or, she said, "There's a chance you'll meet someone from your institution who you normally would not see, but who shares common interests. Even with remote and virtual programming, you can connect with experts in the field and potential mentors."

Areeba Kara MD, MS, FACP, SFHM

Dr. Kara is an associate professor of clinical medicine and associate division chief with the division of general internal medicine and geriatrics at Indiana University School of Medicine in Indianapolis.


Dr. Kara

Dr. Kara, who has worked in hospital medicine since 2003, has found herself mentoring in a variety of roles, not unlike many others in hospital medicine. This includes talking to colleagues about their challenges in managing work and life responsibilities, discussing difficult clinical scenarios, and providing feedback on a grant proposal or manuscript writing. "Everyone who has experiences, skills, or knowledge that someone would love to develop is positioned to be a mentor," she said.

She also helped develop her division's programming for faculty development and points to mentor-mentee relationships that have formed through participation in the SHM's committees and special interest groups.

Mentorship in hospital medicine is particularly important as the specialty develops its identity, she says. "As the earliest waves of hospitalists start to approach retirement, it's important to retain and grow what we have learned," Dr. Kara said. "Hospital medicine is home to some of the most burnt-out clinicians in medicine. Engaging in your passions can be protective against burnout, and mentoring helps others find their passions and engage in them bravely."

Dr. Kara would like to see some of the gaps related to the representation of women and those historically underrepresented in medicine in terms of leadership roles, in both general and hospital medicine, filled. "Those in positions to mentor and sponsor others should consider how they can equitably support the richly diverse and talented hospitalists across the country," she said.

Jilian R. Sansbury, MD, FACP, CHSE, FHM

Dr. Sansbury is the program director of the transitional year residency program, associate program director of the internal medicine residency program, and chair of the department of medicine at Grand Strand Medical Center in Myrtle Beach, S.C.

Dr. Sansbury has worked in hospital medicine since 2015. She now works in a hybrid role in both inpatient and outpatient capacities. As part of her role, she creates and delivers a leadership lecture series for residents at the hospital. The lectures cover topics like how to be a good decision-maker, personal financial guidance, self-care, and maintaining fun in life as you develop in your career. "The residents always comment on how useful the discussions are, and they appreciate the break from a traditional didactic lecture," she said.


Dr. Sansbury

One mentoring success she recalls is a resident who let her know how proud he was that he hired a cleaning service once a month. "House cleaning was a big point of argument for this resident and his significant other, and this change made a huge impact on many levels for him. For me, it was the realization that my message got through about prioritizing your time off for self-care and leisure, and that working on relationships rather than cleaning the house is important for maintaining our sanity!"

Mentoring plays an important role within medicine because of the many life roles physicians must maintain, Dr. Sansbury says. "As a woman in medicine, I didn't have a good grasp of how difficult it would be to work full-time and have young children. That was and still is the most challenging part of fulfilling my dream of being a physician. It's so important to understand what this reality looks like and how to work with it to achieve each of your goals." As a mentor, she tries to provide insight into what her process has been to help other women navigate the field.

Dr. Sansbury urges those considering their potential role as a mentor not to underestimate their own experience. "Your input is invaluable to them and their growth and transition to a career in medicine—even something as simple as managing your monthly budget or what self-care looks like for you," she said.

Meghan Sebasky, MD, FACP, SFHM

Dr. Sebasky is internal medicine clerkship co-director, health sciences clinical professor, and associate vice chief of academics and medical education in the division of hospital medicine at the University of California, San Diego.


Dr. Sebasky

Dr. Sebasky, who has worked in hospital medicine for 13 years, takes part in an innovative mentor-related work group. The work group matches early-career faculty with one or two senior mentors in the division to form a "mentoring pod" to complete an achievable project that is likely to result in scholarly output.

"We theorize that matching mentors and mentees who are aligned with a defined, operational, quality improvement, or medical education project will create a successful mentorship relationship for the duration of the project and potentially into the future," she said.

Dr. Sebasky encourages those seeking a mentor to reflect on their role as a mentee. "A successful mentee is the driver of the relationship and has taken time to reflect on their goals prior to engaging a mentor," she said. Potential mentees also should look for people in roles they aspire to have in the future or who are doing work that's of interest to them.

"Start with one person on that list, and find a time to meet with them to explore compatibility. Potential mentors are everywhere, and I would propose that you seek out multiple [mentors]," she said.

She also calls mentorship an "interesting journey" as new hospitalists often seek mentors and then, before realizing it, they themselves have enough experience and connections to be mentors. However, they may not have received dedicated training or faculty development on how to be an effective mentor.

A traditional view of mentorship involves a "senior" hospitalist meeting with a "junior" hospitalist, but she says that this is only one model that can be successful. "Take a moment to consider the mentors you interact with currently. I think many of us will be able to identify peer mentors, near-peer mentors, or mentorship groups that have created opportunities for us and contributed to our professional growth, even if we have not previously given these individuals the 'mentor' label," she said.

Ann M. Sheehy, MD, MS

Dr. Sheehy is University of Wisconsin (UW) Health senior medical director of population health and president of the UW Health accountable care organization, deputy director for health policy research for UW Center for Health Disparities Research, and professor in the department of medicine, division of hospital medicine, UW School of Medicine and Public Health, all in Madison, Wisc.


Dr. Sheehy

In her previous role as division head of hospital medicine for more than a decade, Dr. Sheehy and her leadership team helped support hospitalists to achieve clinical, educational, research, and administrative goals. This included fostering manuscript collaborations and advocating for time to successfully compete for National Institutes of Health Career Development (K) awards. "Most importantly, we developed a leadership team that I think was able to be nimbler in mentoring physicians in areas of specific interest," she said.

Dr. Sheehy points out that she sees mentoring as a team effort but that she is particularly proud of helping to grow the division from 13 to 80 people over her time as division head.

Mentorship within hospital medicine is particularly important because most hospitalists are not fellowship-trained and may not have been career-mentored before. "In that sense, mentorship fills a gap, especially for newly trained hospitalists," she said. "In addition, hospitalists quickly become health systems experts because hospitalist practice is closely aligned with hospital operations, quality and safety, health policy, and medical education. As a result, hospitalists have so much to offer in health care at large, and are ideally suited for many leadership roles, such as chief medical officers, chief quality officers, and residency program directors. Mentorship is critical for hospitalists wanting to pursue such roles."

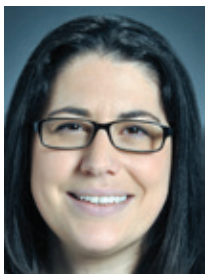
Dr. Sheehy encourages those who want to pursue interests outside of clinical work, such as research, to be intentional about carving out time for those interests. "Mentorship and sponsorship are important components of that," she said. ■

Seizing the Moment: Hospitalists' Roles in Reproductive Care

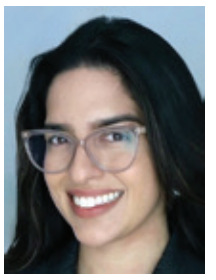
Identifying unmet needs and managing contraceptive care

By Abbey Masonbrink, MD, MPH, Vanessa McFadden, MD, PhD, SFHM, Eileen Barrett, MD, MPH, and Gisele Nogueira Bezerra, MD


Dr. Masonbrink


Dr. McFadden


Dr. Barrett


Dr. Bezerra

Dr. Masonbrink is a pediatric hospitalist at Children's Mercy Kansas City and an associate professor of pediatrics at the University of Missouri-Kansas City School of Medicine in Kansas City, Mo. She currently conducts research focused on adolescent health, including substance use treatment and sexual and reproductive health access. She currently receives funding from the National Institute On Drug Abuse of the National Institutes of Health. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. Dr McFadden is a pediatric hospitalist and interim division chief at the Medical College of Wisconsin in Milwaukee, Wis. She conducts research focused on addressing adolescent sexual and reproductive health in the hospital setting. Dr. Barrett is a rural hospitalist, senior medical director and vice-president of quality at WorkItHealth, and also president-elect of the American Medical Women's Association. Dr. Bezerra is a postdoctoral research fellow at Massachusetts General Hospital in Boston and is applying for an internal medicine residency.

A 25-year-old woman is admitted to your service with acute kidney injury due to lupus nephritis in the setting of chronic kidney disease, diabetes, and hypertension. She mentions having menstrual cramps, and upon review of her labs, you see she has a negative human chorionic gonadotropin. In your social history, you recall her mentioning she has one child and is sexually active with her husband. On review of her medications, you do not see contraception listed. How would you approach talking with her about pregnancy intentions, prevention, and contraception, if desired?

Almost half of all pregnancies in the U.S. are unintended.[1] Among adolescents, this rate exceeds 80%.[2] Several factors contribute to this high incidence, including the unpredictability of ovulation, the longevity of sperm viability post-intercourse (up to five days), and constraints related to limited contraceptive access and literacy.[3] The unintended pregnancy rate is a crucial indicator of reproductive health outcomes and reflects whether women and their partners have access to pregnancy prevention resources that support reproductive justice and autonomy.[4]

Women experiencing unintended pregnancy face higher risks of complications, with significantly increased odds of maternal depression during pregnancy and postpartum.[5,6] Additionally, it is linked with poor outcomes in infants, including prematurity and low birth weight.[5] Ensuring the delivery of sexual and reproductive healthcare for all women of reproductive age, particularly for those facing barriers to access, is a critical responsibility of all clinicians, including hospitalists.[2,4]

Despite common perceptions, hospitalists can play an important role in identifying unmet needs and managing contraceptive care.[7] During hospital admissions, hospitalists can identify sexual- and reproductive-health needs and counsel all patients who can get pregnant on contraception and unintended pregnancy prevention. Certain populations are particularly vulnerable to experiencing an unintended pregnancy, including:

US MEC
US SPR
CDC

- Adolescents and young adults frequently encounter barriers to accessing primary and preventive care.[8] One study found that only 38% of adolescents had preventive care visits in the past 12 months, with lower rates among low-income and uninsured adolescents, and only 40% had time alone with their providers.[9] Hospitalizations present a critical opportunity to address adolescents' reproductive health.
- Patients with underlying mental health and/or substance use disorders are also at increased risk for unintended pregnancy.[10,11]
- Women experiencing intimate partner violence may have limited reproductive autonomy. A meta-analysis including data from 29 countries showed that women's experience of intimate partner violence was associated with a 51% increase in the risk of pregnancy and a 30% increase in the risk of unintended pregnancies that resulted in live births.[12]
- Postpartum women are an important population to offer pregnancy prevention and contraception care during hospital admission. More than half of the unintended pregnancies experienced by parous women in the U.S. occur within two years after delivery, and 35% of women have interpregnancy intervals of less than 18 months.[13]

Although studies on how often inpatients are screened for contraceptive needs are lacking, evidence from other contexts, such as substance use disorder, indicates that hospitalists can play an essential role in initiating treatment during inpatient care instead of waiting for outpatient follow-up.[14]

Hospitalists should therefore be proactive and well-informed when discussing reproductive and sexual health, pregnancy intentions, and contraception options. Opening questions like, "Are you planning on trying to become pregnant in the next six months?" can open the conversation to identify unmet needs. If the patient reports no intention of near-future pregnancy, further questions like, "Are you sexually active with someone with whom you could become pregnant? What are you doing to prevent pregnancy?" should follow.

Counseling about contraception methods, including emergency contraception (EC) and condom use, is recommended by national evidence-based guidelines.[15] For those who report current sexual activity and desire pregnancy prevention, hospitalists can discuss contraception options and can offer a quick start (i.e., same-day initiation) for those who are interested. Early identification of a possible need for EC is critically important and can be identified using the question, "Have you had unprotected or under-protected sexual activity in the past five days?" For those who report unprotected or under-protected sexual activity in the past five days, and who do not desire pregnancy, counseling about EC use should be offered and prescribed immediately if desired.

Additionally, if patients desire long-acting reversible contraception, consultation or referral to a clinician who can offer this method (e.g., primary care, Title X clinic, gynecologist) is warranted. If unable to initiate long-acting reversible contraception during a hospital admission, hospitalists can discuss the use of shorter-term contraception options and consider prescribing regular hormonal contraception as a bridge method.

Here are essential facts for hospitalists about reproductive and sexual care including contraception to inform these discussions with patients, peers, and trainees:

1. Contraception methods include barrier methods, hormonal methods (such as oral contraceptive pills, implants, injectables, progestin intrauterine devices, and emergency contraception), as well as non-hormonal intrauterine devices and tubal ligation. For men, there are only two methods available: vasectomy and condoms.

2. Condoms are effective, but only if used correctly; they should be offered as part of dual protection. Under perfect use, condoms are 98% effective; however, with typical use, their effectiveness drops to 87%.[16] The advantages of condoms include their relative affordability and protection against most sexually transmitted infections. It is crucial to discuss dual protection even when choosing a long-term contraceptive method, as this also provides an opportunity to prevent sexually transmitted infections. Half of reported cases of chlamydia, gonorrhea, and syphilis cases in the U.S. in 2022 were among adolescents and young adults aged 15–24 years.[17] Therefore, these discussions should be particularly emphasized within this population.

3. An oral contraceptive called Opill is now available over the counter in the U.S.[18] This is a progestin-only pill that is approved by the U.S. Food and Drug Administration and, when used correctly, is 98% effective at preventing pregnancy. Since it is over the counter, it may not show on pharmacy

Continued on page 20

SHM's Hospital Medicine DEI Scholarship Winner: Nnamdi Igwe

Learn more about this up-and-coming future hospitalist

SHM presented two $25,000 Hospital Medicine Diversity, Equity, and Inclusion Scholarships in April at Converge. Nnamdi Igwe was the recipient of the second scholarship. We spoke with him about his dedication to diversity, equity, and inclusion (DEI).

Igwe

Nnamdi Igwe was born and raised in Nigeria; he moved to the U.S. in 2013. He earned his bachelor's degree in human development from Cornell University in Ithaca, N.Y., and he's currently a third-year medical student at Icahn School of Medicine at Mount Sinai in New York.

As a child in Nigeria, Mr. Igwe saw firsthand the consequences of lack of access to high-quality, high-value inpatient care. His personal experiences ignited his desire to pursue a career in hospital medicine. Throughout his medical school journey, he has been engaged in multiple, successful, quality-improvement and patient-safety initiatives that focus on improving the quality of care for hospitalized patients with limited English proficiency.

After completing his medical training, Mr. Igwe aims to pursue a career in academic hospital medicine, practicing in both the U.S. and Nigeria. He aspires to mentor and teach medical students and residents on how to effectively implement system-wide quality improvement and patient safety projects in hospitals.

Mr. Igwe is grateful to his numerous mentors at the Mount Sinai Division of Hospital Medicine—particularly, Dr. Anne Linker, Dr. Vinh-Tung Nguyen, Dr. Xu Tao, Dr. Andrew Dunn, and Dr. Beth Raucher. With the support of his mentors and this scholarship fund, he will continue to explore his interests in hospital medicine, quality improvement, and patient safety, while advocating for marginalized communities. In his free time, he enjoys visiting museums, taking long walks in a park, eating at ethnic restaurants, weightlifting, and meditation.

SHM

Left to Right: Dr. Kris Rehm, Dr. Greg Johnson, Nnamdi Igwe, and Dr. Eric Howell

Q: What's led to your passion for hospital medicine over other subspecialties?

Growing up in Nigeria, I experienced the effects of inadequate access to high-quality, high-value care. I lost several relatives in hospital settings, and I believe that if they had received better quality inpatient care, they may have been less likely to experience adverse outcomes. These personal losses ignited my interest in improving the care of hospitalized patients, particularly those in vulnerable populations. I hope to create a career in hospital medicine that leverages quality improvement principles to make the hospital a safer place for all patients.

Q: Why is DEI so important to you, especially as it relates to hospital medicine?

DEI is important to me because it promotes the recruitment and retention of a diverse hospitalist workforce that represents the population we serve. I believe diversity in hospital medicine will help promote the delivery of culturally competent care to hospitalized patients.

Q: Medical school is a full-time job on its own. How do you juggle all the outside projects?

Over the years, I have learned good time-management skills. However, what I have found to be most valuable is having a reliable team. My hospitalist mentors have been incredibly supportive, and I know I can always depend on them as we work together to successfully implement various projects. In conclusion, good time management and teamwork make it possible for me to juggle outside projects while in medical school.

Q: What advice would you give people who are just starting medical school?

I cannot emphasize enough the importance of having a mentor who cares about you, your success, your learning, and your overall well-being. As you start medical school, try to connect with attendings, either through shadowing or working on projects with them. Ask to have one-on-one check-ins with them. As time goes on, you will find people you connect with, who can be your mentors long-term.

Mr. Igwe's scholarship is made possible by its Visionary Sponsor, Sound Physicians. Scan the QR code for more information about SHM's DEI scholarship. ■

Spotlight: Oncology Hospitalists

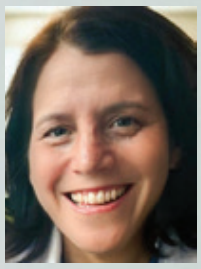
Helping each other build programs from scratch

By Richard Quinn

A lot of hospital medicine goes back to the mid-1990s when the term was first coined and the budding specialty's first bricks were laid.

Dealing with cancer as an inpatient expert wasn't a building block then, but these days, it's the latest growing subspecialty that needs a guiding hand. Enter SHM's Oncology Hospitalists Special Interest Group (SIG), formed in 2023 and led by its co-founders, chair Jensa Morris, MD, FACP, and vice chair Naomi Hodde, MD, FACP, FHM.

Dr. Morris



Dr. Hodde

"We were both building programs from scratch," said Dr. Morris, director of the Smilow Hospitalist Service and an associate clinical professor of medicine at Yale New Haven Hospital in New Haven, Conn. "We were looking for colleagues at other institutions who had more established programs...and hoping to connect with others who had hopefully laid the groundwork and learned from their mistakes."

"It's vitally important, especially when you work in a field that is new or changing, to hear what people at other institutions are doing," said Dr. Hodde, an associate professor of medicine and director of the oncology hospitalist program at the Robert Larner College of Medicine at the University of Vermont in Burlington, Vt. "How they are going about forming their services, staffing their services...learning from other people what they're doing, hearing how they solve problems, and just having somebody to bounce ideas off of is really validating and makes me feel so much more supported."

The experience has paid off for hospitalists at institutions large and small, Dr. Morris says.

"I've already found value as we build and expand and I have continuous streams of questions," she said. "We just initiated a cancer-specific rapid-response team here at Smilow Cancer Center. I reached out to all sorts of institutions to say, 'What are you doing, and how are you doing it? And is it working?' And that helped us."

The SIG holds three of four events annually, including one at SHM's Converge. The others are a mix of video conferencing and an HMX web portal through which the group advertises. One upcoming forum is discussing the role of advanced practice practitioners (APPs) in an oncology hospitalist group.

"What is the best way for them to be integrated? Having a team-based care model for these patients is the standard of care, so how do we all work together?" Dr. Hodde said. "That's something we're going to be raising with clinicians from different institutions...about how other programs might either think about incorporating advanced practice providers or maybe change their role in the clinical team."

Dr. Morris says standardization of structure and care pathways is a key focus, because the more groups can tackle problems the same way, the more they can measure results. "One hundred percent," she adds. "I think hearing how people are doing it, understanding what the evidence teaches us, and then being supported in implementing that at different institutions is how we're going to achieve the best care possible for these patients."

Dr. Hodde says that working with other SIGs—the groups focused on APPs and palliative care, for example—is another way to get more people involved, as is reaching out to folks who aren't even in oncohospitalist medicine but are thinking about it.

"In order to get participation, we have to present content that obviously interests people, but I think what it is, is people have so many unanswered questions, and we have to get the group together around those unanswered questions about how we build or expand our programs," Dr. Morris said. "I think that will keep people engaged. Turns out we're all asking the same things."

One point of pride for the SIG is discussing both victories and failures. Dr. Morris tried at one point to have oncology hospitalists on the malignant hematology service, but it didn't work. She tried despite others having also tried and failed.

"I am humbled often by some of the mistakes that I continue to make despite having been practicing hospital medicine for many years," Dr. Hodde said. "But I think learning from others' mistakes is always helpful. One of the things I've learned is how important it is to get all the stakeholders' voices at the table. That includes the oncologist, the hospitalists, nursing, care management, pharmacy, and therapists. Oncohospitalist medicine is such a fertile ground for high-functioning, team-based care."

Perhaps the SIG's best advice is that its leaders have already been through the birth of a specialty.

"It's exciting to be part of a field that is just emerging," Dr. Morris said. "And what's really interesting, and I'm going to suspect that Naomi feels the same way here, is that when I started in hospital medicine, hospital medicine was an entirely new field. Now, oncology hospitalist is a new field, so I feel like I've been on the leading edge of these two movements." ■

Richard Quinn is a freelance writer in New Jersey.

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Chapter Spotlight: Sacramento

More voices and more involvement mean more excitement

By Richard Quinn

Most chapters for SHM begin with a gaggle of hospitalists meeting up and becoming friends, bound by shared work experience.

Things work differently in the Sacramento chapter, founded as a provisional chapter just last year by a gaggle of hospitalists who were already friends, bound by shared life experience.

"We're all a group of friends who went to residency together, and we all worked at local hospitals in the Sacramento region," said chapter president Adrienne Atencio. "There was always a need to unite all the local hospitals in our region. So, we thought that having a chapter would be a really great way to accomplish that."

Dr. Atencio

The leadership board of the chapter has representation from nearly a half-dozen hospitals in the region—and the group isn't done yet.

"Our goal over the next year or so is to expand to even more hospitals in the area," said Dr. Atencio, an assistant clinical professor and co-chair of clinical operations for the division of hospital medicine at the University of California Davis Medical Center. "The Sacramento region is very large, and there's a lot of hospitals that we haven't even tapped into yet. Our goal is to do more targeted outreach to add to our, so to speak, friend group or network, so we can communicate and problem-solve together. We've faced a lot of the same issues in this area."

One might think that a brand-new chapter wouldn't be organized enough for a poster competition. As is the Sacramento gang's way, that person would be wrong.

"We already set a date," Dr. Atencio said. "It's going to be October 12th. And we've invited the two medical schools in our area— UC-Davis and California Northstate University College of Medicine. We're working on inviting the" physician assistant "and nursing schools. And we invited all of the local residencies."

The poster competition is the latest attempt by the chapter to do outreach.

"We wanted to do it because medical students and residents are the future of our chapter and the future of hospital medicine," Dr. Atencio said. "Getting them engaged early and seeing the benefits of being involved with the Society of Hospital Medicine is important. And we're hoping that it also stimulates the membership aspect and grows our chapter. That's really the big benefit on our end for doing it."

Outreach doesn't stop at the poster competition. Dr. Atencio and her leadership board are scheduling as many meetings as they can to bring folks together.

"One of the ways you keep engagement is just continuing to have meetings on a really frequent schedule," Dr. Atencio said. "If you have meetings only twice a year, people start forgetting about you. But if you have meetings on at least a quarterly basis, and there's always something going on, you never fall out of the minds of the people involved in your chapter.

"And I think the other thing about having frequent meetings is that it has to be something that is important to people. So, we've been really deliberate with the meetings that we've chosen and try to mirror what the group is asking for...interestingly, the group is interested in medical topics, but more than anything they seem to want to establish friendships with each other across the hospitals in our region."

The goal is to get as many different folks involved as possible, so the chapter isn't just academic institutions or just downtown city hospitals. Particularly for a chapter whose geographic reach spreads out some 50 miles in every direction.

"It just makes our institutions better when you can see what other people are doing at hospitals adjacent to you, and what's working and what's not working for them," Dr. Atencio said. "A great example is, that APPs [advanced practice practitioners] are really new to the practice of hospital medicine, and at one hospital in particular, we've had a very tough time getting physician buy-in and incorporating them into our group. But some of the other hospitals in our area have been working with APPs much longer than we have and are integrating them much more smoothly. When you're doing these things, it really helps to have a friend in the area who has either done that or has gone through that and to call on that person to give you advice. It just makes your life so much easier."

Diversity might be Dr. Atencio's favorite part of the nascent chapter. Whether it be geography, career tenure, subspeciality, or something else—the group wants to represent everyone it can.

"We are really special, and we have participation from not just physicians, but from [advanced practice practitioners], practice administrators, medical students, residents," she said. "It's a great diversity of voices. That's the special sauce when there are a lot of people at the table. More voices and more involvement mean more excitement." ■

Richard Quinn is a freelance writer in New Jersey.

Be an Advocate for Voting

How to encourage patients and colleagues to let their voices be heard

By Karen Appold

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Healthcare practitioners have firsthand knowledge about the strengths and weaknesses of the current healthcare environment. "Oftentimes, things that are working well (or not) are the result of policy decisions made at the state or federal levels," said Ann Sheehy (@SheehyAnn), MD, professor of medicine in the division of hospital medicine, department of medicine, at the University of Wisconsin School of Medicine and Public Health in Madison, Wis., an academic hospital with almost 600 beds at its main hospital. "Advocacy is the means to change policy, and voting is the most basic form of advocacy. When physicians vote, they help to select leaders who they think will implement healthcare law and regulations aligned with better patient care and improved clinical practices."


Dr. Sheehy

But, according to Nicole Webb (@DrNikki-4Kids), MD, FAAP, a pediatric hospitalist at a large tertiary urban hospital in California, it's not enough simply to vote. "Increasing voter participation and supporting efforts to combat voter suppression are even more important," she said. "We have to understand the entrenched, structural barriers to voting and participate in efforts to combat them."


Dr. Webb

Structural barriers, such as housing and job insecurity, gerrymandering, lack of affordable childcare, and an ever-widening digital divide, among many other issues, have led to low voting rates in a population that is most critically in need of representation in the political process. "Understanding that, and working toward efforts to increase voting participation in our local communities, is crucial," Dr. Webb said.

Broaching the subject

Bringing up the topic of voting is like discussing any other health topic physicians routinely cover, Dr. Webb said. "Physicians typically ask a lot of pretty invasive questions about sensitive topics because they're important to providing the best care possible," she said. "We have to believe that what we're asking about is important and provide a bit of an elevator pitch for why it matters. You also have to know when to let it go if someone isn't interested or doesn't want to talk about it."

Because politics can be very polarizing, you should frame conversations with patients and colleagues in non-partisan ways aimed at helping to inform them about how to register to vote or cast a vote as opposed to discussions about candidates or political parties, Dr. Sheehy said. For example, a patient may be hospitalized or ill during an election period and may wish to vote absentee rather than vote in person. Programs, such as Vot-ER, help facilitate information sharing about available voting options for patients.

Although the political environment has been fraught in recent years, Atashi Mandal, MD, an internal medicine and pediatric hospitalist at multiple hospitals in southern California, has found that patients are typically amenable to discussions about voting. Oftentimes, patients respond with resignation or apathy, which she views as a ripe opportunity to remind them that the very roots of any healthy democracy reside in each individual's voice, regardless of how helpless one may feel to change anything. "Although an individual vote doesn't ensure a particular result, not participating in the process guarantees dissatisfaction when considering the multiplier effect of all non-voters," she said.


Dr. Mandal

Leveraging patients' and families' dissatisfaction or confusion about various utilization and health plan issues, such as durable medical equipment or nursing home benefits, can be a prime opportunity to provide information on how regulations are created. For example, The Centers for Medicare & Medicaid Services' leadership is politically appointed. Similarly, physicians can discuss how Congress can directly impact healthcare policy. "If someone's congressional representative is on a committee that legislates health policy, point it out," Dr. Mandal said.

Regarding conversations with colleagues, providing statistics can be helpful. "Find out what matters to your colleagues and connect the importance of their voting to an issue or patient they've connected with," Dr. Webb said. "Become familiar with resources that make voting easier."

How to advocate

Many ways exist to promote advocacy. Dr. Webb spends time helping to teach pediatric residents and fellows about advocacy through the California Resident Advocacy Collaborative, which culminates in a legislative advocacy day in Sacramento each year. She's quite comfortable talking with elected officials about priority issues for kids, including a lack of Medicaid parity, increased coverage for services for parents and children, LGBTQIA+ health, reproductive health, gun violence prevention, increased funding for graduate medical education, and access to affordable drugs. Dr. Webb also works with non-profit groups and has seen many of the bills she's advocated for successfully signed into law.

Dr. Mandal has visited Sacramento and Washington, D.C. many times to help inform and educate state and congressional representatives about pertinent legislation that can greatly help or hinder physicians. "The majority of legislators don't have direct knowledge about the grassroots issues facing our patients and profession," she said. "I advise my colleagues to attend at least one advocacy event organized by a local, state, or national professional society, so they can experience what 'advocacy' means. I also encourage everyone to meet their legislators at their district offices. Any constituent can set up a meeting."

Helpful resources

A variety of organizations, programs, websites, and so forth, are designed to promote or help with the voting process. Vote Kids, a non-partisan Get Out the Vote campaign led by the American Academy of Pediatrics, provides information regarding priority child health issues and the implications of different policies for children.

Several other resources for learning everything you need to know about voting, how to register, where and when to vote, and how to advocate for yourself and others are Vote.org, Vote 411, and When We All Vote. Some of these sites will also link users to resources about candidates and issues. These websites were created with the goal of increasing voting participation, particularly for those with historically low access to or participation in voting, Dr. Webb said.

Most states have resources on their Secretary of State website.

Fair Fight Action, which was founded by former Georgia state representative and gubernatorial candidate Stacey Abrams, is designed for individuals who are interested in learning more and getting involved in efforts to combat voter suppression.

Final thoughts

As a group, physicians have abysmally low voter participation.[1] "So much of what governs our lives and practices on a daily basis is determined by the outcomes of state and local elections. However, a strong tendency toward only voting in national elections exists," Dr. Webb said.

On a positive note, absentee voting has helped make voting easier for many individuals who might otherwise face barriers getting to the polls on a certain day due to work obligations or health or mobility issues, Dr. Sheehy noted. On the other hand, voter ID laws and other restrictions and barriers put into place in some areas may impede voting efforts.

The bottom line, Dr. Webb said, is to make the time, make a plan, have a plan B, and remember that you—and all of your patients—will still be affected by the outcome, whether you participate in the election process or not. Although the issues get politicized, the policy decisions made by elected officials affect everyone.

Karen Appold is an award-winning journalist based in Lehigh Valley, Pa. She has more than 25 years of editorial experience, including as a newspaper reporter and a newspaper and magazine editor.

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Reproductive

Continued from page 14

records, underscoring how important it is for all patients—including at admission, during hospitalization, and discharge—to have accurate medication reconciliation.

4. Hospitalists can and should offer—and where desired, provide—emergency contraception to women who determine themselves to be at risk for an unintended pregnancy. It can prevent up to 95% of pregnancies when taken within five days after intercourse. There are four medically appropriate forms of emergency contraception, but two that are most germane to hospitalists: ulipristal (Ella) and levonorgestrel (Plan B). Ulipristal is preferred because it is more effective later in the five-day window and appropriate for use in women who are overweight, although levonorgestrel is available over the counter.

5. Vasectomies are safe and effective and should be encouraged. Data indicate that individuals who have undergone vasectomies often report enhanced sexual satisfaction.[19] Hospitalists can talk with patients about vasectomies, highlighting these benefits, and how pregnancy prevention is the responsibility of both partners, not just the partner who can become pregnant.

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6. Adolescents and young adults necessitate confidential access to sexual and reproductive healthcare services. The U.S. Supreme Court determines that minors have the right to privacy regarding access to contraceptive services. Presently, no state mandates parental consent or notification for minors to access these services.[20] However, Texas and Utah specifically require parental consent for state-funded contraceptive services. Additionally, 27 states, along with the District of Columbia, explicitly permit minors to access contraceptive services without parental involvement. In contrast, 19 states recognize this right only for specific categories of minors, such as those who are married or parenting, and four states lack explicit statutes or policies in this area. Despite the absence of a parental consent requirement, concerns about confidentiality continue to restrict adolescents' access to and use of contraceptives and other reproductive health services.

7. Hospitalists who wish to learn more about providing contraception can consider downloading and using the Centers for Disease Control and Prevention's Contraception app, available via https://www.cdc.gov/reproductive-health/hcp/contraception-guidance/app.html.

In conclusion, addressing reproductive health and contraception during hospital admissions is an important step toward reducing unintended pregnancy rates and improving overall maternal and fetal health. Hospitalists play an important role in identifying unmet contraceptive needs, providing timely counseling, and initiating contraception when desired, ensuring that patients receive comprehensive reproductive care.

Back to the case: We recommend asking the patient in our case, "Are you planning on trying to become pregnant in the next six months?" Depending on her answer, you can then begin a conversation about her contraceptive options, offer her sexual and reproductive healthcare and resources, and connect her with a specialist such as a gynecologist (via consult or referral) to meet her immediate and ongoing needs. ■

View the complete list of references online.

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Nashville, Tennessee

The Division of General Internal Medicine and Public Health at Vanderbilt University Medical Center seeks talented BC/BE Internal Medicine and Med-Peds physicians to join the full-time faculty at the level of Assistant, Associate, or full Professor, on a clinical, educator, or research track.

Clinical positions, including inpatient Hospitalist and outpatient Primary Care, are available for well-trained physicians who wish to focus on direct patient care and medical consultation. We offer flexible scheduling, collaborative care with top specialists, and opportunities to engage in teaching, quality improvement, and scholarship. An academic clinician-educator track position begins at 80% clinical, with additional responsibilities in teaching, scholarship, quality improvement, and administration for qualified candidates. A physician-scientist track provides approximately 80% time for research in collaboration with established investigators in health services research, clinical epidemiology, decision sciences, quality improvement, patient safety, behavioral sciences, and biomedical informatics.

Vanderbilt University Medical Center is a leader in providing high-quality, cost-effective care. We are an equal opportunity employer who values diversity. With robust programs in quality improvement and clinical research, a highly-developed electronic health record, Magnet Recognition for nursing care, competitive salaries and benefits, and a highly supportive environment for faculty, Vanderbilt is a great place to work. With a booming economy and friendly environment, Nashville, TN is a top place to live.

Candidates who are legally authorized to work in the US and BE/BC can apply here: http://apply.interfolio.com/131232

For further information, please contact:
Anne Axon, Sr. Program Manager, Vanderbilt Hospital Medicine
anne.axon@vumc.org

Vanderbilt University Medical Center is committed to principles of equal opportunity and affirmative action.

PRISMA HEALTH

Inspire health. Serve with compassion. Be the difference.

Hospitalist Opportunities

Gorgeous Lakes, Ideal Climate, Award-winning Downtown

Prisma Health is a not-for-profit health company and the largest healthcare system in South Carolina. With nearly 30,000 team members, 18 acute and specialty hospitals, 2,947 beds and more than 300 outpatient sites with nearly 2,000 physicians, Prisma Health serves more than 1.2 million unique patients annually in its 21-county market area that covers 50% of South Carolina. Prisma Health's goal is to improve the health of all South Carolinians by enhancing clinical quality, the patient experience and access to affordable care, as well as conducting clinical research and training the next generation of medical professionals.

Greenville, South Carolina is a beautiful place to live and work and is located on the I-85 corridor between Atlanta and Charlotte and is one of the fastest growing areas in the country. Ideally situated near beautiful mountain ranges, beaches and lakes, we enjoy a diverse and thriving economy, excellent quality of life and wonderful cultural and educational opportunities. Check out all that Greenville, SC has to offer! #yeahTHATgreenville

Ideal candidates:
- BC/BE Internal Medicine Physicians
- IM procedures highly desired, but not required. Simulation center training & bedside training available if needed.

Details Include:
- Competitive salary package with additional compensation for extra shifts at a premium rate
- Professional allowance
- Paid Relocation and Malpractice with tail coverage
- Generous benefits including retirement, health, dental and vision coverage
- 7 on/7 off schedule with 1 week of time off per year
- Group comprised of career hospitalists with low turnover

Available Opportunities:

Hospitalist, Greenville Memorial Hospital Daytime Rounder
- Base salary of $280k – $295k, with an additional $30k incentive bonus
- Academic appointment and opportunities to supervise residents/students
- Full subspecialist back up in-house or by phone
- Comfortable with IM procedures preferred but not required

Nocturnist, Greenville Memorial Hospital
- Base salary of $360K, with a $10K incentive bonus
- Academic appointment and opportunities to supervise residents/students
- Full subspecialist back up
- Comfortable with IM procedures preferred but not required

Submit CV to Natasha Durham, Physician Recruiter: Natasha.Durham@prismahealth.org
View positions online @ Careers.prismahealth.org/providers

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Laurens County Hospital – Hospital Medicine Opportunities

Prisma Health, one of the largest medical groups in the country and South Carolina's largest private, non-profit system, is home to more than 3,000 physicians and advanced care practitioners. We're on a journey to transform the healthcare experience and invite you to join us!

We are looking for board-certified/board-eligible Internal Medicine or experienced Family Medicine physicians to join a dedicated team of professionals at this well-established hospital.

Ideal candidates:

- IM procedures highly desired, but not required. Simulation center training & bedside training available if needed.
- Comfort managing ICU patients with critical care consultation

Opportunity highlights:

- $325k base salary with $30k incentive bonus
- Professional allowance
- Paid Relocation and Malpractice with tail coverage
- 7 on/7 off schedule with 1 week of time off per year
- Additional shifts paid at a premium
- Generous benefits including retirement, health, dental and vision coverage

Community: Laurens affords community where people from surrounding areas still gather downtown to shop in our unique shops on our town square, dine at our one-of-a-kind eateries, and socialize with good friends. A place where education is a priority, and we are diligently creating economic opportunities within and around our borders. Laurens has several incredible parks allowing residents a wonderful quality of living. Lauren's Historical Downtown Square is a beautiful focal point for the essence of our city. Offering all the components for southern hospitality and the sophistication of the larger cities, Laurens is a great place to settle.

Health System: Prisma Health is a progressive and highly integrated academic health care delivery system committed to medical excellence through clinical care, education, and research. With nearly 30,000 team members, 18 hospitals, 2,984 beds and more than 300 physician practice sites, Prisma Health serves more than 1.2 million unique patients annually. Its goal is to improve the health of all South Carolinians by enhancing clinical quality, the patient experience and access to affordable care, as well as conducting clinical research and training the next generation of medical professionals.

We are a Public Service Loan Forgiveness qualified employer.

Submit CV to Natasha Durham, Physician Recruiter: Natasha.Durham@prismahealth.org
View positions online @ Careers.prismahealth.org/providers

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NOW HIRING: Impact the Future of Medicine!

BC/BE Academic Hospitalists
Banner University Medicine
Phoenix & Tucson Campuses

Banner University Medicine offers nationally recognized academic medical centers and world-class hospitals focused on coordinated clinical care, expanded research activities and nurturing future generations of highly trained medical professionals who serve our communities.

Both campuses are ranked as some of the top in Arizona!
Competitive salary plus excellent benefits package with incentive opportunities, as well as an academic appointment at the University of Arizona College of Medicine.

The Division of Hospital Medicine enjoys a diverse, inclusive and collaborative culture, comprised of physicians and APPs, and serves as the main source of clinical education for medical students and residents at University of Arizona College of Medicine in Phoenix & Tucson. Focused on coordinated clinical care, expanded research and educational innovations to prepare the next generation to serve our community,

Banner University Medicine supports career growth through opportunities in:
Clinical excellence & health equity | Medical education & mentorship | Innovation & investigation | Quality improvement & patient safety | Service to the institution & community

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Banner University Medicine

LEADERSHIP ACADEMY

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Meet our newest Mastering Teamwork Faculty Member

Kimberly D. Manning, MD

Kimberly D. Manning, MD, is a general internist/hospitalist who serves as Vice Chair for the Dept. of Medicine at Emory. Over decades of leadership, she has been honored with numerous institutional, regional, and national teaching awards including the Juha P. Kokko Teaching Award—the highest teaching award in the School of Medicine at Emory.

Join Dr. Manning as she leads her upcoming Mastering Teamwork session **Look, Listen, Lead: Communicating with Emotional Intelligence.** During the course you will learn to identify opportunities to strengthen relationships and build trust through respectful communication skills.

In just ONE month, top minds will convene and develop new plans to achieve.

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Society of Hospital Medicine