

# Section on Hospital Care News

American Academy of Pediatrics

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June 2003

## "What, Me Worry?"

Notes from Jack M. Percelay, MD, MPH, SOHC Chair

Three pediatricians are sitting at a bar, a primary care physician, a neonatologist, and a hospitalist... oops, wrong column.

Welcome to the first Newsletter of the Section on Hospital Care. We are provisional no more, and much has happened since the last newsletter. SOHC membership continues to grow, now numbering over 250. Affiliations with the Pediatric Section of the Society for Hospital Medicine chaired by David Zipes and the Inpatient Medicine/Hospitalist Special Interest Group of the Ambulatory Pediatric Association co-chaired by Dan Rauch and Pat Lye are thriving. The PRIS Network chaired by Chris Landrigan is working on its first project. Multiple hospitalist-focused educational programs have been held, and no speaker, nor topic, has survived without interruption and active questioning. Additional peer-reviewed articles have been published. A survey of Academy members revealed satisfaction rates of 85% for the care provided by pediatric hospitalists. Our position in the Academy is now firm. We are establishing relationships with a number of Academy organizations as documented elsewhere in this Newsletter, and a large number of us serve as SOHC liaisons to our local AAP Chapters, further cementing the relationships between sections and chapters. Perhaps the most

telling statement of our acceptance within the Academy is the fact that the new chair of the Committee on Hospital Care, Erin Stucky, is a hospitalist from San Diego Children's. She gained this position through the quality of her work and her commitment to children and the Academy; her position as a hospitalist neither added to, nor detracted from, her qualifications.

So there is much for all of us to be proud of, and additional opportunities to participate, network and exchange viewpoints as documented elsewhere in this newsletter. I personally am convinced that pediatric hospitalist practice will continue to grow and care for more and more children at more and more institutions. I am also convinced that this will provide higher quality, more cost-effective care. Moreover, this can be done in such a way that patient satisfaction and referring physician satisfaction are high, and educational experiences are improved. We've seen it, and we have studies to document it. That's the clear vision in my crystal ball.

What is less clear to me, and where my concern lies, is how to minimize potential negative effects of the pediatric hospitalist movement on the discipline of capital P "Pediatrics" as a whole. Let's be honest;

*continued on page 3*

## From the Editor



This newsletter is filled to the brim. I, as your humble editor, was overwhelmed by the enthusiasm all of you had for contributing. However, I shouldn't have been. Those of you on our active LISTSERV@ know that we are a group of highly opinionated physicians, working together to establish a new field of medicine. This newsletter is designed to be another forum for that discussion. You'll find articles touching on our position in the evolving world of medicine as a whole, reviewing our performance as evaluated by patients and primary care physicians, and commenting on the roles we play as educators and our plans to work together as researchers. There is one article you won't see, simply because we did not have room. It is by Dr. Andrea Maggioni and Dr. Fabiana Rolla, outlining pediatric inpatient services at Miami Children's Hospital. It is worth a read and will be featured next time around. Until then, please read, enjoy, and post our newsletter. Also, feel free to send along some feedback or let us know if you would like to participate. There's plenty more to say!

*Jennifer Daru, MD*

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## Editors

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# 2003 AAP National Conference and Exhibition (NCE) – New Orleans

## Education Sessions

Sponsored by the Section on Hospital Care

AMERICAN ACADEMY OF PEDIATRICS

### Saturday, November 1, 2003

9:30 am - 11:30 am: Seminar S120

3:45 pm - 5:45 pm: Seminar S184

*“Practical Strategies for Reducing Medical Errors in Pediatric In-Patient Settings”*

Glenn Billman, MD & Julie Morath, RN, COO

Sponsored by: Steering Committee on Quality Improvement and Management, Committee on Hospital Care, Section on Computers and Other Technologies, Committee on Drugs, Section on Hospital Care

### Sunday, November 2, 2003

1:00 pm - 3:00 pm: Seminar S256

*“Urinary Tract Infections (UTIs) in Infants and Children - A Comprehensive Overview”*

Ellen R. Wald, MD, FAAP

Sponsored by: Section on Hospital Care, Section on Nephrology

### Sunday, November 2, 2003

3:45 pm - 5:45 pm: Seminar S285

*“Apparent Life Threatening Events: Sorting Through the Evidence to Plan a Useful Evaluation and Establish a Diagnosis”*

Ann Halbower, MD & Benny Kerzner, MD

Sponsored by: Section on Hospital Care

### Monday, November 3, 2003

8:00 am - 4:00 pm: Section Program H310

Section on Hospital Care

8:00 am - Inpatient Management of Status Asthmaticus – Carolyn Kerckmar, MD

*This session will specifically address the problems of inpatient management of moderate to severe asthma on an inpatient pediatric service. Use of an effective hospital-based care path, including the appropriate role of new and standard pharmacologic agents will be discussed.*

9:00 am - Break

9:15 am - Management of Complicated Pneumonia – Richard Jackson, MD; Sheldon Kaplan, MD; Carolyn Kerckmar, MD

*The problems of managing patients with complicated pneumonia will be discussed in an interactive session with faculty from the specialties of pediatric pulmonology, infectious disease and surgery. The discussion will focus on evaluation and management of pleural effusions, choosing parenteral vs. oral antimicrobial therapy and duration of therapy, as well as other adjunctive therapy.*

10:15 am – Break

10:30 am - Pain Control and Sedation for the Pediatric Inpatient – Jolene D. Bean-Lijewski, MD, PhD; Shobha Malviya, MD

*Pediatric hospitalists are frequently asked to provide consultative services that offer pain control and sedation services for hospitalized infants and children. This session will discuss the variety of medications available for these therapies and procedures as well as the monitoring/educational requirements of the inpatient unit that will ensure a safe environment for the patients.*

12:30 pm - Section Business Meeting and Box Lunch

1:30 pm - Professional Communication Skills – Fred A. McCurdy, MD, PhD, MBA, FAAP

*Inpatient physicians must balance the needs of their service, their patients, their consultants, and the primary care physicians who refer patients to their service. It is essential that hospitalists develop productive professional relationships with their outpatient colleagues. Developing a treatment plan, such as admission and discharge criteria, as well as evaluation and intervention may be difficult when the patient's primary care provider differs in their assessment of the patient or their approach to therapy. In this session, we will discuss and practice the skills needed to successfully negotiate the challenging discussions that can develop under these conditions.*

2:45 pm - Maximizing Reimbursement of Inpatient Pediatric Services – Sanford Melzer, MD, MBA, FAAP; Richard Molteni, MD, FAAP

*This interactive session will provide SOHC members an opportunity to learn the most recent standards for billing/CPT coding for their services. A review of commonly provided services, such as technical procedures, procedural sedation, pre- and post-operative evaluation, inpatient and ER Consultation, RSV prophylaxis, administrative work and academic teaching will be included. The focus will be on inpatient pediatric billing and coding procedures.*

Sponsored by: Section on Hospital Care, Section on Pulmonology

### Tuesday, November 4, 2003

3:45 pm - 5:45 pm: Audience Response Case Discussion A484

*“Imaging Efficiency: Matching the Study to the Patient”*

Karen Frush, MD, FAAP & Donald Frush, MD, FACR, FAAP

Sponsored by: Section on Hospital Care, Section on Radiology

### Wednesday, November 5, 2003

6:45 am - 7:45 am: Meet-the-Expert X505

*“A Pediatric Hospitalist Program”*

M. Robin English, MD, FAAP

Visit [www.aap.org/nce](http://www.aap.org/nce) for more information about the AAP National Conference and Exhibition

## What me, Worry?

Continued from page 1

there are significant potential harmful consequences. A complete schism between outpatient and inpatient pediatrics will clearly be deleterious, and it behooves us to carefully look at measures we can take to maintain linkages on a long-term, sustainable basis. As our field evolves, we need to make very conscious decisions to preserve and nurture the connection between inpatient and outpatient pediatrics.

In the Periodic Survey questionnaire on hospitalists, 35% of respondents who used hospitalists indicated that the coordination of care between inpatient and outpatient settings had decreased, and 45% indicated that continuity of care decreased. This is clearly an issue which each individual program needs to examine and work hard to improve. Communication, communication, communication! We cannot become complacent. But ultimately it needs to be more than just calling the primary care physician on the phone. What is going to happen 5 or 10 years down the line if that primary care physician has not stepped foot on the pediatric ward? In the same Periodic Survey, although 43% reported improved career satisfaction by allowing specialization in ambulatory pediatrics, 20% indicated that career satisfaction was diminished due to limited direct involvement in the care of hospitalized patients. Office-based pediatricians need to maintain some minimum experience of the inpatient arena to maintain their diagnostic acumen, triage skills and ability to provide on-going care at discharge. Similarly, if we as hospitalists haven't seen the inside of an office exam room for 5 or 10 years, we will lose our appreciation for the nature of the bond between patient and primary care physician, the difficulty of finding the needle in the haystack, and what care can realistically be delivered on an outpatient basis. The Academy emphasizes the concept of a medical home for each child. For us to be a full part of that home, we need to make sure that hospitalist and primary care physician are each visiting each other's rooms on a regular basis.

What is the answer? Is it special inpatient CME activities for office-based practitioners, inpatient case conferences, or "hospitalist rounds"? Is it co-management or "social rounds"? I don't have the solution; perhaps some of you do. Please share your successes and failures with the rest of us. I raise the concern early, so we can keep it in mind as we grow as a section and as a discipline and thus do well for the children and families we serve, our hospital and office-based colleagues, and Pediatrics as a whole.

This is a tremendously exciting time to be a pediatric hospitalist. It's an amazing group of people to have as colleagues. We're riding the wave, our glass is seven-eighths full. Let's just not forget that empty one-eighth.

*Jack*

### Pediatrics Editorial Board: Positions Available

*Pediatrics*, the journal of the American Academy of Pediatrics, is looking for qualified candidates with **strong educational credentials** and **proven writing skills** for the following positions on the *Pediatrics* Editorial Board:

Allergy and Immunology  
General Pediatrics  
Hematology/Oncology  
Metabolic Disorders  
Neonatology  
Pediatric Surgery  
Pharmacology/Toxicology/Dysmorphology  
Sports Medicine  
Virology

Appointment is for a 3-year term, commencing January 1, 2004. The deadline for applications is 4:30 PM (CDT) July 16, 2003. Nominees need to submit a completed fact sheet, current CV and statement of intent to serve if appointed. Nominees can contact Karen Knafel, Publishing Coordinator, with questions or for application materials (fact sheet, position description) at [kknafel@aap.org](mailto:kknafel@aap.org) or 800/433-9016 ext. 7904.

## Section on Hospital Care Elections: Update

Thank you to everyone who voted online for your SOHC Executive Committee members.

As you know, there were 2 open positions and the successful candidates will each serve a 3-year term (immediately following the National Conference and Exhibition). Your candidates were:

Vincent W. Chiang, MD, FAAP  
Chesnut Hill, MA

Yong S. Han, MD, FAAP  
Missouri City, TX

Ursula S. Kneissl, MD, FAAP  
Concord, NH

Daniel A. Rauch, MD, FAAP  
Scarsdale, NY

For this year's section elections, the Council on Sections Management Committee (COSMAN) decided that all sections with a final response rate of less than 35% at the conclusion of the electronic election would send a print ballot to all section members who did not vote online. Unfortunately, when the online election concluded on April 30, 2003, the Section on Hospital Care had a final response rate of 33.6%. Close, but not close enough! Elections staff were required to adhere to the 35% benchmark and sent out print ballots to those section members who did not vote online. The deadline for returning those print ballots was May 30<sup>th</sup>. We will be sure to notify the membership of their new Executive Committee members soon after the election concludes.

For those of you who did not vote online, we urge you to do so in the future. COSMAN looks very closely at the number of members who vote in online elections. It is imperative that we, as a section, show the Academy our interest and dedication to our section by voting for our leadership.

## Development of the Pediatric Research in Inpatient Settings (PRIS) Network

Over the past year, momentum to develop a PRIS network to collaboratively study key questions in inpatient pediatrics has steadily mounted. In 2002, 25 health care centers had expressed preliminary interest in participating in PRIS. In 2003, we have hospitalists from over 50 centers interested in participating in the network, representing 26 of the United States and Canada.

PRIS is an independent entity developed as a collaborative effort of three organizations: the pediatric section of the Society for Hospital Medicine (peds SHM), the American Academy of Pediatrics' Section on Hospital Care (AAP SOHC), and the Ambulatory Pediatric Association's Hospitalist / Inpatient Medicine Special Interest Group (APA HIM SIG). Last year, we formed a steering committee and developed a mechanism for proposing studies. We have recently drafted rules of governance for the network, based largely on the bylaws developed by the successful PROS (Pediatric Research in Outpatient Settings) network.

Project proposals may be submitted by any member of PRIS. Projects are reviewed by the steering committee and the network as a whole, and those selected for study move forward. Hospitalist groups participating in PRIS are free to participate or not in each project; practices that agree to participate are expected to collect data routinely on the question being studied. Project proposers become the principal investigators for studies (unless they wish to decline), and are principally responsible for design, data gathering, and analysis. PRIS will provide a mechanism by which to conduct the studies, and assistance with study design, revision, and administration. The input of all hospitalists participating in PRIS studies is sought at every stage.

The members of the steering committee are as follows: Christopher Landrigan, MD, MPH (PRIS chair); Jon Feldman, MD (at-large member); Mary Ottolini, MD, MPH (at-large member); Jack Percelay, MD (chair, AAP SOHC); Dan Rauch, MD (chair, APA HIM SIG); Erin Stucky (at-large member and chair, AAP

Committee on Hospital Care); and David Zipes, MD (chair, peds SHM).

We are currently developing a baseline practice survey, and some initial collaborative research project proposals. We expect to distribute the survey within the next several months, which should provide important data on hospitalist system structure and practice variation across the country, as well as information that will aid in the interpretation of all future study results. We also anticipate development of study ideas this fall with commencement of data collection for our first study this winter.

We welcome the submission of additional proposals. If you are interested in being a part of this network, or have a research proposal, please email Chris Landrigan at [christopher.landrigan@tch.harvard.edu](mailto:christopher.landrigan@tch.harvard.edu) and Dan Rauch, secretary/treasurer of PRIS, at [rauch@aecom.yu.edu](mailto:rauch@aecom.yu.edu).

*Chris Landrigan, MD*

*Dr. Landrigan is a pediatric hospitalist and Research/Fellowship Director of the Children's Hospital of Boston. He chairs the PRIS Steering Committee.*

### AAP PRESS ROOM

[www.aap.org/pressroom](http://www.aap.org/pressroom)  
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In addition to late-breaking news, the AAP Press Room also contains information on:

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#### The Editors

Serving as editors of *AAP Grand Rounds* are Lewis First, University of Vermont College of Medicine, and Edgar K. Marcuse, University of Washington Schools of Medicine and Public Health. The Editorial Board and contributing editors for *AAP Grand Rounds* represent a leading panel of expert opinion and discerning judgment in pediatrics. Each Editorial Board member manages a team of contributing editors, working to hone every issue's content for timeliness and pertinence. Our contributing editors come from the Academy's Sections, providing a remarkable breadth of expert coverage.

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## New Clinical Reports

### Physicians' Roles in Coordinating Care of Hospitalized Children

Jack M. Percelay, MD, MPH and the Committee on Hospital Care

#### Abstract

The care of hospitalized children has become increasingly complex and intense and often involves multiple physicians beyond the traditional primary care attending physician. Pediatric and adult subspecialists and surgeons, teaching attending physicians, and hospitalists may all participate in the care of hospitalized children. This report summarizes the responsibilities of the primary care physician, attending physician, and other involved physicians to ensure that children receive appropriate, coordinated, and comprehensive inpatient care that is delivered within the context of their medical home and is appropriately continued on an outpatient basis.

PEDIATRICS Vol. 111 No. 3 March 2003, pp. 707-709

The complete text of this statement can be found at [www.pediatrics.org](http://www.pediatrics.org) or <http://www.aap.org/policy/040134.html>.

### Facilities and Equipment for the Care of Pediatric Patients in a Community Hospital

Ted D. Sigrest, MD, and the Committee on Hospital Care

#### Abstract

Many children who require hospitalization are admitted to community hospitals that are more accessible for families and their primary care physicians but vary substantially in their pediatric resources. The intent of this clinical report is to provide basic guidelines for furnishing and equipping a pediatric area in a community hospital.

PEDIATRICS Vol. 111 No. 5 May 2003, pp. 1120-1122

The complete text of this statement can be found at [www.pediatrics.org](http://www.pediatrics.org) or <http://www.aap.org/policy/S110158.html>.

## Emergency and Urgent Care Subcommittee

### VOLUNTEERS NEEDED

A significant number of the members of the SOHC provide unscheduled ambulatory care as part of their clinical duties. Members of the SOHC report working in the emergency departments of Children's Hospitals, in the emergency departments of community hospitals, and in free standing pediatric urgent care centers. According to a recent survey of SOHC members, 16% of responders work directly in an emergency department, 64% provide consultative services in an emergency department, and 21% provide care in other acute ambulatory settings.

I have been asked by Jack Percelay to form a subcommittee of the SOHC. This subcommittee will look at pertinent issues of pediatric hospitalists working in emergency departments and urgent care centers. It is anticipated that this committee will act as a liaison with the Section of Emergency Medicine.

We are looking for volunteers. The time commitment should be relatively small. Most issues can be discussed by e-mail or phone. We probably will try to meet for a short time during the AAP National Conference and perhaps at other national meetings. If you are interested please contact Doug Carlson, MD, [carlson@kids.wustl.edu](mailto:carlson@kids.wustl.edu) or 314/454-2827.

*Doug Carlson, MD*  
Chair, Emergency and Urgent Care Subcommittee  
St. Louis Children's Hospital  
Missouri Baptist Medical Center

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## Chapter Contacts Needed!

In an effort to encourage collaboration between sections and chapters, last fall the Council on Sections Management Committee (COSMAN) asked each section to designate a member to serve as a contact person for each chapter. This directive was the result of a meeting between members of COSMAN and chapter representatives at the 2000 Annual Chapter Forum.

Thank you to those who have already agreed to serve as a section contact to your chapter. However, we still need contacts for the following chapters:

Arizona Chapter  
California 4 Chapter (Orange)  
Connecticut Chapter  
DC Chapter  
Louisiana Chapter  
Massachusetts Chapter  
Minnesota Chapter  
New York 1 Chapter (Upstate)  
Uniformed Services-West Chapter  
Vermont Chapter  
Washington Chapter

The contact person is not obligated to attend all meetings of the chapter; however, the chapter leadership may call upon the section contact for expertise on a particular issue or to discuss joint projects with the section. If you are interested in becoming a contact for any of the above chapters, please e-mail Stephanie Mucha at [smucha@aap.org](mailto:smucha@aap.org).

This endeavor will go a long way towards establishing linkages between sections and chapters. Your cooperation is appreciated.

Have you visited your AAP Chapter's website lately?

Log-on today ...  
[www.aap.org/member/chapters.htm](http://www.aap.org/member/chapters.htm)

State governments have experienced significant turnover since the November 2002 elections. Twenty-four (24) states have new governors, and there are hundreds of new state legislators. State officials are inheriting fiscal conditions that are the worst since World War II. This is a crucial time for child health advocates as states look to make cuts and raise taxes to balance their budgets. It is important that states do not cut funding for programs that benefit children. Child health advocates will have to work hard to ensure that this does not happen.

### CHILD HEALTH FINANCE

#### State Budgets

The numbers on state budget shortfalls are staggering:

State budget shortfalls reached almost \$38 billion in Fiscal Year (FY) 2002. These shortfalls are happening at the same time there is anemic growth in state budgets. Meanwhile, state revenues have continued to plummet. However, FY 2003 has seen tax and fee increases of \$8.3 billion - the largest state tax increases since 1992. States may be beginning to see tax and other fee increases as necessary moves.

#### Medicaid

The difficult fiscal conditions created problems for Medicaid and SCHIP as growth, specifically in Medicaid expenditures, continued to receive partial blame for overall state budget problems. A recent survey from the Kaiser Commission on Medicaid and the Uninsured (KCMU) is revealing. Medicaid spending grew 10.6% in FY 2001 and 13.2% in FY 2002. The most significant cost driver of this growth has been increased expenditures on prescription drugs. In a breakdown by population, the sources of growth in federal Medicaid expenditures between 2001-2002 again confirm that care for children is not driving expenses. Of the \$15.7 billion in spending growth, 57% went to care for the elderly and disabled, 15% went to children, and 13% went to adults.

Earlier in March, the Division of State Government Affairs sent e-mails to AAP Chapter leaders, asking that they utilize a sample letter to contact their respective governors in opposition to the Administration's Medicaid reform proposal. The Administration's Medicaid reform proposal would eliminate SCHIP as a separate program, allowing states to divide all Medicaid and SCHIP enrollees into "mandatory" and "optional" categories. Moreover, the proposal would provide a limited amount of new funding for Medicaid that would have to be

paid back by the states, in exchange for capped federal funding of the program. Under the proposal, states would be allowed additional "flexibility" to limit benefits and increase cost-sharing in Medicaid and SCHIP, and many of the protections children currently hold would be abolished. We asked chapters to contact their governors as the National Governors Association (NGA) holds considerable influence over the future of this proposal.

These AAP chapter efforts have had a positive effect. The NGA has not accepted the Administration's reform proposal, and instead has formed its own task force to create recommendations on reforming the Medicaid program.

The Academy will be sending its message to this influential NGA task force, to remind the governors that care for children is not driving the increase in Medicaid expenses, and that care for children must be protected as the governors move forward with any new reform proposal. We will soon be asking AAP chapter leaders in states with governors on the NGA task force to again contact their governors with a new sample letter.

#### State Children's Health Insurance Program (SCHIP)

Decreases in income-eligibility for state SCHIP programs were proposed or considered, but not enacted, in **Alaska, Indiana, Missouri, New Mexico, Oklahoma, and South Carolina** during 2002. Enrollment in SCHIP has been capped in **Idaho, Montana, and Utah**.

This year, **Arizona, Missouri, Oklahoma, Texas and Washington** are all currently considering severely cutting or eliminating SCHIP as part of these states' ongoing budget deliberations. **Connecticut, Georgia, and New Hampshire** are all considering capping SCHIP enrollment. **Utah**, however, has recently appropriated enough funding to lift its current cap on SCHIP enrollment this summer. Other states are expected to debate SCHIP funding as budget negotiations continue.

Meanwhile, legislative proposals to increase eligibility for SCHIP have been introduced in **Hawaii** (to 300% Federal Poverty Level (FPL)), **Maryland** (to 350% FPL for employer-sponsored premium assistance), **Iowa** (to 300% FPL), **North Dakota** (to 200% FPL), **West Virginia** (to 250% FPL), and **Wyoming** (to 185% FPL to 7/1/2005, then to 200% FPL). The bill in **Wyoming** has been enacted; this expanded SCHIP program will be offered through a private insurance plan that contracts with the state. The legislation in **North Dakota** has died.

#### Health Insurance Flexibility and Accountability (HIFA) Waiver Program

A number of states have also received approval for Health Insurance Flexibility and Accountability (HIFA) waivers. These HIFA waivers are Section 1115 waivers for Medicaid and SCHIP, which give states the opportunity to significantly change the makeup of their Medicaid and SCHIP programs for certain groups. Under a waiver, states are allowed to offer reduced benefit packages and increased cost-sharing, generating funds for expanded coverage to new groups of people who are otherwise ineligible for these programs. **Arizona, California, Colorado, Illinois, Maine, New Jersey, New Mexico, Oregon, Tennessee, and Utah** have all received approval for HIFA waiver programs to date. These waivers vary greatly, but the vast majority seek to expand coverage to uninsured parents of Medicaid or SCHIP-eligible children, to childless adults, or to both.

#### Medicaid Reimbursement Increases

With budget tightening, a number of states have made changes to Medicaid reimbursement in 2002. Medicaid reimbursement was cut by 5% in **Illinois**, 5% in **North Carolina**, and 5% in **Mississippi**. A proposed reduction of 13.2% was stopped in **Iowa**, and an even larger cut was averted in **California**.

Despite difficult fiscal conditions, a few states raised reimbursement in FY 2003. **Florida, Georgia, Maryland, Massachusetts, New Hampshire, and New Jersey** all raised fees for FY 2003.

As states continue to discuss FY 2004 budgets, it is known that **California, Georgia, Minnesota, New Hampshire, Tennessee, and Texas** are considering lowering provider reimbursement in Medicaid/SCHIP this year. Bills in **Maine, New Mexico, Oklahoma, and South Carolina** have been introduced to raise provider reimbursement in Medicaid/SCHIP. A bill in **Tennessee** has been introduced to study the issue.

#### Prescription Drugs in Medicaid

Virtually every state has instituted or is instituting some form of prescription drug spending control, including step-up procedures, generic substitution requirements, prior authorization requirements, drug formularies, and in some cases prescription limits. A number of states have now begun to form purchasing pools, that will allow for multi-state bulk purchasing of prescription drug medication for Medicaid populations. This will allow these states to negotiate lower prices from drug makers.

*continued on page 7*

## State Government Affairs Update

Continued from page 6

### Single-Payor Legislation

Following a much-publicized defeat of a single-payor initiative in **Oregon** in 2002, an increasing number of states are introducing legislation to require the state to establish a universal health care/single-payor system. Such bills have been introduced in **California, Georgia, Hawaii, Illinois, Maine, New Mexico, and New York.**

### MEDICAL LIABILITY

#### Liability Premiums/Tort Reform

Medical liability reform is a top legislative issue in many states in 2003. **Mississippi, Nevada, Ohio, and Pennsylvania** enacted reforms in 2002. So far in 2003, **Arizona, Arkansas, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Kentucky, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Virginia, and Wyoming** are all considering medical liability reform legislation.

**West Virginia** enacted legislation that 1) places a cap on non-economic damages of \$250,000; 2) eliminates joint liability; 3) sets new standards for expert witnesses; 4) recognizes collateral source payments; 5) provides a homestead exemption for medical providers in case of bankruptcy because of a medical liability ruling; and 6) limits certain third-party claims.

### DISASTER PREPAREDNESS

States are continuing to work on disaster preparedness issues. They are planning for both national disasters and terrorist attacks. The federal government is providing states with over \$1 billion in funding to assist them with this process. States are writing their disaster preparedness plans, and AAP chapters are encouraging them to include pediatric preparedness in these plans. States are also working on this issue legislatively. So far in 2003, at least nine states have introduced model public health emergency powers legislation. The states are **California, Massachusetts, Montana, Nevada, New York, Ohio, Oklahoma, Pennsylvania, and Rhode Island.**

It is positive that states are paying this much attention to a previously neglected issue; however, states are pulling staff and resources from their health departments away from their other crucial duties to tackle preparedness issues - like smallpox. States will have to find a balance. If they do not, then other public health efforts will suffer.

If you have any questions or need assistance with state advocacy activities, please contact the Division at 800/433-9016, ext 7799 or at [stgov@aap.org](mailto:stgov@aap.org). For more information on state advocacy resources and activities, as well as information on immunization, environmental health, injury and violence prevention, safety, scope of practice and nutrition, be sure to visit the State Government Affairs Web page on the Members Only Channel of the AAP Web site [www.aap.org/moc](http://www.aap.org/moc).



### Do We Know How To Find You?

An important new service has been added to the online Member Directory. The "Membership Information Change Form" located within the Members Only Channel ([www.aap.org/moc/memberservices/updatesmemberinfoform.cfm](http://www.aap.org/moc/memberservices/updatesmemberinfoform.cfm)) has been added to provide you with an opportunity to view your address, demographic, and subspecialty information and update it at your own convenience. We understand that members are changing information more frequently. Now, each time you make a change, simply enter it into the form and our database will be updated the following day. This way, there will be no delay in receiving your member benefits.

The AAP online Member Directory, available through the AAP Members Only Channel at [www.aap.org/moc](http://www.aap.org/moc), has recently been improved. With 15% to 20% of our member contact information in a state of change at any given time, the online Directory should be your primary resource to locate colleagues. Quite simply, it has the most accurate, up-to-the-minute contact information available.

With these new changes and enhancements, we believe we can further improve service to members and the public. However, it is also an important time for our members to check their address and demographic information for accuracy.

In the next few weeks, please take the time to visit the Membership Information Change Form ([www.aap.org/moc/memberservices/updatesmemberinfoform.cfm](http://www.aap.org/moc/memberservices/updatesmemberinfoform.cfm)). If you prefer to contact us by phone or fax, you can do this by calling 800/433-9016, extension 5897 and providing one of our service representatives with your updated address information, or faxing your information to 847/228-7035.

## Washington Report From the AAP Department of Federal Affairs

For 33 years, the Academy has maintained a Washington, DC office to ensure that the federal government addresses the needs of pediatricians and their patients. The AAP Department of Federal Affairs, commonly known as the Washington office, works with AAP members on such issues as securing health care coverage for all children, passing medical liability reform and securing appropriate reimbursement for pediatric services.

With the help of AAP members, the Academy has played a major role in helping to create important programs, ranging in the earliest days from poison prevention packaging to the more recent State Children's Health Insurance Program (CHIP). Pediatricians often serve as a source of information in Washington by testifying at congressional hearings, attending federal agency meetings and visiting with members of Congress.

In this Congress, the Academy is working hard to pass medical liability reform. AAP members should contact their U.S. senators and representatives about supporting legislation that would limit the amount of damages awarded in malpractice cases. The AAP-backed bill, "The Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act" (H.R. 5), has already passed the House. We need your help to pass legislation in the Senate this year.

AAP members can get the names and phone numbers of their congressional delegation from the AAP Members Only Channel, [www.aap.org/moc](http://www.aap.org/moc), then click on Federal Affairs. This web area also provides additional background information on medical liability reform, and a sample letter to send to Congress. Questions? Contact Molly Hicks, AAP Dept. of Federal Affairs, 800-336-5475 ext. 3007 or [mhicks@aap.org](mailto:mhicks@aap.org).

In between section newsletters, the Members Only Channel will keep you up-to-date on other federal legislative efforts by the Academy. Another source is the monthly Washington Report column in *AAP News*.

Please feel free to contact the Washington office any time you have a question about federal legislative efforts or if you are interested in advocating for pediatricians and children. Your participation is critical to our success! We can teach the easy steps it takes to help. The phone number is 800-336-5475 and e-mail is [kids1st@aap.org](mailto:kids1st@aap.org).

Dated: April 2003

The name is not the only thing that has changed. There is a growing and dynamic pediatric hospitalist component to the Society of Hospital Medicine (SHM). We are adding pediatric hospitalist members, committee members, committees, websites, newsletter content, sessions at the annual meeting, and more.

Pediatric hospitalists make up only about ten percent of SHM's 4,000 members and likely represent about the same percentage of the estimated 7,000 hospitalists in the country. Just as a reference, there are about 6,000 infectious disease specialists in the country. There has been a pediatric hospitalist on the SHM's board of directors since its inception and SHM has wholeheartedly embraced and supported pediatric hospitalists.

The annual meeting in San Diego marked our second year of having a full contingent of pediatric sessions supported by speakers from across the country. The sessions were excellent and well attended. As usual, there was an abundance of audience participation. A pediatric hospitalist special interest group meeting provided an opportunity to discuss a variety of topics from practice management to clinical issues. In addition to the scheduled meetings, there was plenty of time for networking with our fellow pediatric hospitalists. The practice management pre-course and scheduled sessions were very useful and the vast majority of the topics were applicable to both pediatric and adult hospitalists. A new "mentoring" breakfast was introduced at this year's meeting and, based on the positive feedback, will likely return at next year's meeting. There were discussions of adding a pediatric "master clinician" session for next year's meeting as well. The goal is to make the meeting attractive to pediatric hospitalists by having pediatric specific events to complement the adult specific events.

Look for improvements and new ideas in the pediatric section of the SHM newsletter such as pediatric billing and coding, clinical pearls, ethics, interesting cases and a review of the new Pediatric Hospital Medicine textbook. Brian Pate, the editor of the pediatric section, is always seeking interesting submissions for the newsletter ([bpate@cmh.edu](mailto:bpate@cmh.edu)).

We are also working on updating the pediatric portion of the SHM website to make it more useful. Ideas include a database of practice management tools such as clinical pathways, educational tools and surveys.

A big undertaking is the development of a "core curriculum" for hospitalists. This has

been discussed previously in the listserv and the SHM newsletter. The idea is to define what it is that all hospitalists need to know. The adult hospitalist core curriculum committee is already in existence and there is a pediatric hospitalist on the committee. As the process progressed, we realized that we need a separate pediatric hospitalist core curriculum committee to address the different skills and requirements of the pediatric hospitalist, and we are in the process of creating such a committee.

SHM is also putting together another national survey, which will address compensation and work load. The previous survey is available to members on the SHM website. The new survey will separate out pediatric hospitalists, so we can have data more specific to our specialty. This is very useful information and not really available anywhere else. The SOHC's survey is relatively small both in number surveyed and questions compared to the SHM survey, and the MGMA data is not very specific to hospitalists. Another project, the SHM universe project, continues with the goal of identifying every hospitalist in the country.

SHM would like to have at least one pediatric hospitalist on most of the committees. There are several openings including, ethics, annual meeting planning, core curriculum committee, benchmark, education, ethics, hospital quality and patient safety, membership and research. SHM is very interested in being a happy home for pediatric hospitalists and it provides a very valuable and different role than SOHC. Dr. Jack Percelay and myself have always advocated being members of both. I am open to any ideas that further the cause of pediatric hospitalists. Please feel free to contact me if you have any suggestions or if you would like to be more involved in SHM.

*David Zipes, MD*

Director, St. Vincent Pediatric Hospitalists  
Board of Directors, Society of Hospital  
Medicine

Chair, Pediatric Committee  
[dgzipes@indy.rr.com](mailto:dgzipes@indy.rr.com)



The Society of  
Hospital Medicine  
(formerly NAIP)  
will be doing its

second survey on Hospitalist Productivity and Compensation in September 2003. This will be segmented by specialty with specific data for pediatrics and IM. This survey will be mailed to all the group leaders that SHM can identify. I would urge all pediatric hospitalists to please email Marie Francois at [mfrancois@acponline.org](mailto:mfrancois@acponline.org) with the name of your hospitalists group, the group leader, the administrator, and the contact information (address and email address) so we can include everyone in this survey. Those who participate will receive the results months ahead of others. Be counted!

*Larry Wellikson*

Executive Director

Society of Hospital Medicine (SHM)  
formerly NAIP



Section Rosters  
Now Available  
on the Members  
Only Channel

One of your benefits as a member of the **Section on Hospital Care** is the ability to network with your peers in the field. To make it easier to find and contact your colleagues, the AAP has posted a roster of SOHC members in the Section's area of the Members Only Channel (MOC).

To find the SOHC MOC home page, log on to the MOC at [www.aap.org/moc](http://www.aap.org/moc) and click on the "Hospital Care" on the left-hand side of the screen, under the heading "My Sections."

When the home page downloads, you should see links at the top of the page: "Section Membership Roster" and "Executive Committee Roster." The roster provides mailing address, phone number, fax number, and e-mail, where available.

**NORTHWEST**

**Director needed for NEW Pediatric Hospitalist program**

Newly formed Children's Hospital within a premier medical center in the Northwest is developing a Pediatric Hospitalist program. This is a natural progression for such a medical center, which has been the region's largest Pediatric provider. Very strong hospital and community support. Qualifications include Board Eligible/ Board Certified Pediatrics, Hospitalist experience, start up experience, leadership abilities. Competitive compensation and Benefits package. Live in the Beautiful Northwest and Enjoy Quality of Life!

Contact:  
Shannon Schloneger  
Managing VP-Pediatrics  
Phone: 800/365-8902 x1313  
FAX: 847/384-9505

**PENNSYLVANIA**

**Pediatric Hospitalist - 2 Positions**

We are looking for a full-time pediatric hospitalist to join our group as one of 5 full-time positions, and if qualified, to serve as Director of the Inpatient Program. Bryn Mawr Hospital is part of the Thomas Jefferson University/Main Line Health System, and the Pediatric program is in affiliation with AI Dupont Children's Hospital. We have a 20 bed unit and a busy Emergency Department. Subspecialty support is with AI Dupont, in addition to on-site Pediatric Radiology.

In addition, we are seeking reliable pediatric hospitalist moonlighters to work nights and weekends. Guaranteed hours per month available.

Interested applicants contact:  
Kathleen O'Brien, MD  
Interim Director, Dept. of Pediatrics  
130 S. Bryn Mawr Ave.  
Bryn Mawr, PA 19010  
Phone: 610/526-4261  
e-mail: [kobrien@nemours.org](mailto:kobrien@nemours.org)

**PENNSYLVANIA**

**Director Inpatient Pediatrics**

The A.I. duPont Hospital for Children, in conjunction with the Bryn Mawr Hospital, is currently seeking a director of the Inpatient Pediatric Unit at Bryn Mawr Hospital, in Bryn Mawr, Pennsylvania. Currently staffed by five full time Pediatric Hospitalists, the 20 bed unit is supported by experienced Pediatric Nurses, with strong subspecialty support provided by A.I. duPont Hospital as well as in-house Pediatric Radiology. Bryn Mawr, Pennsylvania, located in the beautiful Main Line suburbs of Philadelphia, has excellent school systems, and is less than a 30 minute drive to downtown Philadelphia.

For further information, interested applicants should contact:

Kathleen O'Brien, MD  
Interim Director  
Bryn Mawr Hospital  
Phone: 610/526-4261  
e-mail: [kobrien@nemours.org](mailto:kobrien@nemours.org)

**UTAH**

**SALT LAKE CITY** - The Division of Pediatric Inpatient Medicine in the Department of Pediatrics at the University of Utah is seeking qualified candidates to join the faculty to provide exceptional clinical care, teaching and research at Primary Children's Medical Center. Applicants must be Board certified or Board eligible in General Pediatrics.

The Division of Pediatric Inpatient Medicine is responsible for faculty coverage on all of the inpatient housestaff teams at Primary Children's Medical Center as well as Attending coverage on a Hospitalist team in cooperation with nurse practitioners. In addition, faculty are closely involved in creation, implementation and evaluation of multidisciplinary care process models aimed at improving communication and patient care.

Division members also are actively involved in the majority of medical student and resident teaching in the inpatient setting. Interested applicants must demonstrate a strong desire for exemplary teaching.

Although this is a clinical appointment, opportunities exist to conduct research in a variety of areas including education, outcomes/quality improvement, medical informatics and clinical projects. Faculty are encouraged to develop relationships within the Department and with other Departments and Colleges to foster research through collaboration.

Salt Lake City is a wonderful town with multiple cultural, educational and recreational activities available.

Interested applicants should send a CV and references to:

Chris Maloney, MD  
Division Chief, Pediatric Inpatient Medicine  
c/o Pediatric Critical Care  
Primary Children's Medical Center  
100 N. Medical Drive  
Salt Lake City, UT 84113  
Phone: 801/588-3283  
FAX: 801/588-3297  
e-mail: [chris.maloney@hsc.utah.edu](mailto:chris.maloney@hsc.utah.edu)

The University of Utah is an Equal Opportunity Employer and welcomes applications from minorities and women and provides reasonable accommodations to the known disabilities of applicants and employees.

**COLORADO**

Pediatric Hospitalist position, community practice in Colorado metropolitan area. Attractive salary, call schedule and hours. Call or e-mail: 719/776-3760, [jmarchant2002@yahoo.com](mailto:jmarchant2002@yahoo.com)

**INDIANA**

**Pediatric Hospitalist Opportunity in Indianapolis**

We have an opening for a BC/BE pediatrician to join our 4 physician hospitalist group and full time pediatric nurse. We are part of the rapidly growing St. Vincent Children's Hospital system in Indianapolis. Our free standing, pediatric hospital opened in January 2003. We are a tertiary care hospital with a PICU, NICU, pediatric emergency department and 40 inpatient beds. Our primary responsibility is caring for inpatients. We are also responsible for the inpatient education of the family practice and transitional interns. The program has been in existence for five years and has undergone steady growth since its inception.

Contact:  
David Zipes  
Director, St. Vincent Pediatric Hospitalists  
Board Of Directors, Society of Hospital Medicine(formerly National Association of Inpatient Physicians)  
Phone: 317/338-5013  
FAX: 775/521-0507  
e-mail: [dgzipes@indy.rr.com](mailto:dgzipes@indy.rr.com)



**SEEKING POSITIONS**

Hospitalist with 5+ years of experience looking for a hospitalist position with a strong educational component at an academic center. Residency Director or Clerkship Director position desirable. Strong administrative and academic credentials.

Heidi Wolf MD, FAAP; Assistant Clinical Professor; Ward Director; Hospitalist Section Head  
Georgetown University Hospital;  
[heidi.wolf@medscape.com](mailto:heidi.wolf@medscape.com)

Experienced general pediatric hospitalist, looking preferentially for a non-academic clinically-focused opportunity. Aside from the expected inpatient care, am comfortable with medical evaluations in the Emergency Department / Urgent Care in addition to well baby / minor sick newborn care and attendance at low-risk deliveries. Would prefer a position volume-weighted towards pediatric as opposed to neonatal care. (Comfortable with clinical 'bedside' teaching and limited didactic lectures.) Immediate availability to interview, with start date contingent only on credentialing / licensing requirements. (Currently licensed in CA, WI, OR, WA, and OH; current PALS and NRP / NALS certificates; ABP board-certified in general ped.) If interested, please contact: Dr. Don Milligan (MD) - phone: 920/406-0641.

A survey by the AAMC indicates that academic hospitalists consistently have major teaching responsibilities.<sup>1</sup> This comes as no surprise. In teaching centers across the country, hospitalists play pivotal roles in both resident and student education. Pediatric hospitalists have clearly joined the ranks of those educators. In quite varied ways, they have embarked upon the exciting task of training the next generation of pediatric clinicians.

Yet as the hospitalist ranks swell, and their value becomes more and more evident, their responsibilities seem to be multiplying as well. The challenge for many academic hospitalist groups will be to remain effective educators while still serving a multitude of roles in the hospital setting—providing top quality care, improving efficiency, and establishing best practice models, to name a few. In his article “Teaching by hospitalist physicians: a practical approach,” Bellet points out that “the teaching program must be structured in such a way to help members of the team achieve their goals.”<sup>2</sup> We could not agree more. At Connecticut Children’s Medical Center, the teaching hospital for the University of Connecticut Department of Pediatrics, we have tried to remain effective by building the educator role into the “structure” of our hospitalist group.

Our group is composed of five individuals, three full-time and two part-time. All of us actively participate in both resident and student education. While one attending is on service as the “clinical attending,” another is assigned a “teaching attending” role. The latter person is free of major clinical duties and can devote more time to medical students and to evaluation and feedback of all learners. The “clinical attending,” meanwhile, leads a team composed of a second year pediatric resident, two interns, and two to three medical students. By allowing a second year resident to lead, rather than a third year, our group serves a special role: our close supervision of the team allows graduated autonomy for this budding senior resident. This month with us is seen as a transition to the greater supervisory role of the third year.

The roles of the members of our hospitalist group are also intertwined with the training program. For example, one attending is the Residency Program Director and another is the Associate Residency Program Director. We also run the third and fourth year medical student inpatient clerkships. All of us attend morning report, frequent the resident conferences, and of course teach students and residents on rounds. This hopefully seamless integration between clinician and educator is the only way we can “get it all done” in a

manner that is both practical and realistic.

This structure has allowed us to stay current and even innovate in the area of education. Like others in the country, we are converting to a “competency-based” approach to student and resident education. That is, the learner will be expected to demonstrate competence in specific areas and the evaluation will directly reflect those competencies. To aid in this process, we do an attending-level observed H&P for each third year medical student, using an actual patient. This process has yielded a great deal of value for both the student and the teacher, in a way that is not possible with rounding alone. We use a checklist to evaluate the student, with a focus on communication, professionalism and the basic components of the H&P. Most recently, we have received a Kaiser Permanent grant to create an instructional videotape on presenting effectively in the inpatient pediatric setting. Students and interns will use this tool to help them master the art of oral presentation.

#### Conclusion:

While it is a challenge to be effective as both hospitalists and educators, our approach has been to integrate the two roles. In our case at least, this integration has allowed us to be better at both.

Anand Sekaran, MD

*Dr Sekaran is an Assistant Professor of Pediatrics at the University of Connecticut School of Medicine and Director of the Inpatient Pediatric Clerkships at Connecticut Children’s Medical Center.*

#### References:

1. Bentsen TP. The hospitalist—a controversial new role. AAMC Reporter 1998;7:6-7.
2. Bellet PS. Teaching by hospitalist physicians: a practical approach. Medical Teacher, Vol. 24, No.4, 2002, pp.434-436.



## ABSTRACT

### Pediatricians’ Attitudes Toward and Experiences with Pediatric Hospitalists: A National Survey

Jack M. Percelay<sup>1</sup>, Karen G. O’Connor<sup>2</sup> and John Neff<sup>3</sup>

<sup>1</sup> Pediatrics, Children’s Hospital of New York, New York City, New York; <sup>2</sup> Health Policy Research, American Academy of Pediatrics, Elk Grove Village, IL; and <sup>3</sup> Department of Pediatrics, Children’s Hospital of Seattle, Seattle, WA.

**Background:** Pediatric hospitalist programs consisting of dedicated inpatient attendings on the general pediatric ward have become increasingly common, but national data on pediatricians’ use of hospitalists are lacking.

**Objective:** To assess the extent of and reasons for pediatricians’ use of pediatric hospitalists (PHs), the impact of hospitalist programs on practice, and satisfaction with care provided by PHs.

**Design/Methods:** American Academy of Pediatrics (AAP) Periodic Survey mailed in 2002 to 1626 randomly selected U.S. members. RR=59%; n=654 pediatricians practicing in office or clinic based settings.

**Results:** Forty percent of pediatricians are affiliated with hospitals with full-time PHs (n=252). When available, PHs care for ~45% of patients and utilization by pediatricians varies: 40% report no patient referrals to PHs while 38% report all patients are referred. Of those who use PHs (n=158), the most common reasons for referral are better care provided by PHs because of PHs full-time hospital presence (61%) and specialization in inpatient care (53%). 53% say attending inpatients takes too much time away from office practice. Most pediatricians agree that using PHs makes office practice more manageable and predictable (78%) but 59% say using PHs limits their ability to maintain inpatient skills and 44% say it limits participation in major inpatient management decisions. 43% say use of PHs improves career satisfaction by allowing specialization in ambulatory pediatrics while 20% say limited direct inpatient involvement diminishes career satisfaction. Most pediatricians say use of PHs increases overall quality of patient care and office productivity (68%, 57%), while 45% say continuity of care is decreased. Overall, 87% are satisfied with the care provided by PHs to their patients and 83% believe their patients are satisfied with this care.

**Conclusions:** Among AAP members practicing in an office or clinic based setting, an estimated 18% of general pediatric inpatient care is provided by PHs. Quality of care and practice style drive pediatricians decisions to refer to PHs. Pediatrician and perceived patient satisfaction with the level of care provided are high; nonetheless, continuity of care and involvement of the primary care pediatrician in inpatient management are areas for improvement.

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