

Section on Hospital Care News

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Summer 2004

“What, Me Worry?”

Notes from Jack M. Percelay, MD, MPH, Chairperson



Welcome to what is very likely to be the last Newsletter for the Section on Hospital Care. Our recent bylaws referendum approved

the name change to the Section on Hospital Medicine and later this year we will formally don this name and a new acronym. This change reflects the evolution of “hospital medicine” as an established discipline. We are an established entity with an important and accepted role to play.

With this maturity also comes obligation, but first we should celebrate our achievements thus far. The party is already planned—Denver, July 28-31 2005, the Pediatric Hospital Medicine Conference. This promises to be THE MEETING for pediatric hospitalists in 2005. I encourage as many of you as possible to be there. Thanks to APA for taking the lead (and assuming the ri\$K) of sponsoring the first of what will hopefully become a biennial event rotating sponsorship among the APA, SHM, and of course the AAP.

These changes in terminology naturally push the question, “Is pediatric hospital medicine a sub-specialty?” I speak here privately as a front-line observer of the

process. The following comments do not reflect any policy of the AAP. That disclaimer aside, it’s clear to me that we as pediatricians will follow the lead of whatever happens in adult hospital medicine. The American Board of Pediatrics is not going to approve Pediatric Hospital Medicine as a designated sub-specialty until and unless the Board of Internal Medicine approves Hospital Medicine as a sub-specialty.

There are advantages and disadvantages to a subspecialty. Three years of additional training is a major cost and obstacle for future hospitalists. But a subspecialty designation allows us to more clearly define who we are and what we do. Once again SHM is taking the lead by outlining core competencies for both pediatric and adult hospitalists. A subspecialty would designation give us an additional measure of prestige among our colleagues, but ultimately we must earn respect by investing sweat equity in rendering excellent clinical care, reorganizing systems of hospital care, and contributing to pediatric research.

What are the economic implications of being a subspecialty? How can we

continued on page 8

From the Editor

Finally our newsletter has begun to take a regular format. Inside we have commentaries and articles on what pediatric hospitalists are doing in both academic and non-academic settings across the nation. Dr. Zautis and colleagues are back with another interesting case for hospitalists (this one stumped me). We also have a fantastic write-up of the comprehensive hospitalist programs occurring through St Louis Children’s and associated hospitals. Dr. Ruhlen has presented some questions about patient safety that he is hoping you can answer, and Dr. Han has begun to unravel some of the mysteries of coding for hospitalized patients through case examples.

Please read, enjoy, and post our newsletter. We hope that it provides an opportunity for learning and discussion, both on the SoHC listserv and elsewhere. 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 A. Daru, MD

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American Academy of Pediatrics
SAN FRANCISCO 2004 *National Conference & Exhibition*
October 9-13

REMINDER

Program for Section on Hospital Care Members

Date: October 11, 2004

Moderator: Laura J. Mirkinson, MD
Education and Program Chairperson

8:00 am	Poster Session
8:30 am	Session: "The Febrile Infant"
9:45 am	Break
10 :00 am	Session "RSV Bronchiolitis"
11:15 am	Break
11:30 am	Section Business Meeting & Box Lunch
1:15 pm	Session: "Complementary and Alternative Medicine"
2:30 pm	Break
2:45 pm	Session: "Radiation Exposure"
4:00 pm	Adjourn

Visit www.aap.org/nce for more information about the AAP National Conference and Exhibition

And ... SOHC is also sponsoring a seminar with the Section on Endocrinology entitled, "Type 2 Diabetes, Obesity, and the Metabolic Syndrome"!!



You are the Consultant

Lisa B. Zaoutis, MD, Children's Hospital of Philadelphia
Keith J. Mann, MD, The A.I. duPont Hospital for Children

You are the general pediatrician consulted by the orthopedic surgeon for a 5 year old little girl admitted to the orthopedic service for presumed osteomyelitis of the right middle finger. The patient had been admitted just one day earlier with a history of redness and swelling of this finger for 3-4 months prior to admission. There was no history of trauma, fever, extension of the swelling to the rest of the hand, nor erythematous streaking up the arm. The primary care physician had been treating the finger with topical antibiotics without improvement. Work up as an outpatient included an x-ray which was suspicious for osteomyelitis. Subsequent MRI of the hand and finger confirmed the diagnosis of osteomyelitis. On admission, the patient had been started on intravenous oxacillin with plans for placement of a PICC line for completion of the parenteral course of therapy.

The little girl's past medical history was remarkable only for a left wrist "buckle" fracture at the age of 3, which was splinted and healed with complete satisfaction to the orthopedist, patient and family. The mechanism of injury was a fall onto an outstretched hand while at a playground. She takes no medication except for a daily multivitamin for children, has no known allergies, is up-to-date on her immunizations, has a normal diet and development, and has no significant family history. She lives with her mother, father, older brother, and family dog, which has never been known to nip or bite anyone. Her review of systems is completely negative including no night pain, no weight loss, no cold intolerance, no limitation of activity (e.g., writing, coloring, fingerpainting). She is right-handed.

On examination, she has remained afebrile since admission with normal vital signs. She is well appearing with the only abnormal findings related to the middle finger of her right hand. Around the distal phalanx there is mild erythema and swelling, but no break in the skin and no increased warmth. The

nail appears normal but slightly wider than the corresponding nail on the left middle finger. There is no tenderness and she exhibits full range of motion of the finger, including the DIP, without discomfort. Light touch, pinprick, position, and vibration are intact. All other joints are fine. Except for a few small, scattered anterior cervical nodes, there is no significant lymphadenopathy.

You review the diagnostic tests obtained on admission and the MRI obtained the day prior to admission:

*** A basic metabolic (chemistry) panel was completely normal.

*** The complete blood count revealed a white blood count of 9,300/mL, hemoglobin of 12.5 g/dL, platelet count of 325,000/mL with 47% neutrophils and 46% lymphocytes.

*** An erythrocyte sedimentation rate was 7 mm/hr and a c-reactive protein was <0.7 mg/dL.

*** A blood culture obtained 36 hours previously remains negative.

*** The MRI report described "a subungual lesion in the central portion of the distal phalanx of the right middle finger with 2mm area of central necrosis, but no fluid collection." The impression suggests that osteomyelitis is the process. You review the images and confirm the findings described in the report.

The orthopedist is concerned about the atypical presentation for osteomyelitis and would like you to weigh in before placing the PICC line and committing the child to prolonged intravenous antibiotics. One of the following approaches proves to be a prudent choice on your part:

1. Concerned about chronic osteomyelitis, you recommend proceeding with PICC line placement and treatment with intravenous antibiotics for 4-6 weeks to cover

organisms that commonly cause osteomyelitis. If symptoms persist after the completion of the antibiotic therapy, further investigation would be warranted.

2. Hold antibiotic therapy and recommend biopsy of the lesion visualized on MRI to evaluate for malignancy or nonmalignant tumors.
3. Bone scan to look for other lesions (infectious or noninfectious).
4. Neither further diagnostic evaluation nor treatment for this process as it does not interfere with the child's function.

see page 10 for the answer ...

Questions or comments regarding this article can be directed to Dr. Zaoutis at zaoutisL@email.chop.edu or Dr. Mann at kmann@nemours.org.

Submissions Wanted

Have an idea for a future article?

Interested in writing a featured column for an upcoming issue?



Need to promote an educational activity or professional opportunity?

WE NEED YOUR SUBMISSION FOR THE NEXT NEWSLETTER!

For more information, please contact Jennifer Daru at jdaru@childrensmemorial.org.

Update from the AAP DC Office

FAAN Network

The AAP Department of Federal Affairs invites you to be a part of FAAN. FAAN (or Federal Advocacy Action Network) is a network of Academy members who help support federal legislative and regulatory activities from their positions as constituents. Members choose the level and range of activities that suit their busy schedule, from simply faxing or calling congressional members about issues of concern, to requesting a personal meeting. Over the years, the FAAN network has affected numerous positive gains for children and pediatricians, thanks to AAP member commitment to child health advocacy efforts. FAAN members receive education and guidance and updated legislative information on the issues they take action on from the AAP Department of Federal Affairs.



Federal Affairs Resources

In between section newsletters, the Member Center Federal Affairs page will keep you up-to-date on federal legislative efforts by the Academy. Another source is the monthly Washington Report column in AAP News. For breaking news on Capitol Hill, the Dept. of Federal Affairs sends out special alerts to members of the Federal Action Advocacy Network (FAAN) telling them to take action on legislation when needed.

Contact Us

You can contact the Washington office any time if you have a question about federal legislative efforts or if you are interested in advocating for 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.

Be Informed!!



Get Involved!!

Subscribe to the Section on
Hospital Care **LISTSERV®** Today!

To join, visit the SOHC web site at
www.aap.org/sections/hospcare/

Join the Discussion!!

And list digests are now available !!!

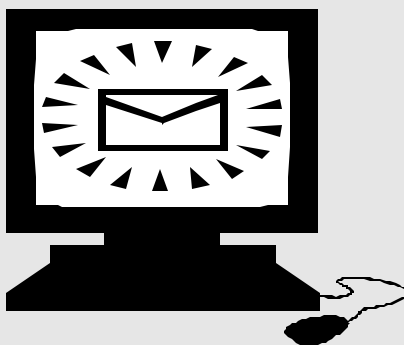
If you would like to receive a weekly digest of list messages instead of receiving list messages as they are posted, you can now send the request to the listserver.

Please keep in mind that when you turn on digesting, you will no longer receive list messages as they are sent, and if you were to send a message to the list you would not receive replies to your message. Any replies would be in the digest.

List digesting is not for everyone, and you should only activate digesting if you receive too much e-mail on a daily basis, or, for example, you are going on vacation. If everyone on the list were to enable digesting, there wouldn't be any list messages to digest.

To turn on digesting for yourself, simply send an e-mail message to listserv@listserv.aap.org and in the message body type "set SOHCAAP digest" without the quotes. You can leave the subject line blank.

If you want to turn off digesting in the future and receive list messages as they are posted, simply send the same message to the listserver, but use "set SOHCAAP nodigest" as the command line.



Update on the Pediatric Research in Inpatient Settings (PRIS) Network

PRIS, the hospitalist research network, was formed in 2002 and has grown considerably in the past two years. The mission of PRIS is to improve the care of hospitalized children by developing the evidence base for inpatient pediatric care.

There are currently over 80 medical centers and nearly 200 hospitalists involved in the network, and we are on the threshold of launching an initial collaborative research study of bronchiolitis.

This past fall, we conducted a survey of pediatric hospitalists nationwide to better understand the scope of practice, and to guide further research efforts. Approximately 200 pediatric hospitalists participated in the survey, and provided detailed information about their practice environments, training needs, finances, and disease management strategies. The results of the survey generated three abstracts, which were presented at the Pediatric Academic Societies meeting in San Francisco this May:

1. PRIS Survey: Pediatric Hospitalist Roles and Training Needs
2. Variation in Inpatient Management of Common Pediatric Diseases: a Study from the Pediatric Research in Inpatient Settings (PRIS) Network
3. Financial Health of Pediatric Hospitalist Systems: a Study from the Pediatric Research in Inpatient Settings (PRIS) Network

The authors of these abstracts are currently preparing manuscripts for publication in peer-reviewed journals.

At the APA's Hospital Medicine SIG meeting in San Francisco, we discussed our next steps: 1) seeking core funding to support the network's development; 2) conducting a multi-center prospective study of bronchiolitis (a disease process for which inpatient management was found to vary widely on the PRIS

survey); and 3) soliciting further study proposals from members. We hope to launch a study of bronchiolitis this winter, and to have at least a couple of additional projects in development over the next year.

If you are interested in being a part of the network, or have a research proposal, please e-mail Chris Landrigan at christopher.landrigan@childrens.harvard.edu.

Chris Landrigan, MD
Children's Hospital Boston
Chair, PRIS Steering Committee

Congratulations!!!

Please join us in congratulating the following successful candidates from the 2004 Section on Hospital Care Executive Committee election:

Chairperson:

Jack M. Percelay, MD, MPH
term: 2004-2006

Executive Committee Member:

Jennifer A. Daru, MD
term: 2004-2007

Laura J. Mirkinson, MD
term: 2004-2007

Each person will officially take office at the close of the 2004 NCE in San Francisco.

And thank you to all of the candidates and the Nominations Committee for running a great campaign!



Do We Know
How To
Find You?

Reminder ... the "Membership Information Change Form" located within the Member Center of www.aap.org (www.aap.org/moc/memberservices/updatesmemberinfoform.cfm) offers 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 is available through the Member Center at www.aap.org/moc. 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.

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.

AAP PRESS ROOM

www.aap.org/pressroom

Online Home for AAP
Public Relations

In addition to late-breaking news, the AAP Press Room also contains information on:

- Hot Topics
- Immunization Resources
- News Releases
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- News Features
- AAP Spokespersons
- AAP Policy Statements
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Billing Corner: Understanding E/M Coding

One way to improve billing is to perform an audit at scheduled intervals (quarterly or annually) for the distribution of billing (E/M codes) for each member of your group or for the group as a whole. This data can be compared to published E/M distribution data, and the individuals or group can then work to achieve similar distribution or at minimum uniformity among group members. The code distribution data here is from an academic pediatric hospitalist service in Seattle and may not be applicable to your service but serves as a starting point:

*** Initial Hospital Visit ***

Code	Frequency used
99221	5%
99222	61%
99223	34%

*** Subsequent Hospital Visit ***

Code	Frequency used
99231	25%
99232	66%
99233	9%

By looking more closely at how these codes are chosen, the group may have more success with collection. The examples below are taken from the CPT 2004 for the defined E/M services since these are the published standards.

*** Initial Hospital Visit ***

99221 – low severity

1. Mononucleosis and dehydration.
2. Laceration of upper eyelid admitted for IV abx prior to surgery.
3. Cellulitis of foot requiring bed rest and IV abx.

99222 – moderate severity

1. Peritonsillar abscess or cellulitis requiring IV abx.
2. Generalized atopic dermatitis and secondary infection.
3. Fever, limp and painful hip motion of 18 hours duration.
4. Acute asthma attack unresponsive to outpatient therapy.
5. Suppurative sialoadenitis

and dehydration.

6. Two week hx of sore throat, now with dysphagia. Exam with necrotic tonsils with adequate airways, and small palpable nodes.
7. Chronic sinusitis and sever headache unresponsive to oral abx.

99223 – high severity

1. Persistently suicidal latency-aged children, whose parents have requested admission to provide safety during evaluation, but are anxious about separation from her.
2. 36-hour hx of sore throat and high fever, now with sudden onset of lethargy, irritability, photophobia, and nuchal rigidity.
3. Victim of child abuse with CNS depression, skull fracture, and retinal hemorrhage.
4. One day old with cyanosis, respiratory distress, and tachypnea.
5. Recurrent tachycardia and syncope.
6. High fever and proptosis.
7. DKA with vomiting, dehydration, fever, and tachypnea.

*** Subsequent Hospital Visit ***

99231 – stable, and recovering or improving

1. Day three receiving meds for uncomplicated pneumonia.
2. Lobar pneumonia with vomiting and dehydration with clinical improvement with no fever and tolerating oral fluids.
3. Uncomplicated asthma, clinically stable.
4. Responding to IV abx for ear or sinus infection.
5. In traction for congenital dislocation of the hip.
6. Acute gastro and dehydration on IVF and now stable.

99232 – responding inadequately to therapy or has developed minor complication

1. Fever, pharyngitis, and airway obstruction,; after 48 hours develops a maculopapular rash.
2. Unstable bronchial asthma complicated by pneumonia.
3. Bacterial meningitis treated with IV abx for one week, now with fever.
4. LLQ pain and fever, not responding to therapy.

99233 – patient is unstable or has developed significant complication or a significant new problem.

1. Caustic ingestion, who now has fever, dyspnea, and dropping hemoglobin.
2. Pansinusitis complicated by a brain abscess and asthma, not responding to current treatment.
3. Electrical burns to arm with ascending infection.

References:

- 1) Melzer et al. Pediatrics July 2001; 108: 79-84
- 2) CPT 2004; 12-13, 400-405



This article is brought to you by the SOHC Subcommittee on Billing and Coding

For additional information, please contact Yong Han at yshan@texaschildrenshospital.org

Practice Profile: Washington University/St. Louis Children's Hospital Hospital Medicine Program

Doug Carlson, MD, Director of Pediatric Hospitalist Program, Washington University

Beth Everts, Physician Recruiter, St. Louis Children's Hospital

We began development of our pediatric hospitalist program in 1997 when we started providing pediatric and nursery services at Missouri Baptist Medical Center, a pediatric affiliate of St. Louis Children's Hospital. We now have 24 pediatric generalists/hospitalists providing an array of hospital based services at St. Louis Children's Hospital, Missouri Baptist Medical Center and Barnes-Jewish hospital.

Mission Statement

We are group of general pediatric physicians dedicated to providing hospital-based care to a diverse patient population. We are committed to the continuity of patient care while providing education to families, medical students, and house staff.

Services/Responsibilities

ST. LOUIS CHILDREN'S HOSPITAL

General Pediatric Inpatient Unit

We provide general pediatric attending level coverage on inpatient floors for all otherwise unassigned patients. This includes supervision of medical students and a resident house staff team. Teaching is done both at the bedside as well as in didactic sessions.

Ambulatory Procedure Center (APC)

The APC operates weekdays Monday through Friday to perform invasive procedures and diagnostic studies that require sedations for both inpatients and outpatients at St. Louis Children's Hospital. The center facilitates a wide range of procedures, including but not limited to bronchoscopy, endoscopy, sedation for radiological procedures, PICC line placement, and ophthalmologic procedures. The hospitalist role in the APC is to oversee nurse administered sedations for radiological procedures. In addition, the hospitalists provide deep sedation for some of the procedures. The hospitalists receive extensive training in advanced airway skills with the anesthesiology staff in order to perform this service. Teaching is also

provided to the Pediatric house staff, as sedation training is part of a required rotation.

Pediatric Intensive Care Unit

Our responsibility for the PICU is to provide evening/overnight coverage for about 50% of the days per month. We work directly with the PICU attending staff, nurse practitioners, and house staff. We assist in supervising the on-call residents and medical students in patient management, admissions and discharges, and all procedures. At all times, there is an ICU attending available on call.

Center for After Hours Referral Emergency Services (C.A.R.E.S.)

The C.A.R.E.S. unit offers community pediatricians as well as hospital-based subspecialists an eight bed unit for private referrals during evenings and weekends. It is staffed by one hospitalist attending, one or two medical technicians, one or two registered nurses, and a unit secretary. All patients seen in the C.A.R.E.S. unit must have been referred in for further evaluation. The goal of the center is to provide more directed and tailored care to patients who have already either seen or spoken to their regular physician. About 6,500 patients are seen annually in the C.A.R.E.S. unit.

Emergency Unit (E.U.)

The role of the hospitalists in the E.U. is to provide care at the second attending level in the presence of a primary pediatric emergency attending. We provide coverage in two separate shifts, from 9:00 a.m. until 5:30 p.m. and from 5:30 pm until 12:30 am 7 days a week. Duties include the supervision of medical students and residents as well as direct patient care. The annual volume is 55,000 patients.

Transport

The Saint Louis Children's Transport Team has a physician on every trip. Our group provides coverage from 7:00 am until 6:00 pm Monday through Friday. During evening and weekends,

residents and fellows have the opportunity to go out on transports. Most trips are comprised of the physician, a transport registered nurse, and an emergency medical technician. About 1,500 annual trips are made by ground, helicopter, and fixed wing. About half of the transports are neonatal and half are pediatric. Travel includes hospitals in Missouri and Illinois as well as other neighboring states.

MISSOURI BAPTIST MEDICAL CENTER (MBMC)

Newborn Services

There is an onsite pediatric hospitalist 24 hours a day, 7 days a week to provide a variety of services for newborns born at MBMC. We attend all cesarean section deliveries, complicated deliveries, and provide emergent care and support to newborns in need after birth. Pediatric hospitalists provide daily newborn care and education to those families whose pediatrician is not on staff or who have not yet chosen a pediatrician. We also work with the neonatologists in the Special Cares Nursery, helping to care for those infants who are ill or are born prematurely. There are about 4,300 deliveries at MBMC annually with a special care nursery daily census generally of between 10 and 20 newborns.

Emergency Pediatric Center

Emergency care is available 24 hours a day, 7 days a week in the Pediatric Unit located on the 1st floor of MBMC. Onsite pediatric hospitalists work with pediatric nurses to provide urgent and emergent care to children and their families. Annually 6,500 patients are seen in this unit.

Pediatric Inpatient Unit

There are 8 observation beds located in the Pediatric Unit for those children who need further care or observation. The pediatric hospitalists frequently work with a patient's own pediatrician

continued on next page

Practice Profile

(continued from page 7)

to coordinate care for the child and their family.

BARNES JEWISH HOSPITAL **Newborn Services**

The 9400 Assessment Nursery is the well-baby nursery for Barnes-Jewish Hospital. A small core group of hospitalists provide service in 2 week blocks for this primary teaching service. Clinical responsibilities include daily rounds with the resident team and assessing each newborn. There are no delivery room responsibilities. Teaching responsibilities include teaching sessions with the well-baby and special care nursery teams several times per week. We also provide teaching, instruction, and certification in neonatal resuscitation to the residents and medical students through the Neonatal Resuscitation Program. The 9400 clinical working group meets once per month to address clinical issues and to develop evidence based clinical guidelines. There are about 4,500 annual deliveries at Barnes-Jewish Hospital.

Responsibility Breakdown

Each physician in our group has slightly different responsibilities. On average each physician spends about 60% of their time at St. Louis Children's Hospital and 40% at MBMC.

All physicians work at MBMC providing pediatric and newborn services and in the C.A.R.E.S unit and the Emergency Unit at St. Louis Children's Hospital. All other services, PICU, transport, sedation and the Barnes-Jewish Hospital assessment nursery are provided by a subgroup of our larger group depending on interest and expertise.

Requirements Include:

- 1) completion of an accredited residency program; 2) "board certified" or "board eligible" by the American Board of Pediatrics; 3) licensed by the State of Missouri; and 4) valid DEA number

For additional information on this practice profile, please contact Doug Carlson at carlson@wustl.edu or Beth Everts at beverts@iland.net.

Chairperson's Report

(continued from page 1)

make sure that our services are appropriately valued when a large benefit of the care provided by hospitalists consists of creating and improving systems of care? There isn't a CPT code for sitting on your institution's QI committee. Subspecialty designation is not a quick route to financial success. The best we can expect from subspecialty designation alone is a separate division with a chief who is first and foremost a hospitalist. Throw in a corner office and a window if you're lucky.

To look at long-term financial viability, we have to start thinking outside of our small box. Currently we strive to maximize reimbursement by checking off ten items in the review of systems and counting IV fluids as contributing to the complexity of decision-making in hyperbilirubinemia. Don't get me wrong, complete documentation, and thorough and thoughtful care are the cornerstones of what we do. But they will not solve our problems. Just look at the problems facing our colleagues in endocrinology or any of the other less procedural subspecialties and you will see this is not the answer. We need to think beyond 99221-99223.

Global codes for inpatient care may be a part of the solution. Surgeons have their E&M services bundled into the procedure code. Neonatal and pediatric critical care services now include daily global codes. Would some sort of daily global code more appropriately reflect our work as hospitalists? We see patients several times a day. We actively coordinate care. Codes 99231-3 may accurately reflect the traditional daily visit of the office-based practitioner, but they do not reflect our work. The Public Policy Committee of the SHM is just beginning to explore this issue. The AAP offers additional opportunities and venues to work for changes in inpatient reimbursement.

Yet even a revolution of this magnitude would not place pediatric hospital medicine on a firm financial footing. For as long as Medicaid reimburses less

than Medicare, we suffer risks of insolvency. All children need and deserve access to high quality medical care.

As pediatricians first and hospitalists second, we need to work nationally and locally to assure that children have appropriate financial access to care—ambulatory and hospital-based, general and subspecialty, physical health and emotional and mental health. The Academy is working at the chapter, state and national levels to promote children's universal access to care. Help with your local chapter and state activities. This is a much more pressing battle than that of a subspecialty designation for hospitalists. It is vitally important for Pediatrics and crucial for children. Speak up loudly and often. Relay your direct experience of children who have suffered from limited access to care. Vote!

Jack

GET INVOLVED IN YOUR CHAPTER!



Section Representatives Needed!!!

The Section on Hospital Care has been asked to designate a member to serve as a contact person for each chapter. The contact person is not obligated to attend all meetings of the chapter; however, it is hoped the individual will attend at least the chapter's annual meeting. In addition, 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 serving as the Section's contact for your local chapter, please contact Niccole Alexander at nalexander@aap.org.

Professional Opportunities

ILLINOIS

Pediatric Hospitalists Needed at Chicagoland Community Hospitals

Become a valued physician at one of the nation's premier pediatric hospitals! Since its founding in 1882, Children's Memorial Hospital has been recognized nationally for excellent comprehensive clinical service. We offer high quality patient care, a rewarding academic work environment and the opportunity to work with some of the finest physicians in pediatrics.

We have two openings for Pediatric Hospitalists. These programs provide on-site, in-house coverage of pediatric in-patients in a community hospital setting. Coverage extends to labor and delivery as well as the nursery, there is neonatal back-up available. 91 shifts are required: a shift consists of 24 hours in-house. (Part-time would be considered).

Benefits include malpractice insurance, medical and dental plans, as well as a retirement plan.

Requirements: Must be boarded or board-eligible in Pediatrics, with strong delivery room skills preferred.

If interested, please send your CV to: Children's Memorial Hospital
Attn: Dan Polk, MD
2300 Children's Plaza Box #45
Chicago, IL 60614
773-880-3482
Fax 773 880-3061
dpolk@childrensmemorial.org

BE/BC Pediatrician

The Children's Hospital of Illinois in Peoria, IL is looking for a BE/BC Pediatrician to join a three person pediatric hospitalist program. Previous inpatient experience is preferred. Job responsibilities include general inpatient care, resident/medical student education, sedation and administrative responsibilities. CHOI @ OSF St. Francis is the major teaching affiliate of the University of Illinois College of Medicine at Peoria. It is a 120 bed children's hospital with excellent pediatric subspecialty support. We have approximately 20

categorical pediatric residents as well as 20 combined med / peds residents.

If interested, please contact:
Bill Edwards, MD
Director, Inpatient Care
Children's Hospital of Illinois
(309) 655-3613
william.edwards@osfhealthcare.org

INDIANA

Pediatric Hospitalist Opportunity

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 freestanding, 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 six years and has undergone steady growth since its inception. We are an equal opportunity employer.

Contact:
David Zipes
Director
St. Vincent Pediatric
Hospitalists
Board of Directors Society
of Hospital Medicine
Phone: 317.338.5013
Fax: 775.521.0507
dgzipes@indy.rr.com

TEXAS

Academic Pediatric Hospitalist

The University of Texas Health Science Center at San Antonio is recruiting pediatricians to work as hospitalists to join a team of full time and part time physicians. The hospitalists are the attending physicians for an academic inpatient service and also have the opportunity to cover the PICU at night as the first call doctor, with backup by pediatric intensivists. The physicians work closely with the Critical Care Faculty and the Critical Care fellows in our accredited critical care fellowship. Duties include patient care, medical student, resident, and fellow education,

and the opportunity for clinical research.

Requirements include United States citizenship or permanent visa, board certification in Pediatrics or successful completion of an ACGME Accredited General Pediatric Residency with eligibility to take the ABP certifying exam, eligibility to obtain a Texas Medical License, and experience in intensive care; or interest and motivation in broadening the physician's critical care skills as part of this position. All faculty appointments are designated as security sensitive positions. The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer.

Interested individuals are encouraged to contact:

Dr. Richard Taylor
Division Chief
Pediatric Critical Care
The University of Texas Health
Science Center at San Antonio
7703 Floyd Curl Drive
San Antonio, Texas, 78229-3900
TaylorR@UTHSCSA.EDU



Wanted ... SOHC Web Master

The Section on Hospital Care Executive Committee is looking for a SOHC Web Master.

The successful applicant would oversee SOHC's hospitalist e-library (coming soon) as well as supervise content on the Section web site.

The position includes an annual "thank you" honorarium of \$500, plus other benefits.

For more information, please contact
Nicole Alexander at
nalexander@aap.org.

You are the Consultant: Answer

Continued from page 3

An excisional biopsy was performed and the specimen was sent for pathology, and for routine bacterial cultures as well as culture for acid-fast bacteria and fungus. The biopsy showed osteoid osteoma and all the microbiologic studies were negative. The orthopedic surgeon felt confident that the entire nidus was removed and the patient was discharged home, free of a PICC line and IV antibiotics due to your astute clinical judgment.

Osteoid osteoma is a benign neoplasm of the bone affecting children and young adults. The average age of presentation is 18-19 years, with a range of 4 - 40 years. Most lesions occur in the lower extremities, but the upper extremities can be involved as well. Osteoid osteoma is typically painful, with a gradual onset of pain over several months. The pain is often worse at night, and the vast majority of patients report relief with aspirin or other anti-inflammatory medications. Occasionally, lesions in the fingers may be pain free, presumably due to poor innervation of the tumor. Fever, chills, and other systemic symptoms are not part of the clinical picture. Bednar, et al published a review of forty-six patients with histologically confirmed osteoid osteoma of the upper extremity. Twenty-four of the lesions were located in the wrist and hand and twenty-two were in the arm and forearm. A mass or swelling as the initial presentation was more common in the wrist and fingers but pain was more common in those involving the forearm. Of the six recurrent lesions, five occurred in the hand, stressing the importance of close follow up, especially in this patient.

Osteoid osteoma has an important differential diagnosis including osteomyelitis and malignancy. Acute, chronic, and chronic multifocal osteomyelitis are three distinct entities that should be considered, although none closely fit the clinical presentation of your patient.

Acute osteomyelitis typically occurs in the metaphysis of long bones in growing children. The presentation of acute osteomyelitis often differs with age. A fairly sudden onset of fever, malaise, and other signs of systemic illness can be a presenting symptom at any age. In infants, irritability and decreased use or movement of the affected extremity is often noted. In older children, bone pain and limited range of motion in the adjacent joint are more common presentations. Your patient's several month history of redness and swelling without pain, without limitation of motion, nor signs of systemic disease makes acute osteomyelitis unlikely. For this reason, committing your patient to placement of a PICC line for 4-6 weeks of IV antibiotics may not be indicated at this point.

Chronic or subacute osteomyelitis can present as a localized bone abscess, also referred to as a Brodie's abscess. It may result from untreated or inadequately treated acute osteomyelitis, most often occurring in long bones. Subacute cases often present with fever and pain, whereas patients with chronic abscesses are frequently afebrile with minimal systemic symptoms. The complete blood count and erythrocyte sedimentation rate can also be normal in chronic cases. The lack of pain, the location, and the absence of history of a preceding infection in your patient makes this an unlikely diagnosis, however it should still be considered. The proper diagnostic modality and

treatment for Brodie's abscess involves surgical culture, curettage, and drainage followed by intravenous antibiotics, making your recommendation of surgical culture and biopsy appropriate for this possibility.

Multifocal osteomyelitis can either be infectious or noninfectious. Chronic multifocal osteomyelitis (CRMO) is a rare, inflammatory, noninfectious cause of lytic bone lesions in children. It primarily affects girls during childhood and adolescence and presents with recurrent, self-limiting attacks of multifocal bone pain, often associated with overlying warmth and erythema. There is often an association with other inflammatory conditions, such as arthritis, acne, or colitis. The complete blood count is often normal. In your patient, the prolonged swelling with only unifocal involvement, and the absence of pain make CRMO or multifocal osteomyelitis unlikely. Therefore, a bone scan looking for other lesions would be a test of low diagnostic yield.

Ewing sarcoma, osteosarcoma, or metastatic lesions of other malignancies deserve mention in the differential diagnosis, however these are unlikely in the clinical scenario presented. Pain (often worse at night), swelling, limitation of motion, and tenderness over the involved bone or soft tissue are common presenting symptoms for malignancies. Osteosarcoma occurs equally in males and females, typically before the end of puberty, during the adolescent growth spurt. The location is usually confined to the metaphysis of long bones. Ewing sarcoma also occurs in the second decade of life, but is more commonly confined to the diaphysis of long bones or flat bones, such as the ribs. Systemic symptoms of weight loss, fever, and malaise are more commonly associated with Ewing sarcoma and metastatic malignancies compared to osteosarcoma. Your recommendation for excisional biopsy would reveal these unlikely, but worrisome diagnostic possibilities.

Reference: Bednar MS, Weiland AJ and Light TR
"Osteoid Osteoma of the Upper Extremity"
Hand Clinic. 11(2): 211-21, 1995



Section Rosters Available on the "Member Center"

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 Member Center (MC).

To find the SOHC MC home page, log on to the MC at 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.

Courses, Seminars, and Upcoming Hospitalist Meetings

CATCH/Medical Home National Conference

July 16 – 17, 2004 in Chicago, IL

Beautiful downtown Chicago is a perfect place to learn about Medical Homes and improving health care for children in your community. The Community Access to Child Health or CATCH/Medical Home conference is designed for pediatricians, residents, health care professionals, state and federal public health employees, child advocates, other professionals and family representatives who are dedicated to working with children with special health care needs. Participants will learn about practical strategies to provide Medical Homes and improve access to health care; asset-based community development; assessing quality improvement; screening and surveillance; coalition building and successful models of care from community-based initiatives around the world. A pre-conference workshop will also be offered on “social capital” - the processes between people, which establish networks, norms and social trust, and facilitate coordination and cooperation for mutual benefit and improved health.

For more information on the CATCH/Medical Home Conference, please visit their web site at www.aap.org/catch/nationalconf.html.

PREP: EM

An Intensive Review of Pediatric Emergency Medicine

August 7 – 11, 2004 in Toronto, ON

The primary goal of PREP: EM is to provide an intensive review of topics in pediatric emergency medicine that are identified by major headings on the American Board of Pediatrics Subspecialty Certifying Examination Content Outline developed by the Sub-Board of Pediatric Emergency Medicine, as well as disseminate information on recent developments in theory, diagnosis, and management of pediatric medical emergencies

Attendees will learn state-of-the-art pediatric emergency medicine, hear “what’s new,” explore alternative management strategies, and discuss controversial issues encountered in daily practice

For additional information on the PREP: EM Course, please visit the “2004 at glance” section of the Pedialink web site at www.pedialink.org.

31st Annual Mayo Clinic

Pediatric Days

September 9 – 10, 2004 in Chicago, IL

The 31st Mayo Clinic Pediatric Days is designed to provide pediatricians, family physicians, physician assistants and nurse practitioners with current information on a variety of medical and surgical conditions affecting children and adolescents. Topics address new developments in pediatrics as well as subjects of interest noted by previous course attendees. Our key themes this year are gastroenterology, cardiology, neurology, genetics and pediatric surgery.

The \$400 (physician) and \$200 (Resident/PA/Nurse/Technician) registration fee includes tuition, comprehensive course syllabus, continental breakfasts, lunches and refreshment breaks.



For additional information, please call 800/323-2688 or 507/284-2509 or you may visit the web site at www.mayo.edu/cme/peds.htm.

2004 Course on Neonatal and Pediatric Critical Care Transport Medicine

October 10 – 12, 2004 in San Francisco, CA

Sponsored by the AAP Section on Transport Medicine

If you are physician or allied health professional interested in neonatal or pediatric transport issues, plan to attend the 2004 Course on Neonatal and Pediatric Critical Care Transport Medicine and Section Program, which is scheduled for October 10 – 12, 2004 in San Francisco! The Course will be held in conjunction with the American Academy of Pediatrics National Conference and Exhibition (October 9 – 13).

Topics that will be covered this year include: “Legal Aspects of Transport Medicine,” “Ambulance Safety,” “The Referring Center’s Perspective,” “New Shock Guidelines,” “Advances in Infant Transports,” “Transport Enigmas,” “Survival Techniques,” “Bioethics of Transport Medicine,” “Pain and Sedation,” and “Telemedicine.” 2004 also marks the first time in which attendees will be able to participate in the Section on Transport Medicine Scientific Program. Attendees will hear presentations as well as view posters on the latest neonatal and pediatric transport research.

For an additional nominal fee, attendees will have the opportunity to observe and participate in workshops at the Center for Advanced Pediatric Education or CAPE at Lucile Packard Children’s Hospital at Stanford (for additional information on CAPE, visit www.lpch.org/cape). This center employs leading edge simulation-based technology that enhances training in the pediatric sciences. Workshop participants have a fabulous opportunity to experience challenging medical scenarios that could be found on transports of critically ill children.

Additional information on the 2004 Transport Course is available on the Section on Transport Medicine web site at www.aap.org/sections/transmed/, or you may contact Niccole Alexander, SOTM Manager, at 847/434-4799 or at nalexander@aap.org.

If you have a professional opportunity that you would like highlighted in an upcoming newsletter (or posted on the SOHC LISTSERV®), contact Niccole Alexander at nalexander@aap.org.

Section Subcommittees Forming Now!!

Following is a complete list of SOHC volunteer opportunities. If you are interested in any of the activities, please complete the section below and fax it to Niccole Alexander at 847/434-8000. Or you may submit your interests via e-mail at nalexander@aap.org. **Please note ... if you have responded to previous calls for volunteers in 2004, no need to resubmit the request.**

- Newsletter, other publicity
- Section education program
- *AAP Grand Rounds*—review of the literature
- Coding, documentation and reimbursement
- Pediatric resident education
- Communication systems/electronic medical records
- ER liaison
- Neonatology/nursery liaison
- Critical care liaison
- Transport liaison
- Section on Residents liaison
- Sedation services
- Employment/ job clearinghouse
- Legal issues/liability
- Patient safety
- Board re-certification and sub-specialty board (with APA and SHM)
- Fellowships/PGY-x for Hospitalists (with APA and SHM)
- Government regulations and interactions
- Quality of life issues
- Use of physician extenders in Hospitalist programs
- Pediatric Hospitalists in community settings



An Addition to the SOHC Web Site

The Section on Hospital Care's web site now includes a Pediatric Hospitalist Program Resource!!

SOHC has established the database as a new web page for Section members in the Member's Center of the Section web site. The resource may be used to identify programs similar to your program across the nation, as well as seek out potential job opportunities.



To check out the resource or the Section's web site, please visit www.aap.org/sections/hospicare/

Many opportunities will overlap with other entities such as PRIS, SHM and the APA SIG. If appropriate, you may be referred to these organizations.

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Section on Hospital Care Volunteer Sign Up Sheet

Name: _____

E-mail: _____ Alt E-mail: _____

Phone: _____ Fax: _____

Interests (up to three):

**Return to:
Niccole Alexander
via fax at 847/434-8000**

First Do No Harm ... Patient Safety Forum of SOHC

Michael E. Ruhlen, MD

The establishment of this forum initially appeared to be a relatively easy undertaking. After all, since publication of the Institute of Medicine's 1999 report, *To Err is Human*, copious amounts of patient safety material have appeared in print, conferences and the Internet. AAP efforts have included establishment of the Steering Committee on Quality Improvement Management (SCOQIM) in 2001. An Academy-wide resource for the development of quality initiatives, practice guidelines, technology and evidence-based medicine, this Committee includes liaisons from the Agency for Healthcare Research and Quality (AHRQ), the National Association for Children's Hospitals and Related Institutions (NACHRI) and the Academy's own Section on Epidemiology. Furthermore, an Academy Policy Statement "Principles of Patient Safety in Pediatrics" appeared in *Pediatrics* in June, 2001, and an Academy patient safety research agenda has been established. Nationally, multiple other entities such as the AHRQ and the Institute for Safe Medication Practices have established pediatric quality initiatives and review resources. So, our work is done, right? No, it's just beginning.

Pediatric hospitalists will increasingly be at the forefront of inpatient safety efforts for logistical and practical reasons. While agendas for quality improvement and research have been established, there are vast opportunities for our section members to contribute time and talents to the effort. This forum creates a mechanism for communicating tips and insights, asking questions and promoting collaboration on important safety topics. All aspects of patient safety will be open for exploration here.

To initiate discussion, questions raised by the Institute for Safe Medication Practices are highlighted below:

1. What steps does your group or facility take to ensure that demographic and clinical data such as age, weight, allergies, diagnoses, pregnancy status and monitoring information (lab values, vital signs and other parameters that gauge the effects of medications and the underlying disease process) is readily available to guide treatment decisions?
2. How does formulary management in your institution contribute to physician decision support? How frequently are non-formulary medications prescribed? What mechanisms support the use of high-alert medications or treatments? (digoxin therapy, for instance) Do you utilize pre-printed order sets? Is drug information readily accessible to nursing units?
3. What alerts does your system employ to protect against unsafe orders? Does your institution provide computerized physician order entry and can you access it directly? Does your institution allow abbreviations, and if so, have you had difficulty with specific abbreviations? What are you doing to enhance the accuracy of verbal orders?
4. What steps have you or your institution taken to avoid labeling errors?
5. What is your institution's policy on the use of home medications in the inpatient setting? Are sample medications allowed for inpatient use? Are standardized preparations and concentrations made available for all medications?

6. Are hospitalist personnel familiar with the types and use of infusion devices used in the institution? Does a member of the medical staff sit on committees that select new devices?

7. What is the impact of environmental factors such as poor lighting, cluttered work spaces, noise, frequent interruptions, high patient acuity, staffing patterns and excessive workload on errors?

8. Does your facility or group employ system-based error-reduction strategies? Are medication safety programs offered at medical staff meetings? Do you utilize order-writing guidelines such as those promoted by the ISMP?

9. Does your facility teach patients to protect themselves from medication errors by educating them about their medications and encouraging them to ask questions and seek input? Is a pharmacist available for patient education?

10. Have you established a non-punitive system for identifying, reporting, analyzing and reducing the risk of medication errors? Are reports of near-misses freely exchanged among the hospital staff?

SOHC would like to hear from individuals, programs or institutions that have dealt successfully with these and similar issues, and to highlight these successes in this forum. Please consider sharing your expertise with your colleagues.

Submissions may be sent to:

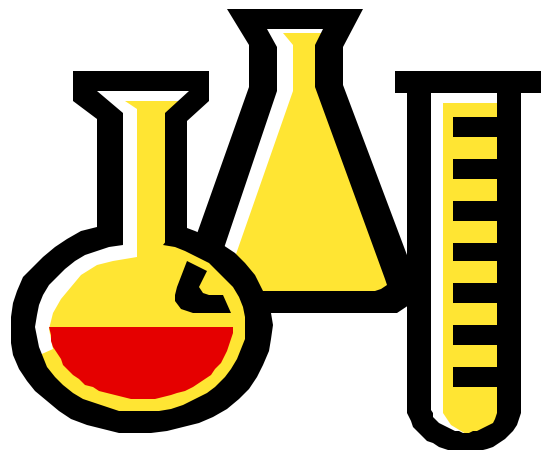
Michael.Ruhlen.MD@ProMedica.org

or

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Reference:

ISMP items accessed on January 19, 2004 at www.ismp.org



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