

# Section on Hospital Medicine News

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Winter 2005

## "What, Me Worry?"

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



Happy New Year and happy new name and acronym for the Section. We are now officially the **Section on Hospital Medicine (SOHM)**. 2005 promises to be a

special year for the Section with two major developments in store. The first is already in the works. Under the leadership of Tim Hartzog our Web site is being updated with improved capabilities to exchange information and materials we can use to improve our programs and practice of pediatric hospital medicine. This electronic library will quickly become one of the major resources of the Section. Thanks Tim for moving us forward in this direction.

The second major new event is the Pediatric Hospital Medicine Conference being held in Denver, July 28-31, 2005. The conference is sponsored by all three major pediatric hospital medicine organizations with the Ambulatory Pediatric Association taking the lead for this initial endeavor. The conference promises to be the largest gathering of pediatric hospitalists ever, so we're bound to set off and change a few light bulbs. It is being organized under the same format as the San Antonio confer-

ence in November 2003 with structured group meals that promote informal networking as valuable as the formal sessions. Plan your summer now so that at least one to two people from your group can make it. Bring the family and stay an extra day or two in Denver; the mountains are beautiful in the summer. Moreover, you can tell your patients not to worry because a sat of 91 at sea level reflects the exact same amount of oxygen in your blood when you were "mile high in Denver last July." Depending upon attendance, we'd like to repeat this event every two to three years.

Our Section continues to grow, as does the field. New textbooks, a proposed curriculum, and a Pediatrics Clinics of North America are on the way. This offers us new opportunities and responsibilities. One such responsibility we might not often think of involves children in foster care. At the Annual Leadership Forum held this past August, the care of children in foster care was highlighted with a poignant personal vignette from a physician who spent her adolescence in foster care. This woman was profoundly influenced by the physician who saw her for her regular check-ups during her time in foster care. He treated her with an element of respect and expectation that helped nourish in her the self-esteem for her ultimate success. This was a potent

*(continued on page 7)*

## From the Editor

Jennifer Daru, MD

Welcome to the Winter 2005 edition of the AAP's Section on Hospital Medicine newsletter. There is a lot to learn from this edition. Inside you will find an interesting write-up on how Minnesota Children's Hospitals and Clinics is approaching their growing inpatient population. You'll notice that Dr. Berkowitz calls this system a "rounding model," as the physicians involved do not meet even Wachter's definition of hospitalist, with less than 25% of their overall time spent taking care of hospitalized patients. Controversial for a hospitalist newsletter? We welcome your thoughts, as their option is worth discussion. In addition, our billing and coding section finally sorts out once and for all how billing for consult work. By way of example, Dr. Zaoutis and her team have come through with another interesting "You are the Consultant," where the diagnosis and treatment will hopefully help our patient breath easier. Other updates from our hospitalist partners are enclosed as well. We welcome your feedback and submissions, as there is always plenty more to say!



*Jennifer*

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## Editors

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# 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 pediatric hospitalist consulted by the emergency department (ED) for a 1-year-old Caucasian male with stridor and respiratory distress.



The patient presented to his private physician for a well child exam earlier that day. He was noted to be in mild to moderate respiratory distress with inspiratory stridor at rest that worsened during periods of agitation. There was no history of fever, rhinorrhea, cough or congestion. He was given a nebulized racemic epinephrine treatment without improvement and was transported to the ED by emergency medical services.

You see the child shortly after his arrival to the ED and notice that he is having mild respiratory difficulty and audible stridor. He looks relatively comfortable and you decide to further question the parents. The child was a full term spontaneous vaginal delivery without any complications. Mom had excellent prenatal care, normal ultrasounds and normal prenatal labs. Within the first month of life the parents noted occasional "noisy breathing." The child's pediatrician reassured them that this was likely a benign entity that would resolve over time. The "noisy breathing" persisted throughout the first year of life. No workup was done, and the parents continued to be reassured by their physician.

The parents report that the loud breathing is worse when the child is ill with upper respiratory tract infections and usually is worse when he is agitated. They have not noticed any change in the noise with the patient's position. The

child does not have any words, but is able to babble appropriately. The parents reported that he has a "husky" voice. He also is a voracious eater with no choking or swallowing difficulties. The patient is developing well, has received all immunizations and is on no medications. There is no significant family history of cardiac disease, laryngeal webs or rings, asthma, or cystic fibrosis. There are no ill contacts at home and he is not in daycare.

On exam the patient is alert, active, and playful. He demonstrates mild respiratory distress at rest with audible stridor and increased work of breathing. He is afebrile with a heart rate of 150 beats per minute and a respiratory rate of 40 breaths per minute. His oxygen saturation is 95% on room air. His height and weight are 50th percentile for his age. He has no rhinorrhea, normal appearing tympanic membranes, moist mucosa, and a normal examination of his oropharynx. There is no anterior or posterior cervical lymphadenopathy, no neck fullness, and no torticollis. His lungs are clear except for transmitted upper airway sounds. He has audible, inspiratory stridor and subcostal and intercostal retractions that are more pronounced when agitated, but do not change with position and seem well tolerated. His abdomen, heart, extremities, neurologic and skin examinations are normal.

The ED has obtained an upper airway fluoroscopy, which is normal. You recommend one of the following, which reveals the diagnosis:

1. Bedside nasopharyngeal laryngoscopy by otolaryngology
2. Radiographic contrast esophagram ("barium swallow")
3. Chest radiograph
4. Radioisotope-labeled milk scintigraphy ("milk scan")

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*For the discussion and answer turn to page 10.*

# Don't Forget To Vote!!

In 2005, voting section members of the Academy will vote for open positions on Section Executive Committees using an electronic ballot system.

The on-line ballot, as well as the candidates' biographical information, will be available beginning March 1 at a dedicated election URL; [www.aap.org/elections](http://www.aap.org/elections). Because not all members have computer access or capability, and because voting is a right and a privilege, paper ballots are available (by request only) by contacting the AAP Department of Committees and Sections at 800/433-9016, extension 4079. Affiliate members are not eligible to vote in section elections.

Ballots, whether paper or on-line, must be received by the AAP no later than Friday, April 30, 2005, in order to be counted. If section members inadvertently vote both by paper ballot and on-line, **only the on-line ballot will be counted**. Staff hopes that the Web-based ballot is found to be an efficient and enjoyable means by which to vote for the candidate(s) of your choice.

For the Web-based election, section members will receive an e-mail notification when the on-line ballot is available, which will contain the link to the ballot site. There will also be a link to the ballot site from the member center of the AAP Web site. In order to enter the ballot, section members will need to enter the pre-assigned log-in number and password, which will be provided within the broadcast e-mail notification. For those who are unable to locate their log-in number and password, instructions will be provided on the election Web site. In addition, a technical support e-mail address also will be provided.

Those elected in the election will take office in November 2005 following the AAP National Conference & Exhibition. Any questions about this new service may be directed to:

**Carolyn Mensching**  
Manager, Section Administration  
Department of Committees and Sections  
847/434-4079  
[cmensching@aap.org](mailto:cmensching@aap.org)

# Hired! Web Master for the Section on Hospital Medicine

Timothy Hartzog, MD

A couple of months ago, the Section on Hospital Medicine Executive Committee appointed me to serve as the Section Web Master. In this position, I will oversee SOHM's hospitalist e-library (coming soon), serve as content manager for the Section Web site, and supervise over our very active LISTSERV®.

I am currently in the process of redesigning the Web site to be a better professional resource for Section members. My first step is to change the overall look and

feel of the site and to create an e-library on hospital medicine. I have worked with Barry Markovitz, MD from PEDSCCM.org in the development of PedsCCM: The Pediatric Critical Care Web site (<http://pedscm.wustl.edu>). This Web page functions as a central bulletin board for pediatric critical care specialists from around the world.

Revamping our Web site and establishing a hospitalist e-library will be a huge undertaking for our group and will probably take months to get started. However, knowing that the Internet serves as an inexpensive way to discuss and develop materials that benefit children receiving hospital care, I believe that in the long run what we are doing is beneficial to physicians, parents and patients alike.

Following this article is an outline of my goals and objectives. Please review all of them and let me know if you have any comments or suggestions – I welcome your feedback!

Timothy Hartzog, MD  
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## Goals:

- To become an informational hub on issues related to pediatric



- hospital care
- To be a premier provider of information for pediatricians and pediatric hospitalists
- To be the #1 hit on a pediatric hospitalist's electronic Web site list when seeking information.

## Posted on the Public Side

- AAP News alerts that are applicable to hospital medicine
- Additional Web links and resources
- Parenting resources for hospitalized children

## Posted on the Member Center Side

- Job postings
- Hospitalist resources
  - Collection of protocols and materials developed by pediatric hospitalists
  - Begin by collecting protocols and pathways from pediatric hospitalist programs and posting PDF files to allow members to download examples as they develop pathways. These pathways are not officially endorsed by the AAP.
- Develop resources for measuring the quality of care – want examples of a chart review form and what data programs are monitoring
- Upcoming hospitalist-related CME events
  - AAP and non-AAP conferences
- Registry/database of pediatric hospitalist programs and contact information
- Articles on the business side of hospitalist medicine
  1. Coding tips
  2. Employment contract issues
  3. Malpractice issues
- Access to the hospital medicine LISTSERV® archives
  - Include summaries of discussions for future reference.
- SOHM newsletter archive

## Future Initiatives:

- To create an evidence-based journal “club” with the latest articles related to hospital care
- To post recent research data
- To develop resident education materials similar to [www.picucourse.org](http://www.picucourse.org)

## Section Bylaws

The Section recently approved a change to the SOHM bylaws, which allowed residents to join and changed the name to the Section on Hospital Medicine. The SOHM Executive Committee would now like to confirm the leadership roles within the Section to ensure smooth transition from one chairperson to the next. Look for another referendum in Spring 2005.



## Pediatric Referral Service Enhancements

The Department of Membership and Department of



Information Technology are happy to announce the latest enhancement to the Pediatrician Referral Service (PRS) ([www.aap.org/referral](http://www.aap.org/referral)). The PRS was launched in the fall of 2002 with a city, state or country search mechanism. Effective August 16th, 2004 the PRS is now searchable by specialty or area of interest. Medical Specialty/Special Interest listings do not necessarily imply board certification in that specialty. This new service is tied to the section membership of our members. The Pediatrician Referral Service has proven to be a valuable benefit for AAP members, receiving over 4000 site visits monthly.

## PRIS Network Update

Christopher P. Landrigan, MD,  
MPH, Chair, PRIS Steering  
Committee

As you may know, Pediatric Research in Inpatient Settings (PRIS) has been planning to launch a study of bronchiolitis in hospitalized children for the past year. In the midst of developing our plans, we were presented with an exciting opportunity to participate in the 25th Multicenter Airway Research Collaboration study (MARC-25), funded through the Emergency Medicine Network (EMNet) [EMNet Director: Carlos Camargo, MD, DrPH; Principal Investigator: Jonathan Mansbach, MD]. A number of PRIS members are serving as site principal investigators in this collaborative EMNet-PRIS project.

The primary aim of this ED-based project is to develop prediction rules to determine if children with bronchiolitis are safe for discharge to home or are at high-risk of having a severe outcome. Data collection will occur this winter, and hopefully we will have some preliminary results by the time of the planned pediatric hospitalist meeting in Denver this July. We are looking forward to an exciting project that should advance our knowledge of bronchiolitis care, and help reduce some of the unwarranted variability in the care of this extremely common condition.

PRIS is also in the process of writing up the manuscripts from our hospitalist survey that were presented at the academic pediatrics meetings last spring. In addition, Patrick Conway, MD is leading a study evaluating differences in the management of common conditions by hospitalists and community pediatricians.

We are tentatively planning an inpatient-based bronchiolitis study for next winter, and hope to engage the participation of many PRIS centers in this effort. We welcome proposals for additional future collaborative studies – I would be glad to speak with anyone interested in serving as a principal investigator for a study conducted through PRIS. I can be reached at [christopher.landrigan@tch.harvard.edu](mailto:christopher.landrigan@tch.harvard.edu).

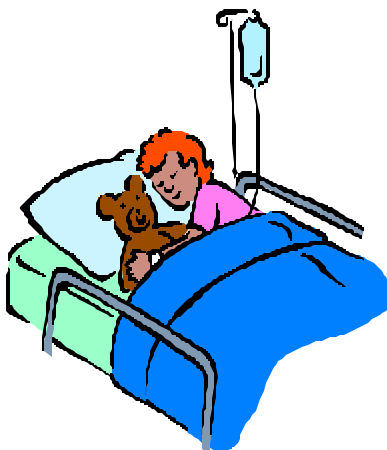
## Rule of Six Changes

Erin Stucky, Chair  
Committee on Hospital Care

Thanks to efforts of many, JCAHO will allow the Rule of Six to continue for the next 3 years, during which time outcomes and implementation strategies will be monitored. The notification of this change from the mandate to eliminate the Rule of Six effective January 1, 2005, was received just last month. This is a great example of working together with a large accrediting body to ensure quality care for children is directed in a safe and evidence-based manner.

**Please note:** ANY institution wishing to continue using the Rule of Six must submit a waiver which must be accepted by JCAHO. This waiver should include the critical safety systems features such as smart pumps, pharmacist-directed drip creation, pre-printed code sheets with drip calculations, and other automated system enhancements that allow for double-checking calculations.

I would appreciate feedback on what each institution will be submitting to JCAHO, and what methods by which a change in medication errors will be documented. I can be reached by e-mail at [estucky@chsd.org](mailto:estucky@chsd.org). I would encourage all to track these changes with great detail, and be willing to share the information with partner institutions so that we may all learn from each other. This is a great quality project from which we can learn how to best care for children.



## Bookstore Features

### Dedicated to the Health of All Children



This official commemorative volume of the 75th Anniversary of the AAP is a richly illustrated and thoroughly researched historical record, tracing the practice of pediatrics from Colonial times, through the founding of AAP in 1930 to the present day. Many AAP-led advances in pediatrics are recounted in essays and archival photographs, while a look at the future offers hope for continued progress in the face of new threats to child health.

### About Children

Like a documentary film in print, this unique new book explores nearly every facet of modern American childhood. Essays by renowned health and policy authorities blend with evocative photography and informative charts and graphs to provide vivid insights into more than 40 wide-ranging topics, such as child abuse, immunization, education, poverty, ADHD, obesity, and more!



### Challenges in Pediatric Diagnosis



The renowned journal's editors have selected their "top 100" cases and updated them to create a fascinating new collection that serves as a valuable mini-reference.

### Child Abuse: Medical Diagnosis and Management

This updated edition of the definitive child abuse text offers a practical, objective, evidence-based guide to the medical diagnosis and management of child abuse.



To order these or other products, please call (866)843-2271 or visit the AAP Bookstore at [www.aap.org/bookstorepubs.html](http://www.aap.org/bookstorepubs.html).

# Billing Corner: Understanding E/M Coding

Yong Han, MD

It is imperative to remember the three Rs prior to initiating and providing a consult. These must be documented either by the requesting or consulting physician in the medical record.

1. Request - The physician requesting the consult must be documented. This should be a part of the consultant's note as well as recorded as a written or verbal order.

2. Reason - The specific reason for the consult should be documented.

3. Report - This can be written or dictated by the consultant.

There are five levels (**99251-99255**) for inpatient consultative services, so one must keep in mind the guidelines associated with each of the respective levels. Here is a brief description of each code:

## **99251**

*History* – problem focused

*PE* – problem focused

*Medical Decision Making* – straightforward

*Face-to-Face Time* – 20 minutes

## **99252**

*History* – expanded problem focused

*PE* – expanded problem focused

*Medical Decision Making* – straightforward

*Face to Face Time* - 40 minutes

## **99253**

*History* – detailed

*PE* – detailed

*Medical Decision Making* – low

*Face-to-Face Time* – 55 minutes

## **99254**

*History* – Comprehensive

*PE* – Comprehensive

*Medical Decision Making* – moderate

*Face-to-Face Time* – 80 minutes

## **99255**

*History* – comprehensive

*PE* – comprehensive

*Medical Decision Making* – high

*Face-to-Face Time* – 110 minutes

Note that face-to-face time only becomes a component of consultation billing when counseling and/or coordination of care is more than 50% of the consultation time. Some examples of each level of consult are

provided below.

## **99251**

1. Orthopedic patient on IV antibiotics who has developed candidal infection of the mouth.

2. Orthopedic patient with complaints of localized dental pain.

## **99252**

1. Recommendations for antibiotic therapy for a patient with synthetic heart valve who will undergo urologic surgery.

2. Evaluation of possible drug induced eruption.

## **99253**

1. Evaluation/treatment of fever following abdominal surgery.

2. Evaluation/treatment of new onset seizure with normal exam and history.

## **99254**

1. Evaluation for 15 year old with painless swelling of proximal humerus with lytic lesion by x-ray.

2. Evaluation of 13 month old with spasmodic cough, respiratory distress, and fever.

## **99255**

1. Consult for patient with severe pancreatitis complicated by respiratory insufficiency, acute renal failure, and abscess formation.

2. Consult for evaluation of patient seen in ED with severe, closed head injury who is admitted to another service.

Hospital care-subsequent inpatient codes (**99231-233**) are used for follow-up visits done by the consultant on subsequent days. These visits should be for the daily management of the treatment plans delineated in the initial consult. Make sure that the problem that you (the consultant) are billing for is different than that of the admitting physician if you are planning to use these codes.

If you are called to the Emergency Department to consult on a pediatric patient, then use outpatient consultation codes (**99241-245**) to bill unless the patient is admitted to another service. Requirements for these codes are similar to the inpatient consult codes except that the typical face-to-face times are slightly shorter (15 minutes for **99241**, 80 minutes for **99245**).

## References:

1. Coding for Pediatrics 2004
2. CPT 2005

This article is brought to you by the SOHM Subcommittee on Billing and Coding. For additional information, please contact Yong Han at [yshan@texaschildrenshospital.org](mailto:yshan@texaschildrenshospital.org).

## Member Activity Spotlight



The Member Activity Spotlight <http://www.aap.org/moc/> is an opportunity for members to share their personal accomplishments and contributions with the AAP community. A recent review of the Member Activity Spotlight archives on the AAP Web site revealed that there have been no subspecialists featured. Please consider submitting your story. This is a wonderful opportunity to share your work and a chance to inspire others.

Submissions can be sent to Katy Lerman at [klerman@aap.org](mailto:klerman@aap.org). And don't forget to include a photograph!



[www.aap.org/pressroom](http://www.aap.org/pressroom)

Online Home for AAP  
Public Relations

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# Practice Profile: Children's Hospital and Clinics Minneapolis Rounding System

Sheldon Berkowitz, MD, Medical Director  
Minneapolis Children's Clinic

In July 2003, our group of hospital-based general pediatric clinic doctors made a change to a more formalized rounding group system to care for our inpatients. Prior to that time, each pediatrician would round on their own patients, as well as any patients they admitted the night before, before starting clinic at 8:45 am. As a result, each individual pediatrician was managing their inpatients during the day, dealing with housestaff and floor nurses, while also working in a very busy outpatient clinic. With the addition of two new pediatricians, a decision was made to change the way we cared for our inpatients. This article will describe the first year of this experience.

Children's Hospitals and Clinics has two main campuses in the Twin Cities - one in Minneapolis and one in St. Paul. It is the largest children's hospital system in the upper midwest and, with the exception of organ transplantation, provides essentially all pediatric specialty services. Our group is located on the Minneapolis campus, where there are 185 inpatient beds. Presently, there are 6 pediatricians based in our clinic and involved with our inpatient rounding, 3 pediatricians who work part time in the clinic and do some inpatient work, and 3 pediatric nurse practitioners who do not have any inpatient responsibilities. The 6 primary pediatricians' FTEs range from 0.85 to 1.0 though we all share call and inpatient responsibilities equally.

Our rounding system does not meet the definition for being a hospitalist as we do not spend the majority of our time, or even 25% of our time, with inpatient responsibilities. Presently we are responsible for the inpatient service about every 6 weeks for a week at a time starting at 5pm on Friday. Through the weekend, the on-call person covers the nursery, rounds on the inpatient service and handles admissions and consults. During the week, other members of the group cover overnight call and the nursery. When you are the inpatient rounder during the week, you do not have any clinic responsibilities and likewise, the clinic doctors do not have any inpatient responsibilities. Children's Hospitals and Clinics utilizes a city-wide nurse triage system for outpatient calls, so

that most of the overnight calls we receive are about our inpatients. Our hospital has a fulltime housestaff made up of pediatric residents from the University of Minnesota, family practice residents from various Twin Cities' programs and medical students from the University of Minnesota. Housestaff are involved with all of our patients and work under our supervision. Our group does not have emergency room, NICU or PICU responsibilities, as we have fulltime, in-house attending level staff in each of these areas 24- hours per day. We also are not involved with conscious sedation as our critical care group handles that responsibility.

We provide inpatient care for 5 categories of patients. The first is our own clinic patients who need hospitalization. Since our clinic tends to attract large numbers of patients with very complex health care needs, our patients tend to be hospitalized at a higher rate than the general population. The second group is patients that subspecialists have asked us to either follow with them or to admit to our service with the subspecialist on consult. The third group is patients referred to Children's by physicians from the metropolitan and out-of-state areas who are not on staff at the hospital (both of these last 2 groups are often patients with complex health care needs who require the expertise of a tertiary center such as ours). The fourth group is in-town patients who are admitted through the emergency department and whose physicians are not on staff. The fifth and final group is patients whose pediatricians are on staff at the hospital, but have found it advantageous for their own practices to have inpatient coverage provided by our group. Typically, these are practices that are either located at a significant distance from the hospital or do not tend to have many inpatients. We currently provide inpatient care for 7 pediatric groups beyond our own on a regular basis.

As is typical with most pediatric inpatient practices, we see a lot of seasonal variability with our daily census. Our census tends to be lower from June through September, ranging from 8 - 15 inpatients/day, and higher from November through

April, ranging from 13 - 22 inpatients/day. This year alone, we have seen our average daily census increase from 14.4 inpatients/day for all of 2003 to 16.8 inpatients/day through May 2004. Our inpatient days for our group have increased 15% during the same period. It is not clear exactly why our inpatient census continues to climb. We believe it is a combination of a general increase in hospital bed days this past winter, as well as an increasing number of groups using our services for admissions. As we look back over the first year of this new rounding system, everyone would agree that it is immensely successful. While we are very busy when we are the inpatient rounder, the decreased stress when you are not rounding is wonderful. Not only are you not arriving early and rushing to see your inpatients, but you are able to focus on your clinic patients without constant interruption. Initial concerns about loss of continuity have not been an issue for our own clinic patients, as we consult each other regularly and also do social visits for our own primary patients. We have only heard an occasional complaint from families about not having their primary doctor taking care of their child. In addition, floor nurses, housestaff, subspecialists, and referring colleagues are pleased to have the attending continuity for a week and find it easier to know whom to contact about the patients.

The major problem we have encountered is the workload while you are covering the inpatient service. Days can be long. On weekends, rounding can easily take 10-12 hours, while weekdays are usually a little shorter. It is stressful to balance direct patient care, working with multiple housestaff (often receiving 20 pages before 10:00 am), and teaching.

As we look forward to the second year of our rounding system, the biggest change we anticipate is adding a second part-time rounder during the week days in the winter months. We are concerned the workload is too great for one person to provide appropriate care without burnout. We anticipate this additional attending will

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## "What, Me Worry?"

(continued from page 1)

reminder that our brief interactions can have a significant impact. It's not the immediate feedback of fixing a nursemaid's elbow, or weathering a child through a case of meningococemia, but it is in fact another life saved. I encourage you all to make that special effort to connect with children in foster care. Who knows...that child may be telling a story about you sometime in the future.

On a less sanguine note, winter also means that RSV is in full swing. Although I favor the clinical diagnosis of bronchiolitis with routine precautions but without routine RSV testing, I am resigned to doing the RSV shuffle until we all have hospitals with single rooms. More frustrating to me is that we still don't have the body of knowledge we need to most appropriately treat (or not treat as the case may be) RSV. Put me down in the Cincinnati school; their data seem compelling. Yet we haven't moved to that standard of care nationally, and I'm beginning to think that some of it is our own fault. We seem to be paralyzed in a search for perfect randomized, double-blinded data. Incremental change would seem much better. No stone throwing in my glass house. Practice varies significantly within every group I have worked with. This means outcome comparison across groups would be moot because there is no specific treatment approach being measured.

Hence, my plea for 2005. If we as individual hospitalist groups can narrow variability within our own practices, we offer the opportunity to create comparisons of outcomes between groups. Granted, we are not controlling for disease severity or population differences. Nonetheless, there is useful information to be gathered by analyzing the variability of practice that is already taking place. Within your own program, coming up with a relatively uniform practice style—call it guideline, protocol or pathway, just don't call it late to dinner—will allow you to improve efficiency and decrease the potential for errors within the population you serve. And it's not just RSV. It's ALTE, gastro, r/o sepsis. Once we get this step in place within our individual programs, we can work within the Section, PRIS, and/or other entities to create some uniform data collection and comparisons, generate benchmarks and

(continued on page 10)

## SOHM Executive Committee Meeting Actions – Oct. 10, 2004

In accordance with the recent bylaw amendment, changed LISTSERV® address to one that complements the new Section name, [aaphospmed@listserv.aap.org](mailto:aaphospmed@listserv.aap.org).

Concerning one of the 2004 Chapter Resolutions, contact staff about adding inpatient topics to the brochures/educational materials list.

Ask Marketing if brochure contents can be added to section home pages for downloading. Also double-check that brochures are automatically translated into Spanish (and other languages where applicable).

Create a list of Section members that will serve as part of a SOHM "Speaker's Bureau" for upcoming educational events/activities. Each person would be required to submit a video or PowerPoint presentation from a recent talk/session, evaluations, or recommendation letters from 5 people who can attest to his/her ability.

Create an e-Quipp module centered on hospital medicine topics. Possible first topic: Asthma.

Review bylaws regarding leadership positions. If amendments are needed, prepare for distribution in early 2005 to members.

Inform staff that the Section would like to be added to the *AAP News* subspecialty rotation.

Draft an application letter that will be included as part of the Section application packet.

Finalize the new member letter that will be sent to all new members of the Section.

Work with staff on ideas to reach out to Residents within the AAP and educate them on hospital medicine as a career. Convene a subcommittee of other Section members interested in resident issues.

Prepare Guiding Principles statement for BOD/Executive Staff re-review and in preparation for publication. Ensure that all concerns have been addressed.

Discuss the Web master position and terms with Dr. Tim Hartzog, appointed by the EC to serve in that role.

Create a contact list for residents who are interested in becoming a pediatric hospitalist and contact Academy Chapter Directors to find out if they have any local connections to residents with an interest in pediatric hospital medicine or in joining the Section.

Inform staff that Dr. Rauch will be serving as the 2006 Program Chairperson and Section Education Chairperson.

Divide the Academy chapters/districts and assign them among the EC members. Each person will serve as a contact for chapter liaisons and others with state/regional interests.

Update/research the pediatric hospitalist survey instrument in preparation for distribution in 2006. The revised instrument will cover salary, job duties/responsibilities, and benefits.

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**For more information on the  
above action items, please contact  
Nicole Alexander at  
[nalexander@aap.org](mailto:nalexander@aap.org)  
or  
(847) 434-4799.**

## Practice Profile

(continued from page 6)

round in the nursery first and then join the primary inpatient rounder in the hospital for the rest of the morning. The two rounders will work together and divide the patients in such a way to preserve continuity of care. The second rounder will work in the clinic in the afternoon.

In conclusion, the change to a full-time weekly inpatient rounder for our group is a big success for the patients, pediatricians, and nursing staff. We believe the above adjustments will only make the system work better in the future.

*I would like to thank my colleagues  
Milagros Santiago, MD and Gretchen  
Rierson, MD for their editing suggestions.*

# Professional Opportunities

## TORONTO

### General Pediatric Hospitalist

The Hospital for Sick Children in Toronto, Ontario, Canada, is looking for 1 General Pediatric Hospitalist to join a very well established group of 6 others. The job involves predominantly working on the inpatient general pediatric units as a hospitalist on weekdays, with some daytime weekend coverage for about 10 weekends/year. Providing general pediatric consultation services to the surgical inpatient services and interventional radiology service is expected (instead of inpatient attending) for about 3 months of the year.

There are many opportunities for teaching and research. Sick Kids in Toronto is the largest pediatric academic health sciences centre in Canada and has a long tradition and international reputation of excellence in clinical care, research and teaching. The general pediatric inpatient unit provides care predominantly for complex tertiary care type patients.

The successful candidate must be eligible for licensure as a pediatrician in Canada and will be expected to provide clinical service in a scholarly manner, and will be supported in pursuing teaching and/or research endeavours. Qualifications required include excellence in general pediatric clinical care, teaching, and scholarly work. Graduate studies and/or fellowship training will be regarded as a significant asset.

Toronto is the largest city in Canada and is highly regarded as a multicultural centre which provides an outstanding quality of life. Interested individuals should submit a letter of application, a curriculum vitae, and the names and addresses of three references, by February 28, 2005, to:

**Dr. Jeremy Friedman,**  
Division Chief, Paediatric Medicine  
Department of Paediatrics,  
Hospital for Sick Children,  
555 University Avenue,  
Toronto, Ontario, Canada M5G 1X8.  
(416) 813-7368 phone  
(416) 813-8345 fax

## NEW YORK CITY

### Pediatric Hospitalists/Educators

The New York University School of Medicine Department of Pediatrics seeks 2 BC/BE pediatricians for a new academic pediatric hospitalist program. The program will be centered at its two teaching hospitals: Tisch Hospital of NYU Medical Center with a 34 bed high intensity unit with medical, surgical, and oncological pediatric patients; and Bellevue Hospital, with a 24 bed unit with general pediatric and surgical patients. Both hospitals are full-service hospitals with level IV NICUs, active PICUs, and 24/7 ERs. These hospitals are the major sites for pediatric medical student, resident and fellowship training at the medical school and are in midtown Manhattan.

We are looking for candidates with strong clinical skills and an interest in teaching and research. Involvement in the teaching programs will be substantial. There is active research in the Division of General Pediatrics, which these pediatricians will be part of, and we encourage applicants with an interest in research to apply. This is an exciting opportunity for someone interested in hospital care, urban medicine, and a truly academic environment.

The minimum requirements include board eligibility, preferably with several years of clinical experience in inpatient medicine, or chief residency, or academic general pediatric fellowship training. Tisch Hospital of NYU Medical Center is the university hospital of NYU School of Medicine and is located within the medical school. Bellevue Hospital is the oldest municipal hospital in the US, the flagship hospital of NYC's Health and Hospital Corporation system, and is located next door to the medical school. Both are in New York City. Interested candidates, please send curriculum vitae and cover letter (preferably by e-mail) to:

**Benard P. Dreyer, MD**  
Chairman (Interim)  
Department of Pediatrics  
NYU School of Medicine  
550 First Avenue  
New York, NY 10016  
e-mail: [bpd1@nyu.edu](mailto:bpd1@nyu.edu)

## HOUSTON

### Pediatric Hospitalist Fellowship

The Baylor College of Medicine Pediatric Hospitalist Fellowship Program is recruiting fellowship applicants for the 2005 academic year.

This two-year program focuses on clinical experience, academic teaching, research, and administrative skills primarily at Texas Children's Hospital, a busy 715-bed tertiary care referral center. Texas Children's Hospital is the largest free-standing children's hospital in the U.S. Named in 2004 as one of the top four pediatric hospitals in the nation by U.S. News and World Report, Texas Children's Hospital has garnered a reputation for excellence in research and clinical care. Baylor College of Medicine is equally prominent, with over \$300 million in research dollars, it is considered one of the nation's top medical schools.

Clinical experience focuses on inpatient acute care as part of the inpatient hospitalist program that currently treats more than 3,000 patients per year. Additionally, we offer electives in Transport Medicine, Observation medicine, Anesthesia, Newborn nurseries and Intensive Care. Electives also are offered in over 40 subspecialties, including child protection and advocacy.

**For further information and an e-mail description of the curriculum, please contact Charles G. Macias MD, MPH at [cgmacias@texaschildrenshospital.org](mailto:cgmacias@texaschildrenshospital.org) or (832) 824-5416.**



# Professional Opportunities (continued from page 8)

## SALT LAKE CITY

### Pediatric Hospitalists

The Division of Pediatric Inpatient Medicine in the Department of Pediatrics at the University of Utah is seeking 2 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 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 development 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  
Associate Medical Director,  
Primary Children's Medical Center  
Director,  
Medical Student Education in Pediatrics  
100 N. Medical Drive  
Salt Lake City, UT 84113  
[chris.maloney@hsc.utah.edu](mailto:chris.maloney@hsc.utah.edu)  
(801) 588-3283 phone  
(801) 588-3814 Fax

## LEXINGTON

### Pediatric Hospitalist

The University of Kentucky Department of Pediatrics is seeking a Pediatric Hospitalist to participate in the growth of our hospitalist program. UK Children's Hospital is a teaching institution affiliated with the UK College of Medicine, located in the heart of the beautiful Bluegrass region of Kentucky. Our hospitalists manage referred pediatric inpatients and provide inpatient consultation for children admitted to the general pediatric ward and outpatient observation unit (no ICU or NICU coverage). Broad research and teaching opportunities are readily available. Pediatric or Med/Ped (BE/BC) candidates with a primary career interest in pediatric hospital medicine can send a CV and cover letter to:

**Jeffrey Bennett, M.D.**  
Director, Section of Hospital Medicine  
Department of Pediatrics  
Kentucky Clinic, Rm J406,  
740 S. Limestone  
Lexington, KY, 40536  
or by e-mail to:  
[jeff.bennett@uky.edu](mailto:jeff.bennett@uky.edu)

## WILMINGTON

### Pediatric Hospitalists

The Division of General Pediatrics at Nemours/Alfred I duPont Hospital for Children is establishing a pediatric hospitalist program and will be hiring 5 full-time pediatric hospitalists. Interested physicians will provide in-hospital coverage, with clinical responsibilities including co-management of medically complex patients on surgical services, oversight and teaching of pediatric house staff, staffing a short stay unit, and general pediatric service attending. Interested candidates should have a major interest in providing inpatient care, excellent communication skills and teaching ability. Alfred I. duPont Hospital is a 180 bed, full service teaching hospital associated with Thomas Jefferson Medical College.

Interested candidates, please send curriculum vitae and cover letter to:

**Jan Roberts-Jolly**  
Employment Manager  
Nemours/Alfred I. duPont Hospital for Children  
1600 Rockland Road, Suite 3B-372  
Wilmington, DE 19803  
[jlobert@Nemours.org](mailto:jlobert@Nemours.org)  
(302) 651-5589 phone  
(302) 651-6119 fax

## BRYN MAWR

### Pediatric Hospitalist

Bryn Mawr Hospital/duPont Children's Health Program a teaching hospital with a long tradition of meeting the health care needs of its community, seeks BC/BE pediatricians for its inpatient pediatric hospitalist group. Position includes patient care for a wide variety of patients admitted to the pediatric service's 20-bed pediatric inpatient unit. This unit is covered by 5 full-time hospitalists and 1 part-time hospitalist, 24/7 in a full-service community hospital. The unit enjoys strong medical and surgical support from sub-specialists from duPont Hospital, as well as hospital-based pediatric radiology. Transport service available with active outreach program supported by duPont Children's Health Program and academic affiliation with Thomas Jefferson University.

Interested candidates, please send curriculum vitae and cover letter to:

**Jan Roberts-Jolly**  
Employment Manager  
Nemours/Alfred I. duPont Hospital for Children  
1600 Rockland Road, Suite 3B-372  
Wilmington, DE 19803  
[jlobert@Nemours.org](mailto:jlobert@Nemours.org)  
(302) 651-5589 phone  
(302) 651-6119 fax

## SAN DIEGO

### Pediatric Hospitalist Fellowship

A well established pediatric hospitalist program is accepting applications for pediatric hospitalist fellowship beginning July 2005. Candidates must be BC/BE in pediatrics by the beginning of the fellowship. Excellent opportunity with diverse curriculum. Overview available on CSSD Web site at:

<http://www.childrensspecialists.com/body.cfm?id=21&action=detail&ref=18>.

Please send CV and direct inquiries to:

**Children's Specialists of San Diego Hospitalists**  
Dr. Erin Stucky  
c/o Admin assistant Susan Stafford at  
[sstafford@chsd.org](mailto:sstafford@chsd.org) or  
(858) 966-5841 phone

# You are the Consultant: Answer

(continued from page 2)

## Discussion:

Although all of the diagnostic tests listed would have been a reasonable next step, the bedside nasopharyngeal laryngoscopy reveals laryngeal papillomata. This confirms the diagnosis of recurrent respiratory papillomatosis.

A barium swallow could identify anatomic entities that compress the esophagus and thereby compress the airway. Fixed lesions tend to produce biphasic stridor (inspiratory and expiratory), but monophasic noises may predominate. Although unlikely based on the presentation in this patient, gastroesophageal reflux (GER) may be demonstrated on this study, as might a tracheoesophageal fistula or swallowing dysfunction with or without laryngeal penetration.

A chest x-ray may reveal a right-sided aortic arch or mediastinal mass. Evidence of chronic lung disease or localized infiltrate may also be seen, which may indicate chronic or episodic aspiration.

A milk scan is often useful to demonstrate GER reflux with aspiration (or "micro-aspiration"). Chronic GER, especially with aspiration or laryngeal penetration is considered a cause of airway inflammation or reactive airway disease.

Laryngomalacia is a common condition and may have been the clinical diagnosis made by the primary pediatrician in this case. Typically, the stridor of laryngomalacia improves with prone or upright positioning, and is more pronounced with the supine position. Airway fluoroscopy is often used to evaluate the dynamic movement of the extrathoracic airway (e.g., hypopharynx, larynx, and proximal trachea), however, it is not a sensitive study for laryngomalacia. Nasopharyngeal laryngoscopy is a more definitive study, and can evaluate the severity and, in some cases, the etiology of "noisy breathing".

**Recurrent respiratory papillomatosis (RRP)** is a disease of exophytic airway lesions caused by human papillomavirus (HPV) types 6 and 11. RRP is the most common benign lesion of the larynx among children and is a frequent cause of childhood hoarseness. There are approximately 2,300 new cases per year in the US. An association between cervical HPV infection in the mother and the incidence of RRP has been established, although a history of maternal HPV is not always elicited.

In most pediatric series, RRP is diagnosed between 2 and 4 years of age with an average delay of 1 year between onset of symptoms and diagnosis. The classic triad is stridor, respiratory distress and progressive hoarseness. Stridor may be the initial presentation in younger children where dysphonia often goes unnoticed. Chronic cough, recurrent pneumonia, failure to thrive, dyspnea, dysphagia, and ALTE's are less common presenting symptoms. A mistaken diagnosis of asthma, croup, allergies, vocal cord nodules, or bronchiolitis/bronchitis is often made. The physical exam may be helpful. Infants should be placed in various positions to elicit any changes in the stridor. In contrast to infants with laryngomalacia, a vascular ring, or a mediastinal mass, a child with RRP would not be expected to



demonstrate much change in the stridor with change in position. This disease should be considered in any child who exhibits persistent or prolonged hoarseness, dysphonia with respiratory distress, or recurrent stridor.

The disease is often difficult to treat because of its tendency to recur and spread throughout the respiratory tract. No single modality has been shown effective in consistently eradicating RRP. The current standard of care is surgical therapy with a goal of complete removal of papillomata. In patients with extensive disease, debulking without complete removal is accepted. Severe disease is defined as the need for more than four surgical procedures per year, distal spread of disease, or rapid regrowth. Although surgical management remains the mainstay therapy for RRP, as many a 10% of patients will require some form of adjuvant therapy due to severe disease. The most commonly recommended adjuvant therapy is alpha-interferon. The exact mechanism by which alpha-interferon elicits its response is unknown. The proposed mechanism is that interferon blocks the viral replication of RNA and DNA and alters cell membranes to make them less susceptible to viral penetration. Ribavirin has also shown some promise in the treatment of aggressive laryngeal papillomatosis.

**Ref:** Derkay, CS. Recurrent respiratory papillomatosis. *Laryngoscope* 2001;11:57-69.

Questions or comments regarding this article can be directed to Dr. Zaoutis at [zaoutisL@email.chop.edu](mailto:zaoutisL@email.chop.edu) or Dr. Mann at [kmann@nemours.org](mailto:kmann@nemours.org).

"What, Me Worry?"  
(continued from page 7)

identify best practices. We do not need to wait for fully randomized studies. We can start here and now by working within our own programs to identify what we feel are best practices, monitoring our outcomes, and then comparing results across programs.

There, that should keep you busy until 12/31/05.

---Jack

# Upcoming Hospitalist Meetings

## AAP National Conference and Exhibition 2005 Section Program: Section on Hospital Medicine

Date: Monday, October 10, 2005  
Moderator: Laura J. Mirkinson, MD, FAAP

8:00 am - 9:15 am  
The New Immunology

9:15 am - 9:30 am  
Question and Answer

9:30 am-9:45 am  
Break

9:45 am - 11:00 am  
Tapping into Meningitis

11:00 am -11:15 am  
Question and Answer

11:15 am- 11:25 am  
Break

11:25 am – 12:30 pm  
Post-traumatic Stress Syndrome

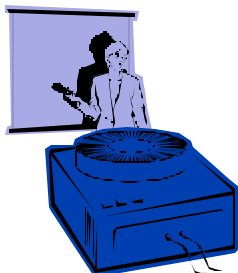
12:30 am -1:45 pm  
Section Business Meeting & Box Lunch

1:45 pm- 2:00 pm  
Break

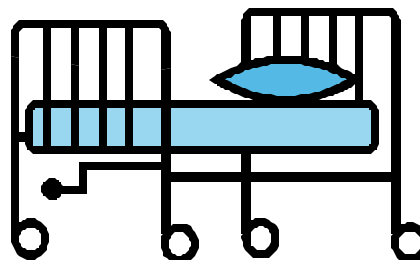
2:00 pm-3:15 pm  
The Many Faces of Mycoplasma

3:15 pm- 3:45 pm  
Question and Answer

3:45 pm- 4:00 pm  
Closing Remarks



## Pediatric Hospital Medicine 2005



July 29 - 31, 2005  
Denver, Colorado

*Presented by:*  
APA, AAP - Section on Hospital Medicine, and SHM

Workshop Areas to Include:  
Clinical, Education/Teaching, Research,  
Practice Management

Additional details will be posted at [www.ambpeds.org](http://www.ambpeds.org)  
Or contact the APA National Office:  
703-556-9225 x106 or [connie@ambpeds.org](mailto:connie@ambpeds.org)

### SuperCME 2005

April 13-16

Hilton - Walt Disney World Resort

Session and registration information is available at  
[www.pedialink.org/pedialink/cme/coursefinder/  
Detail.cfm?ld=15880&area=liveCME](http://www.pedialink.org/pedialink/cme/coursefinder/Detail.cfm?ld=15880&area=liveCME)

### AAP CALL FOR ABSTRACTS

AAP National Conference

and Exhibition

October 8-11, 2005

Washington, DC



**SUBMISSION DEADLINE:**

**April 15, 2005**

Submit electronically starting in February from the AAP  
Web site

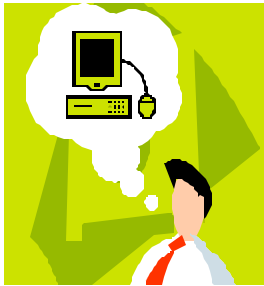
<http://www.aap.org>  
under "Professional Education"

Questions?

Contact [abstracts@aap.org](mailto:abstracts@aap.org) or 847-434-4079.

# First Do No Harm ... Patient Safety Forum of SOHM

Ron Nicholis, MD



Computers have changed how we provide medical care. In the inpatient arena, computerized records and order entry can improve patient care and safety by speeding communication and delivery of care and helping to eliminate medical errors. I would like to share with SOHM the quality assurance initiatives involving integration of the electronic record and computer-

ized physician order entry (CPOE) that our hospitalist team has undertaken at Children's Mercy Hospitals and Clinics in Kansas City, Missouri and our satellite facility, Children's Mercy South in Overland Park, Kansas.

Our hospitalist program encompasses both campuses. We cover the inpatient floors in our satellite facility and a fixed number of beds on one of the inpatient floors in the main facility. Both are covered by hospitalists 24/7 in-house without residents other than the occasional resident or student doing an elective rotation with us. We also serve as attendings on the Resident General Pediatric Service throughout the year. Our hospitalists all rotate in all of these areas. Over time, our hospital has come to count on our involvement to improve the standard of care for all of the inpatient general pediatric areas.

The most dramatic impact our hospitalist section has had is in the development of the electronic record and Computerized Physician Order Entry (CPOE) at Children's Mercy Hospitals and Clinics. Working with the Information System (IS) department at our hospitals, we started with the electronic record. Our IS department developed templates for H&Ps, progress notes, discharge summaries, and free text notes, allowing us to type our notes directly into the computer creating an electronic record. A minority of the hospitalists have continued to dictate their notes with a stat return providing timely electronic records for our shift work and for communication with the primary care providers (PCPs) of our patients. As soon as we electronically sign an electronic record, with only a few more keystrokes we can fax the document (H&P, progress note, or discharge summary) to the PCP. They get same day information in their office about their patient's care and they have the record for ongoing care once the patient is discharged. This requires no secretarial action; it can all be done by the hospitalist.

The electronic record allows us some efficiencies of practice as well. We can start a discharge summary at the time of admission and use the copy and paste features of the computer as well as direct typing to develop the document over the course of the hospitalization. The discharging physician only has to edit the document and make the final changes; complete the discharge exam; electronically sign it; and fax it to the PCP. This gets the discharge summary to the PCP frequently before the patient has even left the floor! An added benefit to the hospital is the discharge summary is never dictated by the hospitalists because it is quicker for us to do it on the com-

puter directly, thus saving transcription costs.

Once we were all doing our notes electronically, we began to pioneer CPOE for our hospital. With the ingenious efforts of our IS department we were able to develop electronic ordering that completely eliminated our need for paper orders. Initially, only the hospitalists were using this system, but now most of the inpatient hospital providers including the residents and nurse practitioners participate. Of note, records in our PICU are still on paper because we do not yet have a commercial product capable of meeting their needs electronically. But, help is on the way. We are in the process of installing another commercial system that will have the capability of an electronic record and CPOE for our entire hospital, including the PICU.

Electronic records allow us to access a patient's information in a timely manner anywhere there is a computer. The record is always legible. In addition, it allows some of the ancillary services to do their job without having to "find" a chart.

Electronic orders create efficiency and drive safety in multiple areas. As soon as the physician electronically signs the order it immediately goes to the area(s) necessary. There is no middle person entering the order into the computer, eliminating delay and a possibility of error secondary to order legibility. Nursing and pharmacy, or nursing and lab will get the order at the same time from the physician.

Safety is also increased through the ready availability of information. There are alerts noting the patient's allergies on each ordering screen so you do not have to look them up. Since our nurses also enter all of their clinical information into the electronic system, all vital signs, respiratory therapy and nursing interventions and notes are available to us in the computer. Our lab, radiology, and pathology reports are also available electronically.

CPOE also reduces error in medication usage and dosing. Because we use CPOE, only our formulary medications are available in the system. For this reason, we also have an electronic non-formulary order screen that allows us to complete orders for non-formulary items and requires the physician to document justification for this choice. The patient's weight is documented on each order automatically and our pharmacy still reviews each of the orders for appropriateness and safety. We have standardized order screens for Digoxin and other drugs prone to error.

Hospitalists in our institution have been versatile and flexible enough to pioneer some of these new challenges furthering the cause for patient safety.

## **Other Safety Initiatives**

It is worth mentioning some of the other safety initiatives hospitalists have been involved in at our institution. Activities include the development of Clinical Practice Guidelines (CPG's); aiding the development of the practice of evidenced based

*(continued on page 13)*

# Patient Safety

(continued from page 11)

medicine at our facility; reviewing and reporting on QA monitors for sedations/complications, medicine adverse drug events, indications for transfer and referral from our satellite facility to the main hospital; and prescribing of the asthma action plan at the time of admission for a diagnosis of status asthmaticus. The section also solicits post-discharge problems or issues from the families with a post-discharge questionnaire, and the section chief reviews the results for actions needed by our section.

There are many other QA and patient safety activities performed at our hospitals, some of which are noted below in response to the questions proposed by Dr Michael Ruhlen in the last edition of this newsletter:

## **HOW AVAILABLE IS IMPORTANT PATIENT INFORMATION?**

Patient information to include allergies, lab values, and diagnoses are available in the electronic medical record. They require some training for individuals to learn where to find them. However, as mentioned above, when a physician is ordering, allergy information is directly before the physician for each medication order.

## **FORMULARY MANAGEMENT/ALERTS TO SUPPORT PHYSICIAN DECISION MAKING?**

We use electronic or preprinted order sets for high risk medications e.g. amphotericin, digoxin, PCA, non standard PCA, electrolyte bolus, and non-formulary medications. These are monitored by the Pharmacy & Therapeutics (P&T) committee. Information for all drugs is available to nursing, and there are pharmacists available in 5 different areas of the hospital for at least 12 hours, 7 days a week and pharmacists available 24/7 at both facilities. Lexi-Comp and Micromedex are available on-line. Dose range testing is currently done by the pharmacy while we are awaiting the electronic version for the provider point of contact promised to be available in our new system, and we use Pyxis Profile to ensure that pharmacy has noted an order for appropriateness.

## **HOW DO YOU PROTECT AGAINST UNSAFE ORDERS?**

We use CPOE in most patient areas. Alerts are used for some electronic orders e.g. PCA. Verbal orders are discouraged and the "Write it and Read it Back" policy is taught. See Question #2.

## **WHAT STEPS HAVE BEEN TAKEN TO AVOID LABELING ERRORS?**

There are policies governing labeling of medications which identify when and what labeling must occur.

## **DOES YOUR INSTITUTION ALLOW HOME MEDICATIONS?**

There is a hospital policy on the use of home medications. They are generally not used unless the patient has a medication which is unavailable through the pharmacy, and is deemed necessary by the attending physician who can then order the use of the home medication. Nursing is provided with information on the drug through our pharmacy. Samples are not used on any inpatient unit and are controlled by a stringent policy for any outpatient use, discouraging their use at all because of all the rigid requirements for using them. Our pharmacy uses standardized concentrations for all injectables.

## **ARE HOSPITALISTS FAMILIAR WITH TYPES AND USE OF INFUSION PUMPS?**

Our hospitalists are generally not familiar with the infusion pumps which are controlled by nursing, but our anesthesiologists are because they use them. Our pumps are maintained to JCAHO and FDA standards.

## **IS THE WORK ENVIRONMENT PROTECTED FOR PROMOTING PATIENT SAFETY?**

Our medication rooms are behind a closed locked door and they are uncluttered and quiet, with good lighting. The physicians, however, do their ordering on any computer in the hospital so they may be in a busy area at the time they are ordering.

## **DO YOU USE SYSTEM-BASED ERROR REDUCTION STRATEGIES?**

Our hospital uses "root cause analysis" and medication error reporting is anonymous. Medication tips go out to all providers monthly by e-mail and are available on the computer. All providers have been educated on Institute for Safe Medication Practices (ISMP). The P&T committee monitors all patient medication safety issues.

## **DOES YOUR FACILITY TEACH PATIENTS TO PROTECT THEMSELVES?**

Education for patients/families is done by pharmacy for outpatient medications and nursing for inpatient medications, and medication cards by our design are available for distribution to patients. JCAHO and ISMP published information has been made available for all patients and employees.

## **DO YOU HAVE A NON-PUNITIVE SYSTEM FOR DEALING WITH MEDICATION ERRORS?**

There is an online medication events reporting system that goes directly to legal and then anonymously to the manager and pharmacy to promote non-punitive reporting of medication events. There have been other initiatives to promote patient safety to include administrative patient safety rounds and a Nursery Medication Error Committee to evaluate near misses and to promote recommendations for system improvements. M&M is an organized activity by the Department of Pediatrics.

That completes my synopsis on "Patient Safety" at our institution and I would encourage you to send in reports on hospitalist involvement in patient safety from your institutions. What we can learn from each other we will not have to invent ourselves.

**Ron Nicholis MD**  
Hospitalist/Information Systems  
Children's Mercy Hospital  
Kansas City, MO  
[rnicholis@cmh.edu](mailto:rnicholis@cmh.edu)

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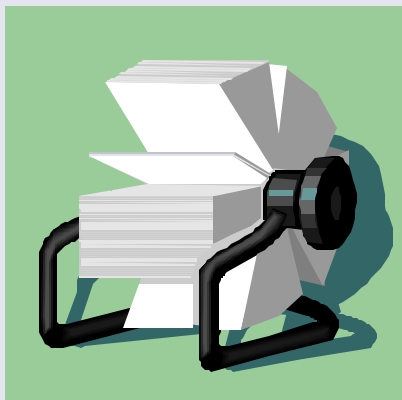
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