



# “What, Me Worry?”

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

Apropos the title, I am of the opinion that we, as pediatric hospitalists, don't need to worry any more about being accepted by the pediatric community. Initial fears have been relieved. For better or for worse, we are here to stay. Our job is to make sure it is for better. First and foremost for better patient care, and secondarily for better practice styles for physicians.

Honestly, when I first started thinking about a “Provisional Section on Hospitalists,” my motives were much less altruistic. I wanted to compare notes with other hospitalists to look at job satisfaction issues. Working with the members of the Steering Committee, staff and leadership within the AAP, and section members, I am pleased to have evolved into the “Provisional Section on Hospital Care.” We are really doing some amazing things, and have tremendous opportunities to impact on general pediatric inpatient care.

Our educational programs are directed towards the specific needs of inpatient practitioners, be s/he hospitalist or primary care pediatrician. In 2000 we had 6 hours of programming; that will increase significantly in 2001 and 2002. I strongly urge all of you to attend the AAP meeting this October 20-24, 2001 in San Francisco. We have developed an exciting program of both clinical and administrative issues that promises to be THE MEETING for pediatric hospitalists

this year. Our LISTSERV offers an ongoing exchange of information and viewpoints, but as they told Jed, “California is the place you oughta be” this Fall to meet with colleagues and participate directly in the Provisional Section on Hospital Care activities.

And in fact, our efforts are devoted to inpatient pediatric practice. The policy statement the PSOHC is proposing does not advocate for hospitalists, but advocates for voluntary systems to preserve the rights and privileges of community practitioners while preserving collegial relationships for hospitalists. The notion of establishing a PRIS network (Pediatric Research in an Inpatient Setting) presents the possibility of answering important clinical questions encountered on the general pediatric ward. Decreasing medical errors benefits everyone, and proper inpatient CPT coding is important for hospital-based and office-based practitioners alike.

Our niche is the pediatric ward and other parts of the hospital as well. However, our evolution is Lamarckian not Darwinian. We have acquired this expertise through our experience and interest, our trials and tribulations. As such, these beneficial adaptations are not limited to our progeny. Instead, we have the opportunity to spread share this experience widely and allow our expertise to spread to the whole community of pediatrics, to colleagues older, younger

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Section on  
Hospital Care  
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# "Just for Kids"

## Hospitalist Program at Kosair Children's Hospital, Louisville Kentucky

Gerard P. Rabalais, M.D., M.H.A.

•Professor of Pediatrics •Chief, Division of Infectious Diseases •Vice-Chairman for Administrative Affairs  
•Medical Director, "Just For Kids" Hospitalist Program

The Department of Pediatrics at the University of Louisville School of Medicine now offers the "Just For Kids" Hospitalist Program at our inpatient teaching facility, Kosair Children's Hospital, a 250-bed free-standing children's hospital. Supported in large part by a generous grant from the Children's Hospital Foundation as a two-year pilot project, this program kicked off in July 2000. The goals of this program were to:

- provide excellent general medical inpatient care to the patients admitted from our primary care, resident-based outpatient clinical practices
- improve communication with local and regional referring physicians
- improve clinical teaching of medical students and residents
- reduce variability in utilization of clinical resources in the care of inpatients

The "Just For Kids" Hospitalist Program replaced a system of general inpatient ward team coverage that had several problems. Each of four ward teams had a mixture of both private and university service patients. A Department of Pediatrics faculty member was assigned to each team to provide teaching of medical students and residents, manage the clinical needs of the patient, provide appropriate documentation in the medical record and prepare a bill for physician services. Forty-eight different faculty members served in

this capacity in the course of an academic year and, as such, we saw great variability in teaching skill and interest, clinical resource utilization, medical record documentation and attention to patient billing paperwork.

This new program required reorganization of the pediatric resident ward inpatient teams. All Departmental general inpatients were placed on the hospitalist team. The hospitalist team is comprised of one attending physician, two upper level residents, four interns and four to seven medical students. The average daily census is 15 patients.

Seven faculty members were selected to serve as attending hospitalist because they had excellent skills in teaching, patient management, and communication with referring physicians. The grant covers the equivalent of one FTE faculty member's salary which is split between two hospitalists each serving for approximately four months per year. These two faculty members fulfill the remainder of their clinical and administrative duties in other Divisions within the Department of Pediatrics. The remaining four months of hospitalist attending coverage are provided by five other Departmental faculty members. Each attending hospitalist makes rounds seven days per week and is available for questions 24 hours per day in a two-week block of service. Because the program is based within an academic teaching program, attending hospitalists do not take call in the hospital.

Unique features of this service include a one-page faxed summary of the hospitalization to the referring physician within 24 hours of discharge. A Palm Pilot-based data collection system is used to capture demographic, clinical and billing information on the patients admitted to the hospitalist service. Each attending hospitalist has a Palm Pilot loaded with phone numbers of referring physicians, and a pharmaceutical database from Epocrates.com.

For more information about the "Just For Kids" Hospitalist Program at Kosair Children's Hospital, you can reach Dr. Rabalais at 502-852-3774.



Email Dr. Rabalais at:

[gpraba01@gwise.louisville.edu](mailto:gpraba01@gwise.louisville.edu)



NEED AN APPLICATION???

Any pediatrician who spends a significant amount of time exclusively managing hospitalized patients is invited to apply for membership in the PSOHC. To request an application to join the PSOHC, contact the AAP Department of Membership at 800/433-9016 or send an e-mail to [membership@aap.org](mailto:membership@aap.org)

## Research Update

The Universe Project was begun by the National Association of Inpatient Physicians (NAIP) during the past year. The purpose of the project is to identify all adult and pediatric hospitalists in the United States. The project is going well and preliminary data will be presented at the Fourth Annual Meeting of the National Association of Inpatient Physicians, which will be held at the Georgia World Congress Center, Atlanta, Georgia, March 27-28, 2001.

If you or your colleagues are pediatric hospitalists, please contact Ms. Rita Miller (phone 1-800-843-3360, ext: 2584 or e-mail: [rmiller@mail.acponline.org](mailto:rmiller@mail.acponline.org)), so that the survey of pediatric hospitalists can be completed as soon as possible. If you would like to be placed on the NAIP mailing list to receive the NAIP's newsletter, *The Hospitalist*, please contact Ms. Miller or visit [www.naiponline.org](http://www.naiponline.org).

If you or your colleagues are pediatric hospitalists and are not on the List Serve of the Provisional Section on Hospital Care of the American Academy of Pediatrics, please contact Ms. Stephanie Mucha, Manager, Committees and Sections, American Academy of Pediatrics (phone: 847-434-4799 or e-mail: [smucha@aap.org](mailto:smucha@aap.org)).

*Paul S. Bellet, M.D.*  
Children's Hospital  
Medical Center  
Cincinnati, Ohio

## NAIP News

The NAIP 4th Annual Meeting will be held March 27-28, 2001, Atlanta, Georgia. "Quality and Inpatient Care: Hospitalist at the Forefront" The program will feature presentations on error-reduction, quality improvement, informatics, PDA's and non-physician providers in addition to organizational and clinical topics.

The Meeting will be held in conjunction with (at the beginning of) the annual meeting of the American College of Physicians - American Society of Internal Medicine. Therefore, Atlanta will be a busy place with somewhat limited hotel availability. Clinical Vignette and Research competitions are being featured. The clinical material will focus on adult medicine, but there are many topics of interest to those pediatric hospitalists who have conquered the organizational questions of their practices and are moving more into quality improvement issues. Visit the NAIP website for additional information.

<http://www.naiponline.org>.

*Michael Ruhlen, MD*  
PSOHC Steering  
Committee Member

## NAIP Error-Reporting Initiative

"We are now well into the NAIP project in partnership with DoctorQuality.com and many of you have already reported near misses and actual errors that you have observed in your hospital.

Please think about using this reporting site. It is anonymous and easy to use and an error can be reported in just a few minutes.

You can report near misses as well as actual errors. Common errors include incorrect medications ordered or administered, incorrect dosing, or manner of delivery. There are errors in tests ordered or in orders being taken off the chart. There have been adverse clinical events and administrative errors.

This an opportunity for NAIP and hospitalists to take the lead in this area. The AMA is considering launching a project similar to ours.

You can reach the site at <https://www.doctorquality.com/METS/NAIP> (note the "s" in https) The login and the password are both: naip (in lower case).

This information is available as a link from the NAIP homepage and will be online throughout this project."

*Laurence Wellikson, MD*  
Executive Director, NAIP

(submitted by Michael Ruhlen, MD)



# Executive Summary

## COMMITTEE ON HOSPITAL CARE MEETING

November 11-12, 2000

The Committee on Hospital Care (COHC) met on November 11-12, 2000 in Seattle, WA. The following is a summary of the Committee's activities and initiatives discussed during that meeting:

- The Board of Directors recently decided to change the current structure in which Section members acted as liaisons to Committees. The new structure allows every Committee to have one Section member that will be counted as a core member of the Committee with the right to vote and same term limits as other Committee members. Dr. Neff agreed that Dr. Percelay would be the natural candidate for that Section member position and that decision was approved in May 2000. All other Section liaison positions will be sunsetted at of July 2001. The COHC felt that having input from the Sections on Anesthesiology and Surgery was very important for the Committee. The COHC still felt they needed two additional positions and strongly recommends continuation of the two Section members, surgery and anesthesiology.
- The Section on Epidemiology asked Dr. Neff if the COHC would be interested in co-sponsoring an education session titled, "Reducing Errors in Children's Healthcare: Practical Strategies Using Information Technologies." Dr. Neff agreed and Dr. Lannon, from the SOEp, will submit that proposal for consideration and

presentation at the 2001 National Conference and Exhibition.

- After many revisions due to Board of Directors' request, the "Child Life Services" was published in the November 2000 issue of *Pediatrics*; the "Palliative Care for Children" statement was developed by the Committees on Bioethics and Hospital Care and was published in the August 2000 issue of *Pediatrics*; the "Precertification Process" statement was written as a revision of the 1992 statement of the same name and published in the August 2000 issue of *Pediatrics*.
- The COHC originally decided to write a statement on the topic of pediatric organ and tissue donation. Dr. Hardy is the lead author on this statement. In Dr. Hardy's absence, Ms. Mucha recorded the suggestions of the Committee and will forward those comments to Dr. Hardy.
- An Intent for Statement for "Guidelines for Admission and Discharge for Pediatric Intermediate Care (Stepdown) Units" was submitted and approved by ACBOCS in February 2000. This statement will be co-authored by COHC, SCCM, and SOCC. The COHC discussed the August 31, 2000 draft written by the SCCM.
- The statement entitled, "Physicians Role in Coordinating Care of Hospitalized Children" was originally published in *Pediatrics* in 1996, and the

COHC decided to revise the statement. Dr. Percelay, lead author, provided a revised copy and will work with staff to create the intent.

- The statement entitled, "Medical Staff Appointment and Delineation of Pediatric Privileges in Hospitals" was originally published in *Pediatrics* in 1990 and updated in 1996. Dr. O'Connor, lead author, submitted an intent for revision for Board of Directors consideration. That intent was approved with the suggestion of making the document shorter. The COHC discussed the statement revision and agreed that the credentialing focus should be on hospitals, specifically.
- Dr. Striker submitted an intent for statement titled, "Pediatric Pain Management." This intent was not approved because the Committee on Psychosocial Aspects of Child and Family Health (COPACFH) is currently working on a similar statement.
- The COHC explored the idea of writing a statement focusing on family centered care. Dr. Eichner and Ms. Ostric decided to take the role as lead authors on this statement.
- The next Committee meeting is scheduled for March 10-11, 2001 in Chicago, IL.

Stephanie Mucha  
Manager, Committee on Hospital  
Care

# Executive Summary

## Provisional Section on Hospital Care Steering Committee

October 29, 2000

The Steering Committee of the AAP Provisional Section on Hospital Care (PSOHC) met in conjunction with the 2000 Annual Meeting on October 29, 2000 in Chicago, Illinois.

The following is a summary of the Section's activities and initiatives discussed during that meeting:

- The first annual report of the PSOHC was reviewed. The Provisional Section is doing very well in the areas of educational programming, membership recruitment, producing an informative newsletter and communication with membership at large.
- Dr. Percelay is now a full Committee on Hospital Care (COHC) member. Dr. Percelay briefly reported on the COHC's activities.
- Dr. Percelay created and distributed a salary survey to PSOHC members in the summer. He distributed the results of the survey thus far and mentioned that he plans to continue collecting the information and once it is finalized, the results will be available to PSOHC members.
- The AAP Division of Health Policy Research suggested that the Steering Committee submit a topic for an AAP Periodic Survey of Fellows. The Steering Committee was very interested in participating in a Periodic Survey that will be mailed to a random sample of

the AAP membership in 2001. Dr. Percelay has been working with AAP staff to formulate questions to be included in the survey. Dr. Percelay reported that the topic has been submitted for consideration in the next periodic survey.

- Formal bylaws need to be written in order for the Provisional Section to be considered for full Section status. The Committee commented that they would like their membership criteria to include everyone who has an interest in-patient pediatrics. Their membership should include affiliate and international members as well.
- The PSOHC reviewed the programs they sponsored at the 2000 Annual Meeting: "Caring for the Acutely Ill Asthmatic"; Section Program: Provisional Section on Hospital Care; "The Appropriate Use of Antibiotics in the Inpatient Setting"; "The Focused Inpatient Evaluation of the Infant with An Apparent Life Threatening Event"; "The General Pediatrician and the General Pediatric Hospitalist: Collaborative Care of the Pediatric Inpatient."
- At the May meeting, the Steering Committee discussed authoring a policy statement. At that time, Dr. Strong had preliminarily written a draft of the statement that will focus on specific guidelines for pediatric hospitalist programs. This

statement will express opposition for the need for mandatory referrals from the pediatric primary care physician (PCP) to the pediatric hospitalist. The Steering Committee agreed that there is a need for this statement and approved the submission of an Intent for Statement on this topic.

- The Section Newsletter, with Dr. Mirkinson as the editor, was printed and distributed to the membership in the summer. The Committee agreed the newsletter was well received by the membership.
- Dr. Ruhlen announced that as of April 2000, he was no longer a member of the NAIP Board and his position was assumed by Dr. David Zipes, a pediatrician. Dr. Ruhlen also announced that the NAIP leadership was still interested in making themselves available for PSOHC educational programs if we were interested in having them speak. The NAIP 4th annual meeting is scheduled for April of 2001 in Atlanta, and as always, pediatricians are more than welcome to present at the scientific sessions. Finally, the NAIP has undertaken a "Universe of Hospitalists" project in which they hope to identify all practicing hospitalists in the United States.

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## PSOHC Executive Summary

Continued from page 5

- The Steering Committee discussed a possible future goal of creating a Pediatric Research in an Inpatient Setting (PRIS) network. It would be similar to the Pediatric Research in an Office Setting (PROS) network. At this point, the PSOHC is in the exploratory phase of this idea. The Committee discussed various ideas, the first step involving soliciting interest from the PSOHC membership via the LISTSERV and newsletter. Once a few people willing to take a leadership role, are identified, they can start to explore in more detail and network with other people. This group could possibly observe the PROS group and see how they do things, and perhaps the PSOHC could try to adapt that network to fit their needs. The Committee sees their first actual research project starting in 2 to 3 years, but perhaps investigating this PRIS idea could lay some of the groundwork for future research. Dr. Percelay mentioned that PROS coordinators meet annually. It may be worthwhile for a PSOHC representative to attend that meeting in the future. The Committee tabled this discussion until the next meeting.

*Stephanie Mucha*  
Manager, Provisional Section on  
Hospital Care

### PSOHC Anticipates an Exciting & Comprehensive CME Program for the 2001 National Conference and Exhibition

The Provisional Section on Hospital Care held their first educational program at the October 2000 Annual Meeting in Chicago. I was pleased to find our sessions very well attended and that the participants enjoyed lively discussions with each other and with our speakers.

The 2001 National Conference and Exhibition (formerly the Annual Meeting) will give AAP and PSOHC members another opportunity to explore topics pertinent to inpatient pediatric medicine. We have a very ambitious program planned for 2001, with a full day Section meeting as well as sessions we are sponsoring throughout the conference.

Our Provisional Section on Hospital Care Program will include the following topics:

- “Controversies in the Management of Diabetic Ketoacidosis in Young and Older Children”
- “Effective Teaching in the Inpatient Setting”
- “Maximizing Services and Reimbursement/CPT Coding for Inpatient Pediatric Services”
- “Maintenance and Trouble-shooting of Indwelling Central Catheters in Pediatric Patients”
- A business Luncheon for PSOHC members will be included.

In addition, our Section is sponsoring a number of other sessions for all AAP members. These topics also focus on medical issues particularly pertinent to inpatient medicine:

- “The General Pediatrician and the General Pediatric Hospitalist-Collaborative Care of the Pediatric Inpatient” (Audience Response Case Discussion)
- “Antenatal Renal Ultrasound and its Significance for the General Pediatrician” (Selected Short Subject)
- “Medication Errors in the Inpatient Pediatric Setting” (Plenary Session)
- “The Diagnosis and Treatment of Childhood Encephalitis and Viral Meningitis” (Audience Response Case Discussion)
- “Managing Status Asthmaticus on the Inpatient Pediatric Ward” (Two Hour Seminar)

Suggestions from attendees of the 2000 meeting had a significant role in forming the 2001 program, and I anticipate more ideas and input from our Section members to continue to help direct the focus of our future programs. As always, we welcome all interested pediatricians and pediatricians-in-training to join our Section and general program sessions. Any pediatrician with an interest in inpatient pediatric medicine will find programs of interest sponsored by the PSOHC.

I look forward to joining new and old members of the PSOHC at the 2001 meeting. See you in San Francisco!

*Laura J. Mirkinson, MD*  
Education Chair, Provisional Section  
on Hospital Care



## Practice Profile

### St. Vincent Pediatric Hospitalists

**Contact:**

David Zipes, MD, FAAP  
Pediatric Hospitalist Director  
Pediatric Urgent Care Center Director  
St. Vincent Hospitals and Health Services  
2001 West 86<sup>th</sup> Street  
Indianapolis, IN 46260

**Start Up:**

July, 1998

**Practitioners:**

4 full time physicians  
David Zipes, MD  
Adriane Lioudis, MD  
Anna Kostelanetz, MD  
John Plewa, MD

**Training:**

3 board certified pediatricians, 1  
board eligible pediatrician

**Employer:**

St. Vincent Hospitals and Health Services

**Census:**

Average: 10 inpatients  
Range: 4-20  
Admit: 3-4/day  
Discharge: 3-4/day  
Consults: 0-2/day  
Ground Transports: 4-5 per *month*

**Hospitals:**

St. Vincent Hospital- large, not for profit, community hospital with 32 pediatric beds and 10 PICU beds  
Pediatric Urgent Care Center- 6 room after hours center open 36 hours/week

**St. Vincent Hospital:**

St. Vincent Hospital, for a variety of reasons, decided to expand its

pediatric program in 1998. They decided to compete head on with the local children's hospital, which had a near monopoly on anything but routine inpatient pediatrics. Prior to that, St. Vincent Hospital's pediatric floor functioned as a low level community hospital with an ADC of about 6. Since then, it has developed into a well functioning tertiary care center with most specialties, including CV surgery (open heart and ECMO), oncology and pediatric hospitalists represented. Our group of hospitalists was and still is the only pediatric hospitalist program in the state of Indiana. We are currently designing our new 25 million-dollar pediatric pavilion with completion planned for fall of 2002.

**History of the Hospitalist Program:**

In 1998 two pediatric hospitalists were hired to help provide night time and weekend coverage to the fledgling pediatric program. The initial plans did not include the development of a "true" hospitalist program. We started backwards, but have managed, with much perseverance, to develop a full-fledged hospitalist program. We now have 4 full time hospitalists with some moonlighter back up. As the only pediatric hospitalist program in the state, we had a lot of initial resistance from both the administration and the physicians in the community. Presently we take care of 65% of all pediatric admissions, are in house almost 24 hours per day, and are an integral part of the hospital. With our good reputation and focus on communication, we continue to grow rapidly.

We are in house 6/7 nights per week and during the day as needed. The pediatric intensivists are in house the times we are not. We cover pediatric ground transports for all but 18 hours/week. There are 4 to 5 family practice and transitional interns/residents on our service per month and we provide the bulk of their inpatient education. ER consults occur approximately 3 times per week. We have just begun staffing an urgent care center that is

open 36 hours/week. We have not been involved with the nursery or NICU. We are the back up for the conscious sedation nurse practitioner. Though the pediatric floor has grown tremendously in both acuity and volume since we have been here, our major problem remains the expense of in house coverage in conjunction with the relatively low average daily census. Because, both the hospitalist program and, in essence, the hospital are new we can not just rely on "buy in" as a means to success. Unfortunately, or fortunately, the volume of pediatric inpatients is much less than our adult counterparts. Our "buy in" has grown rapidly over the last 2 years, but the ADC on the floor is only around 20. Additionally, we are charged with providing in house nighttime coverage, which is expensive and not terribly financially remunerative. Last fiscal year we collected in professional fees about half of our cost center's budget. We have taken on many different responsibilities in order to become an integral and necessary part of the hospital, and to "justify" our program.

**Schedule:**

Clinical hours are 50-55 hours per hospitalist per week. We are in house Monday, Tuesday, Wednesday, and Friday from 5pm-8am (15 hour shifts) and Saturday and Sunday from 12pm-8am (20 hour shifts). The other hours are covered on an as needed basis and via pager. Typically, our daytime person comes in at 8am on the weekdays and stays until at least 2pm and covers until 5pm via pager. Additionally, we cover the urgent care center Monday-Friday from 6pm-10pm and weekends from 9am-5pm. We rotate relatively equally through days, nights and the urgent care center. Our usual rotation is as follows:

Doctor "A": Monday-Friday days and Thursday night via pager. Daytime ground transports on Monday and Friday and for 24 hours on Thursday. Signs out at noon on Friday and is done for the week.

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# EMPLOYMENT OPPORTUNITIES

Pediatric Hospitalist position available in Southern New Jersey Community Hospital affiliated with AI DuPont Children's Hospital. Cover pediatric ward, nursery, L&D and ER consults. We strive for clinical excellence. Excellent benefits. Contact [MGoodman@Nemours.org](mailto:MGoodman@Nemours.org).

Exciting opportunity to join an existing group of 5 pediatric hospitalists at the Beth Israel Medical Center/Singer Division in New York. The pediatric service is dedicated to the care of patients with neurologic, neurosurgical and orthopedic problems. The successful candidate will join a multi-disciplinary team to provide pediatric care to these patients. Applicants must be Pediatric Board eligible or Board certified and possess a New York State medical license and this is not a J1 opportunity. Excellent salary and benefits. Interested candidates should forward a CV to Dr Edward E Conway Jr, MS, MD, and Acting Chairman of Pediatrics at Beth Israel Medical Center/Singer Division, fax 212/870-7271, or e-mail [econway@bethisraelny.org](mailto:econway@bethisraelny.org).

Lehigh Valley Hospital, Allentown, PA. Pediatric Hospitalist group, established 1992, seeks one hospitalist and one CCM certified/eligible intensivist, one of whom will serve as director, inpatient Pediatrics. Group covers 20 bed general Pediatric Unit/Level II PICU which is part of The Children's Hospital of Philadelphia network. Two existing intensivists. No NICU/DR. Successful candidates will be members of the CHOP faculty practice plan. Pediatric surgery, Heme/Onc, Pulmonary, Cardiology on site. Medical student, resident rotations. Excellent living environment 70 miles from Philadelphia/ 90 miles from NYC. Inquiries: Carol Voorhees phone: 610/402-7008 e-mail [carol.voorhees@LVH.com](mailto:carol.voorhees@LVH.com) or write: John D. Van Brakle, MD, Chairman, Pediatrics, LVH, 2166 S. 12th Street, Allentown, PA, 18103. Please include CV.

We are a private hospital-based Inpatient Pediatrics Hospitalist practice taking care of sick children of all ages in the hospital, on the wards, and occasionally in the ICU. We also do Level 2+ Special Care Nursery and well-baby nursery care, as well as the occasional Neonatal transport. We do not have an office practice and see patients on a referral basis.

We are looking for both a Pediatric Hospitalist or other Subspecialist comfortable with taking care of sick newborns as well as another Neonatologist to assist us in providing year round coverage of our Level 2+ Nursery and hospital services.

These individuals should be willing to help take care of sick children of all ages, both neonatal and older, in the hospital when on call. In general we limit our sick newborns to ones greater than 1000 grams and 28-to-30 weeks gestation, smaller ones being transferred.

If you have an interest in joining or hearing more about our practice, please contact:

Dr. Jack Liggett or Vicente Romero  
New Century Pediatrics  
P.O. Box 1426  
Lima, Ohio 45802  
Office: 419/226-9585  
Answering service: 800/585-5007  
Fax: 419/226-4375  
[JLig45805@aol.com](mailto:JLig45805@aol.com)

Community Hospital 45 minutes north of New York City is seeking Board Certified pediatrician with hospitalist experience to fill full-time position in start-up program. Forty member department with three neonatologists on staff. Competitive salary. Fax CV to 914 666-1965 or respond by e-mail to [sriccio@healthstar.org](mailto:sriccio@healthstar.org).

Applications are now being accepted for 2 full time, and one part time Pediatric Hospitalist to join two full-time hospitalists in a lovely suburban Community hospital in Southern New Jersey, located 20 minutes from Philadelphia.

Responsibilities include @ 48 hours per week (including one over night in house every 4-5 days) providing medical and consultative service and teaching family practice residents on an 18 bed Pediatric Unit. Daily rounds are made on "clinic" patients in a well baby nursery and consultation services are also provided to a busy ED.

A partnership with a well-known Children's Hospital in nearby Delaware has been completed. Expansion of Pediatric services in the ED and on the floor are planned for the near future. Salary and benefits are very competitive.

Prospective candidates can contact Mark J. Hummel, MD, medical director, at:

Mark J. Hummel, MD  
Virtua Health System-Voorhees Division  
101 Carnie Boulevard  
Voorhees, NJ 08043  
856/325-3563  
[mhummel@virtua.org](mailto:mhummel@virtua.org)

Full-time hospitalist on Eastern Shore of Maryland. We are located 70 miles east of Washington DC and are looking for an individual who will appreciate the advantages of small town living. Ours is a team of 7 hospitalists covering 24/7. We are looking a special person who will be happy in a small town environment surrounded by water, Canada geese, and beautiful vistas. Please send CV to Dr. N. Snow. Fax:410/745-4112, or email at [njsnow@dmv.com](mailto:njsnow@dmv.com).

## What me, Worry?

Continued from page 1

and the same age as ourselves; to people who share our niche, other hospitalists, and to other varieties within the species *Doctorus pediatricus*, namely the office based practitioner.

Towards this end, for maximum dispersal of information and sharing of experiences, we are establishing a PSOHC resource library which will be open to all Academy members. If you have any written materials which are relevant to the practice of inpatient medicine—sample pathways, order sets, H&P formats, progress note formats, billing forms, schedule templates, satisfaction surveys, or great free delivery 24 x 7 inexpensive Chinese Restaurant menus, please mail a hard copy or e-mail a file to Stephanie Mucha, the AAP Manager to the PSOHC, at [smucha@aap.org](mailto:smucha@aap.org). We will work to get these materials posted on the web in a downloadable form to help other pediatricians. We may face some disclaimer issues that this does not reflect Academy endorsement of any practice parameters, but it will be a valuable resource for hospitalist and non-hospitalist alike. Please note that to make this library work, there can be no proprietary restrictions. So, if you want it copyrighted, this isn't the place. Notations of "may be reproduced with acknowledgment" are welcome however.

I look forward to seeing some rounder wheels and better mousetraps.

**Jack**



## A PLEA FOR BOXCARS

Some clinical questions which will hopefully generate dialog if not answers...My mentors who grew up before sat monitors seem to think that sat monitors often prolong RSV hospitalization rates without improving outcome. I tend to agree. Why are we so hung up on the saturation rate? I think it's because that's a number we can non-invasively measure. Aren't other numbers just as important. Think about the oxygen delivery equation. The amount of hemoglobin present is as important as the saturation. A child 88% saturated with a hemoglobin of 11 is going to deliver more O<sub>2</sub> than a child who is 93% saturated with a hemoglobin of 9, but no one seems to count the boxcars. We just seem to be interested in how full they are. In the PICU I've had occasion to measure mixed venous saturation as a component of oxygen consumption and metabolic demands. Is there a potential role for venous saturation in determining which kids are marginal with limited reserves? And, how do you do it in Denver? Is PaO<sub>2</sub> important on an absolute level. I know partial pressures of oxygen will differ by elevation, but I haven't heard that bronchiolitis is treated differently in Colorado than in California. Does 2-3 DPG even it all out by shifting the oxygen-hemoglobin dissociation curve? I don't know. I'm very interested in hearing other people's opinions about the science behind the concerns of oxygenation in RSV bronchiolitis. My personal take is that the clinical evaluation of a child's ability to tolerate feeds is the most important assessment in most cases of mild RSV. I wouldn't want to eliminate sat monitors completely, but I do feel they are more hinderance than harm in the child who is lounging around on the ward with sats in the 88-92 range, tolerating feeds. I expect that before sat monitors, wise clinicians sent these kids home and they did just fine. Any comments? Please direct them to the LISTSERV for a virtual discussion.

Jack

## SALARY SURVEY

Included in the newsletter (on page 13) is a summary of the salary survey information received to date.

I could not determine any regional trends, and in order to preserve confidentiality given the small sample size, I have not listed the state where the practitioner is located. This is not a statistically valid sample, but I do think it's the best information we have. Obviously there is a wide range of practice arrangements and a wide range of compensation. Please note, no attempt was made to determine the volume or type of services provided.

I did notice several trends.

1. Taking call from home generally meant coming in very infrequently, less than 20% of the time. Many people must take call from home backing up residents. If night volume was at all significant (>20% of time on-call spent in the hospital), people tended to be in-house.
2. Benefit packages were fairly standard in terms of vacation time and CME time. CME allowance did range significantly for those who commented—\$1000-3000+/yr.
3. Academic practitioners were paid less than private practitioners.

I hope this information is helpful to you if you are paid less than what you determine norms to be. If you are paid more, I'm sure you deserve it, but I still wouldn't let the hospital administrators know.

If you haven't yet completed a survey, this is an on-going database. Please complete the survey attached to this newsletter and fax it to Stephanie Mucha at 847/434-8000.

Jack

\*See Page 13 for Salary Survey Results\*



## Practice Profile

*Continued from page 7*

Doctor "B": Urgent care center Monday-Friday and Saturday in house.

Doctor "C": Tuesday and Wednesday in house and entire weekend at the urgent care center.

Doctor "D": Monday, Friday, and Sunday in house.

The in house person also covers ground transports. One of the intensivists comes in house if we go out on transport. We have \$35,000 per year to spend on moonlighters at \$50 dollars per hour to help cover vacations and the occasional weekend off.

### **Patients:**

Though we have large seasonal variations, our average census is 10 with, 3-4 admits per day and about as many discharges. Around 40% of our patients are admitted for less than 24 hours. The majority of our patients come from the primary care physicians with a few unassigned or out of town patients. It is a completely open unit and both pediatricians and family practitioners can and do care for inpatients. We tend to have the more complicated or labor intensive patients as well as a lot of the subspecialty patients (usually co-managed). We occasionally see patients after discharge either in the ER or urgent care center. These are usually out of towners or very complicated patients.

### **Hospitalist Demographics:**

There are two male and two female hospitalists, all with general pediatric residency training. Two have been out of training for a year and one just finished in July. The fourth has been a hospitalist since 1996. All are married and three have children. No one, as is the case for most pediatric hospitalists, has done a hospitalist fellowship.

### **Finances:**

We are all salaried employees of the hospital with a soon to be implemented bonus plan based entirely on productivity. Our professional fees only cover about half of our cost center, largely due to the expense of in house coverage and a small, but increasing ADC. The administration has not put any direct value on all of the other services we provide or the revenue, outside of professional fees, we generate for the hospital. The urgent care center we recently took over has been a money loser since it opened a few years ago with our good reputation in the community we hope to turn it around. Already, several of the offices have scaled back their weekend hours and send their patients to us. We have successfully improved our finances and our position in the hospital by multitasking (rehab coverage, transport, conscious sedation, resident education, etc.) and we continue to look for new opportunities.

### **Teaching Responsibilities:**

We created a hospitalist service rotation and have 4-5 interns/residents per month. They also cover most general pediatric patients not on our service. We are the main inpatient educators and round with the residents at least twice daily and meet formally for lectures 3 times per week. There is a resident in house 24/7 and they follow almost all of our patients. They have actually restructured their rotation to be able to spend more time with us. The residents uniformly enjoy our service and the one-on-one teaching. They have also benefited by taking care of more complicated patients and by participating in more procedures.

### **Future Plans:**

We are building a new pediatric pavilion with 40 inpatient beds. This will begin to solve our volume dilemma assuming we can fill it. A sister hospital, approximately 10 miles from our main facility, is expanding its services to include deliveries and is

looking to us to provide part or all of the desired 24/7 in house coverage. We would also provide newborn care, ER consults and, potentially, inpatient care as well. A pediatric ER will be opening soon and we may do some shifts there. The Children's Specialty Hospital (an inpatient rehabilitation facility) has asked our group to handle some of the general pediatric needs for their patients. We have had discussions about providing inpatient care for other hospitals and large pediatric groups in the area. We will continue to grow our service and the size of our group. As the only pediatric hospitalists in Indiana, we will continue our uphill battle to prove our value to the system, the administrators and, most of all, our patients.

## Be Informed!!



## Get Involved!!

Join the Provisional  
Section on  
Hospital Care  
**LISTSERV®** Today!

The **LISTSERV®** allows PSOHC members to communicate through periodic e-mail messages. So far, this list has maintained very lively discussions.

If you would like to join the **LISTSERV®** simply: e-mail Stephanie Mucha at [smucha@aap.org](mailto:smucha@aap.org) with "PSOHC LISTSERV" in the subject line. \*\*Be sure to include your name and contact information.

**NOTE:** E-mail will be the primary form of communication for PSOHC members - if you do not have an **e-mail address, we encourage** you to get an account soon!

## Intent for Policy Statement



In addition to sponsoring informative academic sessions at the Annual Meeting in Chicago, the Steering Committee of the PSOHC conducted its annual business meeting. Many items were discussed including a formal “Intent for Policy Statement” needed to advance preferred “policies” through the ranks of the AAP section approval process. The proposed document is intended to clarify the intent of the PSOHC and the AAP as to how pediatric hospitalists should be best inserted into the fabric of pediatric practice and patient care.

In our previous newsletter, we had described our fervent intent to make voluntary use of pediatric hospitalists a cornerstone of the section policy. We believe this is not only the right approach to take but also the only design with hope of wide-spread acceptance throughout the pediatric community. With this anchor principle in mind, we crafted the “Intent” statement with the following six points that we feel would enhance the hospitalists role in the care for pediatric patients. These items were sent initially to the Council on Sections Management Committee (COSMAN) and the Council on Committees Management Committee (COCOMAN) for review. The intent was further reviewed by the Advisory Committee to the Board on Committees and Sections (ACBOCS) on January 20, 2001 and APPROVED!!! Though the exact final wording will surely look different following the editing

process, the following proposed items comprise our currently recommended policies:

1. The AAP should support the implementation of only voluntary designs of any Pediatric Hospitalist programs. Pediatricians, and other qualified primary care providers, should always have the option to admit and manage their own patients and to participate in unassigned patient admissions at their desire / discretion. This policy is consistent with similar policies and statements of the AMA, NAIP (National Association of Inpatient Physicians), and the AAFP (American Academy of Family Practice).
2. Each pediatric hospitalist program should be designed with the unique needs of the community’s patients, physicians, and those of the host institution in mind.
3. Any implemented pediatric hospitalist program should include in its design provisions for adequate/ appropriate outpatient follow-up. The style can be variable to the institution/ community resources (staff member assignment on a rotation basis, community clinic systems, hospitalists providing limited post-discharge follow-up, other).
4. Physicians serving in the role of pediatric hospitalists should have minimum training experience equivalent to a three year MD or DO approved pediatric residency.

5. Provisions in each program should include efforts for seamless communication at the time of admission and discharge between the hospitalist and the physician providing outpatient care.
6. The AAP, through the Provisional Section on Hospital Care, should provide direction for members interested in designing and implementing a pediatric hospitalist program.

Certainly, as pediatric hospitalist programs continue to evolve and to become a more widely accepted practice model, many additional issues will arise that will warrant more wide-spread policy development. There is already a need to develop accurate, statistical measures of quality, efficiency, and cost in this arena. Measurements of the uncompensated benefits these programs bring to institutions and their communities are also needed. Methods (and motives) of data collection and any potential use of such data will need to be carefully monitored to ensure that they aren’t unfairly wielded in attempts to force mandatory use of pediatric hospitalists. Some managed care companies and medical delivery systems have already tried to impose hospitalist management for inpatients. The AAP, through this Section and its policies, should be ideally positioned to offer resistance to such attempts.

If you have any questions or concerns about the intent and direction of the PSOHC, please feel free to contact any of the Steering Committee members.

*Gary B. Strong, MD*  
PSOHC Steering Committee  
Member

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# 2000-2001 Pediatric Hospitalist Salary Survey Summary Data

Setting	Hrs/wk	Hrs/wk	Employment	Salary	Salary	compared	Benefits
U= urban	in-house	on call/ called in	U =Univ/Med School	starting	5 years	to	Std =
S=suburban			H= Hospital			office	4 wks vac
R=rural			HMO			based	1 wk CME
			P=Private Medical Corp			colleagues	Health
			S=Self-employed				Retirement
U	36	0	P	\$50-75/hr			retirement only
S	40	0	P	115	125	<	health only
U	40	0	S	145	145	<	none
U	55	21/?	P	90	150	?	2 wks CME
U/S	60	20/3	P	110	?	=	1.5 wks CME total
U	60	30/11	P	130	180	N/A	3 wks vac, expense allowance
U	40	15/0	P	140	140	>	2 wks CME, 3 vac
S	48	0	P	112	120	>	Std
U	48	42/2	H	120	140	<	
S	48	20/4	H	110	140		Std
U	30	60/?	U	85		>	Std
S	45	0	U	110	N/A	<	Std
U,S	38	16/3	U	88	92	<	2 wks CME
S	40	8 4	U/H	85	85	=	3 wks vac
S	40	0	H	120	NA	>	Std + life
S	38	15/0	H	110	120	>	no CME, accrue PTO
S	38	35/0	H \$72/hr days, 82 night, holiday	120	130	>	Accrue PTO, no CME or Vacation
U	42	13/2	H	115	129	>	life
R	40 incl call	varies	H, cover 2 hospitals	130	?	>	~5 wks vacation, 2 wkss CME + dues
S	49	0/0	H (call paid separately)	85	95	<	disability, 5 wks vac
U	55	0	HMO rotate as hospitalist	80	130	=	6 wks vac
U	48	0	H	110	140	>	Std + bonus
S	45	0	H	90	100	=	no CME
S	55	24/6	P	100	150	=	4 wks vac start, 6 wks@3yrs, profit sharing
U	55	48/10	P	120	160	?	4-6 wks vacation, profit-sharing
U	60	108/0	H/U	88	98	=	Std
S	40	?	U	100	115	>	Std
S	40	40/8	H	105	120	>	403b + some expenses
U	45	15/2.5	u	120		>	Std
	50	18/6	Group	94	128	=	disability, CME, dues, + bonus
S	50	0	H	90	125	<	CME expenses
U	40	0	H	140	155	=	6 wks vac
U	45	0	P	120	148	<	Std
U	45	0	H	138		<	5 wks vac
U	50	0	P	135	150	start >, @5y <	Std
U	50	0	P	135	150	start >, @5y <	6wk CME+vac, pre-tax health/life, + bonus
U	52	24/?	H/U	125	145	=	Std
U	24 (parttime)	20/3	H	125	140	<	2 wks CME
S	60	24/?	H	115	130	=	3 wks vac

updated 1/31/01

## NOTE:

**If you haven't yet completed a survey, this is an on-going database. Please complete the attached survey form and fax it to Stephanie Mucha at 847/434-8000.**

Please faxback this survey to:

**\*Stephanie Mucha, Division of Hospital and Surgical Services\***  
**Fax: 847/434-8000**

Or return by mail to:

American Academy of Pediatrics – ATTN: Stephanie Mucha  
141 Northwest Point Blvd  
Elk Grove Village, IL 60009-0927

**\*\*\*Pediatric Hospitalist Salary Survey\*\*\***

*Thank you for participating in this confidential survey of pediatric hospitalist salaries and compensation. This information will be made available only to members of the Provisional Section on Hospital Care (PSOHC) and of the NAIP Pediatric Section.*

**Job Description**

State in which you practice: \_\_\_\_\_ Setting: urban    suburban    rural

Hours worked per week (do not include call from home): \_\_\_\_\_

On-call from home (Ave # hrs/wk): \_\_\_\_\_ Ave # hrs/wk called in from home: \_\_\_\_\_

**Employment (circle one)**

University/Medical School Employee      Hospital Employee      HMO Employee

Private Medical Corporation/Group Employee      Self-employed

Other \_\_\_\_\_

**Salary**

Starting Salary (for a new hospitalist): \_\_\_\_\_

Salary after approximately 5 years: \_\_\_\_\_

Compared to office-based practitioners in my organization this is: lower    equal    higher

**Benefits (circle those that apply/fill in the blanks)**

Health Insurance      Retirement      \_\_\_\_\_ Weeks CME      \_\_\_\_\_ Weeks vacation

Other \_\_\_\_\_

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_