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See the SOHM Program on page 14.
Making the Rounds
Laura J Mirkinson, MD, FAAP

I am sure that, like most of you, I am happy to be out of the influenza and rotavirus season—even if it means an equal number of children who are wheezing! If flowers and children grow in the spring, then, apparently, so do AAP sections. We are an active and evolving section with nearly 600 members.

Along with our growth and activity comes a responsibility to our membership and our patients. This past March, the Executive Committee of the Section met for our semi-annual meeting at the AAP headquarters in Elk Grove Village, Illinois. Two of our goals for that meeting were to develop a strategic plan and identify a mission statement for the Section. I would like to share these with you here.

Our strategic plan for 2006-2007 incorporates many important goals, including some that are highlighted below:

- Focus on CME for pediatric hospitalists such as the Pediatric Hospitalist Meeting 2007 and our Section’s programs at the AAP’s 2006 National Conference & Exhibition in Atlanta, including a poster session.
- Identify and serve the needs of pediatric hospitalists, including enhancing our newsletter and website and serving as advocates for hospitalists within the AAP’s broad membership.
- Develop a “Pediatrician’s Tool Kit” for hospitalists to use as a guide to start new or review existing pediatric hospitalist programs.
- Contribute to the AAP’s library of patient brochures with particular attention to inpatient topics.
- Support research that evaluates the influence and impact of hospitalists in pediatric medicine.
- Develop strong liaisons, and work cooperatively with sister organizations.

Our mission statement incorporates the principles of advocacy, education and service, with the goals of providing the best possible care to hospitalized children and advancing the field of pediatric hospital medicine.

Mission Statement: The Section on Hospital Medicine of the American Academy of Pediatrics is “dedicated to the health of all children in the hospital setting through advocacy, education and service.” This vision incorporates the core principles of safe, effective, timely, efficient, equitable, and family-centered health care.

Advocacy
The AAP SOHM is dedicated to being a leader in inpatient pediatric hospital medicine in the pediatric community—advocating for the health and safety of hospitalized children.

Goals:
- Focus on improving the care of hospitalized children.
- Promote quality and sustainable pediatric hospitalist programs.
- Embrace transformation and change in order to improve access, safety, clinical excellence and communication in pediatric hospitalist services.

Education
The AAP SOHM is dedicated to being a leader in the education of health care providers, patients and families.

Goals:
- Promote and provide high quality continuing medical education for pediatric hospitalists and other health care providers.
- Develop educational programs for professionals incorporating topics on clinical expertise, technological advancements and professional development.
- Build partnerships with other organizations that support our mission of education.
- Develop educational tools for parents, families, and patients that improve the understanding of the conditions and circumstances that necessitate hospitalization in children.

Service
There are two elements to service. The first is supporting children and their families in receiving top-level quality care from hospitalists as ensured through the pillars of advocacy and education. Second, the AAP SOHM is dedicated to being a leader in identifying the professional needs of pediatric hospitalists.

Goals:
- Promote and support high quality and sustainable pediatric hospitalist careers through education, professional development and communication.
- Build pediatric hospitalist presence and leadership within the American Academy of Pediatrics.
- Provide a venue for communication for pediatric hospitalists by providing the community of pediatric hospitalists with a LISTSERV® and website.
- Support and contribute to initiatives that promote fair reimbursement for pediatric clinical, administrative and educational hospital-based services.

As always, I am particularly interested in making sure that the members of our section find our efforts productive and useful. I encourage every member to become involved in the section, participate in our subcommittees and projects, and contact me personally if you have suggestions for improving or expanding the activities of the section.

I look forward to hearing from you!

Laura
mirkil@holycrosshealth.org
Welcome to the July 2006 edition of the AAP’s Section on Hospital Medicine News. In this issue you will find a great write up of a busy program at California Pacific Hospital in San Francisco. Also, for all of you interested in sedation, we have written up the recent conference in Ohio and an update on new billing codes. Our neonatal medicine article will make sure you are up on the important new changes in the Neonatal Resuscitation guidelines and Dr Robbins’s article will inspire us all to make a difference through clinical research.

You may notice that our structure has changed. In concert with the SOHM’s new mission statement, “Dedicated to the health of all children in the hospital setting through advocacy, education and service,” we have created feature columns which will help keep you informed on the practice of hospital medicine. We will continue our Practice Profile and Billing and Coding Corner columns to help you with the construction and business side of hospital medicine, but we will shift our emphasis towards maintaining and building the knowledge level across the field. As the only publication focused specifically on Pediatric Hospitalists, we want to be sure we serve as a major support for keeping your skills up-to-date so you can help your patients receive the best care possible.

Our next edition will incorporate an editorial board:

- **Editor-in-Chief** Jennifer Daru, MD jadaru@gmail.com
- **General Editor** Sheldon Berkowitz, MD Sheldon.Berkowitz@childrensnm.org
- **On the Wards** Julie Lipps Kim, MD jlipps@stanford.edu
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- **Practice Profile** Susan Wu, MD suwu@chla.usc.edu
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- **Hospitalists On-Line** Jennifer Maniscalco, MD JManisca@cnmc.org
- **Pediatric Hospital Morbidity & Mortality** Mary Ellen Valletta, MD, JD valleme@peds.ufl.edu
- **Billing & Coding Corner** TBA

In addition, in this and in every issue there will be Section on Hospital Medicine Subcommittee Updates to keep you informed of what our Section’s special focus groups are accomplishing.

If you are interested in participating in a subcommittee, contact one of the leaders (see page 2). If you are interested in writing, deadlines are in April and October. Just email one of the editors or me with your ideas. Our goal is to keep building so please send feedback my way. There is plenty more to say!

Jennifer jadaru@gmail.com
On the Wards

Hospitalists Perform Research in Community Hospital
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There is a popular running instructional book entitled *The Courage to Start* targeting people who see running as an enterprise with worthy results but who have not engaged in exercise in some time and really don’t know how to even begin what seems to be a daunting task. Their predicament reminds me of the community hospitalist who feels that clinical research is an enterprise with worthy goals but feels overwhelmed by the daunting prospect of beginning and following through with a project. Community hospitalists often have barriers that may not be present for our academic/university associated colleagues. For many of us, our work schedule is heavily weighted towards the daily (and nightly) demands of direct clinical care. Squeeze in those patient care meetings and administrative committee meetings, and there is little time for anything else.

Lack of knowledge and experience in research can be obstacles as well. Many university hospitals offer workshops, meetings, and a network of mentors engaged in research activities that encourage and support young (or not-so-young, but inexperienced) researchers; but support and instruction can be harder to find in a community hospital setting. Many of us in community hospitals choose our type of work because we enjoy patient contact—research and administrative function may not be our priority.

There are, however, those who believe that engaging in clinical research is indeed a worthy goal; participating in research within the Pediatric Research in the Inpatient Settings (PRIS) network can be a way to fulfill that goal without getting overwhelmed. My limited research experience, thus far, has been with the Emergency Medicine Network (EM-NET), which launched a project in the fall of 2004 focused on studying infant bronchiolitis. Getting started was as easy as responding to an e-mail soliciting physician participants for this multi-center study. Several e-mails later, with guidance from the project director and their support personnel, we had gathered some preliminary data from our Medical Staff Office and the Office of Medical Information, which indicated that we had the patient volume to participate. Next, a package of material, downloadable from the password protected EM-NET website, provided a starter kit. The materials included a full copy of the protocol, consent forms, data collection sheets, and samples of IRB required materials.

Well, what was next? One advantage to working in a smaller community or regional hospital is that everyone knows everyone else. Like a small town, if one person can’t answer your questions, they can call a friend who will know where to point you next. The chief of your hospital’s Institutional Review Board (IRB) is a great place to start, and if you don’t know who that is, the medical staff office, chief physician, or your department chair probably will. On the IRB is the Human Protection Administrator, charged by the Federal Government with protecting human research subjects. This administrator will be able to provide support in ensuring that you implement the protocol in a way that meets federal requirements.

Each resource, in addition to providing support, led to another resource to help support the project. One of the IRB physician members translated our consent form into Spanish. Research assistants to gather data were needed but we had no funding to hire additional personnel. Fortunately, my colleagues in my physician group were willing to serve in this capacity. Unlike some academic settings, there is a physician from our group on duty in the hospital at all times, and they all kindly consented to be trained in data gathering. The EM-NET website had online training as well as conference call sessions, and on-going e-mail or telephone support as the project moved forward. For maximum patient recruitment, we decided to involve all of the ER staff including nurses, respiratory therapists, physician assistants, and finally, of course, the ER physicians. The secretarial assistant for the ER staff remembered me taking care of her grandson in the ER one night, and was only too glad to help publicize our project to the ER staff, who were very enthusiastic about helping out, which was essential to the success of the research effort. Our goal was to enlist every eligible patient over a very short (2-4 week) time period.

The patient recruitment period went smoothly. The after-study entailed some data-gathering from chart review. To do this, the nursing staff and medical information office staff provided much needed assistance. Our lack of statistical expertise and experience with medical writing was not a handicap when participating in this project. The principal investigators were responsible for the analysis and presentations of the data. Each physician participant also has the opportunity to access the data, should they wish to go further in the analysis and publication of a secondary study.

Practicing medicine in a non-academic setting initially seemed to be an obstacle to participating in clinical research. Executing clinical research in a smaller community hospital turned out not to be a disadvantage; the closely knit hospital community, the novelty and pride of being associated with a national multi-center study, worked in our favor. A neophyte runner who finishes his first race can be proud of his accomplishment even with the knowledge that he is not ready for a marathon. Our group is equally proud of our small, but valuable, contribution to a worthy research endeavor.
Pediatric Critical Care and Sedation

Pediatric Moderate Sedation: A Review of the Second International Multidisciplinary Conference on Pediatric Procedural Sedation
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The need for skills-based, not specialty-based, credentialing for moderate sedation, a call for more research on the long-term effect of moderate sedation agents, and an exhortation for regional and multi-institutional cooperation in areas of quality improvement and patient safety were some of the topics discussed at the Second International Multidisciplinary Conference on Pediatric Procedural Sedation, sponsored by the Pediatric Sedation Research Consortium and Columbus Children’s Hospital. The meeting, held in Columbus from May 30 to June 1, 2006, brought together sedation experts from across the country and the spectrum of health care providers in an open forum discussion on ways to improve the quality of health care delivered in the process of providing procedural sedation.

Dr Joseph Cravero, Associate Professor of Anesthesiology and Pediatrics at Dartmouth Hitchcock Medical Center and one of the organizers of the research consortium, discussed the variation for pediatric sedations among different institutions and the lack of knowledge on what constitutes best care. He also decried the minimal or non-existent exchange of research and sedation processes between institutions and encouraged the attendants to increase the level of participation in the Pediatric Sedation Research Consortium, a group of institutions dedicated to the exchange of data related to pediatric sedation processes. Already, there is valuable data emerging from this research interaction.

Several areas of controversy were discussed, including the restrictions placed by individual institutions on the use by certain providers of specific medications, such as Propofol, and a need to reevaluate the credentialing process, from a specialty-based assessment of qualifications for the use of procedural sedation medications, to a skill-based competency, which can qualify individuals from different specialty and provider groups.

The Joint Commission on Healthcare Organizations (JCAHO) has a formal process for the credentialing of non-anesthesiologists to provide sedation. It calls for individual institutions to develop their own protocols while establishing that the individual who performs moderate sedation must be “qualified to rescue patients from deep sedation and are competent to manage a compromised airway and to provide adequate oxygenation and ventilation.” These requirements are similar to those set forth by the AAP, the American Society of Anesthesiologists (ASA), and the American College of Emergency Physicians (ACEP). The consensus is that whatever credentialing process is followed, the individual providing moderate sedation must possess the skills necessary to manage cardio-respiratory consequences of a patient going into a deeper level of sedation than the one intended.

Several medications were discussed in the context of the conference, including Ketamine, Propofol, Etomidate, Chloral Hydrate, as well as newer agents such as Dexmetetomidine. Also, a recent review of pediatric sedation was published in The Lancet and Pediatric Clinics of North America. Below is a discussion of some of the medications most commonly used by pediatric hospitalists.

Ketamine

Ketamine is a dissociative anesthetic with rapid CNS penetration. It causes profound sedation, analgesia and amnesia at dissociative doses. The dosing is dependent on its route of administration:

IV: 1-2 mg/kg slowly over 1 minute, repeat 0.5-1mg/kg every 10 minutes as needed
IM: 3-6 mg/kg, repeat 2-4 mg/kg after 10 minutes
PO: 5-10 mg/kg 45 minutes prior to procedure. This is the least effective route of administration.

Several controversial aspects surrounding Ketamine use were discussed at the conference. There was a conversation about the need for an anti-cholinergic medication to reduce oral secretions, and the use of benzodiazepines to control the so-called “emergence” phenomenon. There is data suggesting the emergence reaction is uncommon, usually mild if it occurs, and therefore does not warrant prophylaxis with benzodiazepines. As for the administration of glycopyrrolate or atropine to reduce secretions, the evidence suggests that, if you’re going to use one, glycopyrrolate is more effective since it does not cross the blood brain barrier like atropine does and gives you less tachycardia.

Another controversial aspect regarding ketamine is its effect on intracranial pressure and its use for lumbar puncture. Dr John Berkenbosch, Associate Professor of Pediatrics and Pediatric Critical Care at Kosair Children’s Hospital in Louisville and Director of the University Children’s Sedation Service, reported in his talk “Propofol/Ketamine & Dexmetetomidine” that the use and safety of ketamine for lumbar punctures has been well established by the Hematology-Oncology literature, but that its utilization should be questioned in cases when LP opening pressure is needed.

Yet another area of controversy is the use of ketamine in infants. This off-label use of the drug seems to be generally accepted and supported by the literature.

Chloral Hydrate

This sedative-hypnotic has no analgesic properties. Its peak

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Neonatal Medicine

Changes in Guidelines for Neonatal Resuscitation
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The American Heart Association and American Academy of Pediatrics have published newly revised Guidelines for Neonatal Resuscitation. Over the past three years, many hours have been spent reviewing available evidence-based literature and preparing recommendations for a revised neonatal resuscitation program. These efforts culminated in the publication of the International Liaison Committee on Resuscitation (ILCOR) Consensus on Science and Treatment Recommendations (CoSTR), as well as the American Heart Association’s Guidelines for Emergency Cardiovascular Care, and are the basis for the 5th edition of the Textbook of Neonatal Resuscitation, which will be available any day now.

This revision focuses heavily on the evidence surrounding practice and makes changes where appropriate. The major changes are focused on provision of oxygen during resuscitation, care of the meconium-stained infant, assessing effectiveness of ventilation, epinephrine administration, temperature control and guidelines for withholding or withdrawing resuscitation.

The NRP continues to recommend 100% oxygen for resuscitation of the term neonate though the data is insufficient to support this recommendation. If you start with less than 100%, the recommendation is to increase to 100% if the patient is not improving over 90 seconds. There is good evidence to suggest that preterm infants (<32 weeks) suffer harm from over-oxygenation, and the new guidelines suggest the use of an oxygen blender and saturation monitor to guide the level of oxygen used and maintain saturations 90-95%.

The recommendations regarding meconium have attracted a great deal of attention from our obstetrical colleagues as well as pediatricians. A large randomized controlled multi-center trial demonstrated no benefit from intrapartum suctioning for meconium-stained infants, therefore suctioning before delivery of the shoulders will no longer be routine practice. The recommendations for care after delivery are unchanged.

A few changes focus on the critical importance of delivering adequate positive-pressure ventilation. Heart rate and breath sounds, rather than chest movement, are suggested as an initial screen for adequacy of PPV with rising heart rate being the initial, more important indicator. Laryngeal mask airways have been found to be effective for infants who cannot be ventilated with bag-mask or cannot be intubated. In addition, there is increased emphasis on the use of CO2 detectors, which was previously optional. Rising heart rate and positive CO2 detector are now primary indicators of correct endotracheal tube placement.

There are two changes in the recommendations regarding medication use during resuscitation. Previously the recommended route of initial epinephrine was through the endotracheal tube. This is likely ineffective, and the guidelines now recommend intravenous administration (via umbilical venous catheter) as the initial route of administration if possible. A higher dose of endotracheal epinephrine (up to 1 cc/kg of the 1:10,000 solution) may be given before intravenous access is obtained. There are also more stringent requirements regarding the use of naloxone with continued emphasis on the inappropriateness of this as a primary resuscitation method. Only patients with continued apnea after successful administration of PPV and a history of maternal narcotic administration in the past four hours should receive naloxone. The recommended route of administration is intravenous.

A new area of emphasis is temperature control. Maintenance of body temperature for very low birth weight infants is emphasized, including the use of polyethylene bags. The roles of hypothermia and hyperthermia were closely examined. There was insufficient evidence to recommend the use of hypothermia on infants with suspected asphyxia although there is a suggestion that this practice may reduce brain injury in neonates who have suspected hypoxic-ischemic insult. There is strong evidence that hyperthermia worsens brain injury in these babies. Emphasis was placed on maintaining normothermia in all infants.

Finally, there are two new chapters in the coming 5th edition of the NRP manual. One focuses specifically on the resuscitation of the pre-term infant, and the other discusses ethics and end-of-life care. The previous edition was the first to discuss these critical topics; the 5th edition does so in more detail. Preparing for pre-term birth with a team approach is a major focus—with the pediatrician, obstetrician and parents all in discussion and assisting in decision making together. As in previous editions, noninitiation of resuscitation and discontinuation of any life-sustaining treatment during or after the resuscitation are emphasized to be ethically equivalent. Providers are reminded to consider withdrawing support when functional survival is felt to be highly unlikely. The specific suggestion is that in babies who have a high chance of survival and acceptable morbidity risk, resuscitation is almost always indicated, and this would generally include babies with gestational age greater than or equal to 25 weeks, and most babies with congenital malformations. Discontinuation of care is suggested after 10 minutes of “continuous and adequate” resuscitation if there are no signs of life (no heart beat and no respiratory effort).

There are many internet resources available to those who would like more information. The ILCOR Guidelines were published in the May issue of Pediatrics, electronic pages. The New AHA/AAP Guidelines are published in the AHA’s Guidelines for Emergency Cardiovascular Care, available at www.americanheart.org/eccguidelines. The evidence-based worksheets from the ILCOR review are available as www.c2005.org. The NRP website is available through http://www.aap.org/nrp/about/about_workgroupedu.htm.
Midazolam

This benzodiazepine is one of the most common agents used for procedural sedation, usually in combination with another agent if analgesia is required. The time for its peak effect is about 2-3 minutes if given IV, and its duration is about 45-60 minutes. It can be given via PO, PR, IM, and intranasal routes, all with variable peak time and duration. The clinical effect of the oral route has been found to be unreliable. Of note, some children need higher doses on a per-kilo basis, and paradoxical agitation and crying has been reported widely. As with any benzodiazepine, there is concern for respiratory depression, especially in the presence of opioids.

Two other agents not routinely used by hospitalists were discussed extensively. These are Propofol, and the newer (and still not approved for children) Dexmetetomidine.

Propofol

This medication is a sedative-hypnotic anesthetic with no analgesic properties. It has become popular because of its rapid onset of action and recovery, lack of agitation, and antiemetic and euphoric qualities. Its main side effect is hypotension (usually transient), respiratory depression, apnea, and anaphylaxis (risk if allergic to eggs or sulfa). It is for IV use, given as a 1-3 mg/kg induction bolus, then 2-4 mg/kg/hr infusion. Higher bolus and maintenance doses may also be used. There is data about the addition of ketamine to blunt the hypotension caused by induction with propofol. There is also evidence in the adult literature that ketamine reduces the need for airway manipulation and respiratory depression, but studies in children are not widely available. Some institutions and hospitals limit its use to specific providers by classifying it as a deep sedation agent.

Dexmetetomidine

Precedex® is an ultra-short acting sedative hypnotic, with analgesic properties. It causes sedation by acting on alpha-2 adrenergic receptors in the locus ceruleus section of the brain stem, and causes mild analgesia by modulating the release of substance P from the spinal cord. In adults, the dose is 1mcg/kg IV as induction, then a maintenance infusion of 0.2-0.7 mcg/kg/hr for a maximum of 24 hours. In children, the loading dose is reduced, or omitted, and the maintenance infusion is the same as in adults. Its adverse reactions include hypotension (less than with propo-
Pediatric Critical Care and Sedation
(continued from p. 8)

(fol), bradycardia, nausea and hypoxia. So far, the limited data available for this drug suggests it has minimal significant respiratory effects, moderate cardiovascular effect requiring no intervention, and lack of recovery–related agitation. Newer research will have to involve its use in comparison with other agents and its long term effects.

The goal of moderate sedation is to provide an effective, time-efficient, painless and non-traumatic experience to our pediatric patients. There is a great need for research involving moderate sedation practices among pediatric hospitalists. Most of the current research involves anesthesiologists, critical care and emergency department physicians. There is also a need to involve ourselves in institutional credentialing and to help create QI processes.

As the number of pediatric sedations increases, pediatric hospitalists have an opportunity to intervene in these procedures. As the practice evolves, our specialty has ample opportunity to produce research that can then be shared among groups in order to reduce the variability among institutions and to improve adverse event monitoring and prevention. Our presence in the hospital makes us ideal candidates for these roles. We should embrace the practice and strive to make it better.

2 Joint Commission on Accreditation of Healthcare Organizations. Comprehensive accreditation manual for hospitals. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organization, 2005
Billing and Coding Corner

**Moderate Sedation Coding**
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On January 1, 2006 *Current Procedural Terminology* (CPT 2006) published by the American Medical Association was updated and now includes codes for moderate sedation for children. *CPT 2006* describes moderate sedation as “a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.” Also stated is “moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.”

The following are considered part of moderate sedation services and are not reported separately:
- Assessment of the patient (also not included in intra-service time)
- IV access and fluids
- Administration of agents
- Maintenance of sedation
- Monitoring of vital signs including pulse oximetry
- Recovery (also not included in intra-service time)

*CPT 2006* states “intra-service time starts with the administration of the sedation agent(s) requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.”

The codes are as follows:

**99148** Moderate sedation provided by a physician other than the health care professional providing the diagnostic or therapeutic service; under 5 years of age, first 30 minutes intra-service time.

**99149** Age 5 years or older, first 30 minutes.

**99150** Each additional 15 minutes intra-service time.

**99143** Moderate sedation provided by the same physician that is providing the diagnostic or therapeutic service. This also requires the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; under 5 years of age, first 30 minutes.

**99144** Age 5 years or older, first 30 minutes

**99145** Each additional 15 minutes

At St. Louis Children’s Hospital we have been using these codes when the level of sedation most closely matches the description of moderate sedation in *CPT 2006*. While the level of sedation is based on the response of the patient, there are drug regimens that most often produce moderate sedation. When using a combination of an opiate and benzodiazepine, parenterally or orally, and when using nitrous oxide with or without an opiate, the level of sedation achieved is usually moderate.

When using ketamine, pentobarbital or propofol, we use codes for deep sedation. We do not use the new moderate sedation codes for these patients because the level of sedation is usually most consistent with deep sedation as defined by the American Academy of Pediatrics and the American Society of Anesthesiologists: “a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.”

We are having success with coding and billing the new moderate sedation codes. Each area of the country is likely to have varying degrees of success and frustration in working with third party payers in the reimbursement of sedation. The following references used in this article may be of assistance:

Practice Profile

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HISTORY

California Pacific Medical Center (CPMC) is a tertiary care, community hospital located in San Francisco. CPMC and its physicians have been caring for children for over a century, and CPMC has enjoyed hospitalist coverage in pediatrics for close to 20 years. Initially, the program was a group of independent contractors who provided 24/7 coverage to the inpatient units and nighttime coverage to the neonatal and pediatric intensive care units.

At that time, the majority of daytime coverage on the ward was provided by residents from pediatric programs in the area (Children’s Hospital Oakland and University of California at San Francisco) under the supervision of private doctors in the community, who followed their patients in the hospital. A “house pediatrician,” who was a volunteer from the community, followed only unassigned patients.

In 2001, the hospitalist system evolved when one full-time hospitalist was hired to expand the program, providing 24/7 coverage for the patients on the wards. The program was well received by the community physicians, and the quality of care continued to improve. In 2001, less than 10% of hospital admissions were covered by the hospitalist service and in 2005, more than 95% of the admissions were covered by the hospitalist service.

Starting in 2004, the PICU/NICU Critical Care Transport Program, which had also been previously staffed by independent contractors, came under the umbrella of the Hospitalist Division.

MISSION STATEMENT

The CPMC Pediatric Hospitalist Program strives to provide high quality, compassionate, family-centered care to sick children and their families. The hospitalists are respected clinicians who promptly and efficiently coordinate subspecialty referrals, procedures, imaging studies and ancillary services. Our goal is to be the place where physicians wish to send their own children for care.

SERVICES/RESPONSIBILITIES

Each year over 2,000 children are admitted to CPMC’s Pediatrics ward and PICU. The NICU is located in a different hospital building, and presently the NICU operations are separate from the PICU and the Pediatric Hospitalist Program. Pediatric hospitalists, intensivists, and subspecialists employed by the Physician Foundation at CPMC, who work closely with families and referring physicians, determine the best course of treatment for pediatric patients and manage the pediatric inpatient care. The hospitalists also provide transport services from hospitals encircling a wide geographic range.

CPMC offers a 25-bed Pediatrics unit and 8-bed Pediatric Intensive Care unit. These units care for children from birth to 21 years and provide a broad range of services that include transport, subspecialty referrals, tests, procedures, and admission/discharge. The provision of all services is facilitated by a core group of one part-time and eight full-time pediatric hospitalists.

The hospitalist group provides 24/7 coverage for the Pediatrics ward, 24/7 on-call availability for critical care transport, ER consults for pediatric patients, and night coverage for the PICU. Hospitalists coordinate transports, admission and discharge for all pediatric patients, including follow-up. The hospitalists are involved in multiple administrative roles including hospital and departmental committees, marketing and outreach efforts, and quality assurance projects. Additionally, the Hospitalist Program is actively involved in medical education, contributing to the University of California at San Francisco (UCSF) Pediatric Residency Program and UCSF Medical School curricula through daily resident and medical student teaching on-site, providing multiple grand rounds presentations, and participation in PALS, BLS, and CPR teaching.

The daily attending rounds create the patient care plan with a multidisciplinary approach. Team rounds combine teaching and decision-making for the residents and medical students working in coordination with social workers, case managers, chaplin services, Child Life, nursing, physical and occupational therapy, nutrition, and pharmacy. As a result, the plans are known and communicated consistently to the families and referring doctors. Additionally, discharges, studies and procedures are completed in a timely manner.

PATIENT EXPERIENCE

The ward census has grown in recent years, partly due to the excellence of the inpatient units (PICU and NICU) and partly to the establishment of a full-time hospitalist service in 2001. This growth occurred despite the loss of some high demand specialty services (GI, Neurology) and was aided by the growth of others (Cardiology, Cardiovascular Surgery, and Oncology). The average ward census is approximately 13 patients. Ward and PICU admissions are divided into regular

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Subcommittee Updates

Early Careerists and Residents Subcommittee

Our subcommittee was formed in October, 2005 at the National Conference & Exhibition in Washington, DC. Our main goals and objectives are to:

- Establish communication between the Section on Hospital Medicine (SOHM) and the Section on Residents (SORe)
- Get the word out about hospital medicine to residents and young careerists
- Work on furthering relationships between the SOHM and the SORe and, in near future, the Section on Young Physicians (SOYP)

At the NCE, Dr Alison Holmes, chair of the subcommittee, attended dinner with the SOHM executive committee, and spoke directly with the executive committees of both the SORe and SOHM about mutual interests and related goals. The residents have solicited our sponsorship on a resident-generated resolution regarding education about inpatient billing and coding. The residents also wanted information on how to find out about hospitalist job openings.

Our last SOHM newsletter was focused exclusively on new careerists. This newsletter issue was sent to all members of the SORe (all 10,000 of them) and to all pediatric program directors. Resident membership in the SOHM has increased from 58 to 64 individuals, about a 10% increase since we began our outreach efforts in February.

Dr Jennifer Daru, the subcommittee’s executive committee representative, and Alison Holmes wrote an article for the semianual Resident Report, a print newsletter that goes to all 10,000 residents. Entitled “Career Corner: So you want to be a Hospitalist?,” it can be viewed on page 6 at http://www.aap.org/sections/resident/RRSpring2006.pdf. It was right on the outside when it arrived folded in the mail. Dr Daru also wrote an article for the January, 2006 SOYP newsletter entitled “On Considering Pediatric Hospitalist Medicine.”

Two projects are currently underway. We have just finished composing a survey about resident perceptions of and attitudes about pediatric hospitalists that will be sent to residents at 8 to 10 programs. Results will be presented in poster form at the upcoming NCE in Atlanta. Our second project involves outreach to pediatric residents and physicians at residency-sponsored career days. Many residents work with their AAP state chapters on these days. In the past, these have tended to focus on careers in pediatric primary care. We are starting to gather slides and a speaker list so pediatric hospital medicine can also be presented as a career option at such gatherings.

Our subcommittee activities are many, but our active members are not. Please email Alison Holmes at aholmes@crhc.org if you are interested in helping in any of the above efforts or have new ideas of your own!

Coding and Billing Subcommittee

The AAP SOHM Coding and Billing Subcommittee is completing the survey for distribution of E/M codes for Pediatric Hospitalist programs from around the country. This will be the largest survey done thus far and will hopefully serve as a benchmark for other programs. The results from this survey will be presented at the 2007 NCE in Atlanta. In addition, the subcommittee hopes to develop additional resources, such as a reference manual, to further assist its members.

If anyone is interested in becoming a member of this subcommittee, please contact Yong Han at yshan@texaschildrenshospital.org.

Palliative Care Subcommittee

The Palliative Care Subcommittee is a fledgling subcommittee that is still navigating the nascent field of Pediatric Palliative Care and its future course. We have shared a resource list as well as a BENCH survey of Pediatric Palliative Care programs.

We have developed the following goals:

- Promote palliative care as a continuum of hospital and outpatient care
- Promote pediatric hospitalists as a natural conduit to palliative care
- Promote the education and networking of pediatric hospitalists in palliative care
- Promote the connection between adult and pediatric palliative care that may apply to the latter area—apply lessons already learned.

We are always welcoming new members as we grow. Please contact: Maggie Hood, Chair of the Subcommittee on Palliative Care at Margaret.Hood@multicare.org.

Join an SOHM Subcommittee:

- Coding and Billing—Contact: Yong Han yshan@texaschildrenshospital.org
- Community Hospitalists—Contact: Karen Kingry Kkingry@suburbanhospital.org
- Palliative Care—Contact: Maggie Hood Maggie.hood@multicare.org
- Critical Care—Contact: Jack Percelay jpercelaymd@yahoo.com
- New Careerists and Pediatric Residents—Contact: Alison Holmes aholmes@crhc.org
- Medical Informatics and Technology—Contact: Timothy Hartzog tim@hartzoghealth.com
Practice Profile (continued from p. 11)

 (>23 hours) and observation (<23 hours) status. The observation category includes short stays for monitoring and testing, as well as short procedures, such as bronchoscopy, blood transfusions, 23 hour EEGs, etc. Interestingly, there has been an increase in the average length of stay in the PICU (8.3 days in 2004 and 9.3 days in 2005) and a slight increase in the average length of stay on the ward (2.7 days in 2004 and 3 days in 2005). We attribute this to the increasing complexity of patients kept at the hospital.

The Emergency Department at CPMC is the point of entry for many of our patients. There is an average of 6400 ED visits per year under the age of 18 years at two hospital campuses. Of these visits, 7.2% require admission to the inpatient service.

The Patient Satisfaction Survey scores are consistently in the 90th %ile. Patient/parent communication is a priority for the hospitalist service as well as coordinating care with the outpatient pediatrician.

TRANSPORT

At CPMC, a collaborative program is in place to provide comprehensive ground ambulance and air transportation services. The ground transport team service is provided primarily by a private company and is composed of paramedics, EMTs, and/or CPMC critical care nurse and pediatric hospitalist. The air transport team service is provided by an air transport medical company and is composed of a pilot, nurse or respiratory therapist, and a CPMC pediatric hospitalist. The CPMC transport team travels to a referral facility, performs all necessary functions to stabilize the patient for transportation, and monitors the patient until the safe arrival at CPMC. The pediatric transport volume has increased 244% from 2003 – 2005. In 2005, over 280 patients were transported by CPMC services.

HOSPITALIST OUTREACH

The Hospitalist Program performs site visits at referring hospitals and physician offices and participates in educational opportunities. We are also able to communicate with several hundred pediatricians in our referral area through the monthly electronic newsletter. This publication includes updates, highlights new services, reviews our clinical experience in a given disease and gives clinical case scenarios. You may view the newsletter through the following web address: http://www.thehealthgateway.com/cpmc2.

Additionally, a quarterly family newsletter, “Healthy Kids: From Our Family to Yours,” provides useful information to over 17,000 Bay Area families and showcases inpatient services.

The Hospitalist Program is also sponsoring a day-long conference on October 6, 2006, geared toward the Pediatric Hospitalist physician. The conference called “Frontiers in Pediatric Hospitalist Medicine” will feature expert speakers in the areas of critical care management, toxicology, radiology, pain management, CV surgery, and hematology/oncology. The goal of the conference is to focus on areas of Pediatrics specifically encountered by hospitalists. For more information about the conference or the CPMC Hospitalist Program, please contact Oded Herbsman, Chief of Pediatric Hospitalist Division at Herbsmo@sutterhealth.org.
American Academy of Pediatrics

2006 National Conference & Exhibition—Atlanta, GA

SECTION ON HOSPITAL MEDICINE

Section Program
H316
Monday, October 9
8:00 am - 4:00 pm

Moderator: Daniel Rauch, MD, FAAP
Education and Program Chairperson

8:00 am Poster Session

8:30 am Session: Issues in Post-Operative Care
Sarah McBride, MD

9:45 am Break

10:00 am Session: HIPAA in the Hospital
Edward Gottlieb, MD, FAAP

11:15 am Break

11:30 am Section Business Meeting and Lunch
Laura Mirkinson, MD, FAAP, Chairperson

Jeff Chinsky, MD, FAAP

2:30 pm Break

2:45 pm Session: Inpatient Ethical Issues
Sheldon Berkowitz, MD, FAAP

4:00 pm Adjourn

JOB ADS

Full-time & Casual Pediatric Hospitalist - Coon Rapids, MN

Come and join our growing new program! Allina Health System seeks a BE/BC Pediatrician, experienced in Hospitalist service. Will provide coverage at the Mercy Hospital Pediatric Unit. Mercy Hospital, a 252 bed facility, responds to a wide range of health care needs with various specialty services. All Allina Facilities will implement a new electronic medical record system, which includes physician order entry.

For more information contact:
Sadie R. Vagher
Allina Physician Recruitment Services
2925 Chicago Avenue
Minneapolis, MN 55407-1321
(800) 248-4921
recruit@allina.com

Academic Pediatric Hospitalist - Wilmington, DE

The Division of General Pediatrics at Nemours/Alfred I. duPont Hospital for Children is establishing a Pediatric Hospitalist program. Responsibilities will include in-house coverage as the general pediatric service attending, consultation and co-management of medically complex patients on surgical services, and teaching of pediatric house staff and medical students. Flexible scheduling; full or part-time is possible.

Interested candidates should have a major interest in providing inpatient care, excellent communication skills and teaching ability. Hospitalists will participate in hospital endeavors to improve patient care and safety. Nemours/Alfred I. duPont Hospital is a 180-bed, full-service teaching hospital associated with Thomas Jefferson Medical College.

Send curriculum vitae and cover letter specifying position to:
David Pressel, MD
Director, Inpatient Pediatrics
dpressel@nemours.org
Phone: 302/651-6355
Fax: 302/651-5948
We welcome the eighty medical professionals who either joined or reactivated their membership in the Section on Hospital Medicine during the first half of this year.

Are you interested in building a hospitalist program? Do you need helping restructuring or maximizing your current program?

Hospitalist Concepts, Inc. has experience in building programs in both smaller community hospitals and large academic centers. We focus on developing patient-care centered, economically-viable, sustainable programs.

If you need help with a hospitalist program, call us!

773-744-5677

www.hospitalistconcepts.com  info@hospitalistconcepts.com
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