

Section on Hospital Medicine

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



2005 Edition #2

"What, Me Worry?"

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

Writing from the hotel in Washington in the middle of PAS, two weeks after an inspiring SHM meeting in Chicago, and a short time until the Denver meeting, I'm energized by the enthusiasm and excitement these meetings generate. The Denver conference promises to create an even higher energy level. You don't want to miss it. The Ambulatory Pediatric Association is the lead sponsor and AAP and SHM are co-sponsors. We've selected a mix of clinical, research, education and practice management topics, but what makes the Denver meeting unique is the pure focus on pediatric hospital medicine and the opportunity to interact and network in an intimate setting with upwards of 200 other pediatric hospitalists. For more information on the conference, turn to page 2.

I ponder that we are still small enough as a field that if we fracture ourselves into separate groups, we will become ineffective and inefficient. A hallmark of the development of Pediatric Hospital Medicine has been the collaboration of AAP, APA and SHM. Each organization offers particular expertise and advocacy. We are strongest overall by maintaining an active membership and presence in each organization. APA offers valuable research and teaching expertise along with cutting edge clinical topics at the PAS meetings. SHM is 90+ percent internal medicine, but the logistical and practice management tools of adult hospitalists offer many opportunities for

imitation.

What about the AAP? What specifically is the Section on Hospital Medicine (SOHM) doing for you? We continue to comment on and develop policies related to pediatric hospital medicine and offer the insights and camaraderie of the LISTSERV, a new and improved Web site as well as CME activities. What else?

Yesterday I asked AAP President Carol Berkowitz if she would be willing to help improve pediatric hospitalist scheduling conflicts by declaring that no children shall be sick enough to require hospitalization on Friday nights—that would go a long way to solving some squabbles around weekend obligations in my program. She'd love to accommodate our request, but preferred to focus on the Academy's real work—advocating for insurance coverage for all children. This is a long journey with small steps along the way. The Academy is making progress on the state level, and we will continue to work on the federal level. Look to and work with your local AAP chapter to advocate for changes to Medicaid in your state.

On a more concrete level, the SOHM is engaged in several activities directly related to our practice as hospitalists. First, we will be conducting another salary survey this year, along with a survey of job descriptions and clinical workloads. Second, the national, multi-disciplinary 5-year review for inpatient codes is taking place this year. The RUC (Relative Value Scale Update Committee) has created new vignettes to look at the initial and subsequent hospital care codes for a typical encounter in 2005, and to reassess

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From the Editor

Jennifer Daru, MD

Welcome to the summer 2005 edition of our Section on Hospital Medicine Newsletter. Inside this edition you will find our first article on a combined adult/pediatric hospitalist program. Starting with lofty goals Dan Harrison and colleagues have built a large, successful program with regular support staff beyond the usual physician team. As always the "You are the Consultant" piece presents a case that all of us don't want to miss, and, in a wonderful tie-in, the Billing Corner team will be addressing how to bill for consults. A special addition to our other usual articles is a piece on using PDAs as a hospitalist - highly recommended if you have been trying to decide what programs to put your money into.

Keep an eye out for our next newsletter, which will be our first "Special Edition." It will have suggestions on everything from how to train to be a hospitalist to how to negotiate for a good position.

As always, please read, enjoy, discuss and post our newsletter. Contact me if you would like to contribute.

There's plenty more to say!

Jennifer

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Educational Opportunities

What me, Worry?

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Leadership Academy for Hospital Medicine September 12-15, 2005 Vail, CO

Designed to provide hospitalist leaders with the skills and resources required to successfully lead and manage a Hospital Medicine program now and in the future, the Society of Hospital Medicine (SHM) will hold its second Leadership Academy for Hospital Medicine September 12-15, 2005 at Vail Cascade in Vail, Colorado. Due to small group interactive sessions registration is limited to 100 participants. The faculty is made up of nationally recognized leaders in training executives and leaders in healthcare.

This Academy was first held in January 2005 to outstanding reviews. The September 2005 meeting is more than 50% sold out already. To view the meeting brochure or to register go to the SHM home page at www.hospitalmedicine.org ASAP

Here are some comments from attendees at the January Leadership Academy

“The best conference I have ever attended. It seemed as if it was individually designed for what I am dealing with on a daily basis in my role as hospitalist medical director.”- Dan Harrison

“I look forward to opening my new tool box. I feel like I’ve stepped into a phone book and come out with an ‘S’ on my chest.” - Lee Litvinos

“Even with 18 yrs of clinical/administrative experience as well as a MBA this course was a learning experience and I gained and reinforced critical areas of thinking and actions.” - Anonymous



Mayo Clinic Pediatric Days September 8-9, 2005 Chicago, IL

12.50 category 1 credits towards the AMA Physician’s Recognition Award. Application for CME credit has been filed with the American Academy of Family Physicians and the American Academy of Pediatrics. **Determination of credit is pending.**

Course Description & Audience:

This course is designed to provide pediatricians, family physicians, physician assistants and nurses with current information on a variety of medical and surgical conditions affecting children and adolescents. Our key themes this year are gastroenterology, cardiology, neurology, genetics, developmental pediatrics and pediatric surgery.

Registration Fee:

Physicians/Scientist: \$400
Resident/PA/Nurse/Technician: \$300

Additional Information:

Contact Mayo School of Continuing Medical Education by
FAX: 507-284-0532
Telephone: 800-323-2688
E-mail: cme@mayo.edu
Website: <http://www.mayo.edu/cme/pediatrics-adolescent-medicine.html>



Pediatric Hospital Medicine 2005 July 28-31, 2005 Denver, Colorado

Sponsored by the Ambulatory Pediatric Association, the Society of Hospital Medicine, and the American Academy of Pediatrics Section on Hospital Medicine, the Pediatric Hospital Medicine 2005 will bring together hospitalists to explore the many facets of this growing field. Workshop areas include clinical, education/teaching, research, and practice management. To register, visit www.ambpeds.org. For more information contact the APA national office at 708/556-9222.

the resources involved with each encounter. The vignettes involve a 50 year old with COPD and diabetes and heart failure—no relevance to pediatrics. So, within the Section, we will have the opportunity to devise pediatric equivalents vignettes and create some examples for what we as experts in inpatient care believe constitutes a level 2 H&P, or a level 3 subsequent care visit for example. We can then work through the Academy structure and the Committee on Coding and Nomenclature to endorse these vignettes. No other organization will focus so specifically on pediatric inpatient coding. If any of you doubt the value of these efforts, ask your critical care and neonatology colleagues about the impact global NICU and PICU codes have had on their practice. The AAP SOHM will take the lead on this topic. We know what effort goes into the work we do; we have the expertise, and we have the responsibility. Look to hear more about this process in the coming year.

Another project with a focused deadline is development of a hospital medicine practice improvement module for board recertification. As a part of the new structure for board recertification, you must not only demonstrate mastery of key knowledge in pediatrics, but you will also need to demonstrate ongoing efforts to improve your individual practice. To date, the AAP’s eQipp modules are the only programs approved by the American Board of Pediatrics for meeting this requirement. The AAP has a module in place for ADD and for asthma. These will be targeted towards office-based pediatricians who can pull their own charts to monitor their practice. Unfortunately, just as irrelevant to us as hospitalists as the above 50 year old with COPD. But the Academy isn’t stopping here. Each sub-specialty is being offered the opportunity to develop its own quality improvement module. GI is going first with management of inflammatory bowel disease. We may not have the official moniker of a sub-specialty, but the Academy recognizes that we hospitalists will need our own eQipp module, and it will be the SOHM that will be putting this together for you so that you don’t have to moonlight in an office specializing in ADD to renew your boards in 2010.

That’s what the Section on Hospital Medicine is doing for you ! See you in Denver.

2005 National Conference and Exhibition

Section Program Schedule

Section Program for Section on Hospital Medicine Members

Date: Monday, October 10, 2005

Moderator: Laura J. Mirkinson, MD*

8:00 am - 9:15 am	The New Immunology
9:15 am - 9:30 am	Question and Answer
9:30 am - 9:45 am	Break
9:45 am - 11:00 am	Tapping into Meningitis
11:00 am - 11:15 am	Question and Answer
11:15 am - 11:25 am	Break
11:25 am - 12:30 pm	Post-traumatic Stress Syndrome
12:30 am - 1:45 pm	Section Business Meeting & Box Lunch
1:45 pm - 2:00 pm	Break
2:00 pm - 3:15 pm	The Many Faces of Mycoplasma
3:15 pm - 3:45 pm	Question and Answer

Concurrent Poster Session

- (#22) Pediatric Hospitalists Teaching: The Doctor's Black Bag Series for Pediatric Housestaff
- (#103) Clinical Guideline and Order Set Development and Implementation: A Case Study in Quality Improvement
- (#186) Encephalopathy Associated with Viral Gastroenteritis in Hospitalized Children
- (#243) Yield of Echocardiograms Ordered by Non-Cardiologists on Hospitalized Pediatric Patients
- (#267) Occult Bacteremia in Children in an Area with Poor Immunization Coverage Rates
- (#268) The Pediatric Hospitalist and Image Guided Therapy: A New Model of Care in Pediatrics
- (#450) Sutured Securement of Peripherally Inserted Central Catheters Decreases Complications in Pediatric Patients
- (#458) Comprehensive Care for Medically Complex Children: The Pediatric Hospitalist - PNP Partnership
- (#472) Effectiveness of Hospitalist-Administered Sedation for Pediatric Imaging Studies
- (#617) Provider Specific Differences in Airway Complications: Results from the Pediatric Sedation Research Consortium
- (# 648) Impact Of Standardizing Inpatient Bronchiolitis Care Using Benchmark Data and Computerized Physician Order Entry (Cpoe)

* Daniel A. Rauch, MD is moderating the poster session.



PREPARING FOR LIFE IN ACADEMICS Survival Skills for Fellows & Young Faculty

American Academy of Pediatrics
National Conference & Exhibition
October 7, 2005
Washington, DC

Sponsored by the Section on Critical Care

Target audience:

Fellows at all levels of training in any subspecialty or post-residency training program expecting to enter academics.

Academic faculty in their first few years of appointment.

Preparing for Life in Academics is a one day seminar developed specifically for those preparing to enter academic medicine or just starting their academic career. The course brings together academic leaders from a number of medical disciplines to discuss many of the issues not covered during traditional fellowship training. In this course participants will learn about career essentials such as effective negotiation, techniques to manage time effectively, and how to become involved at a national level. Opportunities to improve teaching skills will be offered through interactive sessions on feedback and delivering effective presentations.

Practices important to the business and organizational aspects of medicine will be addressed. Participants will also learn some of the more challenging areas that confront physicians: disclosing medical errors and preventing malpractice.

Friday, October 7

8:00-8:15am	Intro
8:15-9:15am	Academic Medicine 101: Becoming a Good Citizen
9:15-10:00am	Negotiation Skills
10:00-10:15am	Break
10:15-11:00am	Time Management
11:00-12:00noon	Teaching Skills Overview
12:00-1:15pm	Lunch
1:15-2:30pm	Disclosing Errors/Reducing Malpractice Risk
2:30-3:15pm	Performance Improvement Overview
3:15-3:30pm	Break
3:30-4:15pm	Tracks, Tenure, and Net- working: Three Essentials to your Career
4:15-5:00pm	Effective Presentations

Course Director

Stephen Schexnayder, MD, FAAP

Faculty

Debra Fiser, MD, FAAP
Gerald Hickson, MD, FAAP
Carole Lannon, MD, FAAP
Sanford Melzer, MD, FAAP
Michele Moss, MD, FAAP
Vinay Nadkarni, MD, FAAAP
Diana Wara, MD, FAAP

Registration Information

Please visit <http://s12.a2zinc.net/clients/aap2005/aap2005/public/enter.aspx> to register.

Note: Course is open to NCE registrants only. An additional fee of \$100 is also required. Breakfast, lunch and breaks are provided.



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

Ron Nicholis, MD

In the electronic marketplace many handhelds (Personal Digital Assistants; PDAs) are being replaced by mobile phones for personal database management. In the medical profession there is much more they can do that mobile phones cannot.

Although many of the programs mentioned in this article are available on both Palm and Pocket PC handheld devices, I primarily use them on the Pocket PC. I will be presenting only software that I have used and found to be useful in my practice as a pediatric hospitalist and will name some Web sites that will give the reader access to much more than I am able to present in this article. I should note that I do not have any monetary or compensatory relationship for any of the products or with any of the vendors I mention.

Many physicians know you can use a handheld for clinical references and to manage a personal calendar and contact list, but not all know just how many clinical references are available. Or that they can run PowerPoint presentations from the handheld. Clinical references for the handheld can either be purchased or self compiled, allowing you to place electronic versions of articles or just simply your personal notes on topics on your handheld so that they are available wherever you are.

Published clinical reference material for the handheld when purchased can be either downloaded from Web sites or from CDs onto your handheld. However, to use the material you need to have reader software installed onto your device. The reader allows you to navigate through the reference material to find and read what is of interest efficiently. Different vendors sell reference material that works best on their own reader but many products can be navigated using multiple readers.

An excellent drug database for Pediatrics is *Pediatric Lexi-Drugs* on the Lexi-comp reader available at <http://www.lexi.com>. This product, like other drug databases for the handheld, allows quick access to the information you need by listing multiple categories for each drug, e.g. "usual dosing", "dosage forms" and "pharmacokinetics." This is

similar to what you might find in a book, but with quicker, easier access. *Pediatric Lexi-Drugs* is the one I use most frequently in my practice. Other drug databases that are available are *Epocrates* available at <http://www2.epocrates.com> and *Mobile PDR* available at <http://www.pdr.net> to list a few. When you go to these sites you will find other products available for your clinical practice as well.

Many of us use *The Harriet Lane Handbook* as a reference and it is available for the Palm and the Pocket PC. The information is arranged so you can find what you need either by a table of contents or an index. As you type the subject in the search narrows letter by letter to zero in on the information you are looking for. *The Harriet Lane Handbook* is available from multiple vendors such as Skyscape at <http://www.skyscape.com>, or even <http://www.amazon.com>. Skyscape has many other references for the handheld, e.g. *Pediatrics Survival Guide*, *The 5-Minute Pediatric Consult*, *The Harriet Lane Handbook*, and *Red Book*. *Red Book* is also available through the AAP. The AAP uses another vendor to distribute their product with a reader from High Wire Press (<http://highwire.stanford.edu>).

If you have a subscription to MDConsult, <http://www.mdconsult.com>, an online medical reference service that allows access to full text journal articles as well as several medical textbooks online, you will get access to POCKETConsult and the MobiPocket Reader, <http://www.mobipocket.com>, at no additional cost. The MobiPocket Reader is used by many vendors for handheld navigation of their products. POCKETConsult allows you to get current tables of contents and many abstracts from over 300 journals (you choose the ones you want) automatically when you synchronize your handheld with your computer so you can review the latest editions anytime, anywhere in the palm of your hand. MDConsult also includes access to a free drug interaction tool allowing you to list any drugs you need to compare for adverse interactions.

One of the most powerful handheld Pediatric and medical references I am aware of is UpToDate, <http://uptodate.com>. It is pricey at a little over \$500, but has some features that make this a good value. The

Pediatric section of UpToDate is edited by Dr. Ralph D. Feigen with a large cadre of Pediatric contributors. Unlike textbooks which are updated after several years and are usually out of date by the time of publication, UpToDate is updated quarterly as needed by each contributor and sent to each subscriber on CD. Online you have access to the latest medical information on that topic and you are also able to access the abstracts of the references used by that author for the information they are presenting simply by clicking on the reference number. If a drug is listed in the database, clicking on it opens UpToDate's copy of Lexi-Comp which is even more complete than the one I mentioned above saving you the cost of that product. UpToDate includes graphs, tables, and even radiographs where appropriate and they are continually adding to the reference database which is already quite extensive in most fields of medicine. The search features are excellent and are divided into adult medicine and pediatrics for easy access to the information you desire.

If you purchase UpToDate, you will have access to the entire package online from any computer with internet access and you also will be able to download the information onto your handheld PocketPC (not available for Palm, but I understand it is coming). Because of the extensive nature of the database it requires at least a 1 GB (gigabyte) SD or CF card on your handheld device to handle the information. The good news is that you can now purchase these cards (even 2 GB CF cards) for less than \$100. With this on your handheld, you will have access to the most up to date information on most topics at the point of patient contact and can show the patients the information on your handheld as they ask their questions.

What makes the \$500 price reasonable is you get hour for hour Category I CME Credit for any time you spend using this product online (not yet available on the handheld) for up to 50 hours per year with no need for tests. The time is maintained by UpToDate monitoring your online use of the product and costs only an additional \$25.00 for the 50 hours CME credit per year. Another similar but less extensive

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You are the Consultant

Lisa B. Zaoutis, MD, Children's Hospital of Philadelphia

Keith J. Mann, The A.I duPont Hospital for Children

You are contacted by a family practitioner at a small community hospital that is caring for a 6-month old girl admitted 2 days earlier for cellulitis of the left thigh. The physician provides the following report:

The infant had been hospitalized for fever, swelling and erythema of the left thigh that had developed over the 48 hours that followed her routine 6-month immunizations. Her HIB and DTaP were administered IM in the left thigh and the Prevnar® was administered in the right thigh. Mom explained that the child screamed during and after the injection. The discomfort continued and even worsened over the next 2 days, and the left thigh swelling and redness was noticed the day of admission to the community hospital.

The infant was born at 30 weeks gestation by C-section for vaginal bleeding thought to be secondary to placenta praevia. The NICU course was uncomplicated and the infant was discharged at 36 weeks post-conceptual age. Some developmental delay is recognized (currently unable to roll back-to-front or sit unsupported). The available family history is unremarkable although the father of the child remains unidentified by the 16-year-old mother. The child takes a standard cow's milk-based formula, but when the mom is out of formula she gives the child whole milk.

The physical exam at the time of admission was notable for a fever of 38.5°C (101.3 °F), a fussy but nontoxic appearance, and tenderness, swelling, and mild, poorly localized erythema over the anterior mid left thigh. The hip and knee joints were difficult to evaluate due to the obvious discomfort with manipulation of the left lower extremity. There was no knee effusion and the calf, ankle and foot were normal with good distal pulses and capillary refill. The infant wiggled her toes spontaneously but otherwise would not move that extremity. Aside from mild hypotonia, the remainder of the exam was normal.

The referring physician admitted the child and, after obtaining a blood culture and a CBC, started IV oxacillin. The WBC was 12,000/mm³ with 70% neutrophils and no bands. There was a mild, normocytic anemia (hemoglobin 11 g/dL) and the platelet count was 300,000/mm³.

During the hospitalization, the child did not improve. The fever remained low-grade (max 38.2 °C, 100.8° F) and the exam unchanged. The blood culture showed no growth (more than 48 hours). Earlier on the day of consult, the physician obtained an ultrasound of the thigh that revealed diffuse edema, but no abscess. A repeat CBC was unchanged, and an erythrocyte sedimentation rate was slightly elevated at 25 mm/hr.

The referring physician is requesting transfer of the child to your facility for further evaluation and treatment, which you accept.

When the child arrives, you obtain a history and perform an exam, which are both completely consistent with the report by the referring physician.

You perform one of the following diagnostic tests that reveals the diagnosis:

1. Plain radiograph of the left lower extremity
2. MRI of the left lower extremity
3. Nuclear medicine three-phase bone scan
4. Observation – This is a common reaction to immunizations

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First Do No Harm...

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multidisciplinary medical database, also with CME, for less than \$100.00 can be found at <http://www.emedicine.com> advertised as updated 24/7 by their contributors.

The products mentioned above have the ability to turn the palm of your hand into a medical library, but there is much more. Clinical calculators are available from several sources. Some are free with Skyscape products ("Archimedes") and with handheld textbooks such as *The Harriet Lane Handbook* but the most powerful I have found are in the product called PediSuite available at <http://www.medicalwizards.com>. This product provides a wide range of pediatric clinical information, e.g. growth chart percentiles; an easy to use conversion calculator; toxicology information including antidotes; information and calculators for pediatric codes, fluids, antibiotics, drugs,

drips, sedation and rapid sequence intubations. Furthermore, the navigation and use of the calculators is quick and easy allowing you to enter a weight or age and get the information you need automatically calculated for that specific child. I am very impressed with the facility and depth of this product for practical pediatric hospitalist use.

With products such as Pocket Controller-Professional available through <http://www.soti.net> you can not only control the handheld from a computer with either cable or wireless connection but you can also do a PowerPoint presentation with software from <http://www.westtek.com/pocketpc/presentation/> called ClearVue Presentation. The presentation can be on the handheld, or on the computer screen or on the large screen through the computer connected to an LCD projector.

This is a great teaching tool and you can have all of your PowerPoint presentations in the palm of your hand for use anywhere. A



product called "Margi" available at <http://www.margi.com> allows you to directly connect your handheld through the CF or SD card slot to an LCD projector for your PowerPoint presentation.

This is just a small taste of the potential use of the handheld device in clinical practice. There are many more products available, some as good as or better than those I have presented, but I have personally used and can recommend those mentioned. A great website for the evaluation of Pediatric handheld software is <http://www.pedsonhand.com> or you can try <http://www.handheldmed.com/> to find some of the other products available. Another suggestion is to try doing a Google search at <http://www.google.com> for references you would like to access.

I will leave for another time information on a handheld program developed by and for our hospital for downloading patient information. This allows us to create notes and do billing as well as look up labs, radiology, and microbiology reports. Aah the power of the handheld for clinical practice!

Ron Nicholis, MD
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Practice Profile: The Palomar Hospitalist Program A Combined Adult/Pediatric Hospitalist Program

Dan Harrison, MD

Neighborhood Healthcare (formerly Escondido Community Health Center) had been providing pediatric ER coverage at Palomar Medical Center for several years. Because of many of the same pressures that were fueling the hospitalist wave around the country, Neighborhood Healthcare expanded and partnered with Palomar to create a combined Adult/Pediatric Hospitalist program in September 1989. With the lofty goals of providing the highest quality of care in an efficient and cost-effective manner, regardless of ability to pay, the Palomar Hospitalist Program was formed. In short, we set off to create a Cadillac program not really knowing the difference between a Pinto and a Rolls Royce.

Neighborhood Healthcare is one of the largest private nonprofit community clinics in the San Diego and Riverside counties, providing care to 64,000 children and adults who are uninsured or underinsured. At the time that the hospitalist program was started, Neighborhood Healthcare was providing prenatal care, HIV care, dental care as well as primary care for pediatric and adult patients at five sites in both San Diego and Riverside counties.

Palomar Pomerado Health is a hospital district in North San Diego County that is made up of 2 sister hospitals, Palomar Medical Center and Pomerado Hospital. The district covers an 800 square mile area and is the largest hospital district in California. Palomar Medical Center, where our program started, has 319 acute care beds with 23 licensed pediatric beds and 167 licensed general medical beds. Approximately 52,000 patients move through the ER annually. In addition, Palomar is home to the only trauma center in the North County and has a very active birth center and level II NICU.

Asking Neighborhood Healthcare, a community clinic, to run the hospitalist program made sense for a number of reasons. Like most hospitals around the country, Palomar has a group of patients with very limited resources but chronic diseases that need ongoing care. Unfortunately, many of these patients used the ER for their primary care and frequently ended up admitted to the hospital. The hope was that if the

community clinic was able to intervene that some of these patients would find a medical home at Neighborhood Healthcare where they would get teaching, medications and ongoing care, breaking the cycle of frequent visits to the ER and recurrent admissions. The hospital administration also wanted to strengthen the pediatrics program at the hospital, but the patient volume could not support a full-time pediatrician. By utilizing dual trained/double boarded Internal Medicine/Pediatrics physicians we are able to have in-house pediatrics coverage.

In designing the program we enlisted the help of Hospitalist Management Resources to avoid some of the stumbling blocks in the fledgling program. From the beginning, support from the hospital administration has provided the compensation and ancillary staffing to help assure the success of the program. A full-time Team Coordinator is responsible for coordinating the daily activities of the program. From compiling the daily census/billing sheets to facilitating communication with the consultants and primary physicians, this role has been indispensable. Our team coordinator is able to obtain old records from almost anywhere in the country at the time of the admission and then make sure that every patient has an appointment at the time of discharge and that the records get back to the primary care doctor. A dedicated Discharge Planner works with the group to guarantee that transfers occur in a timely manner and that patients discharged to home have all of the equipment and support to make the discharge successful.

We have also developed a Clinic/Hospitalist RN liaison. The role of the RN Liaison is to make sure that the individuals that would benefit the most from the programs and resources of the community clinic are appropriately plugged in. By obtaining medications for these indigent patients, initiating teaching about their illness and emphasizing the importance of follow-up, the objective is that patients will be better able to manage their disease states and not require frequent ER visits and hospital admissions.

Over the last 7 years the program has grown from an average daily census of about 10 with one Internal Medicine/Pediatrics (M/P) trained physician round-

ing during the day, to an average census in the 60's with 3 Internal Medicine/Family Practice (IM/FP) rounders added to the M/P physician. We now provide 24/7 coverage for the adults, with in-house coverage of pediatrics during the day and pediatric night call from home. We have contracted with several of the primary care groups in the community and have become the primary medical consultants in the hospital. Our group accounts for more than 60% of the adult medical admissions to Palomar Medical Center and virtually all of the pediatric admissions.

Initially, the program was to be staffed by a cohesive group of M/P trained physicians who would see patients both in the hospital and at a M/P outpatient clinic. We quickly realized that not only was growth not going to allow for the small group envisioned, but for the most part the physicians quickly migrated to either inpatient or outpatient settings.

Although we initially started with a 7 day on and 7 day off schedule, we soon switched to a 5 day block schedule. With the increasing census we also quickly evolved into a 24/7 program for the adults, and a home night-call for pediatrics. We have also split the day call to 6 am to 12 noon and 12 noon to 6 pm to ensure that each hospitalist has protected time to be able to care for the patients that are already under their care. This has helped to avoid those late day rounds, keeping length of stay down. Currently we have 4 rounders on during the day; at least 1 M/P trained physician and 3 IM/FP to manage an average daily census of around 60.

We are lucky enough to have a nocturnist for almost ½ of the month to manage the adult night coverage. The other nights are split between the full-time hospitalist, other employees of the clinic and members of the medical community. Because of the busy nature of the night call we have added a "short" call that provides back up from 6pm to midnight. This allows the overnight person to concentrate on cross-coverage and not become overwhelmed with the 6 to 14 admissions that occur each night

Because of the lower patient volume, pediatric call can be taken from home. The M/P trained doctors, as well as other pediatricians employed by Neighborhood

Practice Profile

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Healthcare and practicing in the community work together to cover pediatrics coverage at night.

Over the last 6 years the growing census has demanded that we continue to add physicians. Our goal has been to maintain an average of 15 total encounters per hospitalist. This volume allows for the hospitalist to re-round on the patients and to spend the time needed to meet with the family, follow-up on diagnostic studies and respond to changes in a timely manner.

Our daily census varies from the high forties to mid seventies depending on the time of year. Although the majority of patients admitted to this community hospital are adults, during the winter months there are often more than enough patients to keep a pediatrician busy. Both the adult and the pediatric patients admitted to our service come either through the ER, are referred as direct admissions from an outside physician or are consults from within the hospital.

As the program has grown the demographics of our patients has also changed a bit. With the addition of a number of agreements with local primary care groups we are admitting a lot more of the bread and butter pneumonia, strokes, DKA and CHF as well as more than our fair share of RSV, Rotavirus, Neonatal Sepsis etc. But our service is still well known in the hospital for admitting fasciomas. Since the beginning of the program we have admitted patients with adult Still's disease, Non-HIV associated cryptococcal meningitis and disseminated coccidiomycoses, Maple Syrupe Urine Disease and Isovolemic Acidemia just to name a few. We also care for a number of children with known chronic diseases in phone consultation with the subspecialist at Children's Hospital of San Diego.

Like the rest of the program, the compensation and benefits package has continued to evolve over time. One of the challenges has been to keep up with the moving bar of fair and reasonable compensation for a hospitalist while trying to keep the books balanced. At this point we have a base salary plus an RVU based bonus. Although our based salary has remained about the same, the bonus has risen steadily as we move to a more performance based salary model. In addition to the 15 days off per month there is paid CME and vacation time. We also offer a fairly

standard benefit package including individual medical, 403b and malpractice with tail.

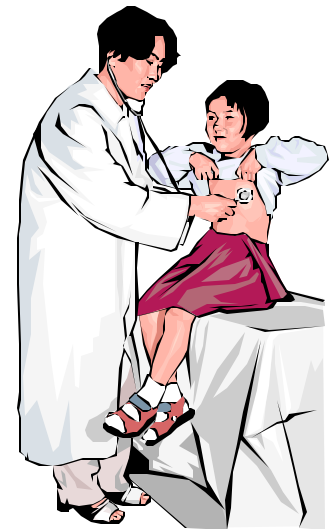
Like most hospitalist programs we have struggled with recruiting and retaining quality physicians in an environment where the playing field is in flux and the demand exceeds the supply. We have struggled with the balance between providing a service to the hospital and medical community (our customers once removed) and being "interns" for the community physicians and subspecialist. We continue to work toward an efficient and dependable system that provides direct communication between the hospitalist and referring physicians in the community.

Unlike most programs, however, we have also struggled with issues that are unique to our combined adult and pediatric program. It is a constant point of discussion as to the amount of work and effort that is involved in the admission and follow up care for a child as compared to an adult. It has been a struggle to change the culture of the local pediatricians whose practice it has been to "send to Children's". We are still trying to define what children are appropriate for our community hospital without subspecialty support. It also has been more difficult to accommodate the seasonal variations in census (i.e., when our pediatric census can more than double during a big RSV year).

Despite these challenges, we have had some significant successes. We do provide a very high quality of care to all patients regardless of ability to pay, in a cost-effective manner. We managed to reduce length of stay and costs per admission by half without increasing the return to ED or readmission rate. We have been able to break the cycle on many of the disenfranchised patients who had been using the ER as their only access to care. We have changed the admitting patterns of many pediatricians in the community who now call us before just sending the patient to Children's San Diego. We have also influenced many aspects of hospital care by serving on committees and being active members of the medical staff.

Our goals for the future are to continue to hone our skills as hospitalist and to provide the highest quality of care possible. We are planning to expand to

the sister hospital, Pomerado Hospital, in the very near future and are looking forward to the new challenges that this represents. We are planning to continue to work on clinical pathways and best practices to help set a bar in quality of care. We are also hoping to re-ignite the push to keep children in their community instead of sending them and their families several miles away to the nearest Children's hospital, a goal that had previously lost some momentum.



SOHM Election Results

Congratulations to Laura Mirkinson, who was elected to Chair-Elect and Michael Ruhlen who was elected to a new term on the SOHM Executive Committee.

Special thanks to our Nominations Committee, Shawn Ralston, Chair, and Doug Carlson for coordinating this year's election. Stay tuned to the LISTSERV for information on future elections.

You are the Consultant: Answer

(cont from page 6)

A plain radiograph of the left lower extremity reveals a fracture of the midshaft of the left femur. Further roentographic imaging ("skeletal survey") reveals 2 healing rib fractures. A CT scan of the head and ophthalmology exam were both normal. The infant likely had a femur fracture prior to the immunizations, and the force of holding the leg and subsequent injection likely caused the intense crying and irritability seen prior to admission. The child was subsequently referred to family services for suspected abuse. Although an MRI of the thigh and a bone scan likely would have led to the correct diagnosis, sedation required for these studies was avoided because you suspected the fracture and ordered the simplest study.

There are several important factors in the history that favor the consideration of abuse. This child was premature and developmentally delayed, both risk factors for abuse and neglect. Low-income status, maternal age, and a single-parent household are all social issues that predisposed this child to abuse as well. Long-bone fractures in infants are almost always related to abuse. It is difficult for an infant to supply the force needed to fracture a long bone unless there is an underlying skeletal dysplasia. Spiral fractures at the diaphysis and metaphyseal or corner fractures of long bones, rib fractures in various stages of healing, and complex skull fractures are other concerning injuries that should lead to an evaluation for abuse. You may wonder about the fever. A femur fracture is a traumatic event that can result in the loss of a significant amount of blood into the surrounding tissue. Along with this local trauma, systemic release of cytokines can cause low-grade fever. Thus, the presence of fever in this child is consistent with the diagnosis.

The initial concern for cellulitis and the reflexive concern for an underlying osteomyelitis could have been avoided by returning to the initial physical exam and laboratory findings. Although the patient was febrile, the remainder of the exam was not typical for cellulitis. Tenderness and swelling seemed to be the most impressive component of the exam. Although

erythema was described, it was mild and poorly defined. The hip and knee joints was difficult to evaluate due to severe, localized pain. Lastly, the child was in enough discomfort that she refused to move the leg spontaneously. The severity of these findings associated with only mild superficial erythema suggests a deeper process, making cellulitis as a cause for her pain and swelling unlikely. Although cellulitis is often painful, careful examination of the adjacent joints is usually possible and spontaneous movement of the affected limb should not be so difficult. The laboratory findings of a normal white blood cell count and a mild elevation in the ESR also lead away from the diagnosis of cellulitis, although cellulitis can occur in the face of normal laboratory findings. A more deeply seated infection, such as pyomyositis or necrotizing fasciitis should also be considered in a child with a fever and painful extremity, but the unimpressive fever, non-toxic appearance of the child, and lack of inflammatory markers leads one away from these diagnoses.

Acute osteomyelitis can occur following invasive procedures ranging from heel punctures to fetal monitoring, thus it is not unreasonable to consider this diagnosis (possibly from an excessively deep immunization). The rapidity of the symptoms following immunization and the normal CBC and ESR, however, make this diagnosis less likely. In children, acute osteomyelitis typically occurs in the metaphysis of long bones. Thus, the midshaft nature of this child's findings should make you think of other causes as well. A bone scan would be an excellent choice if the case presented were more consistent with acute osteomyelitis. A soft tissue infection may be suggested by increased perfusion in the first phase of the three-phase nuclear scan, but is non-specific. One could make the argument that an MRI should be done preferentially because there is a localizing physical finding, however osteomyelitis in infants can be multifocal and a nuclear bone scan would be considered by many to be a better initial test. In this case, the multiple fractures would have shown up as "hot spots" and further imaging, such as skeletal survey or MRI, would have revealed the diagnosis.

Another important point in the discussion of this case is the initial antibiotic choice of oxacillin by the referring physician. Community acquired methacillin-resistant *Staphylococcus aureus* (MRSA) is becoming more prevalent nation-wide. Prevalence in communities has been reported as high as 50-60% of all cultured *S. aureus*. Furthermore, many of the MRSA isolates contain genes that encode for virulence factors often not found in methacillin-sensitive species. These factors predispose to deep-seated infections such as osteomyelitis. The initial antibiotic choice should take into account the resistance patterns in your community. Vancomycin or clindamycin are reasonable options. Furthermore, the importance of making a microbiologic diagnosis is more important than in the past, likely increasing the need for bone biopsy and culture to avoid the long-term empiric use of vancomycin for all cases of osteomyelitis.

The last option, observation, would have been correct if not for the severe pain and complete immobility of the child's extremity. Immunizations can frequently cause low-grade fever, localized erythema, swelling and tenderness. However, the degree of pain and the limitations to movement make this benign entity less likely.

CDC Offers New Web Page

A new Web page for pediatric health care providers has been added to the CDC Child Development Web site. The new page provides tips for primary care practitioners on integrating developmental screening into their practices efficiently, at low cost, and while ensuring coordination of care. A sample flowchart of clinical screening activities and an example of how physician and non-physician staff roles may be delineated to make routine screening feasible are provided as well and can be printed from the Web site http://www.cdc.gov/ncbddd/child/screen_provider.htm

For more information, please contact Carla P. White, MPH, Health Scientist, CDC at carlawhite@cdc.gov

Rule of Six Vs Standardized Drips – Patient Safety and Evidence-based Medicine

[Editorial Comment: The Section on Hospital Medicine is fortunate to count Dr. Erin Stucky among its members. Those of us who have heard her speak at national conferences appreciate her keen ability to interpret the medical literature. Dr. Stucky is Chair of the AAP Committee on Hospital Care and has been a key shepherd of the efforts to create a thoughtful response to the JCAHO National Patient Safety Goal mandate to eliminate the Rule of Six dosing. She comments below on the enactment of responsible change based in evidence. M. Ruhlen]

Pediatric Hospitalists and Intensivists are well aware of the “rule of six”, a calculation used for creating continuous drip medications. For many years, the “Rule of Six” has effectively been used in pediatric and neonatal intensive care units, emergency departments, and by first responders in the field. The “Rule of Six” (RO6) is a weight based equation: 6 times the body weight is the amount of medication in milligrams to be added to 100 milliliters of fluid, resulting in a concentration infusion of 1 microgram/kilogram/minute = 1 milliliter/hour. As is well known, calculation errors are a significant source of concern in pediatrics given weight-based drug dosing¹. RO6 was created years ago to address calculation errors, and has been embedded in pediatric training and reference literature such as *The Harriet Lane handbook*, PALS, *Neofax*, and the *Pediatric Standard Dosing Handbook*.

The use of the RO6 method of calculation has most recently come under heated review by the Joint Commission. The JCAHO’s Medication Safety Alert of August 7, 2003 8(16) started an animated discussion on the safety of RO6. As part of the larger National Patient Safety Goals, recommendation #3b mandates elimination of RO6 and conversion to standardized drip concentrations (SDC). Although some institutions had changed to SDC, a survey performed by Dr Jaimovich of 82 services of PICU, NICU, transport, and ED found 67 used RO6, with 5 of the 15 using SDC having changed due to the anticipated JCAHO mandate². A separate informal survey of CHCA pharmacists noted 10 of the 27 sites had changed to standardized drips, with change again due to the JCAHO mandate alone³. An online survey by

Gaffoor et al from the University of Maryland School of Medicine received 1150 responses; more respondents recalled sentinel (adverse) events with SDC (67%) than with RO6 (51%) $p < 0.001$ ⁴.

In January 2004, leaders in pediatric care, lead by the AAP, began a challenge of JCAHO’s position in a coordinated manner⁵. Through e-mail, letters, and conference calls, discussions with key JCAHO leaders resulted in a modification of their January 2005 standardized drip implementation date. In November 2004, JCAHO stated institutions could petition for a waiver for up to three more years, during which time RO6 may be used. A detailed medication safety plan must be submitted to and accepted by JCAHO.

More institutions have converted to SDC use over the past months, particularly those also caring for adults. Hospitalists in these facilities should review the changes and transition methods carefully. Although change may occur at some site, the issues and concerns still remain:

- lack of data on error rate with RO6 use
- decrease in medication error rate attributed to SDC actually included many system enhancements such as smart pumps, pharmacist-only drip preparation, pre-printed drip sheets for each patient at the bedside
- significant fluid volumes for neonates with SDC
- lack of SDC choices within institutions
- variability in SDC choices between institutions
- inconsistently prepared drips within institutions serving adult and pediatric patients

Throughout this discussion, systems embracing one mode over the other have defended their methods as the most sound. The issue at hand, however, is a much larger one than that of the RO6 versus SDC itself. Discussion on RO6 has received national attention. How we react to external mandates affecting the care of hospitalized children sends a message to more than our local institutions. As individual Hospitalists, we clearly must work within our local and national systems. We may be asked to implement a change being made, but also

have a responsibility to influence it. Assuring medical care decisions for children are driven by evidence and best practice is essential.

References:

1. Stucky ER and the Committee on Drugs and Committee on Hospital Care. Prevention of Medication Errors in the Pediatric Inpatient Setting. *Pediatrics*. August 2003;112(2):431-6.
2. Jaimovich D. Unpublished data. Personal communication April 23, 2004.
3. CHCA. Unpublished data. Personal communication April 23, 2004.
4. Gaffoor MI, Hilmas E, Mathews L, Morrison W, Vaidya V. National Online Survey of Rule of Six versus Standardized Concentrations. Abstract. University of Maryland site www.icudrips.org.
5. W. Benitz (Stanford; COD); T. Corden (Univ Wisconsin; PTAC); R. Dieckman (UCSF; Chair Pediatric Education for Paramedics National Committee); A. Fischer (CA; Kaiser Neonatal Regional Medical Director); K. Frush (Duke; COPEM); R. Gorman (COD Chair); D. Isaacman (Chair Section Emergency Medicine); D. Jaimovich (Advocate Health; Chair Section Transport Medicine; Chair Society of Critical Care Medicine Pediatric Section); J Knapp (Chair COPEM); M. Moss (UAMS; Chair Section on Critical Care); S. Schnexnayder (Arkansas Children’s; American Heart Assoc liaison); M. Speer (Baylor; Chair Section of Perinatology); E Stucky (CHHC-SD/UCSD; Chair Committee on Hospital Care).

Dr Stucky also contributed an article about the Rule of Six in the February 2005 issue of *AAP News*.



Inpatient Consultation Codes

The following codes are used for consultation requests in the inpatient setting. Although the request for consultation can be either verbal or written, it must be documented in the medical record. The consulting physician must also document who requested the consultation, the reason for the consultation, and opinions/recommendation/services rendered. This visit documentation must include all three key elements of decision-making (history, exam, and medical decision). Additionally, a written report must also be sent to the requesting physician.

Rather than the three levels that are used for initial and subsequent hospital visits, there are five levels of consultation codes. Thus it is essential that consultative service rendered reflect the respective level of coding. The five are as follows:

99251 Problem focused history and examination with straightforward medical decisions. (Twenty minutes)

Example:

Initial inpatient consult for an orthopedic patient on IV antibiotics with thrush.

99252 Expanded problem focused history and examination with straightforward medical decisions. (Forty minutes)

Examples:

Initial inpatient consult for recommendation for antibiotic prophylaxis for patient with synthetic heart valve who will undergo urologic surgery.

Initial inpatient consult for possible drug-induced skin eruption.

Initial inpatient consult for dialysis patient with episodic oral ulceration.

99253 Detailed history and examination with low complexity medical decisions. (Fifty-five minutes)

Examples:

Initial inpatient consult for fever

in a female patient post-op from abdominal surgery.

Initial inpatient consult for post-op urinary tract infection management.

Initial inpatient consult for new-onset seizure who has a normal history and normal exam.

99254 Comprehensive history and examination with moderate level of medical decision making. (80 minutes)

Examples:

Initial hospital consult for a 13-month old with spasmodic cough, respiratory distress, and fever.

Initial inpatient consult for patient with fever, joint pains for one week, and rash.

Initial hospital consult for 15 years old with painless swelling of proximal humerus with lytic lesion by x-ray.

99255 Comprehensive history and examination with high complexity medical decision. (One hundred ten minutes) (Sorry, no pediatric scenarios given)

Examples:

Initial inpatient consult for a 36-year-old female to evaluate for abdominal pain, and fever. The patient has developed diffuse abdominal pain, guarding, rigidity and increased fever.

Initial inpatient consult for a 50 year old with a history of previous MI now with acute pulmonary edema and hypotension.

If follow up visits are needed either to complete the initial consult or subsequent consultative visits are requested by the primary physician, then the codes below are used. However, unlike in the initial consultation where all three key elements are required (history, exam, and medical decision), the subsequent consultative codes require only two of the three but the service must continue to confirm to the all E/M services coding and documentation

guidelines.

If the consulting physician has initiated treatment at the initial consult and takes over the care for that particular problem, then the subsequent hospital codes (99231-99233) rather than the codes below are used (in most instances, inpatient codes are the proper codes to use since the Pediatric Hospitalist takes over the care for the referring MD).

99261 Problem focused interval history and examination with straightforward or low complexity medical decisions. (Ten minutes)

Examples:

Follow up consult for evaluation of responses to therapy for moniliiasis.

Follow up consult for review of diagnostic studies ordered at time of first contact.

99262 Expanded problem focused interval history and exam with moderate complexity medical decisions. (Twenty minutes)

Example:

Follow up consult for 6 yo old with endocarditis and changing heart murmur

99263 Detailed interval history and exam with high complexity medical decisions. (Thirty minutes)

Example:

Follow up consult of a pan-sinusitis patient with sudden onset of proptosis.

References:

Coding for Pediatrics 2005
CPT 2005

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

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



SOHM Committee Meeting Actions

Following are actions taken during the last Section on Hospital Medicine Executive Committee meeting on May 11, 2005 (via teleconference):

- The SOHM Executive Committee worked with staff to implement a set of procedures to ensure that only pediatric hospitalists and healthcare providers interested in pediatric hospital medicine are able to join the LISTSERV®.
- Leaders within the Section have been tasked with presenting an overview of pediatric hospital medicine as a profession to Residents and Early Careerists within the AAP and beyond. This will be an extension of the Speaker's Bureau that the Executive Committee is in the process of putting together.
- The Winter 2006 edition of the SOHM Newsletter will be a special edition devoted entirely to issues related to pediatric hospitalist jobs and professional opportunities. The Section will be requesting articles and other helpful information from other Academy Committees and Sections responsible for workforce issues.
- The SOHM Executive Committee approved a measure that would change the manner in which the Chairperson-Elect is selected. The proposed amendment will be sent to the Section membership for review and approval in July.
- Last year the membership approved an amendment that would include a new position on the Section Executive Committee: Immediate Past Chairperson. During the telemeeting, the Executive Committee confirmed that the position should be a non-voting position to comply with Academy policy. As a reference, the change will be included in the July bylaw amendment sent to Section membership.
- Members who volunteered to work on one of the many Section subcommittees will be contacted in late summer by group leaders to begin working on various projects (i.e. enhancements to the Web site, creation of an eQipp learning module, etc.).
- Promotions and advertising for the Pediatric Hospitalist Conference in Denver will continue through the end of July. Leaders have been asked to promote the conference to the membership and within their own institutions.
- The SOHM Web Master, Dr. Timothy Hartzog, is in the process of finalizing the new and improved "member's only" web site. Staff hope to unveil the new site to the Section membership by the end of the summer.
- The Section is leading the charge in creating and producing patient education materials related to the hospitalization of children. An informal poll of the membership will be conducted later this year to gauge what materials members consider important.
- Staff with the Academy's CME/Education Department have been asked to present an overview of the eQipp module to the SOHM Executive Committee in fall 2005 in preparation for the Section to create its own module on some of the basics of pediatric hospital medicine.
- *Guiding Principles for Pediatric Hospitalists* policy statement recently published in *Pediatrics*, along with other related materials will be distributed by the Section to Residents and other Early Careerists who are interested in a career in pediatric hospital medicine. It is also posted on the SHM web site.
- Drs. Jack Percelay, Laura Mirkinson, and Jennifer Daru will be attending the Academy's Annual Leadership Forum (otherwise known as ALF) on behalf of the SOHM. One of the issues that they will be stressing to the group of AAP leaders is the importance of advocating for children in the hospital setting.
- The SOHM Executive Committee approved a measure to offer support to the Committee on Hospital Care with their inpatient pediatric services research project. The project will explore trends related to inpatient services in community hospitals vs. pediatric hospitals.
- SOHM's Policy on Professional Opportunities and Job Advertisements was approved as written by the Executive Committee. A summary of the policy is included with every weekly posting.
- The SOHM Executive Committee has decided to compile a list of budgetary priorities and requirements for the Section to assist with planning future activities and projects. The plan will be drafted during their next meeting in fall 2005.

Volunteer Opportunities Still Available

Following is a complete list of SOHC volunteer opportunities. If you are interested in any of the activities, please contact Niccole Alexander at nalexander@aap.org.

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



Job Opportunity

Carolinas HealthCare System
www.carolinashealthcare.org

**DIRECTOR, PEDIATRIC
HOSPITALIST SERVICE
DEPARTMENT OF PEDIATRICS
Carolinas Medical Center
Charlotte, NC**

The Department of Pediatrics at Carolinas Medical Center is seeking a board-certified pediatrician to be the director of our pediatric hospitalist program. Candidates should have experience in the management of a pediatric hospitalist service, and must have demonstrated excellence in the care of pediatric inpatients. Our new hospitalist service will provide comprehensive care to patients of primary care physicians and sub-specialty physicians in the Charlotte region. The service will be based in the Department of Pediatrics and will run in parallel to the inpatient teaching service. The director will be responsible for program development and administrative supervision as well as direct patient care. Interest in teaching and clinical research is a plus.



The Department of Pediatrics is a fully accredited residency program with 24 pediatric residents and 30 full time faculty members. In addition, there are numerous private pediatric sub-specialists who are fully integrated into the teaching program as adjunct faculty.

Carolinas Medical Center is a 777 bed academic medical center teaching hospital, and is part of the Carolinas HealthCare System (www.carolinashealthcare.org). The Levine Children's Hospital (www.levinechildrenshospital.org) is currently under construction and will be an 11-story, 234 bed facility which will be complete in early 2007.

Carolinas HealthCare System is a not-for-profit, self-supporting public organization, and is one of the largest public systems in the nation. Charlotte, NC is a great place to live. It is a growing and vibrant city and is only 2 hours from the mountains and 3-4 hours from the beaches of SC.

Salary and benefits are highly competitive and commensurate with experience. This position includes a competitive salary, annual bonus, generous CME allowance, great working environment, no tenure requirements, and active participation as a member of the Charlotte medical community. Candidates should send their curriculum vitae and a letter of interest to:

Tracey Black
Physician Services
Carolinas HealthCare System
704-355-0159 Phone
800-847-5084 Toll-Free
704-355-5033 Fax
tracey.black@carolinashealthcare.org

Carolinas HealthCare System is an equal opportunity/affirmative action employer.



Visit us on the Web at
[http://
jobs.pedjobs.org/
search/](http://jobs.pedjobs.org/search/)

And don't miss our first appearance at the 2005 NCE. The AAP PedsJobs Career Fair will be located in the exhibit hall. Stop in and see how the Career Resource Center can benefit both job seekers and employers. AAP staff will help you search jobs and CVs, and schedule appointments in advance. There will be space available for on-site interviews.

Don't be left in the dark!

Join the Section on
Hospital
Medicine
LISTSERV!



To join, please send
an e-mail to
eanaya@aap.org.

You will be asked to complete a short
questionnaire before joining.

American Academy of Pediatrics



NATIONAL CONFERENCE & EXHIBITION

Washington DC

OCTOBER 8-11, 2005

The 2005 AAP National Conference & Exhibition (NCE) is October 8-11, in Washington DC! At the 2005 NCE, general pediatricians and sub-specialists can explore the latest trends in pediatric medicine, brush up on their technical skills, interact with peers, and see the latest in pediatric products.

The educational program includes over 300 sessions in almost 50 content areas, with offerings in quality improvement, practice management, and advocacy, as well as other topics that impact the practicing pediatrician. Attendees can also visit the technical exhibits and learn about the latest products and technology at the largest exhibition of its kind. Get the latest on the NCE at www.aap.org/nce, and make your plans today!

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Stay tuned...The Section on Hospital
Medicine 2006 Edition #1 will be a
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