Hospitalist News

www.ehospitalistnews.com

VOL. 3, NO. 5 | *The Leading Independent Newspaper for the Hospitalist* | MAY 2010

COURTESY CHILDREN'S NATIONAL MEDICAL CENTER

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Core Competencies Defined For Pediatric Hospitalists

BY ALICIA AULT

NATIONAL HARBOR, MD. — After an 8-year development effort, the Society of Hospital Medicine has published core competencies for pediatric hospitalists.

The competencies define the expected standards for all pediatric hospitalists, regardless of practice setting or location, said Dr. Mary C. Ottolini of the SHM's pediatric committee. The competencies also are a means of differentiating hospitalists from primary care pediatricians or other pediatric specialists.

Although the competencies are viewed as the first step in gaining recognition as a new

See **Core Competencies** *page 2*

'No Pay' Rule on CAUTIs Might Not Curtail Payments

BY MIRIAM E. TUCKER

ATLANTA — The Centers for Medicare and Medicaid Service's "no pay" policy for hospital-acquired urinary tract infections is not likely to have much financial impact on hospitals for two reasons: The catheter code is rarely used, and many patients who are diagnosed with UTIs have comorbid conditions that exclude them from the policy.

Those findings, from a retrospective secondary database analysis of Michigan hospitals for 2007, demonstrate that the policy is more nuanced than some reports have made it appear.

"It seems like a simple concept not to pay for a hospital-acquired complication, but this is a complex policy to implement," Dr. Jennifer A. Meddings said at the Decennial International Conference on Healthcare-Associated Infections.

Officially called the Hospital-Acquired Conditions Initiative, the policy went into effect on Oct. 1, 2008. It directed the CMS to choose specific hospital-acquired complications for which hospitals would no longer receive payment, guided by three criteria: 1) the infection had high volume and/or cost, 2) it resulted in higher payment when listed as a secondary diagnosis, and 3) it was "reasonably preventable" through the use of evidence-based guidelines. Catheter-associated urinary tract infection (CAUTI) was the first hospital-acquired condition selected by the CMS for nonpayment.

Potentially, the rule could mean a major loss of payment for hospitals, said Dr. Meddings of the University of Michigan, Ann Arbor. For example, in Michigan the average reimbursement for a case of pneumonia and pleurisy is $6,970. Since Oct. 1, 2008, that would be the total reimbursement for such cases whether or not they're complicated by a CAUTI. In contrast, prior to that date Michigan hospitals would have received $8,495 for pneumonia/pleurisy complicated by a simple CAUTI, and $10,379 for cases complicated with a severe CAUTI manifestation such as pyelonephritis. "So, quite a lot of money is at stake," she said.

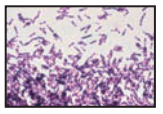
See **CAUTIs** *page 8*

WHAT'S NEW

Bloodstream infections with late onset in very low-birth-weight infants fell from an incidence of 38% to 23% after the start of an infection-control program. **3**

Atrial fibrillation after cardiac surgery was prevented in patients in a pilot study who were randomized to receive amiodarone combined with prophylactic atrial pacing. **5**

Severe *C. difficile* colitis



treated by intracolonic vancomycin via retention enema generally did not require surgery. **6**

Bloodstream infections that occur after central line placement declined only in ICUs with 95% compliance with central line bundle policy. **9**

Hospital rankings based in part on reputation may reflect subjective assessment of quality, but that's not necessarily a bad thing, Dr. Franklin A. Michota says. **12**

Postoperative infections increased from 2001 to 2006 despite widespread infection-control efforts. **14**

Leaders column offers a portrait of Dr. Lori Heim, the first family physician to join the new hospital medicine program at her Laurinburg, N.C., hospital, and an advocate of coordinated patient care in her role as president of the American Academy of Family Physicians. **19**

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Progress on Pediatric Hospitalists

Core Competencies *from page 1*

specialty through the American Board of Pediatrics, it is not guaranteed that a certification process will be forthcoming soon, Dr. Ottolini said at the annual meeting of the Society of Hospital Medicine.

Negotiations with the ABP are ongoing, said coauthor Dr. Erin R. Stucky of Rady Children's Hospital and the University of California, San Diego. The American Board of Pediatrics, however, has not been petitioned to consider a new pediatric hospitalist subspecialty, according to Dr. James A. Stockman III, president and CEO of the board. In the absence of a petition, the board will not formally weigh the pros and cons of introducing such certification, he noted in an interview.

The American Board of Internal Medicine and the American Board of Family Practice have chosen to offer Recognition of Focused Practice in Hospital Medicine, a credential available for the first time in 2010. The new certification requirements will be met through an exam, along with self-evaluation and practice improvement modules to be completed as part of the maintenance of certification process. But the ABP is not certain that such a mechanism would be appropriate for pediatrics, Dr. Stockman said.

Many hospitalists thought that the competencies had already been defined, because a development framework was published in 2006, noted Dr. Ottolini of Children's National Medical Center and George Washington University, both in Washington. In the years since the SHM's pediatric core competencies task force was created, there have been many iterations, corrections, and reviews, she said.

"This groundbreaking event now gives a context by which all pediatric hospitalists can judge their expertise and training. As this new subspecialty emerges, it will give training programs and examiners a body of knowledge and skill to aspire to," commented Dr. Michelle Marks, director of pediatric hospitalist medicine and director of medical operations at the the Cleveland Clinic Children's Hospital.

The final publication contains 54 chapters covering 22 common clinical diagnoses, 6 specialized clinical services, 13 core skills, and 13 health care systems for supporting and advancing child health (J. Hosp. Med. 2010 April 9 [doi:10.1002/jhm.776]).

The competencies are not meant to be all-inclusive, rigid, or easily achieved during residency training, Dr. Ottolini said. They may even be difficult to achieve during a fellowship, Dr. Stucky added.

The competencies were reviewed by 9 section editors, 50-plus authors and contributors, 3 senior editors, 33 internal reviewers, and dozens of external reviewers, including all the major academic and certifying societies, "stakeholder" agencies such as the American Hospital Association and the American College of Emergency Physicians, and pediatric hospital medicine fellowship directors at major children's hospitals around the country.

Next steps include developing assessment strategies, including examinations, simulations, and practice reviews. The competencies themselves also will be continually assessed and revised, Dr. Ottolini said. ■

Disclosures: *Dr. Ottolini, Dr. Stucky, and Dr. Marks reported no financial conflicts.*

Obama Orders Equal Rights Regarding Hospital Visitation

BY ALICIA AULT

President Obama in April issued a call for equal hospital visitation rights for all patients, a move he said would be beneficial especially to childless widows and widowers and to gays and lesbians.

Mr. Obama's memorandum will require the Department of Health and Human Services to create new rules for hospitals participating in Medicare and Medicaid to make it clear that a patient's designated visitor has the same visitation rights as a family member. Hospitals will not be able to deny visitation privileges based on "race, color, national origin, sex, sexual orientation, gender identity, or disability."

Visits can be restricted for medically appropriate reasons. The Centers for Medicare and Medicaid Services (CMS) will be charged with enforcing the new regulations, and with ensuring that patients' advance directives are respected.

For patients whose friends or partners are denied visitation rights, President Obama said in a statement, "the failure to have their wishes respected concerning who may visit them or make medical decisions on their behalf has real consequences," including that physicians and nurses may not have current information about medications and medical histories.

"All too often, people are made to suffer or even to pass away alone, denied the comfort of companionship in their final moments while a loved one is left worrying and pacing down the hall," he added.

The Human Rights Campaign, a Washington-based advocacy group for gays and lesbians, said it had worked with the White House and HHS "in support" of the memorandum. "Discrimination touches every facet of the lives of lesbian, gay, bisexual, and transgender people, including at times of crisis and illness, when we need our loved ones with us more than ever," HRC President Joe Solmonese said in a statement.

In a statement issued after the memorandum, the American Hospital Association said "we recognize how important family support is to a patient's well-being, and we work hard to involve patients and their loved ones in their care." The AHA added that it "will look forward to details of the new regulations as well as direction on coordinating with state laws." ■

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HOSPITALIST NEWS (ISSN 1875-9122) *is published monthly by Elsevier Inc., 60 Columbia Rd., Bldg. B, 2nd flr., Morristown, NJ 07960, 973-290-8200, fax 973-290-8250. Subscription price is $109.00 per year U.S.; $173.00 Outside U.S.*

POSTMASTER Send changes of address (with old mailing label) to HOSPITALIST NEWS Circulation, 60 Columbia Rd., Bldg. B, 2nd flr., Morristown, NJ 07960.

VITAL SIGNS

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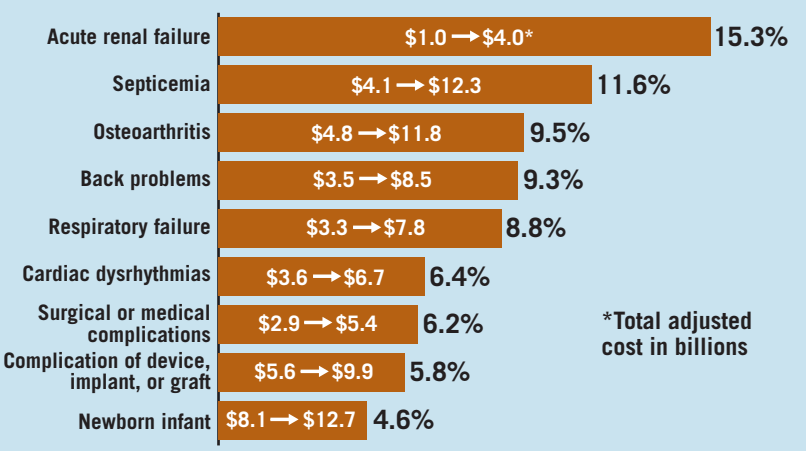

Note: Based on data from the Nationwide Inpatient Sample.
Source: Agency for Healthcare Research and Quality

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