Division updates:

Upcoming Symposium:

INTERPROFESSIONAL INNOVATIONS WORKSHOP

Rady Children's Health Center

4th Interprofessional Innovations Symposium: Transforming Healthcare

Tuesday, October 26, 2021

Via Zoom

8:00 AM to 12:00 PM

Interested in submitting your work?
Email Interprofessionalinnovations@rchsd.org or call (858) 966-8339 for more information

Microsoft Teams

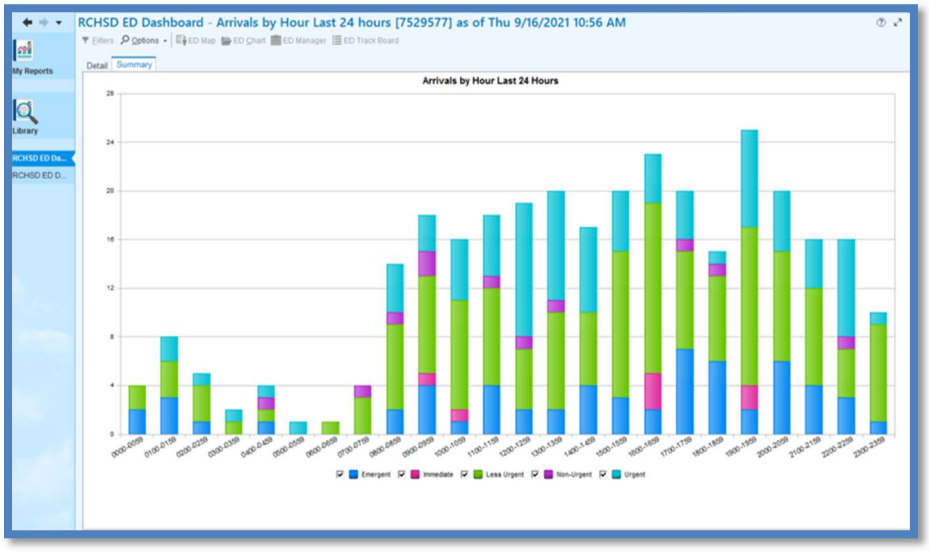
- Teams will be **replacing Slack** for our division updates, by the end of this month.
  - If you login, you'll see you've been added to a division Team for updates with channels similar to Slack

Microsoft

Clinical Director Update

Scott Herskovitz, MD

- *Schedule*
  - December schedule currently in progress
  - January schedule requests due by 10/15/21
  - Please familiarize with the schedule guidelines available to view in Slack, email, and QGenda (pending)
  - Please place all requests (recurring meetings, lectures, vacation, days off, etc.) in QGenda going forward
    - If there are any issues placing requests, please contact Amber
    - Limit of 7 requested days off (unless vacation)
    - Lecture presentation/recurring meetings do not count toward days off requests
    - PEM conferences days don't count toward days off but if not presenting, then they can't be guaranteed
  - QGenda transition completed
  - Winter schedule changes starting December 1
    - PG 7a-4p, PG 3p-12p, PG 11p-8a (new overnight winter shift)
    - PG 9a-6p, PG 5p-2a
    - O 9a-6p, O 5p-2a
  - Moonlighting starting October 1:
    - EDS (rotunda) 12p-9p Monday-Friday
    - EDS (cardiology beds) 12p-9p Saturday and Sunday
- *Staffing*
  - PG Overnight 11p-8a
  - Benefits:
    - Creates 24/7 PG coverage
    - Reduces turnover of BH patients from YB
    - Census remains high 30-50 until 0700 so offloads volume
    - Able to float to YB if nursing can't accommodate PG opening due to BH census
  - Current division needs are greatest **9a-9p**



- *Operations*
  - NICU admissions:
    - Neonatal fever admits can be expedited for NICU admit without ED work up if discussed with NICU attending
  - Emergency Department In-Patient (EDIP):
    - UCSD site visit planned with review of process
    - Initial discussions started with PHM, Endocrine, and PICU

- *Anesthesia/ Sedation*
  - Ketamine approved for non-sedation purposes less than below doses
    - IV less than 0.25mg/kg (max 35mg)
    - IM less than 2mg/kg (max 100mg)
    - IN less than 2mg/kg (max 50mg)
    - Oral less than 1mg/kg (max 50mg)
  - Needs O2 monitoring
  - May use for agitation but coordinate with nursing for monitoring (pulseox, suction, BVM, Orange crash cart)

- *Public Health*
  - Neo-melubrina (dipyrone): banned anti-pyretic available in Mexico and Latin America that can cause agranulocytosis
    - Consider asking in history if leukopenia secondary to unclear etiology
    - Also available as veterinary medicine (next ivermectin?)
  - Influenza/RSV and viral testing in respiratory illnesses
    - Due to COVID disruption of respiratory infection seasonality consider surveillance testing for RSV and Flu in covid negative pts

- *Hospitalist Medicine*
  - Bronchiolitis HFNC changes:
    - Per pathway - 2L/kg/min increased to max 20LPM
      - <50kg: 2 L/kg/min up to 20 max
      - >50mg: 0.5 L/kg/min
      - Adults >=18yo: 60L
    - Pathway algorithm is live
    - Order set update pending

- *Asthma Order Set*
  - Albuterol and Flovent MDI relabeling have moved back to pharmacy responsibility
    - **Please use asthma order set for relabel**

Compassion **A**ccountability **R**espect **E**xcellence **S**ervice

Yan Zhan, MD

"Dr. Zhan consulted our team for a patient who had a concerning history for an airway foreign body. These cases are typically critical and time sensitive. She had obtained all the necessary testing, imaging and ordered all the necessary testing, imaging and ordered IV access even prior to our arrival to seeing the patient in the emergency department. Her thorough and prompt workup allowed us to expedite this patient's care significantly. This was very much appreciated by myself, ENT staff on call – Dr. Leuin, anesthesiology and the entire OR staff! She was also very kind and a great communicator."

Congratulations:

Mylinh Nguyen

For completing the

Stanford Faculty Development Course for Clinical Teachers!

Improvement Updates

Amy Bryl, MD

QI Course (for fellows and faculty)

- 3rd Fridays 0830-1030 am (Next November 19)

FY21 Quality Incentive Project (QIP) Showcase

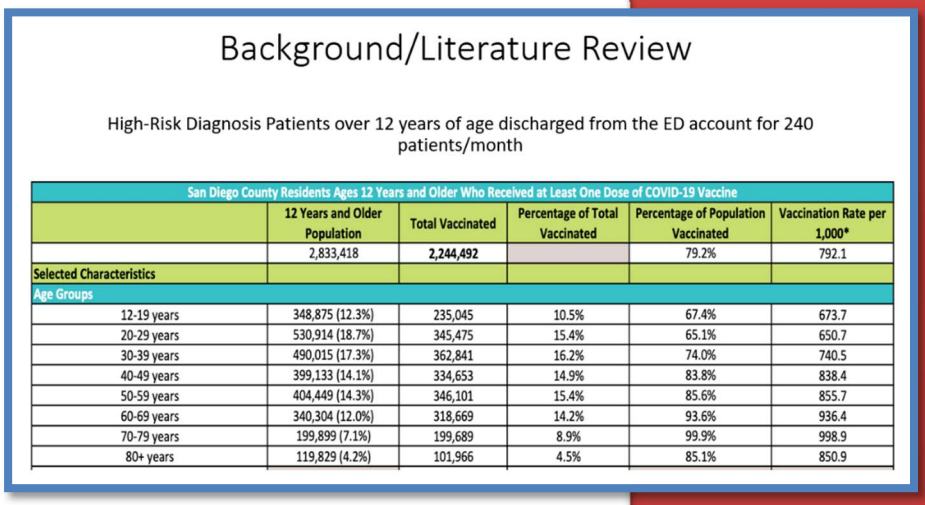
- November 4th; 4:30-6:00p

New ED Quality Incentive Project FY22

- COVID-19 Vaccine Referrals – Conrad

New Discharge Instructions

- Safe Sleep – Zimmerman



Background/Literature Review

High-Risk Diagnosis Patients over 12 years of age discharged from the ED account for 240 patients/month

San Diego County Residents Ages 12 Years and Older Who Received at Least One Dose of COVID-19 Vaccine					
	12 Years and Older Population	Total Vaccinated	Percentage of Total Vaccinated	Percentage of Population Vaccinated	Vaccination Rate per 1,000*
	2,833,418	**2,244,492**		79.2%	792.1
Selected Characteristics					
Age Groups					
12-19 years	348,875 (12.3%)	235,045	10.5%	67.4%	673.7
20-29 years	530,914 (18.7%)	345,475	15.4%	65.1%	650.7
30-39 years	490,015 (17.3%)	362,841	16.2%	74.0%	740.5
40-49 years	399,133 (14.1%)	334,653	14.9%	83.8%	838.4
50-59 years	404,449 (14.3%)	346,101	15.4%	85.6%	855.7
60-69 years	340,304 (12.0%)	318,669	14.2%	93.6%	936.4
70-79 years	199,899 (7.1%)	199,689	8.9%	99.9%	998.9
80+ years	119,829 (4.2%)	101,966	4.5%	85.1%	850.9

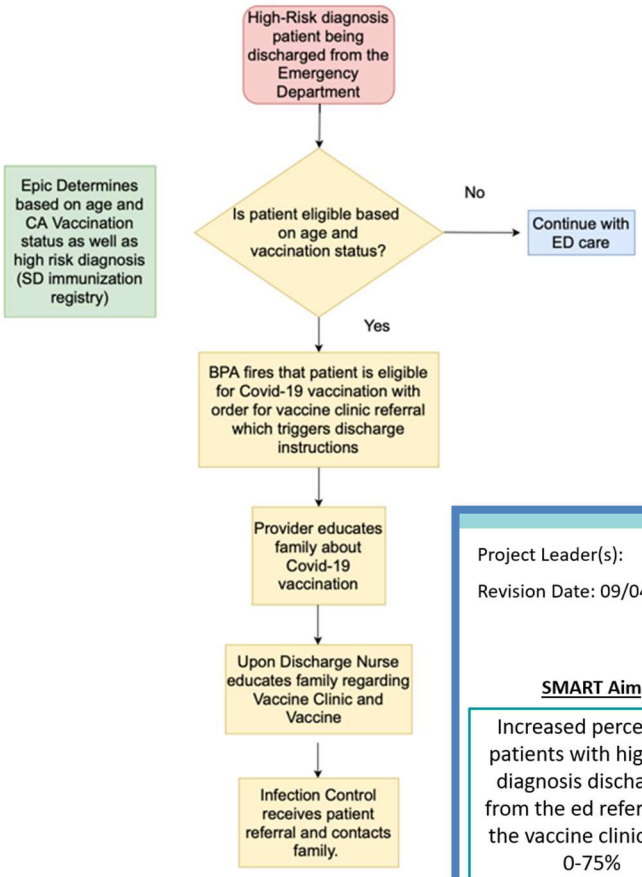
SMART Aim

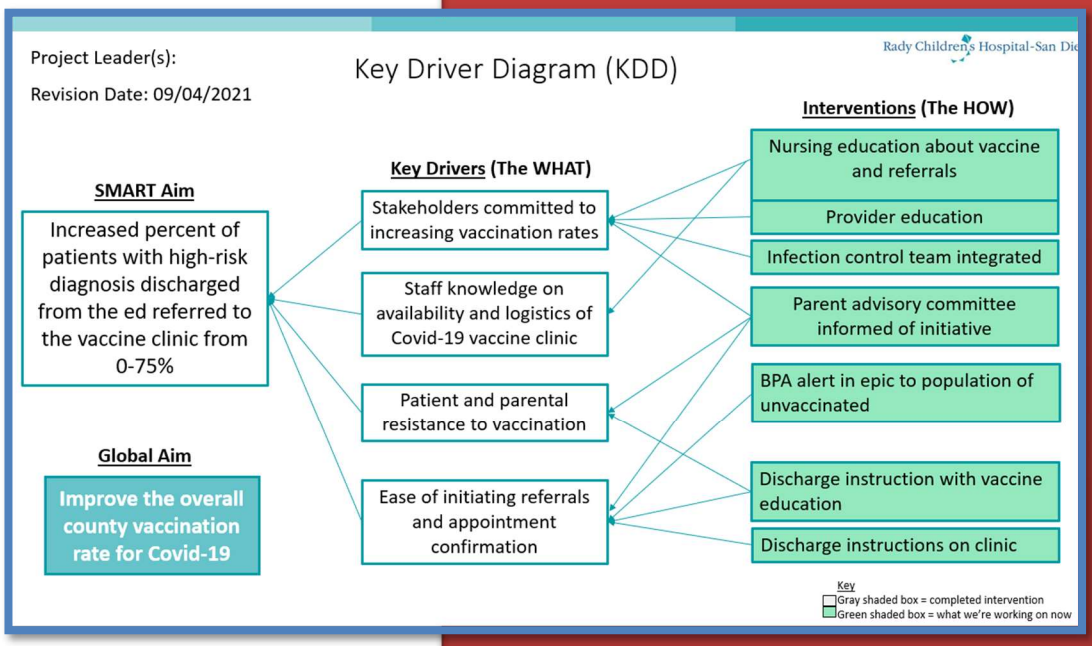
- Population/ Target Audience for Improvement:
  - High Risk Diagnosis Patients Age 12-18 Presenting to and Being Discharged from the Emergency Department
- Global Aim (save the world!)
  - To improve the covid-19 vaccination rate and improve general population health
- SMART Aim:

- To increase the percent of high-risk diagnosis patients seen in the ED that are eligible for and have not received the COVID vaccine that are educated and referred to the vaccine clinic from 0% to 75% by May 31, 2022.

Measures

- Outcome (patient-centered, at least 1):
  - Percent of discharged High-Risk Diagnosis patients vaccinated within 30 days after discharge
- Process (at least 2):
  - Appointments made at the vaccine clinic
  - Percent of patients referred to the Rady Vaccine clinic
  - Percent of times the BPA is disabled and reason
- Balancing (potential harm, at least 1):
  - Patient complaints
  - Return to the ED with vaccine related symptoms



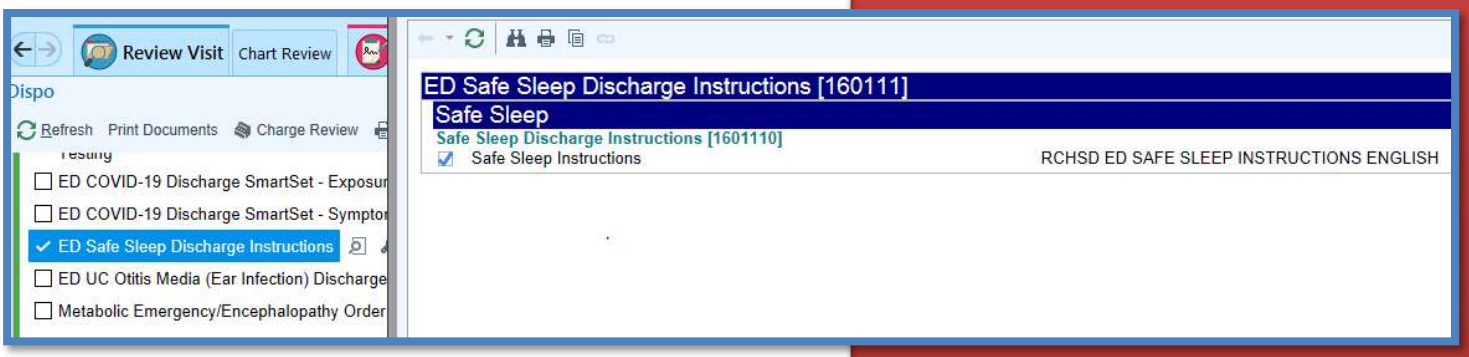


Safe Sleep Practices

Elise Zimmerman, MD

Every year more infants die from preventable, sleep-related deaths than in motor vehicle crashes. What is the cause? Unsafe sleep environments, such as sleeping in the same bed with an adult or sibling, sleeping on couches, car seats and other surfaces for a prolonged duration, and sleeping with too many pillows, blankets, and plush toys in a crib. Although the incidence of sudden infant death syndrome, or SIDS, is on the decline, mortality rates among infants from suffocation from co-sleeping are on the rise.

The safe sleep Discharge SmartSet w/ discharge instructions is now available to use in EPIC. It will appear in the suggested SmartSet section on the Dispo screen for all pts under 1 yrs of age.



Let Amy know if you're interested in starting a QI project!

Fellowship *Updates*

Kathryn Pade, MD and Michele McDaniel, MD

We've started our **Fellowship Interview Season**! We have a record of **143 applicants** this year. Thank you to the faculty and fellows involved. We're looking forward to matching another amazing group of fellows.

Thank you to all our amazing fellow mentors and families for being so supportive of our fellows during a continually trying time for us all. Mentors, please be sure to reach out to your mentee to schedule your next meeting as we enter the second quarter of the year. Fellow family leaders, since we won't be able to have a large-scale holiday gathering, consider making merry with your fellow and family members!

A quick **reminder** to those **faculty working with fellows in Orange**. Given your shifts are now staggered with the fellow shifts, please have the fellows stop seeing patients like they would in Y/B. They should use the hour between 10pm-11pm to wrap up their patients and sign out to the Orange attending.

Research Update

Kathy Hollenbach PhD, John Kanegaye MD, Michael Gardiner MD, & Margaret Nguyen MD

Spring Abstracts

- Details of the major spring meetings are as follows:

Meeting, site	Location/date	Abstract deadline	Internal review deadline, 2359 PST on:
Pediatric Academic Societies **https://www.pas-meeting.org/scientific-abstracts/**	Denver, CO 4/20-27/2022	Jan 5, 2022	Dec 15, 2021
Society for Academic Emergency Medicine **https://www.saem.org/detail-pages/event/2021/11/01/default-calendar/abstracts**	New Orleans, LA 5/10-13/2022	Jan 4, 2022	Dec 14, 2021]

- In order to qualify for division support and incentive, submit abstract drafts for internal review to pemresearch@rchsd.org at least 21 days before the submission deadline. Drafts do not need to be in submission form but must contain description of methods, analysis, and data to allow review team to make meaningful comments.

Incentivizing Manuscripts following National Presentation

Starting with the SAEM and PAS meetings (abstracts due 1/04/2022 and 1/05/2022, respectively), the DEM will require submission of the completed manuscript to a peer review journal for national presentations of quality work and research to qualify for DDF support and incentive. The goal is to increase the proportion of abstract presentations that go on to publication. In addition, the Pediatrics Review and Advancement Committee puts considerable weight on "research in progress" and abstracts that go on to publication. Select for national meetings the projects for which you can draft abstracts and manuscripts concurrently. Upload your manuscripts to the journal submission site within 60 days of presentation. Submit with your receipts the date/time-stamped PDF copy of the completed submission provided by the journal upload site.
The research and QI teams do not require internal review prior to submission. However, early and frequent review produces higher quality manuscripts with greater acceptance rates.

Kuali Tip

Protocols originally approved in the legacy e-IRB now require renewal in Kuali. The Kuali renewal page requires information like the old renewal face pages. The instructions are ambiguous as to additional required documents. Kuali instruction and requests for revision use the terminology "amendment." However, no amendment is required if you are not making changes to the protocol. The one-time rollover from legacy e-IRB to Kuali requires a document transfer. For renewals, upload only the document(s) that reflect the most recent approved version of the protocol (most recent research plan, consents, and supporting forms). No new drafting is required. You can download the relevant documents from the legacy e-IRB site and upload directly to Kuali.
The only transactions to carry out in legacy e-IRB are project terminations during the 21-22 AY.

Compliance Connection

Critical Care Billing on the Same Day as a Regular E/M Visit Code

I have been asked recently whether critical care can be billed out on the same calendar day as a "normal" E/M code (99281-99285), such as in the case of a pt that was perhaps stable or not requiring CC upon ED presentation but then later on deteriorated and required CC services. The answer to this is YES!, assuming that all other critical care criteria are met (30+ min CC delivered, pt has impairment of one or more vital organ systems and you intervened in some way to stabilize, you carved out the time spent performing separately billable procedures, etc…). Be sure that the CC time and which organ system was impaired is clearly documented in your CC note. Additionally, the PEM provider of the CC need not be the same ED provider who saw the pt initially and billed out a regular E/M code.

Another potential application of the CC code is for the pt who is having an acute BH crisis and requires emergent medication management as an intervention to keep both the pt and the staff safe from harm (assuming that you have spent the 30+ minutes involved in providing the CC services). Remember, you can include your time spent charting, reviewing prior records, ordering medications, writing your note, speaking with family and any consultants in your CC time. I suspect that we may be underutilizing the CC code in our provision of care to our more aggressive BH pts who need emergent medication management.

Billing a reg code and CC code on same day should not be a common everyday occurrence. I would only use if i already saw and documented a note on a stable pt who maybe hours later deteriorated and became unstable. If you do this, you will want to note the portion of time you provided the CC as distinct from the time you did not (sep note) And you would not include the total time that day caring for the pt in the CC portion as you could do if you just dropped the single CC code for that visit. If doing it this way, you would write two separate notes on the pt to distinguish the two separate care episodes.

The alternative on such a pt would be to write a single note toward or after the end of visit and bill a single CC code taking into accout the total time spent on that pt on that day (except for time spent on separately billable procedures, of course).

If the pt is requiring CC from the outset, i would just bill a single CC code, even though you may have stabilized the pt and pt remained stable during remainder of ED course.

- Cindy