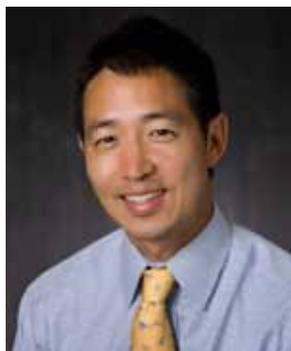


Fall 2009

Issue 4 Volume 2

EDITOR'S WELCOME



I hope that everyone has made it through an early fall peak in patient volumes, linked of course to novel H1N1 influenza. Although keeping up-to-date with prevention and treatment guidelines has been difficult given rapid changes in recommendations and knowledge, courtesy of the Pediatric Alliance and Sarmistha Hauger, a link to local resources is provided in this issue. Our ED and inpatient volumes have dropped in the past week and although the future is always difficult to predict, we think that we're currently awaiting the beginnings of the RSV and seasonal influenza seasons.

In this issue, family-centered care is a return topic and I hope to make it a recurring section of the LinkLetter as our efforts expand here at DCMC. Please send us your thoughts and questions on this topic as all family-centered care efforts must include the medical home. A topic that is a relative newcomer but one that I'd like to frequent our pages is quality and safety, an ever-important headline in health care. Achieving high reliability is a goal of our organization and I hope you'll enjoy the conceptual framework that is presented herein. Finally, Lynn Thoreson, our immediate past chief resident answers some frequently asked questions about asthma.

To segue to some PCRS updates, we were fortunate enough to convince Lynn Thoreson to join our ranks after all we put her through as chief resident. We have also 2 other new faculty members: Joel Blumberg, who many of you will know from practice here in Austin and was actually a former Medical Director at CHOA, and Lynn Campbell, most recently the residency program director at the University of Kentucky. To help you put names with faces, their pictures (and eventually bios) should be up on our website (http://www.dellchildrens.net/for_healthcare_professionals/pediatric_consultation_and_referral_service/our_physicians).

PCRS has recently begun sending admission notifications to your offices by fax. As most patients are admitted during evening and early morning hours, this is a convenient way for us to provide vital information (diagnosis, room number and attending) to you when you were not directly involved in referring the child to us. We have also tweaked our discharge summary process and hope to have all dictations transcribed and faxed to your office with 2-3 days of discharge. Please let us know if you are not regularly receiving these updates. Finally, to continue to stress the importance of communication and feedback to us, we welcome any concerns that you have about the care of your patients on our service. We have a monthly clinical review run by Richard Holt (rholt@seton.org) and Shaida vom Eigen (formerly Ziari, szvomeigen@seton.org) and you may submit cases by email to them at any time. We cannot improve without your input.

Thank you,
Mark Shen, MD
Medical Director, Hospital Medicine
Pediatric Consultation and Referral Service

Asthma: Frequently Asked Questions



Lynn Thoreson, D.O.

The start of a new school year and an extended influenza season provided a reminder of the prevalence of asthma in our community, and the burden of asthma care on families and patients, clinics and emergency rooms, and schools. A recent spike in admissions for asthma exacerbations has made asthma management a common teaching topic on inpatient rounds, and given us an opportunity to utilize

our current multidisciplinary approach to asthma management. We have made some recent changes to our asthma management, including standard ordersets, a new magnesium protocol, and a multidisciplinary quality improvement project to improve the completion of asthma action plans in order to streamline care from the emergency room to the inpatient floor and improve education for patients and families. This is a brief review of some common questions we encounter during a hospitalization for an asthma exacerbation. We hope it provides information about what families can expect during a hospitalization for asthma, and assists with the transition from inpatient to outpatient management.

Is this asthma?

Recent reviews highlight the complexity of this question, particularly in the pre-school age group, and it is a frequent question of parents and focus of clinical discussion during the inpatient stay (1-3). The clinical history is most important for separating wheezing related to asthma, and cough or wheezing attributable to other diagnoses, including bronchiolitis, foreign body, or allergic rhinitis. A history of previous episodes of wheezing, nighttime cough, history of atopy, and episodes associated with common triggers like viral illness, exercise, and weather change, are supportive of the diagnosis of asthma. Clinical response to therapy, including short-acting beta agonists (SABA), which can be frequently assessed during a hospitalization, provides strong support for the underlying diagnosis of asthma. This information along with the family history of asthma and atopy can assist with the discussion of the natural history of asthma with families. Longitudinal studies of children with asthma have identified distinct phenotypes of wheezing: transient, persistent (atopic and nonatopic), and late-onset. Using these classifications can often assist parents in understanding the chronicity and long-term outcomes of the diagnosis, as approximately 80% of toddlers with transient wheezing have no wheezing episodes after age three, whereas less than 30% of children with atopic asthma “outgrow” their symptoms (1,2). There is often some reluctance on the part of clinicians to diagnose asthma in the younger age groups due to concerns of labeling young children with a chronic illness, and there is discussion in the literature whether studies have sufficiently studied and identified the inflammation required for the diagnosis of asthma in this age group (4). Whether we choose to define the condition as asthma

or “wheeze”, as suggested by a recent European Task Force, the natural history and treatment of the condition remains the same and should be the focus of the message to patients and families (4).

Hydrofluoroalkane inhalers (HFA) or nebulizer?

Multiple studies for different age groups and in different care settings have repeatedly shown the effectiveness of HFAs (MDIs) in the management of asthma for both SABA and inhaled corticosteroids. (5,6). Because of the ease of use, portability, and lower cost of HFAs, we have found HFAs to be a viable option over nebulizers for most patients. The keys to success with HFAs are the appropriate use of a mask and/or spacer based on the patient age, and family and patient education. Current recommendations provide varying age ranges for switching from a spacer and mask to a spacer and mouthpiece, although most agree a spacer and mouthpiece are effective in most children five and older. If a mask is to be used, a tight seal is required for appropriate medication delivery. The same recommendations do not hold true for dry powder inhalers (DPI), as preschool age children often do not generate enough inspiratory flow to activate the inhalers. The Expert Panel Report-3 does not recommend their use in those under the age of four (7). As children improve during their hospitalization, we shift our focus from the acute treatment of an exacerbation to the education necessary for discharge and outpatient management. In preparation for discharge, children are switched to HFA, and caregivers and patients are trained to use the devices and observed with treatments. Many families, particularly parents with younger children who have fought through giving a nebulizer treatment, find the HFAs with a mask and/or spacer a much easier method of medication delivery. However, if a child or caregiver has difficulty with the devices or is uncomfortable with the training, we ensure a nebulizer and nebulized medication is available to them at discharge.

What is an Asthma Action Plan (AAP)?

As of July, 2008, The Joint Commission has implemented hospital reporting of the components of the Children’s Asthma Care Set to measure the quality of inpatient asthma care. Included in the Asthma Care Set are the use of relievers for inpatient asthma, the use of systemic corticosteroids, and the completion of a home management plan provided to the patient/caregiver. The pediatric literature shows that AAPs, particularly when symptom-based versus peak-flow based, reduce acute care visits, reported systems, and missed school days for children and adolescents (8,9). In the past year, we have focused our quality improvement efforts in the area of completing asthma action plans. Our goal is to achieve 100% compliance with this core measure, to ensure that all children with a diagnosis of asthma receive an AAP and the education from our respiratory therapy staff that is included with the AAP. This time with the respiratory therapists is an opportunity to reinforce principles taught in the outpatient office, review the use HFAs with a mask and/or spacer, and prepare a plan for asthma management based on symptoms. The AAP should serve as a communication

ASTHMA *Continued from Page 2*

tool for families, clinicians, and schools to appropriately manage asthma exacerbations and exercise-induced symptoms. Reviewing the AAP at follow-up outpatient visits can help reinforce the management plan and improve outcomes (8.9). An online version of the AAP is available at http://www.dellchildrens.net/for_healthcare_professionals/central_texas_asthma_action_plan. If your patient currently has an AAP and has an exacerbation requiring hospitalization, we encourage clinicians and families to provide this plan at admission so we can build upon management decisions made in the outpatient setting.

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- (4) Brand P et al Definition, assessment, and treatment of wheezing in preschool children: an evidence-based approach. *Eur Respir J* 2008; 32, 1096-1110
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- (9) Zemek R et al. Systematic review of randomized controlled trials examining written action plans in children: what is the plan? *Arch Pediatr Adolesc Med*. 2008 Feb; 162(2): 157-63.

I asked Dana Danaher, RN, MSN, CPHQ, our director of Clinical Quality and Patient Safety and John Hellerstedt, MD, our Vice President of Medical Affairs to provide some material on a quality and safety topic with which we are preoccupied. Although the concepts below are taken from industry, they are highly applicable to our current state – we are all working in complex and busy environments where lapses in mindfulness may have direct consequences for our patients' health and safety. This will be our busiest winter yet and we ask you to join us in our quest for reliability, particularly during the referral of patients to the hospital. While we strive to make these transitions smooth and painless for everyone, in the interest of what is safest for the patient, a collective and heightened sense of "uneasiness" may actually be a prescription for success. mws

Taken from "Managing the Unexpected: Becoming a High Reliability Organization"

By Karl E. Weick & Kathleen M Sutcliffe

High Reliability Organizations (HROs) can be defined as organizations which operate under complex conditions all the time & have fewer than expected accidents. The hallmark is not that they are error-free but that errors do not disable it. Examples include the nuclear power industry, aviation, and aircraft carriers. Their success is due to "Mindfulness" that allows: Recognition of the unexpected; Halt or containment of the unexpected; and Restoration of system functioning. The Five Principles of "Mindfulness" are Preoccupation with failure, Reluctance to simplify interpretations, Sensitivity to operations, Commitment to resilience, and Deference to expertise.

Preoccupation with Failure is awareness that weak signals of failure maybe symptoms of larger problems within the system. The organization creates strong responses to weak signals in order to prevent them from increasing in scope and size. Also, individuals are attuned to indications that small discrepancies are enlarging with an understanding that the earlier you catch a discrepancy, the more options you have to deal with it. Enhanced failure detection is utilized such as a checklist to alert to circumstances where conditions may be shaky or have a potential for error. The organization encourages and rewards failure reporting to help identify issues within the system.

Reluctance to simplify interpretations avoids lumping warning signs into generic categories because labels can create hazards and shared labels can be even more hazardous. As a result, individuals carry categories lightly. They walk the process to look for important steps that are potential pitfalls. They utilize this information to prepare against the potential pitfalls.

Sensitivity to operations is seeing what we are actually doing regardless of what we were supposed to do based on intentions, designs, and plans. Threats to operations are organizational culture, the tendency of routines to become mindless, and the overestimation of operation soundness. One common error is for organizations to view near-misses as reassurance of system sufficiency.

Commitment to resilience involves the recognition that errors are inevitable and practices must prevent and cure those that do occur and that the system must continue to function despite some failures of the parts. The components of resilience are the ability to absorb strain and preserve functioning despite adversity, the ability to recover from untoward events, and the ability to learn and grow from previous episodes of resilient actions.

Deference to expertise is migrating decisions up and down the organization. The authority hierarchy does not necessarily correspond to the knowledge hierarchy. The organization involves what the frontline knows and utilizes this information in decision-making and creates flexible decision structures.

Utilizing these 5 principles of Mindfulness, organizations can operate as HROs. Authors Weick and Sutcliffe acknowledge, "It is hard even unnatural, for individuals to remain chronically uneasy, so their organizational culture takes on a profound significance. Individuals may forget to be afraid, but the culture of a HRO provides them with both the reminders and tools to help them remember." pg 125

Family-Centered Care Comes to Austin

An Interview with Chris Brown, MS, CCLS

By Mark Shen, MD



Chris Brown, MS, CCLS, came to Austin in April of 2007 to join DCMC as Director of Child Life and Family Centered Care. Chris' child life career has included training at Johns Hopkins Hospital and clinical or managerial positions at James L. Kerner Hospital in Baltimore, MetroHealth Medical Center in Cleveland, Cook Children's Medical Center in Fort Worth, Children's Memorial Hospital in Chicago, and most recently, The Children's Hospital of Philadelphia.

Chris has assumed leadership roles reflective of her dedication to the further development of the child life profession as well as the delivery of family-centered care, having served as President of both the Child Life Council and of the Association for the Care of Children's Health, and as a current liaison member of the American Academy of Pediatrics' Committee on Hospital Care. Chris is an active speaker at national and international conferences including several trips to assist in the development of the child life profession in Kuwait.

1. Chris, you are a nationally-recognized leader in the field of Child Life. How did you end up also directing a Family-Centered Care initiative? (And thank you for coming to Austin to do all of this!)

As a Past-President and active member of the Association for the Care of Children's Health in the eighties I was privileged to work alongside Beverley Johnson, Terri Shelton, Jennifer Stepanek (author and mother of Mattie Stepanek) and other pioneers of the Family-Centered Care movement. My arrival at the Children's Hospital of Philadelphia in 1995 coincided with a period of remarkable growth and development of a comprehensive family-centered philosophy and care delivery system. The child life program grew from 10 staff members to over 65 in 12 years, including child life specialists, child life assistants, creative arts therapists, school teachers, a family resource center librarian and library assistants. Over that same period CHOP became known as a leader in the practice of FCC and I had the pleasure of supporting that success by sitting on the Family Advisory Council, initiating a Youth Advisory Council, and coordinating the production of an orientation video for families, among other collaborative endeavors.

Similarly, when I was being considered for the Child Life Department Director position at Children's Hospital of Austin in early 2007, and in anticipation of the move to DCMC, senior leadership was committed to more formally integrating family-centered care into our philosophy and practice. The timing was just right and I was thrilled to be able to take on the challenge of developing a high quality child life program and coordinating a team approach to advancing FCC at Dell Children's.

2. How might I, as a physician, notice the impact of family-centered care on my practice?

As the patient and family-centered care movement continues to gain momentum, supported by organizations such as AAP, IHI, NACHRI, NICHQ, (etc.), and as consumers become more and more

empowered, physicians are likely to notice that patients and family members are generally more involved and likely more assertive. Family members increasingly expect to participate in all aspects of their child's care and may be less willing to be asked to leave their child's side during procedures, rounds, or shift change. They want to be with their children when they open their eyes in the recovery room and want to be supported to place their child in a "comfort hold" for medical procedures versus having them held down forcibly by staff. Parents appreciate transparency and are becoming more assertive in seeking information. Family-centered care has also been shown to improve quality and safety outcomes and to reduce litigation. Another significant benefit is seen by physicians and caregivers themselves, many of whom report an increase in their own job satisfaction and effectiveness when engaged in family-centered care.

3. How can the physician community of Austin help with this initiative?

Every physician, associate, student and volunteer that interacts with a patient or family member in any inpatient or outpatient setting has the power to provide care in a collaborative, family-centered way, and thus to impact the success of this initiative. Little things like knocking on patient room and treatment room doors, introducing oneself, and calling patients and parents by name go a long way. Challenges such as providing adequate interpreter services and coordination of care between pediatricians and specialists, and across multiple specialties, can be promoted as priorities by the physician community. Physicians are in the best position to model collaboration with members of the interdisciplinary healthcare team, to teach students and residents how to create partnerships with patients and family members, and to continuously seek to provide care in a way that best meets the unique needs and strengths of each individual. Physician "champions" are needed to assist in the ongoing planning and facilitation of family-centered care training efforts, program evaluation, etc. Interested physicians are invited to join the DCMC Family-Centered Care Steering Committee or any number of (current and future) unit and clinic-based FCC groups.

4. What changes can our patients expect to see at DCMC as a result of this work?

Tangible changes are already underway. Four Central is piloting "Care Boards" (white marker boards) installed in each room to more effectively facilitate family members' abilities to communicate with team members and participate in the care of their child to the extent they wish. In many cases "Family Centered Rounds" are taking place at the bedside with the patient and family invited to participate in information sharing and care planning. Future activities include improved way-finding through signage and maps, increased family member participation on hospital committees, and other projects to be determined by patients and families themselves (e.g., through their involvement on DCMC's Family Advisory Council or Youth Advisory Council). Again, we are very interested in ideas that front-line staff and physicians may have to improve the patient, family, and care provider experience.

The following information is provided from the Pediatric Alliance of Central Texas new e-newsletter. If you are not getting these valuable updates and would like to be on the distribution list, please send your email address to mccarlson@seton.org.

2009 H1N1 Influenza Widespread in Central Texas



The 2009 Influenza season is well underway. Dell Children's Medical Center Emergency Department is seeing record numbers of patients with influenza like illnesses. The vast majority of circulating influenza virus in Texas is novel H1N1 Influenza virus. Most of these illnesses are mild, but children, especially those under the age of two and those with certain high risk conditions are at higher risk for more serious illness.

The situation is changing rapidly and it is a challenge to keep up with information. We have attempted to summarize issues regarding evaluation and management of 2009 H1N1 Influenza infections in children, given the updated recommendations from the CDC regarding, testing and therapy. These can be accessed through Doctor Link at https://doctors.seton.net/fluh1n1_information/.

In the documents, look for a Decision Algorithm to Assist with Testing, Treatment and Prophylaxis (Texas DSHS), Guidelines for Testing, Antiviral Treatment Indications, including guidance on dosing of children and compounding of oral suspension of oseltamivir from capsules. Helpful links are also provided to the CDC and Texas DSHS H1N1 sites.

Sarmistha B. Hauger M.D.
Director, Pediatric Infectious Diseases
'Specially For Children, Dell Children's Medical Center

New Physicians to DCMC Medical Staff since July, 2009 through September, 2009

Name	Specialty
Anant Patel MD	Neurosurgery
Joy Hernandez D.D.S.	Dentistry (pedi)
Sujit Iyer MD	Emergency Medicine (pedi)
Joseph Forbess MD	Cardiothoracic Surgery
Kristine Guleserian MD	Cardiothoracic Surgery
Christopher Jones Jr. MD	Dermatology
Mark Auler MD	Radiology
Hui-Young Chung MD	Radiology
Brandon Langlinais MD	Radiology
John Williamson MD	Radiology
Kelly Hetherington MD	Allergy & Immunology
Jeffrey Apple MD	Vascular Surgery
Lynn Campbell MD	Pediatrics
Vincent Cavaretta III DDS	Oral and Max. Surgery
Harris Rose MD	Orthopedic Surgery
Christina Sheely DO	Orthopedic Surgery
Cristiane Lin MD	Pediatrics
Kyle Rhodes MD	Ophthalmology
Jose Urquidez MD	Physical Medicine & Rehab
Robert Buchanan MD	Neurosurgery
Smitha Murthy MD	Psychiatry
Faraz Kerendi MD	Cardiothoracic Surgery
Erica Garcia-Pittman MD	Psychiatry
Alex Valadka MD	Neurosurgery
Eric Hoenicke MD	Cardiothoracic Surgery
Jeanmarie Connor MD	Pediatrics
Cuong Tieu MD	Psychiatry
Lisa Jacob DDS	Dentistry (pedi)
Brian Hardy MD	Orthopedic Surgery
Ai Mukai MD	Physical Medicine & Rehab
Kit Purdy MD	Pathology
Danielle Sweeney MD	Urology (pedi)
Marouane Bouchareb MD	Radiology
Jason Craig MD	Anesthesiology
James Goodman MD	Pediatrics
Michael Holmes MD	Pediatrics
Daniel Howard MD	Pediatrics
Tiffany Turner MD	Pediatrics
Raymond Harshbarger MD	Plastic Surgery
Michael Connor MD	Ophthalmology
Tammy Dietz DO	Emergency Medicine

Grand Rounds at Dell Children's

for the remainder of 2009

Friday October 30 2009

7:30-8:30 AM in Signe Auditorium

"Medical Legal Partnership"

Dr. Keller (Associate Professor of Clinical Pediatrics, Medical Director of South County Pediatrics, University of Massachusetts Medical School, Worcester, MA)

Ms. Valerie Zolezzi-Wyndham (Legal Director of Family Advocates of Central Massachusetts)

Friday November 13 2009

7:30-8:30 AM in Signe Auditorium

"Fatty Acid Oxidation Defects in the Era of Newborn Screening"

Dr. Arnold Strauss

(Chief of Pediatrics, Cincinnati Children's Hospital)

Friday November 20 2009

7:30-8:30 AM in Signe Auditorium

"The Treatment of Pediatric Asthma"

Ronda Machen, PharmD, RD

(Pediatric Clinical Pharmacist, Dell Children's Medical Center)

Friday December 11 2009

7:30-8:30 AM in Signe Auditorium

"Drugs of Abuse"

Don Williams, MD

(Pediatric Causes of Chest Pain, Dell Children's Medical Center)

Leonard P. Rome C.A.T.C.H. Visiting Professorship

"Medical Legal Partnerships"

David Keller, MD & Valerie Zolezzi-Wyndham, JD
Family Advocates of Central Massachusetts

Wednesday, October 28, 2009

4:30-6: Meeting and Site visit to East Austin Community Health Center

"Successful partnerships: How to make community-based collaborations work"

East Austin Community Center meeting room

211 Comal St., Austin, TX 78702

6:30: Dinner (by invitation only)

"MLP 101: Introduction/overview of MLP and discussion"

Dell Children's Medical Center (DCMC) Back half of SIG Auditorium
4900 Mueller Blvd., Austin, TX 78723

Thursday, October 29, 2009

8:30-9:15: Morning Report (intended primarily for pediatric residents/faculty)

"Non-contributory?! Why the social history is always contributory"

DCMC Conf Rm 3 & 4

9:30-11: Seminar

"Enhancing Community Pediatrics Education—Integrating Medical/Legal education & training into the structure of MLP"

DCMC Conf Rm 3

12:15-1:15: Noon conference (intended primarily for pediatric residents/faculty)

"What does a MLP do? Understanding the issues that MLP can help address"

DCMC Conf Rm 3 & 4

2:30-4:30: Workshop:

"Evaluating your MLP: We know we are doing well, or do we?"

DCMC Conf Rm 3

6:30-8:30: Dinner (community pediatricians and residents/faculty invited)

"Promoting Community Pediatrics & CATCH"—Dr. Louis Appel

DCMC Conf Rm 3 & 4

Friday, October 30, 2009

7:30-8:30: GRAND ROUNDS

"Family Advocates of Central Massachusetts: 5 Years of Medical Legal Partnership (and Counting!)"

DCMC SIG Auditorium

9-11: Meeting/workshop

"Next steps for developing a Medical Legal Partnership in Austin"

DCMC SIG Auditorium

IN THEIR SHOES:

Understanding Cultural
Effectiveness as a Means to Build
Relationships with Families

Tue, Nov. 3rd, 1:00-4:00pm
Wed, Nov. 4th, 8:00-11:00am

Dell Children's Medical Center - Sig Auditorium

Speaker: Noel B. Rosales, MD - Attending Physician,
Director of Cultural Effectiveness Initiative
Children's Hospital of Philadelphia

Followed on both days by interdisciplinary panel discussions:

11/3: *The NICU Experience for Spanish-speaking Parents*
Participants TBD

11/4: *Relationship-building from Hospital to Home*
Paula Bell, RN, DCMC PICU; Michelle Mirsky, parent;
Hanoch Patt, MD, Children's Cardiology Associates;
Natalie Tarrant, MD, Hill Country Pediatrics

****For registration information, please contact Aimee DeRiggi at 324-1000, extension 17081, or Elizabeth Garza at 809-4348 or by email egarza@marchofdimes.com.**

Offered by Dell Children's Medical
Center, March of Dimes NICU Family Support, Seton Network NICU FCCC,
and Pediatrix