

Summer Webinar Series

WEBINAR

Hospital-based Medicine: Trainee Spotlight

Thursday, August 13 2:30-4:00 pm EDT

Moderators

Marie Wang

Mary Ottolini

EDT	Abstract	Title	
2:30 pm		Introduction & General Information	
2:35 pm	3374046	To Test or Not To Test: Utilization of Viral Panels in Asthma, Bronchiolitis, and Pneumonia Across Children's Hospitals	Sana Siddiqui
2:45 pm	3368760	Non-Invasive Ventilation and Rates of Severe Outcomes in Bronchiolitis	Kristen Shanahan
2:55 pm	3378640	Time for a Holiday: De-escalation of Care in Bronchiolitis	Jennifer Hoefert
3:05 pm	3369430	Association of Model of Care for Kawasaki Disease with Utilization and Patient Outcomes	Nathan Money
3:15 pm	3381098	Limited English Proficiency Associated with Delayed Analgesia After Surgery	Carlos Plancarte
3:25 pm	3379761	Progression Of Finnegan Scores In Infants Treated For Neonatal Abstinence Syndrome Via The Eat, Sleep, Console Approach	Rebecca Beagan
3:35 pm	3382928	Factors associated with pediatric hospitalists' intent to pursue subspecialty certification in pediatric hospital medicine	Jessica Truelove
3:45 pm		Wrap Up	

Note: Schedule subject to change based on presenter availability.

CONTROL ID: 3374046

TITLE: To Test or Not To Test: Utilization of Viral Panels in Asthma, Bronchiolitis, and Pneumonia Across Children's Hospitals

PRESENTER: Sana Jamil Siddiqui

AUTHORS (LAST NAME, FIRST NAME): Siddiqui, Sana J.¹; Kafle, Maheshwor¹; Temkit, M'hamed¹; Librizzi, Jamie¹

AUTHORS/INSTITUTIONS: S.J. Siddiqui, M. Kafle, M. Temkit, J. Librizzi, Phoenix Children's Hospital, Phoenix, Arizona, UNITED STATES;

CURRENT CATEGORY: Hospital-based Medicine

CURRENT SUBCATEGORY: None

KEYWORDS: Viral testing, Asthma, Bronchiolitis.

SESSION TITLE: Hospital-based Medicine: Trainee Spotlight |Hospital-based Medicine: Trainee Spotlight

SESSION TYPE: Platform|Webinar

ABSTRACT BODY:

Background: Asthma, bronchiolitis, and pneumonia are common pediatric diagnosis for which viral testing (VT) is not routinely necessary.

Objective: Our objectives are to; 1) describe trends/seasonal variations in VT over the last 5 years, 2) describe the rate of VT associated with individual hospital cohorting practices and 3) describe the rates of VT associated with individual hospitals' use of clinical pathways and electronic medical record (EMR) order sets.

Design/Methods: This is a retrospective chart review using Pediatric Health Information System (PHIS) database over the last 5 years (2014-2018). Patients 0-18 years, admitted with the diagnosis of asthma, bronchiolitis, and/or pneumonia were included. Patients with complex chronic conditions, prolonged hospital stay (>7 days), or pediatric intensive care unit stay were excluded. A hospitalist from each PHIS hospital was surveyed about their institution's VT practice patterns regarding cohorting and the use of clinical pathways and/or EMR order sets. The data was summarized using frequency and percent for categorical variables, mean and standard deviation for quantitative variables, and Chi-squared and Wilcoxon rank-sum tests for associations.

Results: From 2014-2018, there were 373,626 patients included in the study. During respiratory season, VT rates for asthma decreased from 23.9% to 19.2%, from 33.5% to 25.2% in bronchiolitis, and from 31.5% to 27.4% in pneumonia. In non-respiratory season, VT rates were lower for asthma and pneumonia but, were higher in non-respiratory season for bronchiolitis (Figure 1). 92% of PHIS hospitals responded to the survey; 44% utilize cohorting during high census season and 27% specifically use VT for cohorting purposes. VT rates for PHIS hospitals who utilize VT for cohorting compared to hospitals who do not cohort were 32.8% vs 11.6 % in asthma, 36.7% vs 21.1% in bronchiolitis, and 40.0% vs 21.0% in pneumonia (Table 1). VT rates were lowest for hospitals who had disease specific EMR order sets that did not include VT. In asthma and pneumonia, VT rates were lowest for hospitals who had a clinical pathways that did not include VT. In bronchiolitis, VT was lowest in hospitals who did not have a clinical pathway (Table 1).

Conclusion(s): Overall VT rates at PHIS hospitals has decreased in asthma, bronchiolitis, and pneumonia over the last 5 years and does vary slightly depending on season. VT rates are impacted by the presence of cohorting, EMR order sets and clinical pathways for each diagnosis.

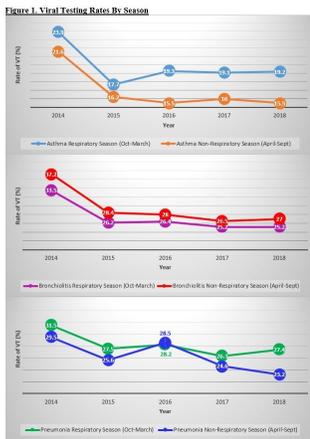


Figure 1. Viral Testing (VT) Rates By Season

Table 1: Association of VT Rates with National Cohorting Practices and Clinical Practice Tools

	Cohorting Practices			P-value
	Cohorting Not Utilized N=201,873	Cohorting Present Without VT N=68,139	Cohorting Present With VT N=82,470	
Asthma	11.6%	13.5%	32.8%	<0.0001
VT Rates	(8,778/75,780)	(4,029/29,872)	(9,375/28,617)	
Bronchiolitis	21.1%	27.8%	36.7%	<0.0001
VT Rates	(19,516/92,546)	(7,930/28,551)	(15,141/41,282)	
Pneumonia	21.0%	16.1%	40.0%	<0.0001
VT Rates	(7,038/33,547)	(2,533/9,716)	(5,030/12,571)	
	Clinical Practice Tool: EMR Order Set			P-value
	EMR Order Set Not Present	EMR Order Set Present, VT Not Included	EMR Order Set Present, VT Included	
Asthma	34.6%	20.9%	35.3%	<0.0001
VT Rates	(4,787/13,824)	(65,632/313,315)	(8,951/25,343)	
Bronchiolitis	29.9%	18.3%	30.3%	<0.0001
VT Rates	(4,691/15,668)	(41,494/227,324)	(33,185/109,490)	
Pneumonia	35.4%	19.7%	22.6%	<0.0001
VT Rates	(16,754/47,336)	(43,187/218,569)	(20,429/90,577)	
	Clinical Practice Tool: Clinical Pathway			P-value
	Clinical Pathway Not Present	Clinical Pathway Present, VT Not Included	Clinical Pathway Present, VT Included	
Asthma	36.8%	20.9%	43.6%	<0.0001
VT Rates	(2,933/7,963)	(68,098/325,412)	(8,339/19,107)	
Bronchiolitis	13.9%	20.5%	32.0%	<0.0001
VT Rates	(3,253/23,389)	(52,222/254,514)	(23,895/74,579)	
Pneumonia	31.8%	20.6%	22.0%	<0.0001
VT Rates	(15,279/47,973)	(41,971/203,900)	(22,120/100,609)	

Table 1: Association of Viral Testing (VT) Rates with National Cohorting Practices and Clinical Practice Tools

IMAGE CAPTION:

Figure 1. Viral Testing (VT) Rates By Season

Table 1: Association of Viral Testing (VT) Rates with National Cohorting Practices and Clinical Practice Tools

CONTROL ID: 3368760

TITLE: Non-Invasive Ventilation and Rates of Severe Outcomes in Bronchiolitis

PRESENTER: Kristen Shanahan

AUTHORS (LAST NAME, FIRST NAME): Shanahan, Kristen¹; Monuteaux, Michael²; Nagler, Joshua¹; Bachur, Richard³

AUTHORS/INSTITUTIONS: K. Shanahan, J. Nagler, Division of Emergency Medicine, Boston Children's Hospital, Boston, Massachusetts, UNITED STATES;

M. Monuteaux, Boston Children's Hospital, Boston, Massachusetts, UNITED STATES;

R. Bachur, Pediatrics, Boston Children's Hospital, Boston, Massachusetts, UNITED STATES;

CURRENT CATEGORY: Hospital-based Medicine

CURRENT SUBCATEGORY: None

KEYWORDS: Bronchiolitis, Non-invasive ventilation, Invasive ventilation.

SESSION TITLE: Hospital-based Medicine: Trainee Spotlight |Hospital-based Medicine: Trainee Spotlight

SESSION TYPE: Platform/Webinar

ABSTRACT BODY:

Background: Non-invasive ventilation (NIV) for bronchiolitis is common despite limited evidence supporting its use to reduce the likelihood of invasive ventilation. Prior research has not evaluated the impact of NIV practice patterns on rates of severe outcomes using national databases.

Objective: The objectives of this study were to characterize temporal trends and associations between the use of NIV in bronchiolitis and two severe outcomes—invasive ventilation and cardiopulmonary resuscitation (CPR).

Design/Methods: This is a multi-center retrospective cross-sectional study using data from 41 children’s hospitals in the Pediatric Health Information Systems database. Previously healthy infants under 12 months old who were admitted for bronchiolitis from 2010 to 2018 were included. NIV included continuous positive airway pressure, bi-level positive airway pressure, and high-flow nasal cannula. Hospitals in the lowest and highest quartiles of NIV utilization were classified as low and high utilizers. Differences in rates of endotracheal intubation (EI) and CPR after the initial hospital day were compared across hospitals with low and high NIV utilization using multivariable logistic regression adjusted for age and clustering by hospital.

Results: 147,288 visits for bronchiolitis were analyzed. NIV utilization increased from 10.4% to 13.0% over the study period ($p<0.001$, figure 1). Rates of EI decreased from 1.2% to 0.5% over the study period, although rates were rising from 2010 to 2016 before declining ($p<0.001$ for overall trend, figure 1). Rates of CPR increased from 0.16% to 0.34% ($p<0.001$). EI occurred in 1.5% and 0.7% of visits at low and high NIV utilizing hospitals, respectively (unadjusted OR 0.43, 95% CI 0.38-0.50, adjusted OR 0.42, 95% CI 0.11-1.63). Odds of EI decreased with age (OR 0.90, 95% CI 0.83-0.97). CPR occurred in 0.03% and 0.2% of visits at low and high NIV utilizing hospitals, respectively (adjusted OR 7.85, 95% CI 1.35-45.77).

Conclusion(s): In a large cohort of infants at pediatric centers, NIV for bronchiolitis rose significantly from 2010 to 2018, while rates of invasive ventilation declined significantly due to a sharp drop after 2016. In adjusted analyses, NIV was not associated with a reduction in invasive ventilation, but was associated with higher rates of CPR. NIV in bronchiolitis may incur an unintended higher risk of CPR, which requires further investigation.

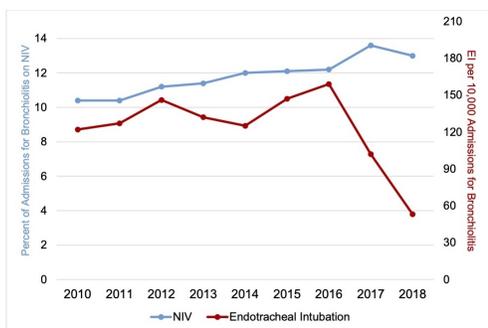


Figure 1. NIV* and EI** in Infants Admitted with Bronchiolitis, 2010-2018
 *NIV, non-invasive ventilation
 **EI, endotracheal intubation

Table 1. Rates of Severe Outcomes in Hospitals with High and Low NIV* Utilization**

Outcome	Hospitals with High NIV Utilization n=38,857	Hospitals with Low NIV Utilization n=42,605	Unadjusted Odds Ratio (95% CI)	Adjusted [†] Odds Ratio (95% CI)
EI [‡] , n (%)	268 (0.7)	653 (1.5)	0.43 (0.37-0.50)	0.42 (0.11-1.63)
CPR [§] , n (%)	99 (0.2)	16 (0.03)	7.88 (4.31-14.40)	7.85 (1.35-45.77)

*NIV, non-invasive ventilation
 **High and low utilization, defined as lowest and highest quartiles of hospital-level NIV for bronchiolitis
 †Adjusted for age and clustering by hospital
 ‡EI, endotracheal intubation after the initial hospital day
 §CPR, cardiopulmonary resuscitation after the initial hospital day

IMAGE CAPTION:

TITLE: Time for a Holiday: De-escalation of Care in Bronchiolitis

PRESENTER: Jennifer Ann Hoefert

AUTHORS (LAST NAME, FIRST NAME): Hoefert, Jennifer A.¹; Gardner, Hannah²; Molina, Adolfo L.³; Grizzle, Karisa⁴; Orr, Mary³; Miller, Kevin H.¹; Miller, Kylee¹; Ponnazhagan, Ranjani¹; Wu, Chang L.³

AUTHORS/INSTITUTIONS: J.A. Hoefert, K.H. Miller, K. Miller, R. Ponnazhagan, University of Alabama at Birmingham, Birmingham, Alabama, UNITED STATES;
H. Gardner, Hospital Medicine, University of Alabama at Birmingham, Birmingham, Alabama, UNITED STATES;
A.L. Molina, M. Orr, C.L. Wu, Pediatrics, University of Alabama at Birmingham, Birmingham, Alabama, UNITED STATES;
K. Grizzle, Vanderbilt, Nashville, Tennessee, UNITED STATES;

CURRENT CATEGORY: Hospital-based Medicine

CURRENT SUBCATEGORY: None

KEYWORDS: Bronchiolitis, Oxygen, Quality Improvement .

SESSION TITLE: Hospital-based Medicine: Trainee Spotlight |Hospital-based Medicine: Trainee Spotlight

SESSION TYPE: Platform|Webinar

ABSTRACT BODY:

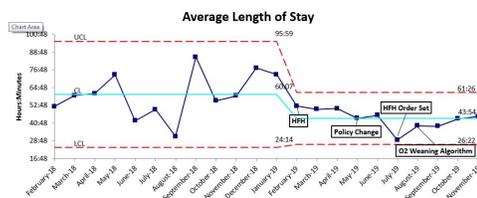
Background: Bronchiolitis is the most common cause of hospitalization in infants less than 12 months old. Use of high-flow oxygen therapy has emerged as a non-invasive method to provide positive airway pressure. However, existing guidelines for weaning supplemental oxygen are limited.

Objective: We sought to decrease duration of oxygen supplementation and length of stay in patients admitted with bronchiolitis through standardization of both high-flow and simple nasal cannula oxygen weaning.

Design/Methods: In this single-center quality improvement project, patients aged 1-24 months hospitalized with bronchiolitis from February through November 2019 were included; patients with chronic lung disease, anatomic airway disorder, cyanotic cardiac disease, or home oxygen use were excluded. An interdisciplinary group implemented a standardized care process for de-escalating respiratory support. Rapid PDSA cycles were conducted and included: creation of a decision tool for weaning high-flow supplemental oxygen (“high-flow holiday”), inclusion into hospital policy, modification of the computerized physician order entry system, and creation of a decision tool for weaning simple nasal cannula oxygen. Data was collected for primary outcomes including length of stay, duration of time on high-flow nasal oxygen, and total time on supplemental oxygen. Balancing measures included transfer to the PICU and 7 day readmissions.

Results: Since initiation of project, 375 patients with bronchiolitis were included, of which 180 required high-flow supplemental oxygen. A baseline comparison cohort (n=450) admitted in the 12 months prior to project start was used. Interventions led to decreases in mean length of stay (60:07 vs 43:54 hours; p<0.01), time on high-flow oxygen (47:50 vs 27:26 hours; p<0.01), and total time on oxygen (53:34 vs 28:48 hours; p<0.01). Additionally, decreases in variability with narrowed control limits were observed (Fig 1-3). Balancing measures remained stable with no significant change in PICU transfer or readmission rate (3.0% vs 3.1%; p=0.86 and 1.8% vs 1.9%; p= 0.97, respectively).

Conclusion(s): Implementation of a standardized care process for weaning high-flow and simple nasal cannula oxygen resulted in a safe decrease of hospital resource utilization for patients admitted with bronchiolitis. Future studies may explore if similar interventions persist at other institutions.



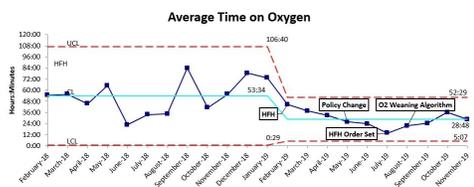
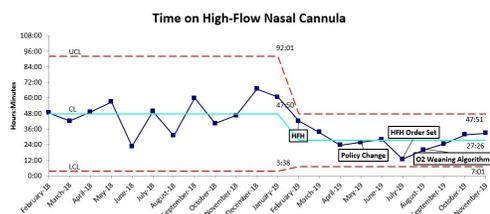


IMAGE CAPTION:

CONTROL ID: 3369430

TITLE: Association of Model of Care for Kawasaki Disease with Utilization and Patient Outcomes

PRESENTER: Nathan Money

AUTHORS (LAST NAME, FIRST NAME): Money, Nathan⁸; Hall, Matt¹; Wallace, Sowdhamini S.²; Coon, Eric³; Tremoulet, Adriana¹⁰; Markham, Jessica⁴; ERDEM, GULIZ⁵; Tamaskar, Nisha⁶; Parikh, Kavita⁷; Neubauer, Hannah⁸; Darby, John⁹; Quinonez, Ricardo¹¹

AUTHORS/INSTITUTIONS: M. Hall, Informatics, Children's Hospital Association, Lenexa, Kansas, UNITED STATES;

S.S. Wallace, Pediatrics, Baylor College of Medicine, Houston, Texas, UNITED STATES;

E. Coon, Pediatric Hospital Medicine, University of Utah, Salt Lake City, Utah, UNITED STATES;

J. Markham, Pediatrics, Children's Mercy Hospital, Kansas City, Missouri, UNITED STATES;

G. ERDEM, PEDIATRICS, NATIONWIDE CHILDRENS HOSPITAL, Columbus, Ohio, UNITED STATES;

N. Tamaskar, Hospital Medicine, Children's National Medical Center, Houston, Texas, UNITED STATES;

K. Parikh, Hospitalist Division, Children's National Medical Center, Bethesda, Maryland, UNITED STATES;

N. Money, H. Neubauer, Baylor College of Medicine, Houston, Texas, UNITED STATES;

J. Darby, Pediatrics, Wake Forest School of Medicine, Winston-Salem, North Carolina, UNITED STATES;

A. Tremoulet, Rady Children's, San Diego, California, UNITED STATES;

R. Quinonez, Pediatric Hospital Medicine, Baylor College of Medicine, Houston, Texas, UNITED STATES;

CURRENT CATEGORY: Hospital-based Medicine

CURRENT SUBCATEGORY: None

KEYWORDS: Consultation, Model of Care, Outcomes.

SESSION TITLE: Hospital-based Medicine: Trainee Spotlight |Hospital-based Medicine: Trainee Spotlight

SESSION TYPE: Platform|Webinar

ABSTRACT BODY:

Background: Kawasaki Disease (KD) is a condition associated with substantial morbidity and hospital cost. Model of care, or admitting service and consultant role designation, varies between institutions for patients with many conditions, including KD. There is a paucity of evidence on patient outcomes based on primary service designation and consultation practice, which may impact hospital resource utilization and patient outcomes.

Objective: To describe model of care variation in children with KD and explore how model of care affects utilization and patient outcomes.

Design/Methods: We conducted a retrospective cohort study of children ≤18 years old hospitalized with KD at US children's hospitals from 2017-2019. The model of care was assessed by survey of Pediatric Research in Inpatient Settings (PRIS) site leads. Hospitals were grouped accordingly: Model 1 (hospitalist primary with as needed subspecialty consultation), Model 2 (hospitalist primary with automatic subspecialty consultation), and Model 3 (subspecialist primary). Next, the Pediatric Health Information System® (PHIS) database was used to identify children with KD and compare utilization and outcomes based on model types. Utilization indices included laboratory tests, imaging, medication use, length of stay, 7-day readmission and total cost of hospitalization. Patient outcomes included coronary artery aneurysms, adverse cardiac outcomes, and need for long-term anticoagulation.

Results: We included 2,080 children in 44 children's hospitals; 21 (48%) hospitals identified as Model 1, 19 (43%) as Model 2, and 4 (9%) as Model 3. No difference was seen in length of stay (p=0.58), or readmission (p=0.88) based on model type, but total cost differed (p<0.001, Table 1). Model 1 ordered more laboratory tests (p<0.001), while Model 3 used more immune modulating medications and obtained more echocardiograms (p<0.001). There were no significant differences between coronary artery aneurysms (p=0.44) or need for long-term anticoagulation (p=0.21) among model types. Model 3 had fewer, though not statistically significant, adverse cardiac outcomes in the six months following admission (p=0.05).

Conclusion(s): Model of care varies for patients admitted with KD and may contribute to variations in resource utilization. Among hospitalized children with KD, admission to a subspecialist team was associated with higher resource utilization but potentially better cardiac outcomes.

Table 1. Utilization and Patient-Centered Outcomes by Model Type

Utilization Indices	Model 1	Model 2	Model 3	p value
General				
Median length of stay in day (IQR)	3 (3, 4)	3 (3, 4)	3 (3, 4)	0.573
Median total cost of hospitalization in dollars (IQR)	11033 (\$899.9, 15319.8)	12434.2 (\$516.6, 16375.8)	12727.4 (\$668.1, 17598.3)	<.001
All cause 7-day emergency department revisit (95% CI)	24 (2.3)	18 (2.4)	3 (1)	0.326
All cause 7-day readmissions (95% CI)	66 (6.4)	46 (6.2)	21 (7)	0.879
Laboratory markers				
Total # of labs per admission per 100 patient days	296.3 (290.9, 301.7)	265.2 (259.2, 271.3)	272.7 (265, 282.6)	<.001
Medications				
Days of IV/oral antibiotics per 100 patient days	30.8 (28.1, 32.5)	30.8 (28.8, 32.9)	27.9 (24.9, 31.2)	0.272
Received IV/oral steroids (95% CI)	150 (14.5)	98 (13.2)	28 (9.4)	0.073
Received immune modulators (95% CI)	23 (2.2)	51 (6.8)	43 (14.4)	<.001
Imaging				
Received <1 echo (95% CI)	187 (18.1)	148 (19.5)	85 (28.4)	<.001
Received >1 echo (95% CI)	355 (34.3)	237 (31.8)	176 (58.9)	<.001
Received advanced cardiac imaging (95% CI)	10 (1)	5 (0.7)	0 (0)	0.217
Received other CT/MRI (95% CI)	84 (8.1)	50 (6.7)	18 (6)	0.349
Cardiac Outcomes				
Coronary artery aneurysms (95% CI)	80 (7.7)	69 (9.3)	28 (9.4)	0.419
Adverse cardiac outcome within 6 months (95% CI)	9 (0.9)	14 (1.9)	1 (0.3)	0.051
Need for long-term anticoagulation (95% CI)	54 (5.2)	28 (3.8)	10 (3.3)	0.209

IMAGE CAPTION:

CONTROL ID: 3381098

TITLE: Limited English Proficiency Associated with Delayed Analgesia After Surgery

PRESENTER: Carlos Alberto Plancarte

AUTHORS (LAST NAME, FIRST NAME): Plancarte, Carlos A.¹; Hametz, Patricia²; Southern, William¹

AUTHORS/INSTITUTIONS: C.A. Plancarte, W. Southern, Pediatrics, Montefiore, New York, New York, UNITED STATES;

P. Hametz, Pediatrics, Children's Hospital at Montefiore, New York, New York, UNITED STATES;

CURRENT CATEGORY: Hospital-based Medicine

CURRENT SUBCATEGORY: None

KEYWORDS: disparity, language , pain.

SESSION TITLE: Hospital-based Medicine: Trainee Spotlight |Hospital-based Medicine: Trainee Spotlight

SESSION TYPE: Platform|Webinar

ABSTRACT BODY:

Background: Prevalent and persistent disparities exist in care provided to minority children with major impact, including an estimated \$35 billion in excess health care costs in 2015 alone. A significant body of research has identified disparities in care for racial/ethnic minority patients. However, the role that limited English proficiency plays in healthcare disparities is less well studied.

Objective: We examined pain management prescribing practices and timeliness of analgesic administration in pediatric patients with LEP families hospitalized after surgical correction of a single limb fracture.

Design/Methods: This 3 year retrospective cohort study examined post-surgical children admitted to an urban, tertiary care children’s hospital with a single limb fracture. Family’s language proficiency was determined by chart review. The primary outcome was time to first analgesia within 12 hours on the inpatient floor. Secondary outcomes included time to first opioid analgesia within 12 hours and four outcomes in the 24 hour post-operative period: any opioid administered, cumulative opioid dosing, number of doses of non-opioid analgesics, and number of pain assessments recorded. We compared the clinical and demographic characteristics of children from LEP vs. English proficient (EP) using t-tests or Mann-Whitney tests as appropriate. To analyze time to first analgesic and time to first opioid, method of Kaplan and Meier, log-rank tests, and univariate and adjusted multivariate Cox-proportional hazard models were used.

Results: 337 charts were screened; 306 met inclusion criteria. Of these, 59 families had LEP and 247 were EP. LEP was significantly associated with delayed time to administration of analgesia in unadjusted analysis (HR=0.68, 95%CI: 0.50, 0.92) and after adjustment for age, number of fractures, meqs of morphine given in the PACU, if NSIAD was given in PACU, insurance status, and admit floor (HR=0.68, 95%CI: 0.50, 0.94). (Table 2, Fig. 1) No significant differences were found for secondary outcomes.(Table 3)

Conclusion(s): In our study, hospitalized children with LEP families receive less analgesia immediately after surgery and had a delay to first analgesic. Studies are needed to identify mechanisms leading to these disparities.

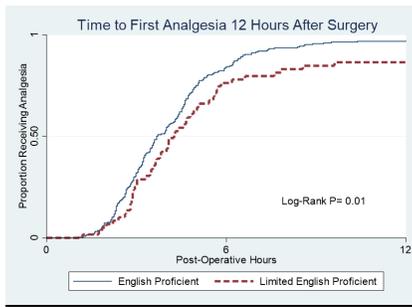


TABLE 1. Patient Demographics and Baseline Characteristics. N=306

	English Proficient (n=247)	Limited English Proficient (n=59)	P value
Age (IQR)	9 (5, 13)	9 (5, 13)	0.78
Gender (% male)	159 (64)	42 (71)	0.32
Insurance Status (% Medicaid)	168 (68)	56 (95)	<0.01
Race/Ethnicity			
Hispanic (%)	92 (37)	42 (71)	<0.01
Non-Hispanic Black (%)	75 (30)	1 (2)	
Non-Hispanic White (%)	27 (11)	1 (2)	
Other (%)	53 (21)	15 (25)	
Location of Fracture (% upper extremity)	136 (55)	33 (56)	0.88
Fracture number (% two fractures)	34 (14)	4 (7)	0.19
Nerve Block (% received)	93 (38)	22 (37)	0.96
PACU NSAID (% received)	51 (21)	17 (29)	0.18
PACU Opioid (% received)	121 (49)	31 (53)	0.62

TABLE 2. Time to First Analgesia or Opioid within 12 hours. N=306

	Unadjusted HR	Adjusted HR*
Time to First Analgesia* (95% CI)	0.68 (1.50, 0.92)	0.68 (0.50, 0.94)
Time to First Opioid* (95% CI)	0.71 (0.16, 1.40)	0.76 (0.38, 1.52)

* Adjusted for age, number of fractures, PACU Meq of morphine given, PACU NSAID given, Insurance Status, and Nursing Admit station

TABLE 3. Pain management in the first 24 hours post-op. N=306

	English Proficient (n=247)	Limited English Proficient (n=59)	P value
Received Analgesia*^ (% received)	239 (97)	51(86)	<0.01
Received Opioid* (% received)	56 (23)	10 (17)	0.34
Floor Opioids Given (% received)	79 (32)	18 (31)	0.80
Morphine Mcg/Kg (IQR)	0.06 (0.04, 0.10)	0.05 (0.04, 0.09)	0.65
Mean Number non-opioid meds	4.74	4.80	0.86
Number of pain assessments (IQR)	5 (2, 7)	6 (2, 9)	0.29

*Analysis of medication given within 12 hours post-op
^Analgesia includes NSAIDs, Opioids, and Tylenol

IMAGE CAPTION:**CONTROL ID:** 3379761**TITLE:** Progression Of Finnegan Scores In Infants Treated For Neonatal Abstinence Syndrome Via The Eat, Sleep, Console Approach**PRESENTER:** Rebecca Beagan**AUTHORS (LAST NAME, FIRST NAME):** Beagan, Rebecca¹; Berkwitt, Adam¹; Cheng, Frances Y.¹; Grossman, Matthew¹**AUTHORS/INSTITUTIONS:** R. Beagan, A. Berkwitt, F.Y. Cheng, M. Grossman, Pediatrics, Yale University School of Medicine, New Haven, Connecticut, UNITED STATES;**CURRENT CATEGORY:** Hospital-based Medicine**CURRENT SUBCATEGORY:** None**KEYWORDS:****SESSION TITLE:** Hospital-based Medicine: Trainee Spotlight |Hospital-based Medicine: Trainee Spotlight**SESSION TYPE:** Platform|Webinar**ABSTRACT BODY:**

Background: Few studies describe the natural clinical progression of Finnegan Neonatal Abstinence Scoring System (FNASS) scores in infants hospitalized for neonatal abstinence syndrome (NAS). The American Academy of Pediatrics (AAP) has devised recommendations for the length of observation prior to discharge for infants treated for NAS, however these recommendations are primarily based on pharmacologic data and case reports. Thus far, there is limited clinical evidence on peak timing of withdrawal signs.

Objective: To assess the progression of FNASS scores for infants treated via the Eat, Sleep, Console (ESC) approach, a model of care focused on optimizing nonpharmacologic interventions

Design/Methods: FNASS scores were retrospectively obtained from the electronic medical records for infants hospitalized for NAS at Yale New Haven Children’s Hospital between Jan 2014-Dec 2016. Infants managed in the NICU were excluded. While FNASS scores were obtained every 4 hours as per protocol, treatment decisions were not based on these scores, but rather based on the ESC approach. Box and whisker plots were created from the average FNASS score for each infant by hours of life (HOL). FNASS scores were considered for the overall population and by opioid exposure.

Results: For infants in the cohort (n=191), average length of stay was 6.5 days and 176 (92%) infants did not receive pharmacologic intervention. 133 (70%) were exposed to methadone, 36 (19%) to buprenorphine, and 22 (11%) to short-acting opioids. Overall, the average peak FNASS score was 6.9 ± 3.2 and occurred at 48-56 HOL. For infants exposed to methadone, the average peak FNASS score was 7.1 ± 2.8 at 40-48 HOL compared to 7.1 ± 4.2 at 48-56 HOL with short acting opioids. For those exposed to buprenorphine there were two equivalent peaks, 6.2 ± 3.2 at 64-72 HOL and $6.2 \pm$

2.5 at 96-104 HOL. A majority of infants (57%) were discharged by 120 HOL.

Conclusion(s): This study shows that the time of peak FNASS score differs by opioid exposure and average peak scores most often occur within the first 72 hours for all opioid exposures studied. This study also demonstrates that although the majority of patients were discharged following the AAP recommendation of a 5-7 day hospitalization, certain infants may be clinically ready for discharge sooner even when exposed to a long-acting opioid. Further work will investigate optimal timing for discharging infants hospitalized for NAS and explore characteristics of infants who may be at risk for delayed withdrawal.

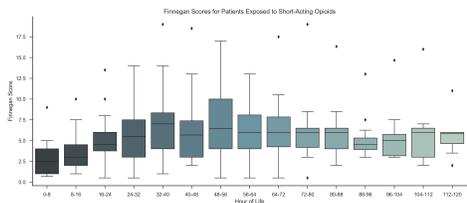
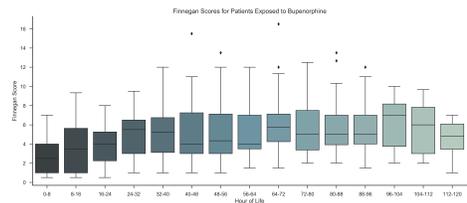
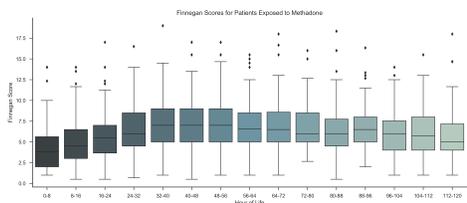
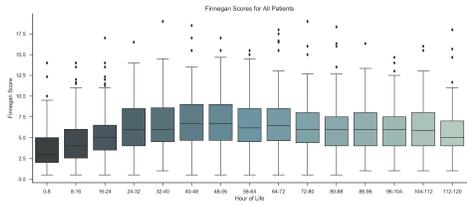


IMAGE CAPTION:

TITLE: Factors associated with pediatric hospitalists' intent to pursue subspecialty certification in pediatric hospital medicine

PRESENTER: Jessica J Truelove

AUTHORS (LAST NAME, FIRST NAME): Truelove, Jessica J.¹; Leyenaar, JoAnna¹; House, Samantha¹; Freed, Gary²; Leslie, Laurel K.³

AUTHORS/INSTITUTIONS: J.J. Truelove, J. Leyenaar, S. House, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire, UNITED STATES;

G. Freed, Pediatrics, University of MI, Ann Arbor, Michigan, UNITED STATES;

L.K. Leslie, American Board of Pediatrics, Chapel Hill, North Carolina, UNITED STATES;

CURRENT CATEGORY: Hospital-based Medicine

CURRENT SUBCATEGORY: None

KEYWORDS:

SESSION TITLE: Hospital-based Medicine: Trainee Spotlight |Hospital-based Medicine: Trainee Spotlight

SESSION TYPE: Platform|Webinar

ABSTRACT BODY:

Background: In October 2016 the American Board of Medical Specialties approved pediatric hospital medicine (PHM) as the newest pediatric subspecialty. Characterizing the number and professional characteristics of hospitalists intending to pursue PHM subspecialty certification is important to understanding development of the field.

Objective: To identify characteristics of pediatric hospitalists who plan to take the PHM subspecialty certifying exam and characterize reasons why hospitalists may opt against certification.

Design/Methods: At the time of enrollment in the ABP Maintenance of Certification (MOC) program in 2018, pediatricians who reported practicing PHM were offered a voluntary survey about their professional duties and intentions to take the PHM exam. We used multivariable logistic regression to identify factors independently associated with exam-taking intent. Qualitative content analysis of responses to open-ended, free-text questions was performed to characterize reasons why respondents did not plan to take the exam.

Results: Of 9615 pediatricians enrolling in MOC in 2018, 5933 completed the survey (response rate 61.7%); 637 reported PHM practice. Of these, 280 (43.6%) reported plans to take the exam, 164 (25.6%) reported they were unsure, and 192 (29.9%) planned not to take the exam. Among pediatricians who practiced PHM exclusively, 76.5% reported that they planned to take the exam. Age was the only sociodemographic factor independently associated with exam-taking intent, with older hospitalists less likely to report exam-taking plans. Factors associated with exam-taking intent included: (i) exclusive PHM practice (OR: 8.3, 95% CI: 4.93-14.1), (ii) full-time work (OR 1.91, 95% CI: 1.03-3.55), (iii) academic appointments (OR: 2.05, 95% CI: 1.31-3.21), and (iv) PHM practice at community hospitals (OR: 0.40, 95% CI: 0.25-0.65). Among those not planning to take the exam, the most frequent reasons cited included: (i) limited PHM practice (n = 66, 33.3% of free text responses), (ii) anticipated change in practice area (n = 38, 19.2%), and (iii) time commitment (n = 31, 15.7%).

Conclusion(s): In this national survey, more than three-quarters of pediatricians who practice PHM exclusively reported plans to take the certifying exam. Hospitalists without academic appointments and practicing in community hospitals were significantly less likely to report intent to take the exam. These trends should be followed and taken into account as the field considers the implications of board certification.

(No Image Selected)
