

Challenges in Providing Pediatric Coverage for Non-Pediatric Medical Centers

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Questions

What do they really want?

Why me?



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Discussion Prompt

How do programs provide pediatric coverage when they might have limited pediatric urologists (perhaps only 1).

What do the adult urologists need to do?

What relationships need to be made with other centers that have a pediatric urology program, etc.

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I've been at Cedars Sinai for 25 years- 20 years on the full-time faculty

For most of those years I have been the only pediatric urologist

1000 bed tertiary teaching and research hospital

Urban Los Angeles

>110,000 annual ER visits, 8000 deliveries, NICU, PICU and 24 bed floor

Separate Peds Urology call schedule

I have been on call by myself 24/7 for more than 15 years




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Expert Opinion

That is not the way to do it!

This next generation would never be that stupid to accept this.



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The real question is

Since the introduction of the Certificate of Added Qualification has adult and pediatric urology diverged too much?



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Scope of the issue

University of Michigan- Mott's Children Hospital

Regional leader, 1 of only 5 children's hospitals in Michigan

Consults

average of 1 per day

Emergency Dept 51%

In patient floor 47%

Diagnosis

Infection 18%

Obstruction/Hydro 11%

Retention/NIB 11%

GU pain 9%

Torsion only 3% (less than 1 per month)

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Scope of the issue

Children's Hospital of Colorado

Less than 1 consult a day

50% of consults from ER

74% presented directly

26% transfers from outside hospitals

Diagnoses

Urinary tract dilation 14%

UTI 11%

Urolithiasis 8.5%

Torsion 7%

Only 36% required some form of intervention

70% OR, 30% bedside, 5% IR

2X more likely for patients transferred in/ more likely at night

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Scope of the problem

For the community hospital urologist

Incidence should be considerably less approx. 1-2 week

small or no peds floor (50%)

no inbound transfers (12.5%)

Only 1/3 require any intervention

Most of the diagnoses are well within scope of training and knowledge

UTI

Stones

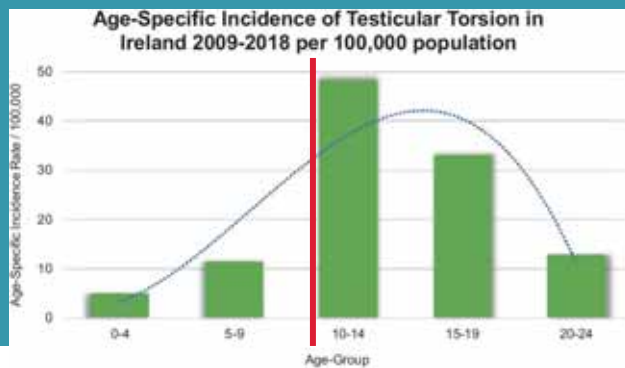
Pain

Retention

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Torsion is the real question

Who gets torsion?



Average weight of 10 yo boy is 71 lbs (32 kg)
14 yo boy is 113 lbs (51 kg)

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What are the range of options for pediatric coverage

- Adult urologist on call
- Contract with a pediatric urologist
- Telehealth- Formal
- Informal
- Pediatric Surgeons
- Transfer out

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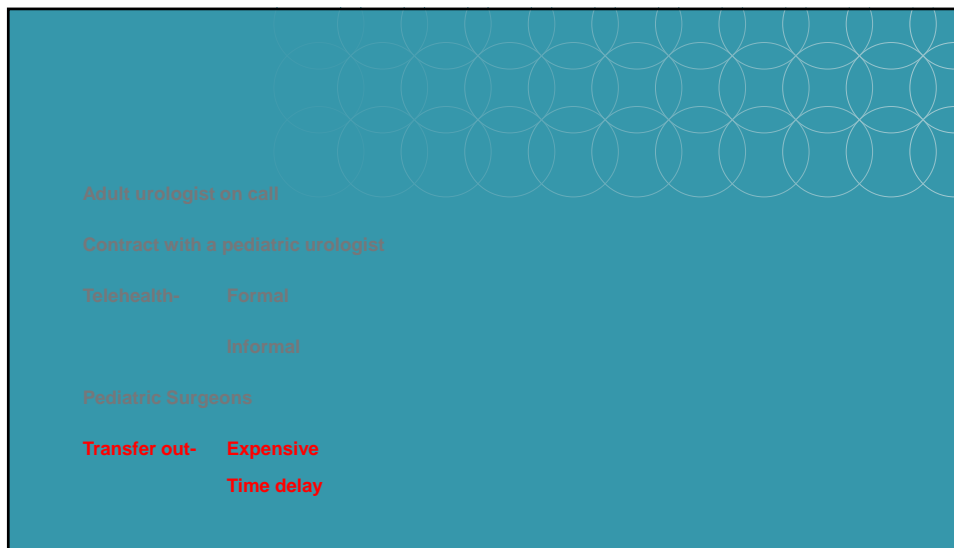
Adult urologist on call

Contract with a pediatric urologist- just too expensive for too few patients

- Telehealth- Formal
- Informal
- Pediatric Surgeons
- Transfer out

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Adult urologist on call

Contract with a pediatric urologist


Telehealth- Formal

 Informal

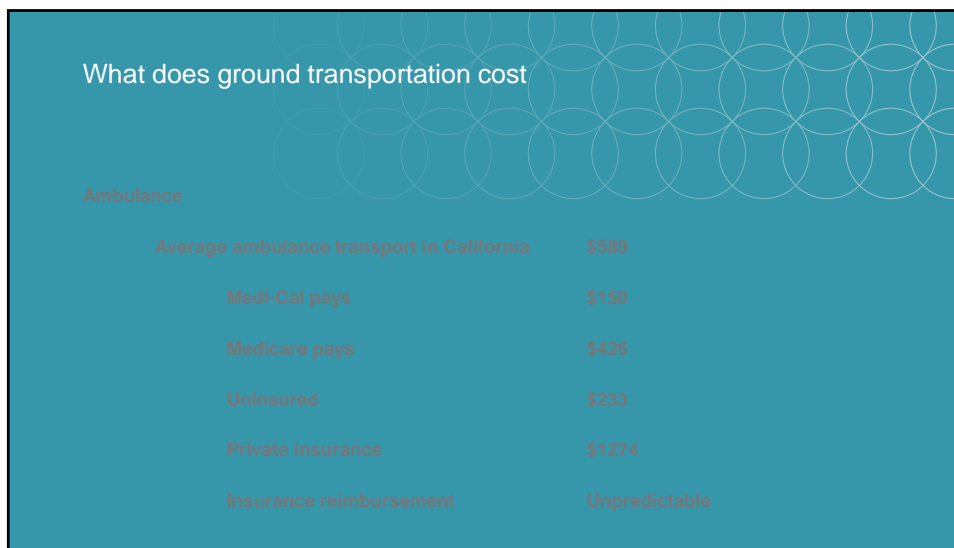
Pediatric Surgeons

Transfer out- Expensive

Time delay

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What does ground transportation cost

Ambulance

Average ambulance transport in California	\$589
Medi-Cal pays	\$150
Medicare pays	\$426
Uninsured	\$233
Private insurance	\$1274
Insurance reimbursement	Unpredictable

 Cedars Sinai California Ambulance Association, 16

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County of Los Angeles Ambulance Rates

Maximum for single patient

Non-emergency, BLS level	\$1567
Emergency 9-1-1 BLS level	\$1702
Non-emergency, ALS level	\$2383
Emergency 9-1-1 ALS level	\$2550
RN or RT up to 3 hours	\$2809
RN and RT up to 3 hours	\$3242

Not always clear who will pay (sending or receiving hospitals) and balance billing

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What does air transportation cost

Median cost of air ambulance services is between \$36,000-40,000

But can go much higher

Distance

Type of aircraft (Helicopter > Fixed wing)

Additional medical personnel

Often considered "out of network" leaving no or insufficient insurance reimbursement

Patients subjected to huge "surprise" bills in the 10s of thousands

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Time delay for Torsion

Does transfer increase the risk of orchiectomy?

Numerous studies- main takeaways

Rate of transfers has been increasing

Particularly at night and weekends

2-3 times increased risk of orchiectomy with transfer in those

< 12 yo

< 24 hours of symptoms

>30 miles in distance

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National review of torsion in Canada

Children treated at small and medium sized community hospitals had the lowest orchiectomy rate

Performed as well as tertiary/academic hospitals

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Answer

Adult urologist- empower to take care of routine peds emergencies including torsion

At least for older children

Contract

Telehealth

Diversion

Pediatric Surgeons

Transfer – reserve only for the truly complicated

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How do we encourage this?

More public support from leading societies- SAU, AUA, ABU and SPU

Reinforce that the general urologist is *the standard of care*

American Board of Medical Specialties (ABMS)-

"there was no requirement for a diplomate in a specialty to hold special certification in a subspecialty to be qualified to include aspects of subspecialty care in his/her practice"

"under no circumstances should a diplomate be considered un-qualified to practice within an area of subspecialty because of a lack of subspecialty certification"

American Board of Urology-

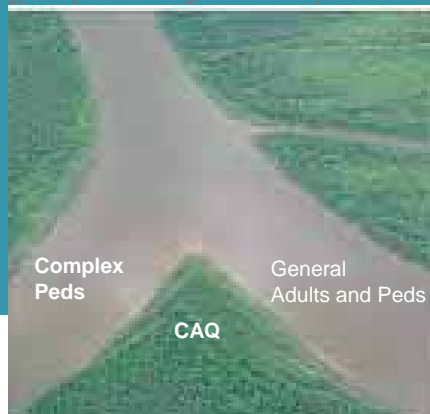
"Subspecialty certification in pediatrics is not meant to limit the practice of the general urologist regarding caring for pediatric patients"

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Intentionality in training

Instead of splitting training into and adult and peds

Split pediatric urology into peds for the generalist and peds for the specialist



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Current education invests significantly in pediatrics

Resident frequently spend 6 months on peds out of a 4 year curriculum (12.5%)

6% of their case log minimums are pediatric

At the 50th %tile of graduating case logs, 10% of cases are peds

15% of in-service questions are peds

But are we incentivizing them to learn the pediatrics they need

Are we providing an expectation that they will care for kids

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Are they learning what they need

Hypospadias-

Considered an index case

10% of their pediatric cases

Recent survey- 97% pediatric urologist do not feel residents should perform hypospadias after residency without fellowship training

In service questions on

Exstrophy, Posterior Urethral valves, Neurogenic bladder reconstruction

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But the problem is if the residents do not expect to be responsible for peels in the future they do not learn the information with the same intentionality

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Need to align the incentives of training to meet the needs of practice

We need to restructure a pediatric curriculum to train the future adult urologist to manage the type of pediatric urology that everyone should know

More time in clinic- evaluation and work up of common pediatric complaints

- infections
- hydronephrosis
- hematuria
- voiding dysfunction
- testis pain

Focus on cases that are common bread and butter

penile/scrotal/groin cases

endoscopic cases

trauma

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Incentives

Orient the curriculum

- Align case log categories
- Appropriate exam questions
- Model behaviors and attitudes

Instill an **expectation** that they will need to care for these children

Prepare the future urologists for the majority of simple peds consults

- just like their predecessors had always done

Transfer to the pediatric urologist those truly needing subspecialty care

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