Prioritization within research is not a new concept. Federal funders and various entities within the Departments of Health and Human Services, including the National Institutes of Health, have used prioritization as an initial step to let clinicians and researchers know the most important research questions that need answering, thus helping promote research funding, research training, and research methods for these areas—all with the goal of improving patient outcomes. In 2012, the Pediatric Research in Inpatient Settings Network conducted a study to define research priorities for the field of Pediatric Hospital Medicine (PHM) based on identifying conditions with high volume, high costs of care (using research methods to relate charges back to costs), and high interhospital variation in care. This study was recently repeated using similar methods to identify what had changed in the interval.

Health care systems are arguably the most experienced at using prioritization as an annual practice to determine their areas of focus. Senior leadership of each health care system prioritizes what they are going to focus on the subsequent year based on their organizational strategy, and then aligns their resources to improve that outcome. They then implement and use data to track and assess whether they met their medical/health, service, or financial outcome goal (some priorities may include more than 1 outcome). The idea is that the tighter the connection between health system leaders’ priorities with the front-line professionals—including physicians, nurses, and other allied health care workers—the more successful they are in implementing the priorities. When health care systems, clinicians, and researchers align in their priorities, this connection is strengthened.

However, we have neglected an important constituency in the prioritization of PHM: the voice of the patient and parent/caregiver. The study of Gill et al provides the patient and caregiver voice to prioritization for questions around hospitalized children. The Canadian Pediatric Inpatient Research Network (PIRN) used a modified Delphi approach with nominal group techniques to broadly survey participants across Canada. Through an iterative process of refining the list of questions, the investigators found that there were very few (4 of 495) questions already answered, a longer list of 71 questions that identify other important clinical areas needing more research, and a top 10 list of prioritized research questions that need answering within PHM. This list includes focusing on issues such as optimizing the care of children with medical complexity, improving communication, supporting Indigenous families, providing mental health supports, promoting shared decision-making, and mitigating time spent in the hospital.

What do we do now that we know what young people and parents/caregivers in addition to health care professionals think are the most important questions to answer for PHM? To answer this question, let’s first quickly review what PHM researchers have added to this American Board of Pediatrics specialty (established in 2019) thus far to improve the outcomes of children who are hospitalized. The PHM researchers initially focused their efforts on describing substantial variation in care in the hospital setting for children. Some of that variation is expected, for example, when sufficient evidence does not exist. The variation often is unnecessary when the evidence base is sufficient but hospitalists are not practicing using the evidence-based best standard. For the lack of evidence, PHM research networks have responded by generating answers based on high-quality research for what to do in those clinical situations. For example, the Pediatric Research in Inpatient Settings Network has published the optimal route of antibiotics (oral or intravenous) for use in
hospitalized children being discharged with osteomyelitis to complete the home antibiotic course. So, what might pediatric hospitalists do when the evidence base is clear but a gap remains between their current care delivery and optimal care delivery? Inclusion of the patient and parent/caregiver for prioritization in the study by Gill et al fills a key, but until now, missing piece. Inclusion of these voices for prioritization should amplify the synergy for when health care systems, clinicians, and researchers also agree there is an opportunity to partner on solutions.

The following is an example of how this might work using just such a partnership from design through rigorous implementation, and ultimately improve medical/health outcomes for hospitalized children. A PHM group could take the list provided in the Gill et al study and perhaps be drawn to priority 2 (What methods of communication are most effective between patients, caregivers, and health care providers on a general pediatric inpatient unit [GPIU]?) and priority 10 (What are the most effective communication methods [eg, handover, rounds] between health care providers on a GPIU?). An astute hospitalist would conduct a literature search and identify a seminal article that reports that a multicenter study of a coproduced family-centered rounds intervention with families and hospitalists and health services researchers found that better adherence to the intervention of daily rounding with nurses and parents/caregivers was associated with less harm to patients with no increase in rounding time. That multicenter study was funded by the Patient-Centered Outcomes Research Institute. The hospitalist would consult with their own clinical teams, the hospital family advisory council (representing the patient and parents/caregiver voice), and their hospital administration. If the parties’ priorities align, they could use quality improvement methods to design their own locally adapted version of the intervention, learning what they can from the original and supporting articles. Because the entities are aligned in prioritization, the hospital administration would provide resources to deploy the intervention, leadership would message this was important (including the PHM leader, the chief medical officer, and other hospital leaders), and a data measurement system would be designed and tracked to see how well the hospitalists, nurses, and parents/caregivers were adhering to the processes. The team could use quality improvement methods to go through plan-do-study-act cycles to support high adherence to the processes, and once achieved, would need to shift to sustaining the gains of the group, so that ultimately this rounding practice would become part of the culture and the default mode of rounding. Another way of amplifying the results for priority 3 (What are best practices and support strategies for Indigenous parents, families, and children and youth on the GPIU?) would be for the hospitalist group to want to focus on disadvantaged groups. The clinical teams would use their quality improvement methods and identify what might need to be changed to improve the processes for these disadvantaged groups, in particular, recognizing that different interventions may be needed. The clinical teams might even create different run charts to focus the attention on the disadvantaged groups to ensure they are making advances toward the goal. Other pediatric specialties have largely replicated much of this roadmap, which has led to improvement in survival for children with cystic fibrosis.

How can PHM move beyond prioritization, include the voice of the patient, partner with hospital administration and families, and use quality improvement methods to improve care for the hospitalized child and their families? There are challenges of course: administrators need to provide financial and analytic resources, data systems need to be in place, faculty and staff need quality improvement training, and parents need to be engaged at all levels, including coproduction of the implementation. However, we believe this promise just might be the sine qua non of why PHM became a specialty.
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Additional Information: Dr Srivastava is the past chair and Dr Wilson is the current chair of the Pediatric Research in Inpatient Settings Research Network (www.prisnetwork.org).

REFERENCES


