

The Young Physicians Section

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™



Fall 2005 Newsletter

Newsletter Editor: Dennis Kuo, MD, FAAP

Opinions expressed are those of the author and not necessarily those of the American Academy of Pediatrics. The recommendations in this publication do not indicate course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Chairperson's Welcome

Welcome to the latest edition of the Section on Young Physicians (SOYP) newsletter. I write this introduction in the relative cool of an air conditioned office as the dog days of summer slowly work their way through my area.

As you read this newsletter the AAP will have completed the Annual Leadership Forum (where chapters, sections, and committees come together to discuss the future policy of the AAP) in August. As the SOYP representative, I can assure you that the concerns of the Section will have been communicated.

The Executive Committee continues working to expand the voice of young AAP members within the Academy and find ways to increase the value of being an SOYP and AAP member. You may have noticed a number of programs that the SOYP will be co-sponsoring at the upcoming NCE in Washington, DC. We continue to look for interesting and innovative topics of interest to our members, so please let us know what you would like to hear and see. We hope to see many of you there. Please stop and talk with us.

Finally, we are working to improve the SOYP listserv so that it is a useful member benefit but not burdensome to you. Once we have decided how to best utilize the listserv we will let you know and give you the opportunity to sign on. Your input will be valuable in this process.

As always, thank you for your membership and please let me or any of the Executive Committee members know how we can be of help.

Enjoy your summer!

David M. Krol, MD, MPH, FAAP
Chairperson
Section on Young Physicians

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Community Pediatrics and Market Share: A New Paradigm

by Wayne A. Yankus, MD, FAAP

Immediate Past Chair of the Executive Committee, Section on School Health

With the many changes in the workforce of pediatrics and the availability of patients, it becomes important for pediatricians who work in the community to rethink and redefine their roles. As Robert Haggerty, MD, an American Academy of Pediatrics (AAP) past president, said in 1995, "We must become partners with others, or we will become increasingly irrelevant to the health of children."

The oversupply of pediatricians in the future will mean a lifestyle change for those entering the workforce. By 2020, the rate of pediatric physician growth is expected to have an increase of 25%, with a child growth rate of only 9%. We, as a profession, need to see the future of market share clearly. Therefore, a new paradigm is necessary.

The definition of community medicine revolves around the community as a place of strength where every child deserves a medical home and where one pediatrician can make a difference. A medical home is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

For us to fit into the business picture of the community, we must consider our plan. What does the patient consider value? Patients must want what we deliver because they never buy a product but buy the satisfaction of a want. Therefore, to secure your market share in your community, you may need to think out of the box and expand your role.

Using community data, which is readily available from schools, town hall, police, etc., you can assemble community-based assets. You also can begin to understand how your community has changed since you began practice. Is your geographic market larger than the town lines? Have the languages changed? Who is the patient today? Are you thinking globally?

Change is good. The future of your practice depends on your flexibility. What are you good at? Are you playing to your strengths? Set some operational goals, budget plans, and objectives.

To reinvent yourself, you may need to learn a language, become an advocate, or change your office time to allow outside work. Many of our colleagues have accepted work as chronic care coordinators, in school-based health centers, and for incarcerated children and adolescents, and developed addiction medicine services in local hospitals, and even theatre medicine for those children who work on stage and in films.

Other examples of supportive change are becoming a travel health center, a doctor without walls (no office but itinerant), providing and instructing in-home care services, or a public policy consult to legislators and public relations agencies.

To achieve these survival goals, the new paradigm often involves merging practices, using allied health services, networking, upsizing or downsizing, and challenging the process.

Find your new niche and remember the cream rises to the top of any profession. You became a pediatrician to make a difference, and you still can in your community.

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Don't Change That Tire Unless It's Flat — Instituting A Medical Home in Your Practice

by Raymond Hubbard, MD, FAAP

It is 8:30 on Monday morning. You have survived another winter weekend. Although you only take call Friday and Sunday nights, and the office opens both weekend days, the stretch from 3:00 pm Sunday to 8:00 am Monday stretches on interminably for some reason. Now you face the day's schedule. Twenty patients, four have special needs. Do you panic?

Children with special health care needs (CSHCN) constitute up to 20% of the patients in a typical primary care practice, but they garner a more significant amount of attention from their providers. In dollar amounts, the unreimbursed cost to care for our children with special needs may range from as low as \$15,000 to as high as \$27,000 per provider per year. Some studies even quote a dollar figure as high as \$42,000. Children with special health care needs visit the doctor more frequently and call with requests that require much administrative time. If you are not equipped to deal with these challenging, but rewarding, children (and families), then panic. Better, turn your practice into a "Medical Home."

Pull out the Supplement from *Pediatrics*, volume 113, 2004. The birth, growth, and development of the Medical Home concept are neatly summarized. Briefly, the term "Medical Home" first appeared in 1967 as part of the American Academy of Pediatrics (AAP) *Standards of Child Health Care*. The concept flourished as part of Hawaii's Child Health Plan in the 1980s and, under combined federal grants and AAP sponsorship, the National Center of Medical Home Initiatives appeared in 1999. In addition to the National Center, a Medical Home Training Program exists, and several states, Pennsylvania among them, have begun programs that vitalize and distribute the concept. In Pennsylvania, under the auspices of Maternal and Child Health Bureau (MCHB) and the AAP, Educating Practices in Community Integrated Care (EPIC-IC) for Children With Special Health Care Needs encompasses more than 4,000 children in 21 practices with more than 240 medical providers, and provides the statewide framework for the Medical Home Concept. Alan Kohrt, MD and Molly Gatto provide the TLC that keeps the many practices on course.

Reading Pediatrics Inc, based in Reading, PA, has three offices, 10 providers (9 MDs, 2 NP), and more than 25,000 patients. The practice became involved with the statewide initiative at its inception. Due to

the size of the practice, we provide care to a diverse population, many with special needs. The quality of care received by our patients varied with the time available to the practitioner, based on patient volume that day, month, and season, and the energy of the practitioner to deal with the system. Whether called upon to facilitate an appointment, make a phone call, or write a letter, most if not all of this care goes unreimbursed. The demands vary and the quality and quantity of encounters involving CSHCN that go unreimbursed have been studied. I direct you to studies by Antonelli *et al* in *Pediatrics*. Early in our experience, we participated in one such study. At that time, we had already made several adjustments to facilitate greater efficiency under the Medical Home concept. In general, over the 6-week study, only 3% of the encounters involved direct physician time. The remainder of the patient encounter was 20% registered nurse (RN)/licensed practical nurse (LPN) time and 77% clerical time. The conclusion drawn from our data states that our physicians and nurse practitioners (NPs) spend their time in face-to-face care of the patients. Appropriate coding for that time still pays the bills. This will be discussed later.

Much has been made about the changes a practice needs to make in both the process and the philosophy of health care delivery to embrace the Medical Home concept. The care must be family-centered, comprehensive, accessible, compassionate, continuous, culturally effective, and coordinated. Partnering with families is key. Realizing the concepts and integrating them into daily operations, without adding to the practice overhead, decries the challenge. Some have compared the process to "changing the tire on a moving bicycle." Over the last three years, we have integrated the changes, and the practice runs efficiently and is more productive. We have a great sense of pride in what we do and how we do it. Our efforts have been recognized and praised by our CSHCN families, regional specialists, especially neonatologists, and even the local newspaper. Yes, our patients with special needs have increased in number, but they flow seamlessly through our daily schedules.

Design your own Medical Home. Much information exists via the Internet at the AAP medical home Web site (www.medicalhomeinfo.org) and others. In Pennsylvania, EPIC-IC provides a PowerPoint pres-

Continued on page 4

entation that encapsulates the goals and core commitments embodied in the medical home concept. We used this presentation to introduce the idea at each of the three practice sites. Nurses in every practice embrace the concept immediately. For the next step, we select a practice team that includes one physician, the practice administrator, and a care coordinator. Our care coordinator is central to the team. She communicates with families, providers, and specialists. She determines patient needs, tracks patient data, coordinates appointments, and even provides key points to the physicians for letters of medical necessity. Working from home, she logs an average of 35 hours per month.

A team of seven parents of children with special needs forms our Parent Advisory Committee. Parents of children with Down syndrome and Autistic Spectrum Disorder comprised the initial advisory group. Other parents were added as the committee expanded its focus. To reward these parents for attending monthly meetings, writing articles for our newsletter, and serving as mentors to other parents, we do not charge them for patient care. It is a small price to pay for their huge contribution in time and ideas that created our Medical Home.

The Parent Advisory Committee has provided us with much assistance and new ideas. First, to identify our children with special needs, without drawing too much attention to them, we determined that adding an asterisk (*) between the first and last name on our superbill allowed recognition without corrupting computer function. As such, our "star" patients could be acknowledged anywhere in our system. A special page also could be created within our system for a medical record that includes a problem list for the patient, a list of current medications, specialists, and phone numbers. Parents update the record at each visit. The record is available to all our physicians as all our office sites. The parents do not need to repeat their story and the provider knows at a glance the key components of the child's history.

Since opening our Medical Home, we have hosted parent information nights where service providers send a representative, in person, to our CSHCN parents, or where we provide a keynote speaker to discuss topics such as advocacy. We have created flow sheets for special needs to help parents track progress, incorporated modified CHATS into our routine child care, started a newsletter, and much more. These changes did not occur quickly, and acceptance required evidence of improvement. We

continue to meet as a team every month.

We have built a home for our "star" children with special needs. How do we pay for it? Pediatricians under code! We incorporated a review of our coding practices into the development of our Medical Home. We recognized that complexity of medical decision-making and time spent in counseling/ coordinating care define the difference between **99213**, **99214**, and **99215** as evaluation and management (E/M) codes, and that most visits for our patients with special needs certainly require complex medical decision making and, often, extended time. We held a general review of coding components for all practitioners and, every 2-3 months, each practitioner receives a "report card" from a senior managing partner. Our practice administrator tracked billing and collection for our **99213-99215** visits. The year before formal institution of our Medical Home, only 179 (0.582%) were coded as **99214**. At the end of our first year of construction, 676 of 37,776 visits (1.79%) received **99214** codes. In 2003, 3.86% of our visits were coded as **99214**, and, in 2004, 7.07% were coded as **99214**. The income derived from the new focus on medical complexity and appropriate coding brought on by the Medical Home concept grew proportionately each year. By 2004, the practice increased income by about \$250,000 per year (about \$25,000 per practitioner), a payment for visits of these children that was more than enough to cover the costs of care coordination and predicted unreimbursed costs of care. The value added to the practice by each new "star" patient is priceless!

The 2005 AAP National Conference & Exhibition (NCE) is October 8-11, in Washington DC!

At the 2005 NCE, general pediatricians and sub-specialists can explore the latest trends in pediatric medicine, brush up on their technical skills, interact with peers, and see the latest in pediatric products.



The educational program includes over 300 sessions in almost 50 content areas, with offerings in quality improvement, practice management, and advocacy, as well as other topics that impact the practicing pediatrician. Attendees can also visit the technical exhibits and learn about the latest products and technology at the largest exhibition of its kind. Get the latest on the NCE at www.aap.org/nce, and make your plans today!

See Page 9 for further information!

MEDICAL LIABILITY Q & A

by Gary N. McAbee, DO, JD, FAAP

Chairperson, AAP Committee on Medical Liability

Q) Do all malpractice payments, no matter how small, get reported to the National Practitioner Data Bank (NPDB) ? Someone mentioned that they thought the reported payments are only those > \$25,000.

A) All payments made on behalf a health care provider are reported to the NPDB. At one time physicians lobbied for a \$30,000 minimum threshold, but were not successful. All payments no matter the size are reported.

Q) If you are initially listed as a defendant in a malpractice suit and then dropped, would this go on your permanent record? What if the claim is dropped, or the plaintiff loses in court— does it still go on the defendant doctor's record?

A) If by “permanent record” you mean “gets reported to the NPDB” then the answer is no. Things that trigger a report to the NPDB are 1) malpractice payment 2) state medical licensure actions 3) clinical privileges actions and 4) exclusions from federal health programs such as Medicaid or Medicare. Some plaintiff attorneys are willing to drop certain defendant doctors from the case prior to settlement. As a defendant doctor, you should always ask your insurer's attorney to request this from the plaintiff's attorney. If your name is dropped **prior** to settlement, then you would NOT be reported to the NPDB.

Q) Isn't the malpractice crisis really about OB/GYNs and neurosurgeons. Since pediatrics isn't high risk we don't have to worry about that, right?

A) Pediatricians certainly don't pay anything close to the rates that OB/GYNs and neurosurgeons pay for professional liability insurance, but we aren't entirely shielded from the malpractice crisis. First of all, you need to know that 1 in 3 pediatricians are sued once over the course of their career—that statistic has remained firm since the AAP started tracking it in 1987. Pediatric malpractice claims are pretty expensive compared to claims against other physicians. The average indemnity payment for a pediatric claim closed in 2004 was \$468,000 or 43% higher than the overall average for all physician specialties closed that same year. That's why pediatricians should be very intentional about where they locate. Investigate the medical liability environment of the area before you decide to launch your career in a particular area even if you aren't responsible for the malpractice insurance initially. You may have to pay for some of the tail insurance when you relocate and this could make you feel trapped 3-5 years down the road.

Q) How does malpractice insurance coverage and tail coverage work for retired doctors? Does one continue to purchase coverage for one's entire life?

A) Over the years many insurers have developed programs that reduce the outlay for tail coverage when a physician terminates coverage at retirement. Some build the cost of the tail into yearly premiums. Others provide free tail coverage to physicians who remain with the company for a certain number of years, usually a set minimum. Most “forgive” the cost of tail coverage for a physician who becomes disabled or dies while a claims-made policy is in effect. Retiring physicians usually qualify for free tail coverage if they retire at the age specified at a certain age listed in the policy and have been insured by that company for a set number of years. These are important considerations and should be thought of before switching carriers.

The information provided in this article is general in scope and provided for educational purposes. It is not meant as a substitute for legal advice. If you have general questions for the AAP Committee on Medical Liability, please send them to Julie Ake at jake@aap.org. The Academy does not have staff counsel and cannot provide legal advice on a specific question.

Telephone Triage in Action: A Practical Skills Workshop

by Elaine Donoghue, MD, FAAP

Numerous studies have demonstrated physician deficiencies in telephone triage skills.¹⁻² The vast majority of pediatric practitioners have had no training in telephone triage methods and pediatric residency programs have just started to teach these skills.³⁻⁴ This is concerning given that an estimated 30% of general pediatric care is delivered via the telephone. Simple organizational techniques and use of protocols can improve performance dramatically, but few educational programs have taught these techniques in a practical, hands-on method. Telephone management skills are best learned in an interactive format with immediate feedback.⁵⁻⁶ Young pediatricians are encouraged to sharpen these skills at this first ever hands-on training session at the NCE in Washington DC.

Why doesn't anyone teach this? Is a frequent lament heard from pediatricians starting in practice. It's one of those situations where the employers assume that the pediatric residency training programs are covering this, but in reality only about 25 percent of pediatric programs teach telephone management skills.

In 2001, the Academy surveyed a random sample of 1622 active members of the Academy in the US to participate in periodic survey #48. One question asked respondents about training in telephone management of pediatric patients. Pediatricians in group practices (80.1%) as well as solo practices (77.6%) were more likely than those in hospital or clinic practices (64.5%) to report their practice provides informal training in telephone management ($p < .001$). Pediatricians in group practices were also significantly more likely to say their practice provides formal training for staff in telephone management, has a written protocol for documenting telephone information, a written triage system and a manual of telephone manners. Computerized telephone management protocols were used more frequently by pediatricians in hospital/clinic practices (18.4%) and group practices (16.3%), than by those in solo practices (5.6%) ($p < .01$).

Telephone Management Resources in Office-Based Practices by Practice Setting, 2001 (percent of pediatricians reporting)

	Solo/two Physician (n=147)	Group/ HMO (n=377)	Hospital/ Clinic (n=164)	
Informal training in telephone management	77.6	80.1	64.0	$p < .001$
Written protocol for ensuring that pertinent information from telephone calls is put into medical records	44.2	69.4	48.8	$p < .001$
Written triage system for incoming calls	43.8	57.0	44.7	$p < .01$
Manual of telephone manners for staff	36.8	51.5	30.4	$p < .001$
Formal training in telephone management	15.9	38.8	29.4	$p < .001$
Computerized telephone management protocol	5.6	16.3	18.4	$p < .001$

Too many have been taught via the SOYP—the Seat of Your Pants Method—these skills are too important to be caught rather than taught. New physicians now need better training in how telephone triage is done. This 2 hour workshop will use interactive techniques to build telephone management skills. During the first hour role playing and small group discussion will be used to teach the principles of telephone medicine. The second hour will switch to a demonstration of computerized telephone triage protocols. A triager will take a phone call and perform the triage using computerized protocols which will be projected onto screen

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Telephone Triage in Action: a practical Skills Workshop *Continued from page 6*

for the audience to observe as the triage process progresses. The audience will be able to listen to both ends of the triage encounter as they watch the protocols being used. Different types of telephone calls will be handled to demonstrate how protocols can be used in different situations such as acute febrile illness, trauma, and chronic illness.

Pediatricians just starting out in practice are often surprised to learn that they are responsible for the advice given by telephone triage nurses. It's only fair that they should know what kind of due diligence they should exercise when signing out to after hours call centers and reviewing documentation of triaged calls. The Section on Telephone Care hopes that this session will give young pediatricians the solid foundation they need on telephone management.

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The Section on Administration and Practice Management

Consisting of Fellows, Pediatric Residents, and Affiliate Members, SOAPM is dedicated to imparting basic and cutting edge administration and practice management information to its members.

SOAPM accomplishes this by developing specialized educational programs and projects and a democratic forum for discussing and disseminating practical information on pediatric administration and practice management.

SOAPM

- Sponsors courses on practice management at the NCE and SuperCME
- Publishes an excellent practice management newsletter
- Uses the most active Listservs in the AAP to share ideas and distribute excellent information in real time
- Offers the annual, "Starting in Practice: The Early Years" workshop
- Manages the Physician Wellness Special Interest Group
- Administers (with the Committee on Practice and Ambulatory Medicine) the MGMA Pediatric Cost Survey
- Develops (with the Committee on Coding and Nomenclature) the Beginning and Advanced Coding Workshops

Who Can Join SOAPM?

SOAPM is open to all Academy Fellows, Resident Fellows, and Affiliates. Section dues are \$25 a year for Fellows, \$10 for Residents, and \$60 for Affiliates. If you have any questions, contact Robert Sebring, PhD, SOAPM Manager, at bsebring@aap.org 847/434-4784, Fax 847/434-4996.

The Business of Pediatrics

by **Mark S. Reuben, MD, FAAP**

*Chairperson, Coding and Management Workshops Planning Group
Incoming Chairperson, SuperCME Planning Group*



Dr. Reuben

Congratulations! You've completed your residency, have a fantastic base of medical knowledge and you're now ready to go out and save the children of the world (or at least in your community). But you have a family to support and medical school debts to pay, and now you realize that altruistic ideals won't pay the bills or put food on the table. Pediatric residencies do a wonderful job of teaching the medical aspects of pediatrics, but rarely do they touch on the business of pediatrics. As much as most pediatricians hate to admit it, the practice of pediatrics has to be a business to survive. Did you learn these "Survival Skills" in your residency? If not (which is the usual case), then the Academy has just the opportunities you need to make the most of the work you are doing.

In addition to a number of practice management courses offered at the NCE, the Academy is offering three excellent opportunities to learn how to "Get Paid for What You Do." November 12-13, 2005, in Newark, NJ, is the Introductory Workshop in the "Get Paid for What You Do" series. What can we teach you and of what value will it be? The essentials of this course revolve around coding. We know that residencies don't teach coding, but it is how you make your living. We will show you how proper coding, without doing any other work, can increase your take home pay by \$10-50,000 per year. We will show you how to code for procedures you are already doing, but for which you are probably forgetting to code. You'll learn how to more effectively bill for those "special needs" kids in your practice for which you want to provide care, but question the economic viability of doing so. There is so much more offered that you need to know to survive – strategies of which you may not even be aware.

December 14-15, 2005, we move to San Antonio, TX, for the Advanced Workshop in the "Get Paid for What You Do" series. If you already have a grasp of coding and know some practice management, then this workshop will hone your skills. We'll teach you advanced coding techniques that will further your productivity. You'll better understand Relative Value Unit so that you can price new procedures and evaluate contracts when they are presented. You'll learn about physician compensation models, consumer driven health plans and so much more.

Completing this series of practice management offerings from the AAP is SuperCME 2006, April 26-29, 2006, in Washington, DC. As the incoming Chair of this CME activity, I can assure you that it offers 4 days of outstanding education in a full array of clinical topics. What makes SuperCME unique is that it has always offered a "Practice Management Track." Next year promises to be very special. Dr. Joel Bradley, this year's Vanchierre Award winner, will cover coding. Dr. William West, an OB/GYN who runs a successful Health Savings Account, will give a first hand account of how Consumer Driven Health Plans work. Want to know how to handle your telephone? Dr. Drew Hertz will tell you about the Academy's new policy on charging for phone calls. Is your office using EHRs? If not, Dr. Kevin Johnson will give you the latest update on what is out there.

If all this is old hat, then you don't need these courses. But if you're like most young physicians, this is an area that has been short-changed in your education. These courses can get you up to speed and put your future on the right track. I hope to see you there.

For more information about the workshop series, "Get Paid for What You Do: Coding and Management in Pediatric Practice," and SuperCME 2006, visit www.pedialink.org/cmefinder.

Attend the 2005 National Conference & Exhibition in Our Nation's Capitol

American Academy of Pediatrics 2005 National Conference & Exhibition October 8-11, 2005 • Washington, DC

2005 Highlights

- NEW FOR 2005! Handouts on Disk: Register for the NCE and receive a CD-ROM with every available session handout, providing a lasting resource on the sessions you attend as well as on those you miss
- Technology Learning Center: New for 2005, the TLC combines informal consultation with CME sessions on topics like EMR, PDAs, and more
- Celebrate "75 Years of Caring" at the AAP's 75th anniversary party
- Pediatrics for the 21st Century: Mental Health – over 40 sessions dedicated to confronting the challenges of pediatric mental health
- Advocacy Training and Visits to Capitol Hill

Plus sessions on:

- Diet, Meds, and Surgery for Obesity
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- Urgent/Emergent Infectious Disease Cases

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- Network with your colleagues informally and at scheduled activities
- Enjoy the historic sites of the nation's capitol, Washington, DC

The 2005 NCE Offers Young Physicians:

Content Geared Toward You

- Programs on starting a practice, practice management, the e-office, and other sessions geared toward the young physician
- A pre-conference course on Preparing for Life in Academics

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The AAP Committee on Pediatric Workforce Announces New Policy Positions:

More Doctors May Not Be the Answer to Improving Access to Health Care

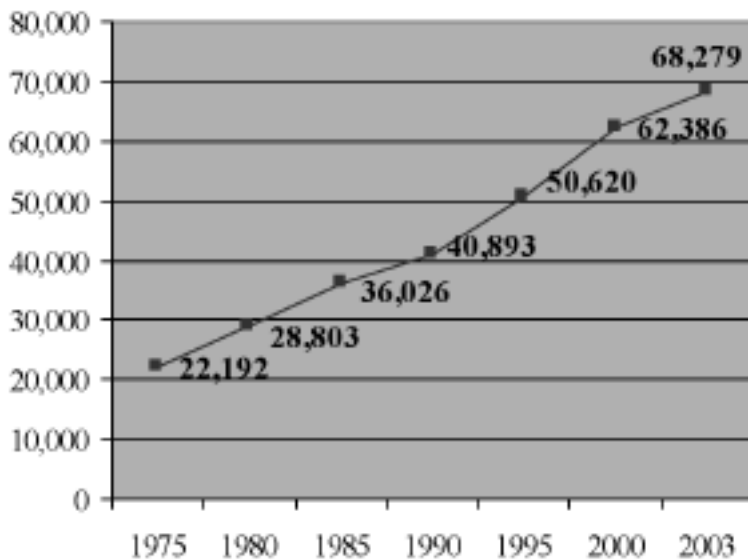
by **Holly Mulvey**

AAP Director, Division of Graduate Medical Education & Pediatric Workforce

In the July 2005 issue of *Pediatrics*, the AAP Committee on Pediatric Workforce (COPW) publishes two landmark documents on the pediatrician workforce. "The Pediatrician Workforce: Current Status and Future Prospects," carefully considers several key factors that will influence the pediatrician workforce.

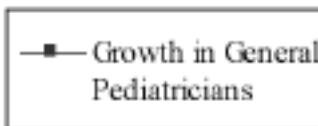
These factors include the growth in the number of pediatricians in relation to the child population; increased numbers of female pediatricians; and a lack of ethnic and racial diversity in pediatricians compared with children. Other factors are addressed as well, such as the geographic distribution of these physicians, pediatricians who are working part-time, and pediatric care provided by other clinicians. These are the key variables in any workforce equation that the Academy and other stakeholders in optimal child health must share with groups, such as federal advisory committees and policymakers, that finance and regulate the supply of the health care workforce.

According to David C. Goodman, MD, MPH, FAAP, COPW member and author of the workforce technical report, "The pediatric workforce is changing rapidly in not just the overall number, but in pediatricians' professional roles and the their patient characteristics." The new workforce technical also describes the processes or models that are used in determining what is the "right" number of pediatricians and if such a claim can, in fact, be made. Indeed, poor access to health care may have little to do with the number of doctors. The revised AAP policy, "Pediatrician Workforce Statement," draws upon the information and perspectives in the technical report to advance a set of recommendations and potential strategies.



Growth in the Number of General Pediatricians

Source: American Medical Association, *Physician Characteristics and Distribution in the US*, 2005 Edition.



"This policy statement is designed to serve as an advocacy tool for AAP efforts at both the national and chapter levels", observes Michael R. Anderson, MD, FAAP, COPW Chairperson. "Additionally," he notes, "statement and the technical report will also serve as a workforce 'road map' for pediatricians who represent the Academy and/or our specialty to external organizations and groups."

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Contrary to the position of other major medical organizations, the AAP opposes increasing the number of medical school positions to improve access to care. Instead, the AAP proposes financial and other incentives to encourage physicians to practice where there are too few doctors. Some of the key points of the new AAP policy are:

- No increase in number of medical school graduates.
- No increase in pediatric residency positions.
- Use graduates of US medical schools, not international schools, to improve access in rural and urban underserved areas.
- Expand the National Health Service Corps and other incentive programs to promote practice in underserved areas.
- Increase diversity among pediatricians to keep pace with the growing diversity of America's children.

For further information, please visit the Committee Web page at: www.aap.org/workforce; or contact Dr. Michael Anderson, Committee Chairperson, at: Michael.Anderson@case.edu; or Dr. David Goodman, principal author of the workforce technical report, at: david.c.Goodman@dartmouth.edu.

Update your Personal Profile

An important service is available on the AAP Member Center. A Personal Profile has been added to provide you with an opportunity to view your address, demographic, and subspecialty information and update it at your own convenience. Simply enter the changes into the form and our database will be updated the following day. This way, there will be no delay in receiving your member benefits.

The AAP online Member Directory, available through the AAP Member Center at www.aap.org, has recently been improved. The online Directory should be your primary resource to locate colleagues. Quite simply, it has the most accurate, up-to-the-minute contact information available.

With these new changes and enhancements, we believe we can further improve service to members and the public. However, it is also an important time for our members to check their address and demographic information for accuracy. **Please take the time to visit the Member Center and click on "Update my Personal Profile"**. If you prefer to contact us by phone or e-mail, you can call 877/THE-AAP1, or send an e-mail to csc@aap.org.

UPCOMING AAP EVENTS

June 23, 2005	Happy 75th Birthday AAP!
Now Through September 2	Pre-registration for the National Conference and Exhibition (NCE) www.aap.org/nce
Sept. 2, 2005 - Sept. 4, 2005	Practical Pediatrics CME Course Beaver Creek, CO Park Hyatt Beaver Creek Resort & Spa
Sept. 10, 2005 - Sept. 14, 2005	PREP ® The Course, Portland, OR Portland Marriott Downtown
Sept. 29, 2005 - Oct. 1, 2005	Practical Pediatrics CME Course – Monterey, CA Hyatt Regency Monterey
Oct. 7 - Oct. 11, 2005	NCE, Washington, DC
Oct. 8 - Oct. 9, 2005	Silent Auction, NCE
Nov. 11 - Nov. 13, 2005	Practical Pediatrics CME Course- Amelia Island, FL Amelia Island Plantation
Nov. 12 - Nov. 13, 2005	Get Paid For What You Do: Coding and Management in Pediatric Practice Introductory Workshop , Newark, NJ Marriott Newark Airport
Dec. 14 - Dec. 15, 2005	Get Paid for What You Do: Coding and Management in Pediatric Practice Advanced Workshop Hyatt Regency San Antonio
Dec. 16 - Dec. 18, 2005	Practical Pediatrics CME Course - San Antonio Hyatt Regency San Antonio

Silent Auctions Items Needed!



At the 2005 AAP National Conference and Exhibition, Oct. 8-10 in Washington, DC, the Academy will hold a special silent auction in celebration of the Academy's 75th Anniversary with proceeds benefiting the Friends of Children Fund. Pediatricians nationwide can donate items such as timeshares, vacation home rentals, quilts and books. Individual AAP members, committees, sections, chapters or group practices can donate items. Minimum suggested donation is \$75. Pediatricians interested in donating an item for the auction should fill out the following form: <http://www.aap.org/75/SilentAuctionDonationForm.pdf>.

SUMMARY OF THE MINUTES FROM THE APRIL 15 SECTION ON YOUTH PHYSICIANS EXECUTIVE COMMITTEE MEETING

APPROVAL OF MINUTES

The minutes and action items of the October 9, 2004 meeting were reviewed and approved with changes.

The agenda (and future agendas) will be organized by the Section's goals.

IDENTIFY KEY AAP COMMITTEES AND SECTIONS

The Section's top goal is to permeate AAP Sections, Committees and Chapters with young voting members in order to help AAP leadership craft programs, policies and services that consider young member issues (almost 50% of AAP membership). The Executive Committee reviewed a list of current sections, committees, task forces and councils as well as a list of young members within these leadership positions. The following organizations within the Academy were identified as initial aims for this initiative:

- Committee on Coding and Nomenclature
- Committee on Continuing Medical Education
- Committee on Medical Liability
- Steering Committee on Quality Improvement Management
- Committee on Pediatric Workforce
- Committee on Practice and Ambulatory Medicine
- PREP Advisory Group
- Task Force on the Family

A discussion followed on whether the Section should start discussions with AAP leadership on creating a young physician "slot" on key committees/sections/other groups.

YOUNG PHYSICIAN WELCOME PACKET

The purpose of a young physician welcome/AAP resource packet is to help young physicians navigate the AAP, become aware of services and leadership opportunities within the AAP, help with transitioning, career "ramping", and other key issues for young physicians.

Dr. Laskey reviewed a draft outline of a welcome/resource packet that will be developed by the Section for its members/potential members. The draft content was reviewed as well as the distribution tiers. The entire program will be contained on a CD-ROM.

It was determined that the CD will be updated yearly, however, the entire contents of the CD will be posted on the Members Only Center (MOC) of the Section's web page so that it can be updated on a regular basis. Not only will the CD serve as a benefit of membership, it will also serve as a recruitment tool for new members.

It was noted that many young physicians are starting families yet may not be working in a family-friendly environment. The welcome packet should contain a compilation of family-friendly employer policies that exist in different pediatric job markets.

ACTION: The Section will consider the development of a survey that will compile a list of family-friendly polices/practices within the world of pediatric medicine to make available on the CD as a service to the Section's membership.

Dr. Bailey noted that the AAP Board of Directors recently had a mega discussion on women in pediatrics where many issues were discussed including part-time careers, career trajectories, work/employer flexibility, life balance, and work style. Dr. Bailey noted that several suggestions were put forth, and a temporary work group will be formed to develop a plan for women in pediatrics issues.

IMPROVE WEBSITE

The second highest-ranking goal for the Section is to create a useful, user-friendly, state-of-the-art web page that includes ALL resources from the AAP for young members.

ACTION: Executive committee members will forward their ideas for a state-of-the-art web page to Dr. Krol and staff by August 30, 2005.

The current Section web page is very basic but includes goals and objectives of section, list of executive committee members, list of chapter liaisons, newsletters, and links to "Flexible Careers for Young Physicians, Women in Pediatrics, and the AAP Committee on Pediatric Workforce.

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**CONTACT AAP DISTRICT CHAIRS
AND DISTRICT VICE CHAIRS**

The third highest ranking goal for the Section is to contact the AAP District Chairs (DC) and District Vice Chairs (DVC) to enlist support and obtain ideas for optimal functioning for the Section.

ACTION: Dr. Krol will develop a short set of speaking points for executive committee members.

It was noted that some contact has been made with young physician chapter liaisons who seem unclear as to what their specific task should be as chapter liaison.

**INCREASE USE OF LIST SERV
WITH HELPFUL LINKS**

The Executive Committee agreed that this goal would be tabled at this time to address other more pressing issues.

**CREATE A HELP GUIDE FOR PROGRAM
FOR MAINTENANCE OF CERTIFICATION
IN PEDIATRICS (PMCP)**

ACTION: Drs. Shipman and Harper will develop a strategy to address this goal.

BUILD A MENTORING PROGRAM

The Executive Committee discussed the development of a formal mentoring program. Both Drs. Harper and Allevi have done research on this topic and noted that mentoring programs are difficult to start and maintain. After a lengthy discussion, it was agreed that the Section will begin by creating mentor/mentee resources/information (an educational module) for the section membership.

**REPRESENTATION IN THE FURTHER
DESIGN/OVERSIGHT OF PEDJOBS**

Since so many young physicians are job hunting, updating CV's, reviewing contracts, etc. during the early years of practice, the Section is interested in services provided by PedJobs.

ACTION: Dr. Krol will contact the PedJobs staff person to determine PedJob's plans for expansion and to determine whether young physician input is desired.

**IDENTIFY YOUNG PHYSICIANS
IN EACH STATE CHAPTER**

Staff noted that the Web Chapter Management System (CMS) software already performs this task so the Executive Committee noted that more focus should be placed on recruiting young physician chapter liaisons. In addition, the Executive Committee agreed that a more descriptive job description should be developed for chapter liaisons.

MEMBERSHIP

Drs. Harper and Allevi noted that in April, 2005, the Section launched a recruitment project, recruiting all eligible young physician members of AAP who do not belong to the Section. The Section also attempted to recruit young physician members who are no longer members of the AAP (dropped for non-payment). To date, over 900 existing members have joined the Section.

It was noted that graduating residents should also be invited to join the Section. Staff noted that each graduating resident receives a letter from the AAP asking them to identify their future plans, which includes an invitation to join the young physician section.

ACTION: Staff will forward a sample of the PI-3 exit letter to the Executive Committee for their review.

**NATIONAL CONFERENCE AND EXHIBITION
(NCE)**

The Section's plans for the 2005 NCE were reviewed. It was suggested that young physicians be invited to the Section on Residents reception scheduled for Friday, October 7 from 6:30-7:30 PM.

ACTION: Staff will add young physicians as co-sponsors of the Friday October 7 reception.

Sections Update: Washington Report

by Taryn Rosenkranz

AAP Staff - Department of Federal Affairs

Access to Care: Legislative Outlook

The 109th Congress was convened in January. The Academy named access to care as its top priority for Congress and will be leading the fight to secure access to quality health care coverage for every child and adolescent. The Academy has already endorsed four bills that would expand access for children. Each of the bills would do a number of different things from insuring more children to the creation of a Medicaid commission. Concerned about recent pressure to cut entitlement programs like Medicaid, the Academy feels it is critically important to gain support for legislation that will expand access not hinder it. The Academy is working hard to gain additional attention and support for the bills in the coming months.

“We know that providing access to care for every child can help to prevent obesity, heart disease and diabetes,” said AAP President Carol Berkowitz, MD, FAAP. “This is why we are urging Congress to come together and work in a bipartisan way to help solve these problems.”

The four bills that have been endorsed by the Academy to date are:

- Kids Come First Act of 2005
- Start Healthy, Stay Healthy Act of 2005
- Bipartisan Commission on Medicaid and the Medically Underserved Act of 2005
- Children’s Express Lane to Health Care Coverage Act of 2005

Insuring every child (*Kids Come First* and *MediKids*)

The Academy endorsed the *Kids Come First* (S. 114) bill, introduced by Sen. John Kerry (D-MA) for the first time in January, which would expand access to quality care for every child under age 21. The bill differs from the Academy’s *MediKids* proposal because it would still remain an option for the states to choose while *MediKids* is a guarantee. The Academy has endorsed the *Kids Come First* bill and will continue to support the *MediKids* bill when it is introduced. The two bills complement each other and are not competing against each other. At press time, the *MediKids* bill was still being drafted. Look to future *AAP News* editions for further updates.

The *Kids Come First* bill was introduced to get states to expand Medicaid coverage for children, get parents to share in the responsibility of covering their children and eliminate enrollment barriers that prevent eligible children from signing up. In this bill, the federal government pays for all Medicaid outreach and coverage costs for children younger than age 21 with incomes at or below poverty level. In exchange, the states agree to pay for its share of a State Children’s Health Insurance Program (SCHIP) or Medicaid coverage expansion to children younger than age 21 whose incomes are under 300 percent of the poverty level. Lastly, the bill requires parents to insure all children younger than age 19 and requires proof of their coverage to avoid forfeiting their federal child tax exemption.

Start Healthy, Stay Healthy

At press time, the bill was awaiting introduction by Sen. Jeff Bingaman (D-NM) and Richard Lugar (R-IN). This bipartisan legislation would significantly reduce the number of uninsured pregnant women and newborns by expanding coverage to pregnant women through the Medicaid and SCHIP programs. The bill would provide states the option to further extend coverage to continuously enroll newborns from birth through the first full year of life.

Medicaid Commission

Sen. Gordon Smith (R-OR) and Sen. Jeff Bingaman (D-NM) introduced a bill calling for the creation of a

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Bipartisan Commission on Medicaid and the Medically Underserved (S. 338/H.R. 985). A companion House bill was introduced by Rep. Heather Wilson (R-NM). Sens. Smith and Bingaman believe that the Medicaid program should undergo a comprehensive and thorough review of what is and is not working and how to improve service delivery and quality in the most cost-effective way possible. A similar review was conducted on Medicare, after it was called for in the Balanced Budget Act of 1997. Many senators have signed on to cosponsor the legislation in response to the president's budget proposal inclusion of \$60 billion in Medicaid cuts. Those who have signed on stated that before any cuts are made to Medicaid, a thorough review of the program should be conducted.

Children's Express Lane

At press time, this bill was awaiting introduction by Sens. Bingaman and Lugar and would give states greater flexibility in the ways they can enroll uninsured children into Medicaid and SCHIP programs, while at the same time increasing government efficiency. The bill would give states the option of establishing that their Medicaid or SCHIP financial eligibility rules are satisfied when a family presents proof that their child is already enrolled in another public program with comparable income guidelines.

Efforts to expand access to care will continue throughout the congressional session. The Academy plans to support other access bills such as the Family Opportunity Act, which would expand Medicaid coverage to families with children with special health care needs and MediKids, the Academy's proposal to insure every child.

AAP members should look to *AAP News*, the Federal Advocacy Action Network (FAAN)'s email action alerts and the AAP Member Center (www.aap.org/moc, click on Federal Affairs) for **legislative** updates throughout the second session for information on when pediatricians should take action. For more information on AAP efforts to provide greater access to care, contact Graham Newson, AAP Department of Federal Affairs, (800) 336-5475, ext. 3001 or gnewson@aap.org.

The **Young Physicians** Section 
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Fall 2005 Newsletter

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