

The Young Physicians Section

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



Spring 2006 Newsletter

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Chairperson's Welcome

Welcome, again, to the latest edition of the Section on Young Physicians newsletter. For me, the spring and summer months mean baseball; coaching, watching, and playing. For our Section, summer brings another group of residents who will soon be transitioning into the SOYP.

This is a great opportunity for current members of the Section to welcome these newly minted pediatricians to your Section, your state chapter, and your Academy (for those who may not have been active in the Resident section). It's also a great opportunity to serve as a mentor to them, whether it is professional issues, career-life balance, "things they never taught in residency", or anything else you might feel like sharing. Though we are all "Young Physicians" there is much that we can teach our colleagues, younger and older.

I'd also like to encourage you to steer any questions or concerns that they or you may have about the AAP or the SOYP to any of the members of the Executive Committee. We welcome any suggestions, criticism, kudos, and dialogue that will improve the value of your membership. We continue to try to find ways to improve the Academy experience for young pediatricians and we cannot do that without your input.

Finally, please seek out your chapter and district representatives to advocate on issues important to you. If your chapter or district does not seem to be addressing young physician issues, ask them to do so. As we try to move a SOYP agenda within the AAP as an executive committee, there is no reason that a grassroots effort cannot take place simultaneously. In fact, it is likely more valuable and more meaningful coming from the local level.

As always, thank you for your membership and enjoy your summer!

David M. Krol, MD, MPH, FAAP
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INSIDE THE YOUNG PHYSICIAN ISSUE

Chairperson's Welcome	1
Young Physician Executive Committee	2
"What's On Your Mind?"	2
Money? What Money? Part 2: Practical Advice about Money Management	3
Telephone Medicine for New Physicians	5
A Wake Up Call	7
Look to the End—Even at the Beginning	8
Pediatric Research in Office Settings (PROS) Seeks Participating, Needs Input from Young Physicians	10
The EMR: Which One is Right for Your Practice?	11
818 Approaches to Addressing Child Health Problems - and Counting!	12
Pediatrics Still a Popular Choice for Seniors in 2006 Resident Match	13
2006 National Conference & Exhibition	14
The American Academy of Pediatrics and The Medical Group Management Association Announce the 2006 Cost Survey for Pediatric Practice	15

"What's On Your Mind?"

by **Dennis Z. Kuo, MD, FAAP**

Executive Committee Member, Section on Young Physicians

We all have a story to tell. This space is *your* forum to tell yours.

There are thousands of SOYP members across the country. You are generalists and specialists, single and married, rural and urban, with and without children, and of every conceivable ethnic background. Despite our incredible diversity, we are all pediatricians, and we are all "young"...at least I still like to think of myself that way.

We may think that we have to find our own path to professional and personal success, and to some extent that is true. However, I think we need to share our experiences with each other, in person and in print, and I see SOYP as an avenue to bring us together. We all know how much managed care, malpractice insurance, and endless regulations are sapping our profession, and how powerless we seem to be at times. There is much we can learn from each other as we move forward, and there is much we can accomplish together.

So I'll put myself to the test, and I'll tell you what's on my mind.

I finished my pediatrics residency at the University of North Carolina in 2000 and worked for a wonderful pediatrics group in northern New Jersey for five years. I then jumped off the straight-and-narrow path and started a primary care research fellowship with the Division of General Pediatrics at Johns Hopkins, which is where I am today.

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Usually when I tell this story, people look at me like I have two heads. *Five years in practice? You went back to a fellowship?*

The short answer is that I returned to academics to continue my education and create new opportunities. I've always been interested in public health issues, and as much as I enjoyed practice, I began to think more about how communities impacted the health of the children in my practice, and started to develop research questions. I eventually realized that I wanted more skills and freedom to be able to answer such questions. The demands of full-time practice didn't leave a whole lot of time to pursue additional education. It took a year to understand that I *could* go back to a fellowship despite being out of residency for so long.

So here I am in Maryland, learning how to eat steamed crabs, quietly rooting for the New York Yankees in hostile territory (at least I'm not in Boston), and finding out that despite being south of the Mason-Dixon line, Maryland restaurants still don't serve sweet tea. I miss practice, but I'm enjoying my fellowship immensely.

I've been reflecting lately about how long the road to a medical career is. It seems that there's now a fellowship for everything. While I'm all in favor for quality training, it makes the training road that much longer.

Right out of residency, I remember talks about "getting your first job" and "signing your first contract." I found fewer resources for those of us facing long-term decisions beyond two years out of residency. What do we need to know about partnership contracts? What long-term options will those of us who work part time have in ten years? How might a fellowship help us, and can we afford one? Does anyone truly know how to code? And finally, how do we handle the financial challenges of assuming so much medical school debt and finally starting a career in

Continued on page 3

"What's On Your Mind?" *Continued from page 2*

your mid-30s, ten years after everyone else seems to have gotten started?

Finances have been challenging during this fellowship, particularly with two children. We do a lot of careful budgeting these days. One interesting bonus: cable TV costs over \$600 a year in Maryland, so we got rid of the TV. After dinner, when we see our six year old curl up with a book and our one year old happily playing with Fisher-Price Little People, we wonder why we even considered having a TV in the first place.

Life is an adventure, and I am thankful for the incredible opportunities that have come my way. I love my career and I can't see myself doing anything else. I hope that all of you are able to take advantage of pursuing your dreams and taking advantage of opportunities that come your way. I believe that we, as young pediatricians, should create our own opportunities, learn from our elders, and share our experiences with each other as we work together for children's health.

Stand up and be heard! Contact me if you have something to say, whether in reply to this article or anything else you feel needs to be heard in this newsletter. My email address is dkuo5@jhmi.edu. I look forward to hearing from you.

Money? What Money? Part 2: Practical Advice about Money Management

by Manny Ng, MD, FAAP

Get what you're worth!

In the last newsletter, we talked about making the most of the money that you're bringing home. But are you getting paid what you deserve? When you first start out, you're the low man on the totem pole. Your mission: build a patient base and learn how a "real" practice works. Odds are that you never learned anything about the business of medicine in residency. I've learned these lessons along the way, many of them by sheer luck. There are some courses that you can take for specific areas, but a good mentor is key. Here's the short and dirty list of things to learn.

Understand insurance.

What's the insurance mix of your practice? What do all the plans mean—PPO, HMO, POS? What's an EOB? If you deal with a lot of third party payers, you're in the only profession in the world where you provide a service to your patients, and someone else decides what they're going to pay for it. Let's say you charge \$100 for an office visit. Your patient's insurance company will only pay you \$60, and in most cases, you're not allowed to ask your patient for any of the remaining \$40. And since you're an excellent doctor, you gave your patient the best quality care you could provide. When you take your car to the mechanic, and he charges you \$100 to fix your brakes, I hope you don't offer him \$60 and say "take it or leave it". If you do, I don't want you following me on the road.

So what's the bottom line? You need to see more patients, because that's the only way you're going to bring income to your business. Each patient comes with their co-pay, be it \$20 or \$2. That's the only money you're "guaranteed" to collect. Spend some time with your billing department and learn what really goes on.

Your time is valuable. Learn to code.

Most of us never learned to code in training and the vast majority of pediatricians undercode. What percentage of your office visits is coded as 99213? If it's more than 70%, you're probably undercoding. If you spend more than 25 minutes in the room, or you order more than a simple test, it's more than a 99213. Don't cheat yourself out of any additional income. You're already giving away a lot of things for free. At the same time, don't overcode: that's called fraud. (Technically, undercoding is fraud too, but I don't think you'll get prosecuted.) It's a good idea to take one of the many coding seminars offered by the AAP.

Continued on page 4

Procedures get paid for.

Even the stingiest insurance companies will pay you more for a procedure. Bill for the silver nitrate to the umbilical cord (chemical cauterization). A small abscess? Drain it yourself. Bill a foreign body removal for taking out a splinter. Of course, know your limits. Don't do something you're not qualified to do. An appendectomy in your office will only land you in a malpractice suit.

Bring in patients and keep them happy.

The balancing act in real practice is to bring in as many patients as possible and make them feel that they're getting their moneys worth. If they feel you're blowing them off, they're going to go to someone else, who may or may not be in practice with you. At the same time, try not to give away too much for free. Pediatricians give away a lot of phone advice, so if you spend more than 2 or 3 minutes on the phone with someone, it probably deserves some face-to-face time (and a bill).

Negotiate your contract.

OK. This is what you've been waiting for. You're working your rear off. What's it worth to your employer? Is there a productivity component to your salary? Some contracts will offer you a percentage of income once you reach a cutoff. How realistic is that cutoff? Find out how much one of the partners brought in charges last year. If you can charge 70% of that in your first year (based on a full time equivalent), you're probably OK.

If you're reading this, you've probably already signed a contract. But the other significant points are vacation, CME time, benefits, and the restrictive covenant. How far away are you going to have to go if you and this practice go your separate ways? If you're in a major metropolitan area, it should not be far. In some big cities, the restriction may be that you can't be in the same building. In rural locations, it may be 50 miles.

What about partnership?

Partnership has its financial rewards, but in tough times, it has its risks. Odds are the partners are doing pretty well. If they're not, there's a management problem. So if you are interested in the partnership track, here are the key questions. How long will it take for you to become a partner and what will it cost? Is it a salary deduction over a period of a few years, or one lump sum? What's the trial period before you can be offered partnership? What is the partnership arrangement? Does one person hold more than 50% of the decision-making? That's a situation you may want to avoid. What's it going to cost you when someone retires? Do you want to pay a million dollars to someone when they leave the practice in a few years?

If you're going to be a partner, learn the business side of things before you sign on. Odds are you don't even understand the terminology. Look at financial statements. Where does the business stand financially? How much does income exceed expenses? How much does the practice owe? How long before those loans are paid off? As a partner, you will be personally responsible for those loans. Legally, if all of your partners run away to their homes in the Cayman Islands, you're stuck for the debt.

Medicine is a business.

Don't forget this if you want to succeed in this profession. Pediatrics is a noble profession but remember, you have all those bills to pay. Learn about the business side of things. Remember that no one will give you something for nothing. You may think the drug representative is buying you lunch or dinner, but the cost of that fancy dinner is recouped with 2 scripts with their drug and your signature on it. What are you giving away for free?

In the end, if you can't make ends meet, you'll need a second income. And if you have kids with the provider of the second income, add some more items to your budget. Diapers, clothes, school supplies... The list goes on. So, welcome to the real world. You're no dummy if you've made it this far, and remember, medicine is a lifelong learning process. Finally, don't forget to take time for yourself as well. There's a world outside your job, and you should take every opportunity to enjoy it.

Telephone Medicine for New Physicians

by Jeffrey L. Brown, MD, FAAP

Executive Committee Member, AAP Section on Telephone Care

The Transition from Training to Practice

The transition from medical training to clinical practice is filled with many unexpected surprises treating medical conditions that seemed uncomplicated may now assume a greater spectrum of subtleties; balancing cost-control issues against quality of patient care may have a direct effect on personal income and professional satisfaction; and, ethical and treatment options may now fall squarely on your own shoulders. Also, quality-of-life issues that were thought to be transient and unique to training may often continue into our daily and professional lives.

Role of the Telephone

Taming the telephone scores high on the list of those physicians who love practicing medicine but want to minimize its intrusion into their personal lives. Used properly, the telephone can save physicians and patients time, money, and worry. Improper use can create misery for those on both ends of the call. The primary care specialties are likely to receive the greatest call volumes. Technologies that are taken for granted by today's physicians (cell phones, faxes, e-mail, text messaging, and PDAs) allow for instant interruption of normal-living activities as the negative tradeoff for having instant data and information retrieval.

A large portion of the formal literature on telephone medicine contains a pediatric imprint because of the unique role that the telephone plays in raising children. For many parents – especially when both are actively employed – the telephone link to a pediatrician has replaced reliance on extended family for both medical and child-rearing advice. The unfortunate combination of anxious and insecure parents, frequent unexpected episodes of illness and injury, and the intrinsic vulnerabilities of children produce a very large number of calls. Once again, the wonderful advantages of instant telephone communication will take a toll on the quality of life for the advice-giver.

Preparation for Professional Telephone Use

Young physicians should actively prepare for this intrusive but necessary component of their professional lives.

- First, there must be an acknowledgement that the skills necessary for good telephone communication should no longer be learned as on-the-job training. As with other professional skills, there should be a constant self-evaluation process with an active learning curve. The skill-set needed should be honed similar to the way we learn physical diagnosis or x-ray reading.
- Second, there should be a formal evaluation of the way that calls are handled both during and after regular practice hours – and this process should be kept in a constant state of improvement to best utilize available resources for the unique patient population in your setting.
- Third, a variety of business considerations must be carefully evaluated to balance patient satisfaction, legal liability, and cost effectiveness.
- And lastly, each physician should acknowledge that there will always be a certain percentage of “unnecessary” calls that will be viewed as trivial, nonessential, or abusive that has the potential to be extremely annoying. Failure to accept this realistic assessment will invariably lead to unhappy doctors who will have very unhappy patients.

Developing Telephone Skills

Similar to taking an in-person history and developing a treatment plan for a patient's illness, there are several basic approaches commonly used for proper handling of professional telephone communications.

Carefully prepared and field-tested algorithmic telephone protocols are available for use from a variety of sources. These are especially valuable for consistency in group practice settings where numerous personnel answer the telephones, and when it is important to monitor the quality of the information being given. These protocols have the disadvantage of sometimes increasing the time needed to complete calls for

Continued on page 6

uncomplicated problems, and they may be impractical in settings where calls are answered away from a stationary desk or computer station.

In smaller practice settings, telephone triage skills can be dramatically improved by:

- Focusing attention on developing a grouping of questions that creates a mental image of the patient. (It is counterintuitive but true that the general question “How sick does your child look?” may sometimes give more useful information than a series of very specific questions.)
- Rapidly assessing the degree of urgency of the problem to determine the disposition of the patient.
- Encouraging parents or patients to express their own perceptions of the severity of symptoms.
- List the most common and the most serious telephoned questions and complaints that are received in your unique practice setting, and master responses to them first. Less common and esoteric complaints should become a secondary focus.
- Practice using language that gives the caller a clear picture of your meaning: Descriptors for a rash might include: “Does the rash look like bug bites or red welts; blisters or pimples; a rough sunburn; red freckles or bruising under the skin”?

For the inexperienced physician, portions of formal protocols and specific triage questions from them can be used to create an individualized system with an eye toward streamlining the triage process. For example, once a clinician learns that a baby with 24 hours of diarrhea is listless and lethargic, he or she can recommend an immediate examination. Determining other parameters by asking about the number of wet diapers, the height of fever, and other specific questions may be useful but becomes less important because an in-person examination will take place shortly regardless of the parent’s answers.

Medical-Legal Liability

- Potential liability is the same for each telephone call as for an in-person office or emergency room visit.
- All medically pertinent information must be carefully documented.
- Patients should be over- rather than under-screened.
- Medications and prescribed treatments should not confuse later diagnosis or mask serious symptoms.
- Treatment and call-back instructions must be precise and unambiguous.

Business Considerations

The business considerations relating to telephone management of patients include:

- Deciding which designated personnel should answer daytime and after-hours calls. Specialized telephone triage centers are an excellent option in some areas, but cost, patient population and other factors, may sometimes limit their usefulness.
- Deciding whether there should be patient billing for calls that don’t require an office visit. At first glance, the answer to this question should be a simple yes. Physicians should be paid for providing professional advice whether it is in person or on the telephone. Physicians’ groups including the Section on Telephone Care (SOTC) of the American Academy of Pediatrics have been working hard to revise CPT codes that would allow insurance reimbursement for such billing. But many complex variables have slowed this process. Some questions to be answered are: Will reimbursement for office visits be decreased if phone-time is paid? Will the paperwork required to bill patients (and possibly collect copayments) cost more than the reimbursement? And, will patients make unnecessary office visits or not make necessary calls to avoid a telephone charge?

Summary

It is not surprising that lectures and articles discussing professional telephone management might be titled “Taming the Terrible Telephone” or “Telephone Care: Friend or Foe?” Each and every patient’s call is the entry point of his or her problem into your system of professional management. Aside from its medical importance, the call is a marketing tool for you and your practice. It can enhance your relationship with your patients and improve your reputation in the community - or it can create the impression that you are uncaring, unavailable, or even worse, that you practice bad medicine. Do not be complacent. Give each call the attention it deserves.

A Wake Up Call

by Ari Brown, MD, FAAP

I surf between NPR and my satellite radio on my daily drive to work. I scan the Yahoo! headlines each time I log onto my computer. I read the Wall Street Journal as often as I can. You'd think I was an investment banker or something. Nope. I am a primary care pediatrician and a member of the AAP Section on the Media.

Why am I obsessive about the news? Because I want to know what my patients' parents will be asking me about in the office today. I used to laugh when my mother told me about the latest pediatric health news she heard on 20/20. I would always reply, "Mom, I don't get my medical information from primetime TV and neither should you." I have come to realize, however, that this is where our families get their health news. That and the Internet, of course. Scary!

I began my pediatric practice in 1995, about the same time that the Internet infiltrated our world. I quickly realized my relationship with parents would be very different than the one my mother had with my own doctor thirty-something years ago.

Pediatricians who are my senior may fondly reminisce about the good old days of medicine.... the doctor made the diagnosis, gave instructions, and the parent went home and implemented the management plan. They didn't have to deal with articles that a parent downloaded from an obscure Scandinavian medical journal, or Internet myths circulated around playgroups.

Our profession has gotten a wake up call. While we doctors may not be concerned about hot-button issues (like thimerosal, for instance), our patients' parents certainly are. We owe it to them to provide accurate information and reassurance. If we don't make office visits a "teaching moment", parents just seek out medical information on their own. And as we all know, a little knowledge can be a dangerous thing! These searches may leave them with more questions than answers, more anxiety than reassurance.

Yes, I have become a news junky. But it keeps me current on the issues my families are concerned about. And my participation in the AAP Section on the Media has given me the opportunity to shape the news my families hear!

The AAP Section on the Media develops relationships with the media to provide accurate messages regarding pediatric healthcare issues. The section also examines the impact of the media on children. We collaborate with groups interested in making that impact a positive one. If you have a passion educating the lay public, come join us!

*Ari Brown, MD, FAAP is a pediatrician in private practice in Austin, TX. She is the co-author of *Baby 411: Clear Answers and Smart Advice for Your Baby's First Year (2nd Ed., 2006)*, a member of the AAP Section on the Media, and a spokesperson for the AAP.*

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/moc, 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.

Look to the End—Even at the Beginning

by Gary N. McAbee, DO, JD, FAAP

Chairperson, Committee on Medical Liability and Risk Management



Dr. McAbee

Joining a growing practice can be exciting and rewarding for the practice and the new doctor, but even the best professional relationships can come to an end over time. A wise person once said, “Let us watch well our beginnings, and the results will manage themselves.” This holds true for professional relationships. Clarity at the beginning—and a well-written employment contract—will serve all parties well. It is especially important if the parting ends on a sour note.

When the employment contract glosses over professional liability insurance coverage, the group and the physician may end up wasting money and time in a court battle.

“Tail” coverage is a major concern for pediatricians and can be a particularly controversial issue because of its expense.

Most professional liability policies are written on a claims-made or claims-reported basis. Employees covered through a group’s claims-made policy are insured for claims arising from their action on behalf of the group as long as the claims are made within the policy period.

In states that have not, physicians face potential liability up to 22 years for their patients injured as a minor.

The time lag between an incident or injury and the filing of a malpractice claim resulting from it is called the “tail.” Because nearly all pediatric patients are minors, the period of exposure to potential malpractice claims can be significant. In many states the law permits a legal adult to sue for injury sustained as a child if the parents did not initiate a suit on the child’s behalf. Seventeen (17) states have lowered the age of majority for malpractice actions. In states that have not, physicians treating minors face potential liability up to 22 years. For this reason, tail coverage is very expensive—typically a multiple of the annual premium.

When employee physicians leave the group, they are not covered under the group’s policy for work on behalf of the group unless an extended reporting period or tail endorsement is added to the policy. A group is usually covered for its vicarious liability for a physician who leaves the group unless that physician fails to obtain tail or nose coverage.

Disputes derived from unclear language in employment contracts can be resolved in court but at considerable expense simply because allegations of breach of contract, specific performance, and declaratory relief are not generally covered by any type of insurance. The parties may likely have to pay for the attorney costs depending on whether the contract specifies who pays for legal costs in the event of a contract dispute and be responsible for any resulting judgments.

Not only are these cases costly, they can be unpredictable.

In *Byrne v. Joliet Medical Group, Ltd*, the US District Court for the Northern District of Illinois ruled that an employment contract required a physician to buy his own tail coverage from the group’s insurer and not from a company of his choice.

In another case an employment agreement said only that a physician would be responsible for paying coverage if her employment terminated before the end of the contract. The court ruled she could not be required to pay when she resigned at the need of the contract term.

The Supreme Court of New York, Appellate Division, also found for an employed physician in a case in which a confirming employment letter stated “insurance will be provided for you” without further specifics. In the subsequent breach of contract lawsuit, the court ruled that the employer was responsible for the tail pre-

Continued on page 9

mium despite the employer's argument that the letter was not an employment contract and he never intended to agree to pay the tail coverage.

In *Meyer v. Superior Clinic*, the Court of Appeals of Wisconsin reached a different conclusion. The clinic's bylaws stated that malpractice insurance was provided for "employees." Because the bylaws did not mention "ex-employees," the court ruled that the provision did not apply to tail coverage for a doctor who had left the group.

A healthcare business attorney is invaluable when considering employment agreements and reviewing insurance policies.

Here are some things you and your attorney should consider about malpractice insurance and tail coverage:

- Who can request tail coverage from the insurer?
- Does the physician pay in the event of resignation or termination with cause?
- Does the group pay a portion of the premium based on years of service? Will the insurer waive the expense for tail coverage if a physician remains with the carriers for a specified number of years?
- Is payment required when tail coverage is selected, or is it deducted from the physician's income?
- If the tail coverage is subject to a deductible, who is responsible for paying it?
- If doctors can obtain prior acts coverage from their next insurer, do they have to provide proof to the group?
- Who selects the program features (policy limits, deductibles—including who pays the deductible—coverage for entities or a physician's personal corporation, etc)?
- Who can change the policy, including the right to cancel coverage for the physician?
- Who is responsible for buying coverage? Not only active insurance, but also prior acts and tail coverage? Is payment for tail coverage based on a specified minimum length of employment?
- Will the group allow the policy to provide coverage for prior acts unrelated to the group? What if the doctor is coming from another state?
- Will the policy cover the physician for moonlighting?
- If the policy contains a consent-to-settlement provision (i.e. reduction in annual malpractice premium if the physician waives the right to contest any malpractice settlement) who makes the decision? The group or the physician?

Pediatricians need to be wary of insurers who do not have high ratings and are financially unstable. For instance, a recent N.J. appellate court (*Johnson v. Braddy, 2005*) ruled that if an insurance company becomes insolvent and a policyholder's damages exceed the \$300,000 cap covered by the state guaranty fund (established by law in every state, these funds give policyholders limited protection in the event that an admitted insurer becomes insolvent or otherwise unable to meet its financial obligations), the defendant would be personally liable for the difference. Thus, medical liability insurers in unhealthy financial conditions place physician insureds at personal financial risk. Know how your insurance carrier is rated and watch for any deterioration.

Medical groups and employee physicians who hammer out clear and specific contract terms regarding the purchase, maintenance and termination of professional liability coverage are likely to have more amicable partings and spend more time seeing patients and less time seeing attorneys, than those who don't.

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 and Risk Management, 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.

Pediatric Research in Office Settings (PROS) Seeks Participation, Needs Input from Young Physicians

by Richard C. "Mort" Wasserman, MD, FAAP

I am writing in my capacity as director of Pediatric Research in Office Settings (PROS <http://www.aap.org/pros>), the AAP's practice-based research network, to inform SOYP members about PROS, invite their involvement, and seek their input.

The PROS mission is *to improve the health of children and enhance primary care practice by conducting national collaborative practice-based research*. In a practice-based research network like PROS, practitioners and researchers work together to generate research questions, design study materials and protocols, collect study data, analyze collected data, and publish results. Practitioners can participate at many levels. Basic participation involves filling out a brief questionnaire and then choosing to participate (all participation is voluntary) in data collection for studies that interest them. Those who wish to be more involved can suggest study ideas, help design protocols, and participate in writing up results for publication.

Since its inception, PROS has conducted studies on a wide range of pediatric topics. The best known PROS studies have been 1) a study published in *Pediatrics* in 1997 that established that puberty in young girls can occur earlier than written in textbooks (as early as six years of age in African American girls, and seven in White girls)¹ and 2) a study published in *JAMA* in 2004 demonstrating that pediatricians using informed clinical judgment were able to employ less aggressive strategies than suggested in guidelines and achieve good outcomes in very young febrile infants.² Findings from PROS studies have led to changes in the clinical guidelines of the AAP and other organizations. PROS provides a way for practicing pediatricians to help generate important new knowledge that will affect the care of millions of children.

As of April 2006, PROS consists of nearly 2,000 pediatric practitioners from 750 practices in 49 states, Puerto Rico and Canada. However, PROS members are disproportionately old when compared with the Academy's general pediatric membership.

This is where PROS needs input from the SOYP. PROS benefited enormously from the input of then-young Baby Boomer pediatricians when it was formed in the mid-1980s. However, the Boomers are headed towards retirement and PROS needs to know from today's young physicians how it can benefit young pediatricians in practice. Current PROS practitioners have indicated that PROS provides many benefits to them. PROS helps satisfy some of their curiosity about the day-to-day content of practice, to what extent their practice is similar to other pediatricians' practice, and whether what they do actually works. We've also been told that PROS satisfies a need for affiliation with a broader group outside their office or clinic. Finally, PROS pediatricians have told us that PROS helps satisfy some of the basic altruism that brought them to pediatrics in the first place, by allowing them to help generate new knowledge that will benefit children beyond those they see as patients.

Do these potential benefits ring true to SOYP pediatricians? What additional benefits could PROS provide that would make participation appealing? What barriers do SOYP pediatricians see to participating in a practice-based research network like PROS. Please email your thoughts to PROS@aap.org or snail mail them to me at PROS, American Academy of Pediatrics, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927.

Any pediatric practice or clinic with at least one AAP member is eligible to join PROS.

If you have internet access, go to <http://www.aap.org/PROS/hotojoin.htm> for more information on how to enroll in the network. If you do not have email access, you can get this information by calling PROS Project Assistant Norma De Santiago at 800/433-9016 ext. 7623.

References

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2. Pantell RH, Newman TB, Bernzweig J, Bergman DA, Takayama JI, Segal M, Finch SA, Wasserman RC. Management and outcomes of care of fever in early infancy. *JAMA* 2004; 291:1203-1212.

The EMR: Which One is Right for Your Practice?

by Division of Pediatric Practice

The Council on Clinical Information Technology (COGIT) is pleased to introduce to you a service where you can research various Electronic Medical Record (EMR) products that are currently being used by pediatricians every day. As part of this service, you can explore where these products are being implemented, for what type of practice, as well as read the experiences of others who are using these EMR products. As of this writing, there are over 30 reviews on 18 different products. Users of existing EMR systems are invited to log on and post their own experiences, to be shared with others!

What kinds of features can you compare with this service?

- General EMR Overviews
- Growth Parameters, Percentiles, Curves
- Data Pertaining to Birth History
- Adolescent Privacy Features
- Immunization Data Handling, Analysis
- Prescription Generation, Transmission
- Installation, Training, Support Issues
- Lookup Features, Identifying Data
- Ease/Methods of Data Entry, Including Pediatric Terminology
- Awareness/Comparison to Age-Based Values
- Standard and Flexible Format Reporting
- Tracking Disclosures, Parental Appendices
- Linkages between Family Members
- Online Patient/Parent Access and Interactions
- Documentation/Assessment of Developmental Milestones
- Practice Management Integration
- Costs, Subjective Value, Return on Investment

In addition to these features, you also have the opportunity to read candid comments relating to overall EMR performance, as well as comments on specific features of a particular EMR. Here are a few examples:

"I had looked at a lot of products and only found a few that were pediatric friendly. Especially liked the fact that this was a PC-based product and that didn't have to learn an entirely new operating system like Unix and get dependent on outsourcing IT to selling company."

Kenneth Hirsch, MD, FAAP

"I have been very pleased with the pre-built templates and the pre-programmed advice and hand-outs that come with the system. They mesh well with the AAP's policies and Bright Futures program recommendations. In addition, changes to meet new guidelines or to customize for personal preference are easily programmed."

Alan Grimes, MD, FAAP

*"We are using fully integrated * system, including billing, scheduling, and internal email. Using since Nov 2003, with 2 full updates of software since then. System has been "down" for 10 minutes since Nov 2003."*

David Arkin, MD, FAAP

Want more information that simple ratings and brief comments?

The site's Buddy List feature provides contact information on pediatricians who've used the software and are willing to answer questions about their implementation. So, how do you find it? COGIT encourages you to log on to their site and read about others experiences and/or post your own!

Please log on today!

<http://www.aapcocit.org/emr>

818 Approaches to Addressing Child Health Problems - and Counting!

by Kristi Canty, MD - CATCH Co-Facilitator, Missouri Chapter

The early years of practice can be a little overwhelming, especially if you have settled into a new community. But there is an important resource available to you. Since 1991 the Community Access to Child Health (CATCH) program has been offering resources and technical assistance to pediatricians who are dedicated to making changes within their communities. While the CATCH program is most often recognized as a source of funding for pediatricians and residents by offering grants CATCH is also a network of child health professionals and advocates that strategize to improve access to care and create solutions to child health issues.

Through the CATCH network, pediatricians have worked with other health professionals and community organizations to develop the 818 planning, implementation, resident and visiting professorship grants that have been awarded. Each individual grant represents the method by which a practicing pediatrician chose to address a health issue. These grants address a wide range of health topics, represent a variety of community collaborations, and serve thousands of children and families.

As an example of the number of grants that can be found per health topic, the following chart shows the number of CATCH grants awarded for each of the American Academy of Pediatrics' (AAP) Strategic Priorities for 2006-2007.

AAP Strategic Priorities:	Total Number of Grants Awarded:
Special Health Care Needs/Foster Care	185
Mental Health	80
Obesity	59
Oral Health	47
Immunizations	39

These unique solutions to identifying and addressing health needs within a community present an opportunity for other physicians to utilize similar approaches within their practices or communities. Listed below are resources available to you to learn more about the 818 (and counting) approaches available to addressing child health problems.

Grants/Project Database

The AAP's Web site houses a Grant/Project Database. This database archives previously funded Community Pediatrics grant projects, including those funded through the CATCH Program, the Healthy Tomorrows Partnership for Children Program, the Community Pediatrics Training Initiative and the Healthy People 2010 Chapter Grants. The database is searchable by seven major categories: target population, health topic, state/territory, project activity, AAP program, AAP district, and project year. By searching this database through the Member Center, you can obtain contact information of the grantees. To access the database, go to: <http://www.aap.org/commpeps/grantsdatabase/grantsdb.cfm>.

CATCH Facilitators

The CATCH Program is based on the concept that local child health problems can be solved locally, often using local resources, and provides opportunities to develop skills in the areas of needs assessment, community asset mapping, resource development, coalition building, and program evaluation. District CATCH Facilitators, Chapter CATCH Facilitators and CATCH staff are available to answer questions if you wish to learn more about a CATCH project or to provide technical assistance as you develop your own community-based program.

For more information, please send an email to catch@aap.org.

Continued on page 13

818 Approaches to Addressing Child Health Problems - and Counting! *Continued from page 12*

CATCH CQ and CQ Listserv®

The CATCH CQ newsletter features articles on pediatricians' community-based activities and the CQ Listserv® provides updates on opportunities and resources available. To be notified of upcoming CATCH activities or to join CATCH CQ or CQ Listserv®, please send an email to catch@aap.org with "Join CATCH CQ and CQ Listserv®" in the subject line (or specify which list you prefer to join).

As CATCH grants continue to be awarded on 80+ health topics; CATCH also continues to provide examples of the many methods available to pediatricians to address the issues. There are currently 818 approaches to addressing child health problems available through CATCH and perhaps the 819th could be you!

Pediatrics Still a Popular Choice for Seniors in 2006 Resident Match

from the AAP Division of Graduate Medical Education & Pediatric Workforce

Pediatrics continues to be a popular specialty choice among prospective residents according to the results of the 2006 match held March 16.

Data from the National Resident Matching Program (NRMP) report that the number of first-year positions offered in the 2006 match increased, while the number of positions filled remained relatively stable. This is a clear sign of sustained and high interest in pediatrics among U.S. medical school seniors.

Of the 2,407 first-year positions offered in pediatrics, 96.5% (2,323) were filled, down slightly from 97.4% (2,327 of 2,388 positions offered) in 2005. These numbers include first-year positions in categorical pediatrics, as well as combined programs in pediatrics-dermatology, pediatrics emergency medicine, pediatrics-medical genetics, pediatrics-physical medicine and rehabilitation, pediatrics-psychiatry-child psychiatry, and pediatrics-primary care.

Of the 2,323 positions filled, 75.3% (1,750) were filled by graduates of U.S. medical schools, a slight increase from 75.1% (1,748) in 2005.

For categorical pediatrics alone, 2,209 of the 2,288 positions offered, or 96.5% were filled in this year's match. This signifies a minimal decrease from 97.4% (2,211 of 2,269 positions offered) in 2005. In 2006, 75.5% (1,688) of first-year positions in categorical pediatrics were filled by graduates of U.S. medical schools, a slight drop from 75.9% in 2005.

Although internal medicine-pediatrics offered 14 fewer first-year positions (from 390 in 2005 to 376 in 2006), the match rate for the combined specialty improved.

Of these, 376 positions, 91.5% (344) were filled, up from 87.2% (340) in 2005. Graduates of U.S. medical schools accounted for 85.5% (294) of the filled positions, compared to 80.9% (275) in 2005.

Match results for other primary care specialties were mixed. The match rate for first-year positions in internal medicine (including combined specialties) increased from 95.3% in 2005 to 95.5% in 2006, while family practice increased from 82.4% in 2005 to 85.1% in 2006. However, both internal medicine (70 fewer) and family practice (50 fewer) offered fewer positions in this year's match. Obstetrics-gynecology, in contrast, offered 10 additional first-year positions in the match, and increased its match rate from 94.7% in 2005 to 97.9% in 2006.

Detailed data tables will be available at: <http://www.aap.org/gme>.

See the May issue of AAP News for additional analysis of the 2006 match.

2006 National Conference & Exhibition

Nothing goes better with CME than sunshine, and Atlanta has plenty of both this fall! Come to the 2006 National Conference & Exhibition and observe the latest trends in pediatric medicine, products and technologies, improve your technical skills, and interact with the nation's leading pediatric experts. Experience all that this conference has to offer:



- A diverse sampling of scientific programs with valuable information that can directly impact patient care/practice, and give you the opportunity to earn up to 53 hours of AMA-PRA Category 1 Credits
- Special Events from the Welcome Reception/AAP Kids Camp, AAP Night at the Georgia Aquarium (sponsored by Johnson & Johnson), AAP President's Reception/Taste of AAP in the Exhibit Hall
- Hundreds of well-known exhibitors, free product samples and networking opportunities
- Fun family programs and onsite child care with the highest staff to child ratios
- Exciting tours of Atlanta (Visit the CDC; Braves Museum and Hall of Fame/Turner Field; Atlanta City Tour; Zoo Atlanta; The World of Coca-Cola; Tour of CNN; Peachtree Treasures - Tour of Rhodes Hall and The Margaret Mitchell House; Stone Mountain Park; Civil War Museum; and Upscale Retail Shopping Shuttles)

Important Dates

June 1–Sept 1

Advanced Registration – Take advantage of reduced registration rates! (Register Online at www.aap.org/nce)

June 1–Sept 8

Deadline to book housing through the AAP Housing Bureau (Call 866/843-2271)

Oct 7-10

2006 National Conference & Exhibition, Georgia World Congress Center Atlanta, GA

For more information on any of the programs or special events, visit us online at www.aap.org/nce, call **866/843-2271** or send an e-mail nceinfo@aap.org.

Honored Guest Speakers



President Eileen Oullette, MD, JD, FAAP will open the 2006 NCE Saturday morning with the AAP President's Address, followed immediately by our keynote speaker address, **John O. Agwunobi, MD, MBA, MPH, Assistant Secretary for Health, U.S. Department of Health and Human Services and Admiral in the U.S. Public Health Service Commissioned Corps.**

Julie Louise Gerberding, MD, MPH, Director of the Centers for Disease Control and Prevention (CDC) and the Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR) will open Tuesday's plenary session.



The American Academy of Pediatrics
and the Medical Group Management Association Announce
the 2006 Cost Survey for Pediatric Practice

by Anne B. Francis, MD, FAAP

Chairperson, Section on Administration and Practice Management

The Medical Group Management Association (MGMA), with collaboration from the American Academy of Pediatrics (AAP), will once again distribute the Cost Survey for Pediatric Practice. This 2006 survey will be based on 2005 data and will be mailed out soon. Data gathered from the survey provide a comprehensive assessment of financial and operational performance indicators, such as:

- Highly detailed revenue data for immunization and evaluation and management codes
- Data categories with multilevel operating cost breakouts for 113 practices that represent more than 935 physicians
- Plus, information on exam rooms, state regulations, fees for administrative forms and support staff

The AAP Section on Administration and Practice Management (SOAPM) and staff provide feedback on the content of the survey. After the survey design is finalized, the AAP staff provide MGMA with contact information for over 1,200 physicians belonging to various sections within the AAP.

Practices who agree to participate and complete the survey will receive a free copy of the final results (a \$300 value). Practices can use this valuable to establish benchmarks, measure quality, and better market their own services. We encourage you to complete the survey when you receive it. If you have any questions, you may contact Heather Fitzpatrick (AAP staff for SOAPM) at 800-433-9016, x. 4784 or hfitzpatrick@aap.org.

Join AAP practitioners around the country...

... in generating knowledge about the best ways to care for children. Pediatric Research in Office Settings (PROS) is looking for pediatricians to help develop and carry out primary care research in the practice setting. Any pediatric practice or clinic with at least one AAP member is eligible to join PROS. For information on being part of this innovative AAP research effort, e-mail: pros@aap.org, fill out and fax this coupon to (847) 434-8910, or mail to:

PROS, American Academy of Pediatrics
141 Northwest Point Blvd. • Elk Grove Village, IL 60007

Yes! I'd like to be involved with PROS research.

Name _____

Degree _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

E-mail _____

The **Young
Physicians** Section **Spring 2006 Newsletter**

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



This newsletter is the official publication of the Section on Young Physicians of the American Academy of Pediatrics. Statements and opinions expressed in this publication are those of the authors and not necessarily those of the American Academy of Pediatrics.