Energized & Inspired: AAP SOMSRFT Long Range Planning Meeting 2015

By Shannon Brockman, MS4, University of Florida College of Medicine

This February, members of the Medical Student Subcommittee (MSSC) joined other leaders from the AAP’s Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT) to reflect on the year’s successes and plan for continued growth and productivity.

The weekend’s programming focused both on leadership development and long-term planning, with a well-balanced blend of interactive programs, organizational updates, and small group discussions. Students, residents, and fellows met in strategic planning workgroups to assess progress on our long-term projects and set new goals for the coming years, ensuring that we continue to stay true to our overall values and mission. The decision was made to continue our F.A.C.E. Poverty advocacy campaign for another year and MSSC member, Genevieve Guyol, was elected to take over as a tri-chair for the campaign. (Continued)
The MSSC broke away for several hours to analyze our efforts to support the leadership, advocacy, and programming endeavors of medical students across the country while encouraging and empowering them to #putkids1st.

On Sunday, the MSSC had the opportunity to present an update on the group’s accomplishments and plans for the future. Here’s a look at the highlights of that presentation:

**Overview of our 2014 Accomplishments**

- Medical Students became full members of the AAP, from our previous status as affiliate members.
- Leadership was expanded to include Assistant District Representatives with several well-qualified applicants for all positions.
- A liaison position to international medical students was added and a Listserv was created for communication with international students.
- Representation was approved in the AMA-MSS General Assembly as National Medical Specialty Society.
- Contact information was collected for almost 200 Pediatric Interest Groups leaders across the country.
- Specific medical student advocacy projects were implemented.
- An online advising Forum called PedsConnect was developed.
- A "Pediatric Interest Group of the Year" Award was created and introduced.
- The quarterly AAP Medical Student News e-newsletter continued production.
- Medical students secured spots in the SOMSRFT Clinical Case Program at NCE 2015.
- We were approved for representation in the AMA-MSS General Assembly as a National Medical Specialty Society.

**Goals for 2015 and Beyond**

- Increase membership and involvement while empowering members to become child advocates and pediatrician leaders of the future.
- Expand participation and meaningful involvement in the annual advocacy campaign.
- Enhance member resources to support the development of inspired and informed future pediatricians.
- Update the organizational structure of the Medical Student Subcommittee to maximize our value and productivity. (Continued)
This year, medical students can look forward to improved membership benefits, extended scholarship and research opportunity, increased mentorship and advising support, updated Pediatric Interest Group resources, and inspiring programming at the AAP National Convention and Exhibition in Washington, DC in October 2015!

Camp Boggy Creek: Advocacy through Empowerment

By Britta Roach, MS2, Philadelphia College of Osteopathic Medicine -- Georgia Campus

“Hey! Camp Boggy Creek, how do you feel? We feel SOOOO good!”

This is the Camp Boggy Creek (CBC) anthem cheered by campers, volunteers, and staff all weekend long. This cheer could not be more fitting for this incredible camp located in Eustis, FL – about sixty miles north of Orlando. From the moment campers and their families arrive on Friday, staff and volunteers set out to ensure that these kids - all suffering from a shared chronic illness - have the most memorable weekend ever. The camp memories begin with song and dance around a campfire, and end with a talent show in the theater. And in between, the activities include archery, boating & fishing, woodshop, horseback riding, arts & crafts, and mini golf, just to name a few. (Continued)
All of these activities would be exciting for any kid (or adult for that matter), but for these kids, the weekend is special because it is perhaps their only time to enjoy these activities while knowing that they are safe, respected, and surrounded by kids just like them. Asked how she felt at CBC, a young camper said it best: “Camp makes me really happy.”

CBC is a member of the SeriousFun Children’s Network, founded by Paul Newman. Because the SeriousFun network is independently managed and financed, CBC does not charge any campers or families to attend. The entire camp is funded by the generosity of individuals, corporations, foundations, and healthcare partners, including the fully functional medical facility fittingly called “The Patch.” The full time medical staff consists of volunteer physicians and nurses who specialize in the illness or disease group being hosted that particular weekend. Through the help of donors and volunteer medical professionals, CBC provides a medically secure environment for thousands of kids annually. While helping thousands of children annually is certainly an achievement, there is still a large and growing need for other camps like CBC, as reflected in Camp Director David Mann’s comment that “there should be one in every state.”

The purpose of CBC is more than just the fun-packed weekends; the campers and families feel the CBC love and support beyond the 232-acre campground. Year round, the staff advocates for the children and their families. Mann points out that CBC “bring[s] awareness to the public by sharing stories and best practices at section and national conferences, presenting educational workshops about specific disease groups, and advocating for our campers through social media.” Of course, child advocacy on this grand a scale is necessary, but CBC also emphasizes the importance of empowering the children and parents to self-advocate. The parental empowerment is achieved through the “Parent Chat Sessions,” which are facilitated by several qualified medical professionals during the evenings around a quiet campfire. These sessions offer an opportunity for parents to share challenges, resources, and success stories.

“Often”, Mann states, “these parent interactions grow into lifelong connections.” Similarly, the kids find empowerment from engaging with other kids who face the same daily challenges. As CBC staff emphasizes to volunteers, “everyone is a camper – Mom, Brother, and Granny.” The goal is that everyone leaves camp on Sunday feeling that they are loved, respected, and, most importantly, not alone in their struggle. Or, in the words of the rich CBC mantra, when the campers leave they “feel SOOOOOO good.”

To learn more about Camp Boggy Creek and how you can get involved, click here.
JeffHOPE: Not Your Average Healthcare Clinic

By Joshua Davis, MS2, Sidney Kimmel Medical College, Thomas Jefferson University

In 2014, the AAP’s Section on Medical Students, Residents and Fellowship Trainees (SOMSRFT) launched the FACE poverty campaign, a multi-faceted campaign designed to address inequalities and barriers to care among children. It is estimated that one in every five children, or 16 million children, living in the U.S. are living in poverty. An estimated 2 million of these children are homeless. These children living in poverty already face unstable home situations with many barriers to accessing proper support systems and healthcare needs. No child deserves to be dealt this unlucky hand at life, but for those who are, there are programs that can help.

JeffHOPE is a student-run clinic at Sidney Kimmel Medical College and Thomas Jefferson University with 6 sites in the city of Philadelphia, 2 of which provide care exclusively to women and children. The organization is coordinated and directed entirely by medical students, under the oversight of a faculty advisor in the Department of Family Medicine. Each week, a core group of volunteers and one clinic director attend each clinic and are responsible for duties, which include advocacy, education, providing pharmacy, and medical procedures. Medical teams are made up of one lower year student and one upper year student under the oversight of residents from pediatrics, family medicine, and OB/Gyn.

In addition to providing acute healthcare needs, JeffHOPE offers several other services. One team of volunteers is responsible for supervising and educating children while their mothers or siblings are seen. HIV testing and several methods of contraception are offered weekly. Recently, a program led by couples and family therapy students, has just begun which provides therapy support to patients who may have depression, anxiety, or may be fleeing abuse. Student also plan holiday events, including Fall and Spring parties for the children at the shelters. JeffHOPE is more than a healthcare center for the underserved and uninsured, which is what makes the program uniquely effective. It uses the acute medical visit as a springboard for advocacy and education for patients. It ensures that children have medical homes; that mothers are educated about smoking cessation, breastfeeding, and reading to their children; and that patients can get access to insurance resources and the social supports they need.

The medical team model also allows JeffHOPE to serve as a rewarding educational experience for medical students and residents while simultaneously providing service to its patients. It offers an opportunity for first year medical students to practice taking a history or measuring vital signs. (Continued)
It also allows more experienced students to expand their clinical skills, learn the intricacies of completing a physical exam on a young rambunctious child through a physical exam, and practice their decision-making skills. Upper year students and residents practice effective teaching skills, while learning about the needs of the homeless and appreciating how to work in a limited-resource environment.

Student-run clinics like JeffHOPE are an excellent way to get involved at a local level and require variable levels of commitment depending on a student’s or trainee’s interest and availability. The clinics help to address a national issue that has been recognized by SOMSRT. Students interested in pediatrics should consider volunteering with their school’s current student-run clinic, starting a student-run clinic at schools that do not have one, or expanding current student-run clinics to offer services to underserved pediatric patients.

To see a recent video about JeffHOPE, please click here.
For more information on the FACE Poverty Campaign, please click here.

References:
According to the National Institutes of Health (NIH), the physical abnormalities are present in 60-75% of patients and consist of the following: short stature; skin pigment changes; anomalies of the thumb, forearms, skeletal system, eyes, kidneys, urinary tract, ears, heart, and gastrointestinal tract; hypogonadism; and developmental delay. Twenty-five to forty percent of FA patients do not have physical anomalies, so the absence of physical anomalies does not rule out the disorder. Progressive bone marrow failure typically occurs in the first decade of life and begins with thrombocytopenia or leukopenia. In patients requiring a bone marrow transplant to cure the hematologic manifestations of FA, the estimated occurrence of bone marrow failure is 90% by the age of 40-50 years; however, the increased malignancy rate is unaffected by bone marrow transplantation. Patients remain at high risk for hematologic malignancies (10-30%) and non-hematologic malignancies (25-30%). The diagnosis of FA primarily relies on a chromosome breakage analysis. As of now, at least 16 genes have been implicated as causative of FA, displaying its genetic heterogeneity. Molecular genetic testing is clinically available, but the chromosome breakage analysis is the pathognomonic test. Treatment mainly consists of oral androgen administration to improve blood counts and G-CSF subcutaneous administration to improve neutrophil counts. Bone marrow transplant is the only curative therapy for the hematologic findings so bone marrow registries are crucial to optimize patient outcomes.

Blood and marrow stem cell transplants are possible thanks to organizations like Be The Match—a national registry consisting of millions of potential donors. After registering for the program, volunteers have about a 1 in 500 chance for a callback for further testing as a potential donor, and a 1 in 38,000 chance of being an exact match. Exact matches can donate stem cells in one of two ways—either through a non-surgical procedure called peripheral blood stem cell (PBSC) donation or via the surgical bone marrow method. FA patients have their blood checked every 3 months for signs of bone marrow failure. Be The Match makes life possible for so many Americans, especially those with FA.

Given its rarity, the treatment of FA remains a medical challenge with much needed funding to fuel current research progress. Because of this, Candi Fisher began Kidz1stFund in August of 2011. She said, “I didn’t know how much money it would make or how successful it would be, but I felt like I had a responsibility to try. I was scared and needed to do something.” Not only has Kidz 1st Fund increased research funding, but it has also boosted awareness and donors for the Be The Match registry. Of those registered with Be The Match through Kidz1stFund, at least 5 matches have donated. Kidz1stFund bone marrow drive volunteers, Gordon and Sharon Small, (Continued)
were voted as *Be The Match* Volunteers of the Year because of their commitment to *Be The Match* and their dedication to expanding the marrow registry within Tallahassee and beyond. Within the Tallahassee community, students have been very supportive. The Seminole Marching Chiefs make up a great portion of new *Be The Match* registry volunteers, while students at the FSU College of Medicine aid at the site of the bone marrow drives with Sharon and Gordon. The Pediatrics Interest Group within the FSU College of Medicine takes pride in seeking out opportunities to broadcast these drives and assist with the fight against FA.

“I Fight Fanconi” has become a familiar phrase in the Tallahassee community, and awareness continues to grow beyond this supportive college town. Although it is unfortunate that Ethan Fisher has FA, his experience has made an inordinate impact that stems beyond his community. Not only has his diagnosis increased funding and awareness of a rare childhood disease, but his story has also helped students to understand a disease through a patient’s eyes. We should strive to be like Dr. Slayton, to realize that patients are not defined by their diseases, to realize the importance of family/community involvement in advancing research, and to practice medicine with diligence, compassion, and keen awareness for rare disorders.

Today, at age 9, Ethan is as energetic as his peers. His local physicians in Tallahassee, Florida, Dr. Van Landingham and Dr. Simmons, coordinate efficiently to make sure that Ethan’s bloodwork is current. The only symptoms Ethan shows of FA are bruising on his back and abdomen, bloody gums when he brushes his teeth, and short stature. Ethan’s symptoms and frequent doctors’ visits do not hinder him from attending school and living a normal life like other boys his age. In fact, Ethan is athletic and enjoys sports like flag football, basketball, baseball, tennis, and golf.

**Acknowledgements:** Candi Fisher, Kidz1stFund Chairwoman; Ali Jones, Kidz1stFund Program Coordinator; Cameron Ulrich, Kidz1stFund Director of Operations

For more information check out *Be the Match*, the Kidz1stFund

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**Advocacy Spotlight: Docs for Glock Safety**

By Shannon Brockman, MS4, University of Florida School of Medicine

Pediatricians continue to speak up against gun violence across the country. The Florida Chapter of the American Academy of Pediatric (FCAAP) and several individual FCAAP pediatricians are lead plaintiffs in a Federal Court case to overturn the State's decision to restrict physicians' First Amendment right to ask about the presence of guns in the home. In collaboration with an independent Los Angeles movie production company called Brave New Films, FCAAP has produced a brief documentary based on the recent gun lawsuit, Firearm Owners' Privacy Act (colloquially referred to as Docs versus Glocks). It is intended as a "call to action" urging patients, parents, students, community leaders, advocacy support groups, physicians, and healthcare organizations across the country to speak up and prevent the passage of copycat first amendment infringement laws in other states.

Check on the short 3-minute video for more information [here](http://www.ncbi.nlm.nih.gov/books/NBK1401/).
Advocacy in Academic General Pediatrics: An Interview with Dr. Ivor Horn

By Mickey Emmanuel, MS1, University of Florida

Dr. Ivor Horn, MD, MPH is a pediatrician and the Medical Director of the Center for Diversity and Health Equity at Seattle Children’s Hospital. Her roles include community-based primary care, research, and leadership in health equity. Dr. Horn was recently named one of Forbes “Top 5 Women Using Technology To Blow Up Social Change”.

How did you become interested in academic medicine, advocacy and community pediatrics?
My interest in academic medicine started in medical school and continued throughout residency with the help of great mentors. The teachers in my outpatient and continuity clinic mixed the evidence-based and the practical in a way that made me engaged, curious, and wanting to contribute to the medical education of others. Another important factor was the diversity in race and ethnicity in the faculty in my medical school and residency program. I could see faces like me doing the work I was interested in doing. It gave me the appreciation to say, “yes, I can do this, too”.

My general academic pediatrics fellowship program also had an advocacy component where I got to do an internship with the AAP legislative office. It helped me see how we as pediatricians can make a difference. I learned skills like media training, which has really carried me. Had it not been for the core lessons I learned from the legislative office, I don’t know if I would be as involved or as comfortable advocating in that space. Currently I advocate on a national and organizational level, as well as by using media and social media as a platform for education.

Can you elaborate on your decision to pursue general pediatrics versus a subspecialty?
In medical school, although I loved the adrenaline rush and procedures in emergency medicine, what really mattered to me was to have a long-term relationship with families. I knew I could only do that if I did primary care. I knew I wanted to be a generalist because I wanted to answer the everyday questions that parents have and partner with them throughout the health care process. (Continued)
How did you become interested in health disparities and equity?
When I was growing up, we didn’t have health insurance. My parents were both employed, but lower working class, and health insurance just was not in the budget. I have always wanted to work with patients and families that didn’t necessarily have that connection with their provider either. Once I became a pediatrician, I saw huge disparities in care and health outcomes and a lot of it had to do with social determinants of health - where children live, learn, work, go to school, and play.

Can you describe your role as an academic general pediatrician and how you integrate both research and community practice into your work?
Currently, I am the Medical Director of the Center for Diversity and Health Equity at Seattle Children’s Hospital. The work that I do now is very different from what I have done in the past because before I focused more on my individual research and clinical care. Now that I have a hospital-wide leadership role, I am responsible for looking at health equity on an organizational level. This is really fun because I get to involve everyone from the researcher to the clinician to think about how we can create a culture of equity for the patients and families that we serve.

From your experience working on both a local and national level, what do you believe are some of the most urgent priorities for health disparities research in general pediatrics?
I think our priorities now should focus on getting out in the community and doing. Much of the research now focuses on seeing if health disparities exist and where, but we should start tackling the problems we see by developing interventions to address them. Let’s start working on solutions - that’s what I would really like to see us do.

What advice do you have for medical students who want to learn more about the field and get involved?
Find someone that you admire and see doing what you would like to do. Then ask them about it and spend some time with them to see what their experiences are like. The more you ask, the more you will learn from other’s journeys and begin to map your own. Get involved in community organizations and volunteer with kids. You will be amazed by how much you learn about the challenges that families and kids face.

One thing I always say is, parents will do for their children what they won’t do for themselves. Pediatricians are like that too. When you become a pediatrician, you become a part of a group of strong advocates for children across the globe.

Filling the Knowledge Gap: Breastfeeding and Anesthesia
By Aarusha Jana Das, MS4, and Asif Kahn, MS4, University of Texas Health Science Center at San Antonio School of Medicine
One of the greatest challenges third-year medical students face is finding their place on the medical team. No student wants to write unread notes or recite known lab values. A powerful role medical students can take on each medical team to significantly impact the healthcare of their patient is to be an advocate. As an advocate, students can ensure that their patient’s autonomy is respected and incorporated into the decision-making process. Through the trust and responsibility gained as an advocate, a student can become the voice of the patient on rounds. (Continued)
With 90% percent of women worldwide breastfeeding their infants, and the practice increasing, the conflict between anesthesia and breastfeeding is becoming more frequent. Despite the advantages of breastfeeding for the mother (involution of uterine size, reduced risk of ovarian/breast cancer and type-2 diabetes, and contraception) and infant (bonding, immunity, optimal nutrition), most anesthesiologists will recommend that a mother discontinue breastfeeding for days post-operatively. Unfortunately, there remains a lot of old misinformation about anesthesia and breastfeeding that is preventing motivated mothers from continuing to breastfeed post-operatively. This provides a wonderfully unique opportunity for students to educate and advocate on behalf of their patients, while also sparking an important discussion in their pediatric department to encourage better breastfeeding awareness.

Any student taking a clerkship in pediatrics, or even obstetrics, can undertake the role of an advocate by promoting continued breastfeeding pre-operatively and post-operatively. Current dogma states that breastfeeding is to be discontinued prior to surgery, and held for at least 24hrs after surgery due to the potential for sedation and respiratory effects on nursing infants. Most anesthesia departments continue to follow this belief despite recent guidelines and literature that clearly state "that although the currently available anesthetic and analgesic drugs are transferred in the breast milk, the amounts transferred are almost always clinically insignificant and pose little or no risk to the nursing infant." Studies have shown that the maternal propofol dose detected in breast milk post-operatively is on average 0.025%, and, similarly, the maternal fentanyl dose detected in breast milk post-operatively is on average 0.033%. These two drugs, like the majority of other anesthetics and analgesics, demonstrate the clinically insignificant doses that are found in breast milk. Furthermore, to those still weary of about the risks of breastfeeding post-anesthesia, a change in the anesthetic regimen can yield less transmission into breast milk and, thus, even safer anesthesia. The key features of an anesthetic or analgesic that will limit its passage into breast milk are high maternal protein binding, high ionization, shorter half-life, and low lipid solubility. Taking these factors into account when selecting a general anesthesia regimen for a breastfeeding mother will further help minimize any drug transmission to the infant. Therefore, making sure that the attending anesthesiologist for your patient is fully aware of the recent literature and guidelines regarding breastfeeding and anesthesia could have a significant impact in ensuring your patient and her infant are receiving optimal care.

As a student on a pediatric clerkship with a patient who desires to continue breastfeeding, this would be the perfect opportunity to advocate for your patient’s right to do so. The belief to defer breastfeeding post-operatively is deeply rooted and needs to be openly discussed and debated. By providing the evidence and demonstrating the significance of breastfeeding, it is possible for you to initiate an informative dialogue in your pediatric and anesthesia departments. Promoting the benefits of breastfeeding and debunking any misinformation about anesthesia and breast feeding will allow for greater care of infants during the highly critical neonatal period. No longer should a breastfeeding mother undergoing a surgical procedure be blindly advised to discontinue breastfeeding, and as medical students, we must ensure we are doing our part as patient advocates.

References:
Cuddle Buddies: Helping Newborn Babies through Cuddling

By Kate Pellegriti, MS2, University of Massachusetts Medical School

Cuddle Buddies, a newborn cuddling program at the University of Massachusetts Medical School, has continued to grow in popularity among medical and nursing students alike. Established in 2013, Cuddle Buddies was created due to growing research suggesting that cuddling has a calming effect on infants who are born prematurely or with medical conditions. Babies who are cuddled have been shown to sleep better, manage stress better, and control their autonomic function better. It has also been shown to decrease the length of stay for infants suffering from Neonatal Abstinence Syndrome (NAS).

In addition to helping infants and introducing first and second year medical students to the Neonatal Intensive Care Unit (NICU), cuddling infants is also the ultimate de-stressor, as one medical student states, “Not only is Cuddle Buddies a great way to give back and connect to our community, but as a busy medical student, it was also a great way to unwind and clear my head.” Although cuddling neonates is not a novel idea, as many volunteer programs exist at hospitals across the country, at the University of Massachusetts Medical School, students volunteer during evening shift hours when other volunteer cuddlers have left for the day. In the evening hours, recovering mothers and spouses, especially those with other children, may not be able to be at the hospital, and this is an optimal time to comfort the babies. As one mother states, “They didn't accept volunteers at my son's NICU--one time as I was there someone called to ask if she could volunteer to cuddle preemies. My nurse looked horrified, ‘can you imagine??’ She asked. ‘Yes’, I replied. ‘It’d be great to know that when I'm at home recovering from my C-section and pumping milk around the clock, and while my husband is at work, someone is comforting my baby.’” Additionally, in the evening hours, medical staff are often thankful for an extra pair of arms, as they are busy (Continued)
“They didn't accept volunteers at my son's NICU--one time as I was there someone called to ask if she could volunteer to cuddle preemies. My nurse looked horrified, ‘can you imagine??’ She asked. ‘Yes’, I replied. ‘It'd be great to know that when I'm at home recovering from my C-section and pumping milk around the clock, and while my husband is at work, someone is comforting my baby.’ ”

with the care of multiple infants and might not have ample time to hold a baby who is uncomfortable or distressed.

Baby cuddlers can be especially helpful in the care of infants exhibiting withdrawal symptoms due to NAS. Although some of these babies are withdrawing from illegal substances used by an addicted mother, many of these babies may be withdrawing from necessary substances prescribed to a mother during pregnancy. Regardless of the substance, withdrawal symptoms tend to cause these babies an overwhelming amount of distress and discomfort, usually exemplified by their characteristic high-pitched cry, in addition to symptoms such as tremors, fever, nausea, vomiting, nasal congestion, sleeping and feeding problems and possibly seizures. Not only does physical contact help put these babies at ease, but studies have also found that it can help give them the edge they need to bounce back and reduce their length of hospital stay. In some cases, the constant presence of human contact and warmth can help prevent a possibly fatal outcome. As future medical professionals, it is important for us to advocate for our patients—no matter how young. It is, perhaps, even more important when those patients cannot speak up for themselves. As one medical student states, “The babies in the NICU are often in need of a little extra love and comfort and it was a great feeling to be able to spend some one-on-one time and provide the extra attention they need.”

If you are interested in learning more about Cuddle Buddies or about how to start a program at your school, please email aylin.sert@umassmed.edu

References:


Understanding Medicaid and State Children’s Health Insurance Program (SCHIP): Where We’ve Been and Where We’re Going

By Danielle Maholtz, MS4, Philadelphia College of Osteopathic Medicine

Healthcare coverage has been a hotly debated topic over the past few years since the implementation of the Affordable Care Act (ACA). However, long before the ACA, the government has been assisting its most vulnerable citizens, including its children.
Over the past fifty years, there have been many reforms to children’s health insurance. These expansions of public insurance for children have come in two waves: Medicaid and the Children’s Health Insurance Program (CHIP). Medicaid provides insurance to more than 62 million people in the US, and is the largest single source of health insurance coverage. Spending for Medicaid is second only to Social Security and Medicare, and it accounts for 8% of total federal spending. While children make up half the number of people covered by Medicaid, their typically low health care costs make them account for only 20% of Medicaid program spending.

To further extend the reach of publicly financed health insurance for lower-income children, CHIP was developed. Because both of these programs play a relevant and necessary role in the health care of children, a brief overview of both programs will be further explained in this article.

Medicaid (or Title XIX of the Social Security Act) was established in 1965, along with Medicare (Title XVIII of the Social Security Act) and to expand health coverage to low-income children deprived of parental support, their caretaker relatives, and disabled individuals. Medicaid is a federal and state partnership with state administration under federal guidance. In Medicaid, the federal government matches state spending at least dollar for dollar and federal matching funds are guaranteed with no present limits. For children, Medicaid provides check-ups, physician and hospital visits, vision and dental care as well as the Early Periodic Screening, Diagnostic and Treatment (EPSDT) comprehensive health services benefit. EPSDT was established in 1967 for all Medicaid children under 21. EPSDT includes screening, preventive and early intervention services and diagnostic services and treatment necessary to correct or improve children’s physical and mental health conditions.

Prior to the ACA, states participating in Medicaid were required to cover children under five who lived in families earning below 133% of the federal poverty level (FPL), and school aged children whose families earned up to 100% FPL. However, the ACA has increased the Medicaid minimum eligibility to 138% FPL for all children until age 19. To fully understand this, you must understand the FPL. The FPL is a measure of income level, based on annual cash income, decided upon by the Department of Health and Human Services. The FPL for 2015 is an annual income of $24,250 for a family of four. To determine the FPL for any other family size you either add or subtract $4,160 for each person from this example. To understand this in the context of Medicaid and CHIP, which has higher income eligibility levels, understand that being at 150% of the FPL means (Continued)
being 1.5 times the FPL for a certain family size. For example: for a family of four at 150% the FPL, their annual cash income would be 1.5 times $24,250, or $36,375.

Despite the benefit of Medicaid to many low-income children, there were still many children in families whose incomes were too high to qualify for Medicaid and therefore remained uninsured. To assist some of these children, CHIP was established in the Balanced Budget Act of 1997. Like Medicaid, CHIP is a partnership between the federal and state governments, but allows states departure from Medicaid in terms of legal entitlement to and requirements for coverage. While open-ended federal financing is offered by Medicaid, CHIP places annual limits on federal funding to states.

Initially, CHIP was funded as a grant to states capped at $40 billion in federal funds over a ten-year period, at higher matching rates than those available through Medicaid. The share of funding made available to a state each year is determined by a formula, which is based on the state’s share of low-income children and uninsured low-income children.

CHIP funds can be used to expand coverage through Medicaid or through a separate program developed by the state. The original CHIP statute authorized funding until 2007, which was subsequently extended by following federal acts. When President Obama signed the ACA in 2010, the federal SCHIP program was further extended to 2015 with laws requiring states to maintain current income eligibility levels through 2019.

After the implementation of CHIP, the proportion of uninsured children fell to 6.6% in 2012 from 15% in 1989. While Medicaid covers four times as many children as CHIP, CHIP covers more than 6 million children over the course of a year, that’s 7.7% of children! As of June 2013, over 28 million children were enrolled in Medicaid with an additional 5.7 million enrolled in CHIP. These are both crucial topics with respect to the health care of children. With the end date of 2015 quickly approaching, this is an important issue to continue to remain informed on and involved in!

UPDATE: A bill has recently been introduced to the Senate that would extend the current CHIP for four more years (S.522). Since the bill’s introduction, many Senators have signed onto co-sponsor this bill. A companion bill has also been introduced to the House (H.R. 919) with many co-sponsors. Please consider writing your senator or house representative to show your support for these bills!

Resources:
Cooking with Kids: My Time as a Los Angeles Schweitzer Fellow

By Christine Thang, MS4, David Geffen School of Medicine at UCLA

Albert Schweitzer, Nobel Prize winning humanitarian-physician, famously said, “I decided to make my life my argument.” In 2012, I became an Albert Schweitzer Fellow in Los Angeles, where I strived to follow these words by making my life my argument. My interest was combatting childhood obesity and its inherent comorbidities. I wanted to help kids, who have many years of life ahead of them, make the necessary choices and changes now, so that their futures could remain bright.

My project was called “Cooking with KP KIDS.” I worked with the existing Venice Family Clinic (VFC) Simms/Mann Health and Wellness Center’s KP KIDS (Kids in Dynamic Shape) Program that was a 7-week course educating kids and parents toward healthier lifestyles. “Cooking with KP KIDS” provided students and their families enrolled in the KP KIDS Program with hands-on cooking classes designed to teach them healthy eating and cooking skills. Each family enrolled in KP KIDS received a KP KIDS Recipe Book and Resource Guide, in addition to a KP KIDS Class Cookbook, which contained recipes submitted by each family.

Each week, there was a “Cooking with KP KIDS” session. During the first week, we made apple slices and peanut butter sandwiches. This presented an opportunity to teach about ingredient labels and avoiding hydrogenated oils. In the second week, we had rice cakes and applesauce. I was unsure about how the rice cakes would be received because I worried that the kids would find them too bland tasting. During class, several kids admitted that they had never tried rice cakes before. However, after trying them, the kids loved them! They were asking for more, and their parents wanted to buy them. This had been my goal—to introduce the families to new healthy and affordable snacks they could have at home. The third week was Greek yogurt and fruit presented as great sources of protein and fiber. In the following weeks, we made fruit kabobs, veggies and hummus dip. The kids were encouraged to try each food at least once, and I was excited to hear "I like it" around the classroom when they tried their bell peppers and zucchini with hummus!

Working with the pediatric patients and their families at the Venice Family Clinic gave me a chance to intervene in the lives of children at risk for developing obesity-related health problems. I helped parents understand nutrition and health issues and taught kids the importance of physical activity and healthy food choices. (Continued)
A second benefit of the program was the interaction between the kids and their families. My hope was that by learning to cook together, the kids could strengthen the relationship with their families while making healthy meals together.

The KP KIDS Recipe Book and Resource Guide served as a supplement to the KP KIDS curriculum by offering more hands-on and interactive components. Families were encouraged to use the resources provided and incorporate them into their daily healthy eating habits. Additionally, the families were encouraged to use the family-friendly recipes at home. As the course ended, students were also encouraged to create their own recipes based on the skills that they had learned. At the last session, families contributed their favorite recipes to a class cookbook, KP KIDS Class Cookbook.

In all, this service project reinforced my interest in pediatrics. It also reaffirmed my interest in fighting childhood obesity as a future pediatrician. Most importantly, it was fun cooking with kids!

For more information on how you can apply for the Albert Schweitzer fellowship, please visit here.

Operation Smile: Small Surgeries that Make a Big Impact

By Sarah Mongiello Bernstein, MS4, Emory University School of Medicine

She was absolutely perfect. She had ten perfect fingers and ten perfect toes. Her eyes were wide and curious and drew you in fondly. She was flawless everywhere — everywhere except for her nose and mouth. She was born in 1959 with a unilateral complete cheiloschisis and palatoschisis, more commonly known as a cleft lip and palate. Where her perfect, beautiful nose should have been an empty, gaping hole. As she matured and developed, she endured multiple surgeries nearly every year for the first thirty-two years of her life. She endured years of name-calling and self-deprecating thoughts. As a child, I could never have surmised the magnitude of hurt that had been fastidiously submerged beneath a barely visible scar above her lip, but it was there just beneath the surface in her thoughts and relationships and career. She was my mother and she opened my eyes to both the miracles and fallibilities of medicine.

This past summer, I had the opportunity to learn more about the management of cleft lips and palates in developing countries when I spent 6 weeks working with Operation Smile in Guwahati, India. Operation Smile is the largest surgical charity of its kind and has provided over 220,000 free surgeries for children and young adults in over 60 countries. In 2011, Operation Smile partnered with the government of Assam and the National Rural Health Mission (NRHM) to open the Guwahati Comprehensive Cleft Care Center (GCCCC) in Assam, India. (Continued)
The state of Assam has a population of approximately 31 million people and only 8 practicing plastic surgeons, some of whom do not perform cleft lip and palate repair. GCCCC was established to address the 800-1000 babies born each year with correctable malformations and the severe backlog of approximately 15,000 clefts in the area. Since the center’s opening, over 10,000 patients from Assam and neighboring districts have been treated there.

During my time in Guwahati, I learned just how pervasive the effects of this malformation can truly be. Cleft lip and palate is the most common craniofacial congenital abnormality worldwide affecting 1 in 700 children. Children with cleft lips are born every three minutes and are twice as likely as their counterparts across the world born without a cleft lip to die before their first birthday. The degree of the defect ranges from a slight misalignment of the lips to severe displacement and hypoplasia of the lips, nose and bones. Larger defects result in a multitude of issues including abnormalities in hearing, speech, appearance, dental formation and feeding which can result in failure to thrive and death.

However, complications of cleft lip and palate extend far beyond functional limitations. The combination of these abnormalities result in many patients feeling isolated from their peers, and can lead to anxiety, depression and social withdrawal. Furthermore, in some rural areas across the world, otherwise healthy children are considered cursed. These children are excluded from school, church and community activities and are often abandoned by their families.

Operation Smile believes that, “Every child deserves access to safe, quality surgical care. Every child deserves a future filled with hope.”

Unfortunately, without physicians willing to give their skills and time, many of these children will never know the life that they deserve. If there is one thing I have that I can give these children, it is my time and my passion—my passion for the art of medicine and my desire to change perspectives one patient at a time.

References:

In October 2014, the student-organized and faculty-mentored Boston Student Health Activist Community (BSHAC) Summit brought together a group of medical students, physicians, and other health professional students interested in health advocacy. This gathering provided opportunities for collaboration and skill sharing among physicians at different points in their training and facilitated exchange between different professional fields interested in health advocacy.

All in attendance shared the common interest in addressing issues of social justice, human rights, and public health. The morning began with several speakers who discussed how to approach healthcare advocacy from different lenses. They explained why our current healthcare system must be improved, encouraged attendees to bring their credibility as healthcare professionals to conversations about injustice in our society, and outlined tactics to affect change. For example, Paul Davis, an AIDS activist from the...
organization Health GAP, spoke about his experiences with birddogging—a tactic which involves publicly asking political candidates targeted questions during campaign events to pressure them to take a stance on a critical issue.

When the group broke into breakout sessions on topics ranging from the effect of climate change on health to an upcoming ballot initiative for earned sick leave in Massachusetts, facilitators offered concrete ways to engage in advocacy efforts such as narrative medicine, utilizing media attention, and lobbying representatives. Residents offered patient stories, attending physicians shared wisdom gained from prior projects, and medical students were inspired to join the movement for these social causes.

Filled with ideas and energy, everyone gathered for final remarks that presented a rigorous framework for evaluating advocacy projects. This closing showed how we can apply the scientific framework of our profession to help turn our ideas for social change into concrete actions by asking a few key questions such as “Who am I advocating to?”, “What am I advocating for?”, and “How am I going to do it?” Attendees left the conference invigorated from spending a day in the presence of others with a common vision and inspired by others at different stages of the training continuum.

The conference provided participants with clarity and purpose that is too often absent from the fragmented stages of medical education. When thinking about the stages of training still before us, it is easy for the flood of fact-based learning to cloud our visions for the types of physicians that we strive to become—a vision that should be rooted in ethics and values. Moreover, since physicians cannot ignore the ways in which social factors influence the health of their patients, it is important that medical students are provided with such opportunities to consider patients’ social contexts and ways in which they can advocate for measures that will benefit the health of their patients. Events such as the BSHAC Summit both empower students to take ownership of their education and provide physicians with opportunities to deepen the interests that shape their unique perspectives within medicine.

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AAP SOMSRFT
Medical Student Subcommittee:

Shannon Brockman
SOMSRFT, Medical Student Subcommittee Chair
University of Florida
shannonebrockman@gmail.com

Aylin Sert
AAP Medical Student News Editor
University of Massachusetts Medical School
Aylin.sert@umassmed.edu

Nan Du – District I Representative
Warren Alpert Medical School of Brown University
nan_du@brown.edu

Genevieve Guyol – District I Asst Rep
Boston University School of Medicine
genevieve.guyol@gmail.com

Chirag Parikh – District II Representative
New York Institute of Technology College of Osteopathic Medicine
cparik02@nyit.edu

Jonathan Witonsky – District II Asst Rep
Albert Einstein College of Medicine
jonathan.witonsky@med.einstein.yu.edu

Ali Mols – District III Representative
West Virginia University School of Medicine
amols@mix.wvu.edu

Joshua Davis – District III Asst Rep
Sidney Kimmel Medical College, Thomas Jefferson University
joshua.davis@jefferson.edu

Rob Sellers – District IV Representative
University of North Carolina School of Medicine
Robert_sellers@med.unc.edu

Sarah Maxwell – District IV Asst Rep
Medical University of South Carolina
maxwelsl@musc.edu

Jennifer Kusma – District V Representative
Ohio State University College of Medicine
Jennifer.kusma@osumc.edu

Rachel Nash – District V Asst Rep
Oakland University William Beaumont School of Medicine
rcnash@oakland.edu

Puja Umaretiya – District VI Representative
Mayo Medical School
Umaretiya.Puja@mayo.edu

Nisha Wadhwa – District VI Asst Rep
University of Chicago Pritzker School of Medicine
nrwadhwa@uchicago.edu

Beverly Patuwo – District VII Representative
 Baylor College of Medicine
patuwo@bcm.edu

Mina Tahai – District VII Asst Rep
University of Mississippi School of Medicine
mtahai@umc.edu

Anne Taylor – District VIII Representative
University of Colorado School of Medicine
anne.taylor11@gmail.com

Natalie Strokes – District VIII Asst Rep
A.T. Still University School of Osteopathic Medicine, Arizona
nstrokes@atsu.edu

Christine Thang - District IX Representative
David Geffen School of Medicine at UCLA
cthang@mednet.ucla.edu

Jennifer Han – District IX Asst Rep
University of California Riverside School of Medicine
jhan037@ucr.edu

Britta Roach – District X Representative
Philadelphia College of Osteopathic Medicine, Georgia Campus
brittanyro@pcom.edu

Sara Kim – District X Asst Rep
Florida International University Herbert Wertheim College of Medicine
skim044@fiu.edu

Sri Kakulavarapu – International Liaison
American University of Integrative Sciences
srikruthi.kakulavarapu@gmail.com

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