We are proud to bring the next edition of our newsletter to the more than 495 SOATT members. Chester has put together another excellent edition which highlights important upcoming meetings, qualitative research in clinical trials, a pediatric device consortia close-up, and Section updates. Of note, we’ll be launching the International Children’s Advisory Network (iCAN) with the 2015 Research Summit in Washington, DC, during the week of June 22nd. This unique and innovative forum will bring together 75 - 150 children advisors, parents, team leaders, and partners from as far away as Australia to learn, interact, and explore ways to provide children and families with a voice in health, medicine, research, and innovation. As always, we encourage SOATT members to become actively involved in the work of the Section and to suggest new ideas and projects that will advance pediatric innovation. Thank you for your passion and dedication to the Section and to children!
From the Editor's Desk
Chester J. Koh, MD, FACS, FAAP
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“Innovation” has become THE buzzword in the healthcare field and especially in the areas of digital health, therapeutics, and medical devices. This also applies to the pediatric healthcare field, but there is still much to be done. However, if you attended one of the recent meetings highlighted in this edition of the newsletter, one would be reassured that new pediatric breakthroughs are just around the corner, and there are many who are actively working to make pediatric healthcare better for the children that have placed their trust in their providers.

While one of my previous mentors had predicted that large conferences would be phased out as the Internet was maturing, it appears that face-to-face and large group meetings still have immeasurable value over video conferences and webinars.

In this edition, we also welcome our colleagues at RTI and their article on patient reported outcome measures which is an important topic in pediatric clinical trials.

This edition of the newsletter also continues the descriptive series on the FDA-funded Pediatric Device Consortia, which provide consulting, project management, and bridge funding for pediatric device projects across the U.S. The Southern California Consortium for Technology and Innovation in Pediatrics, for which I have served as a co-founder, is this month's featured consortium. Dr. Yaniv Bar-Cohen and Jessica Rouset share CTIP’s perspective on the pediatric device development field.

A complete list of the previously described consortia are noted below as well.

We look forward to seeing you at this fall's NCE meeting in Washington DC and especially at the Section's program on pediatric innovation.

We hope that you enjoy reading this edition of the newsletter, and please share it with a colleague, patient, or friend. We welcome all suggestions for articles. It is an avenue of communication for our Section, and for those who share the passion of caring for children and improving our care for children.

Continued on Page 3
Pediatric Medical Device Resource List:

FDA-funded Pediatric Device Consortia (PDC) – a resource for pediatricians, pediatric caregivers, and pediatric specialists in developing their innovative pediatric medical device projects. Available assistance can include consulting, project management, and bridge funding.

Further details can be found in the previous editions of the newsletter at:
(AAP login information required)
or
www2.aap.org/sections/pedsadvances/Newsletters/SOATT_Newsletter_Spring_2014.pdf

Atlantic Pediatric Device Consortium
(Georgia Institute of Technology / Emory University / Children's Healthcare of Atlanta / Virginia Commonwealth University Institute for Engineering and Medicine)
pediatricdevicesatlanta.org

Boston Pediatric Device Consortium
(Boston Children's Hospital / Harvard Medical School)
childrenshospital.org/research-and-innovation/research-initiatives/innovation-acceleration-program

Multidisciplinary Initiative for Surgical Technology Research-Advanced Laboratory (MISTRAL)
(Stanford University / Lucile Packard Children's Hospital / SRI)
mistralpediatric.org

National Capital Consortium for Pediatric Device Innovation
(Children's National Health System / University of Maryland)
innovate4kids.org

New England Pediatric Device Consortium
(Simbex / CIMIT / IPI / Mass General Hospital for Children / Dartmouth University)
nepdc.org

Philadelphia Regional Pediatric Medical Device Consortium
(Children's Hospital of Philadelphia / University of Pennsylvania / Drexel University)
www.PhillyPediatricMedDevice.org

Southern California Consortium for Technology and Innovation in Pediatrics
(Children's Hospital Los Angeles / University of Southern California)
scctip.com

University of California San Francisco Pediatric Device Consortium
(University of California San Francisco)
pediatricdeviceconsortium.org

University of Michigan Pediatric Device Consortium
(University of Michigan)
peddev.org

FDA Pediatric Device Consortia Grants Program
(Office of Orphan Products Development)
fda.gov/ForIndustry/DevelopingProductsforRareDiseasesConditions/PediatricDeviceConsortiaGrantsProgram/
Why Didn’t Anyone Ask Me? Use of Pediatric Patient-Reported Outcomes

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Patient-reported outcome (PRO) is an umbrella term used to describe outcomes collected directly from the patient without interpretation by clinicians or others. PRO data are unique from all other clinical indices and outcomes captured in a clinical trial or clinical practice setting as they are a reflection of the patient experience and provide insight into otherwise unobtainable data on the impact of disease or treatment.

PRO data are collected via standardized questionnaires designed to measure an explicit concept (construct) such as symptoms, activity limitations, functional status, or health-related quality of life. The questionnaires used to collect PROs may also be referred to as instruments, scales, diaries, or checklists depending on their nature and purpose. Collectively, they are referred to as PRO measures (PROMs).

In recent years, there has been increased regulatory scrutiny regarding the development, validation, and use of such tools in a clinical trial setting. Specific guidelines and quality parameters for the use of PROMs are described in detail in the Food and Drug Administration (FDA) PRO guidance for the industry: Patient Reported Outcome Measures: Use in Medical Product Development to Support Labeling Claims. (FDA, 2009). These guidelines encourage the development of content-valid, fit-for-purpose measures. Content validity refers to the “extent to which an instrument contains the relevant and important aspects of the concept it intends to measure” (FDA, 2009) and is assured by direct patient input into the development of a measure through the use of cognitive interviews or focus group discussions. Such qualitative research must be conducted with rigor to avoid interviewer bias and inconsistent data quality and enhance participant cooperation, motivation, and understanding. Several different procedures and techniques may be employed in the course of a cognitive interview, including think-aloud interviewing, verbal probing techniques, concurrent versus retrospective review, and other methods employing vignettes and card-sorting techniques. Fit-for-purpose measures are those deemed to be suitable for use within a particular context and/or population. Cognitive interviews also provide insight into whether a measure is fit-for-purpose by enhancing understanding of the question/answer process, including interpretation of the item and selection of appropriate response, as well as the relevance and importance of the concepts to a particular population.

Changes in legislation over the past several years have led to an increase in the conduct of pediatric clinical trials. The Pediatric Exclusivity Provision of the Best Pharmaceuticals for Children Act (BPCA) provides for an additional 6 months of marketing exclusivity for products under study, and the Pediatric Research Equity Act (PREA) allows the FDA to require pediatric studies if it is determined that the product is likely to be used by a considerable number of pediatric patients or if the product would offer an important advantage to pediatric patients over existing treatments (Varni, 2007). Additionally, while the FDA PRO guidance acknowledges the importance of PROMs in pediatric populations and applies the same level of standards for development, it does not provide specific recommendations to address the challenges of developing tools for use in this younger population. A working group convened by the International Society for Pharmacoeconomics and Outcomes Research (ISPOR) sought to address the key criteria for appropriate pediatric PROM development. These criteria include determination of age for recommended self-report, establishing content validity and utilizing children as experts, determination of the appropriate reporter of information for a child (self- vs. proxy-report), instrument design to facilitate accurate reporting (i.e., form design, electronic vs. pen and paper), and cross-cultural differences (Matza et al., 2013). Cognitive interviews typically provide the necessary insight to address these key criteria; however, cognitive interviewing can be a challenging prospect under ideal conditions but even more so in special populations such as pediatrics. Some standard methods may lose utility under certain circumstances. For example, a think-aloud approach in a pediatric population may prove difficult because it often requires long periods of sustained attention. In addition, Continued on Page 5
children may lack the ability to clearly articulate their experiences, relying on colloquial terminology and requiring special probing and attention to fully grasp the participant’s meaning (de Leeuw et al., 2004 and Willis, 2005).

Attention must be paid to the developmental stages and cognitive abilities of the individual children planned for interview, as procedures that are appropriate for children at one developmental stage may not be appropriate for those at another developmental stage. The American Academy of Pediatrics website (American Academy of Pediatrics, 2015) defines developmental stages as follows:

- Infancy (prenatal to 1 year)
- Early childhood (1-4 years)
- Middle childhood (5-10 years)
- Adolescence (11-21 years)

“These categories are fairly expansive, especially when considering the educational and emotional development of children in these stages. When developing a guide for the conduct of pediatric interviews, it is important to understand an interview participant’s academic level and the general curriculum for children at that educational level so that questions, tasks, and probes are designed appropriately (de Leeuw et al., 2004). Careful consideration will enhance the interviews as it is much easier for the interviewer and less frustrating for participants when the vocabulary and tasks presented are age-appropriate and comprehensible. Overall interview length is also important to consider as the attention span of a younger child is vastly different from that of an older child. These initial considerations will help provide more meaningful and useful qualitative data.

The ISPOR taskforce suggests that children aged 5 and above are most likely capable of some level of self-report. Although self-report instruments have been designed to be completed by children younger than 5 years, there is no clear evidence of reliability or validity of self-report measures in this age group (Matza et al., 2013). The age recommendation for self-report must be considered with respect to the data that need to be captured, the individual needs of the population of interest, and the difficulty of completing questionnaires or diaries in clinical research or practice. In very young children, observer-reported measures provide the most accurate input but are limited in that they may only assess events or behaviors that can be directly observed and cannot intuit feelings (e.g., symptoms such as sensations or a mental state) or more complex constructs such as health-related quality of life.

Despite the challenges of developing self-report measures in children, pediatric PROMs play a key role in furthering the understanding of disease impacts and in improving health outcomes. Pediatric PROMs in clinical trials and clinical practice may help reduce underestimation of psychosocial or functional disabilities by allowing physicians greater insight into the patient experience (Varni, 2005). In certain disease areas and conditions, the absence of a self-report measure could limit the ability to fully understand the impact and/or treatment experience from the patient perspective. Thus appropriate development and administration of pediatric PROMs may help even the smallest of voices be heard.

References
Southern California Pediatric Device Consortium

Editor's note: This article continues the series of descriptions of the FDA-funded pediatric device consortia at several children's hospitals across the U.S. The other consortia were described in previous editions of this newsletter - https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/soatt/Pages/newsletters.aspx (AAP login information required)
or www2.aap.org/sections/pedsadvances/Newsletters/SOATT_Newsletter_Spring_2014.pdf

How the Pediatric Device Consortia are Changing the Odds – the Southern California Consortium for Technology and Innovation in Pediatrics (CTIP) Perspective

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Transformative technologies can greatly impact pediatric care. Not only is technology key to providing cutting-edge care to children with complex disease, it can change the way care is delivered throughout the world. A commitment to developing technology for children can potentially lead to solutions that benefit both the sickest and the neediest.

Unfortunately, the specific needs of children have too often been overlooked by technology development companies because of insufficient returns to justify investment, in even exceptional product concepts. This is due to the relatively small populations affected with rare pediatric conditions as well as the perceived low profit potential when more common conditions are targeted in needy children.

This gap in developing technologies and medical devices for children has been recognized by the United States Congress and efforts have been underway to address the problem. To help incentivize medical device developers to invest in pediatric technologies, the U.S. Food and Drug Administration (FDA) launched the Pediatric Device Consortia program in 2009. In 2013, the Southern California Consortium for Technology and Innovation in Pediatrics (CTIP) was included as one of seven national, FDA-supported consortia.

The 2013 funding cycle distinguished itself from previous cycles by requiring its awardees to assist innovators beyond the walls of their own institutions. This requirement was intended to maximize opportunities to assist pediatric device developers and increase the chances for commercialization success.

For CTIP, this requirement has catalyzed our ability to collaborate across multiple institutions and companies to advance pediatric innovation. We have established a network of physicians, nurses and other caretakers beyond our core institutions, Children's Hospital Los Angeles (CHLA) and the University of Southern California (USC) with active engagement from other medical centers including Kaiser Permanente, the University of California, Los Angeles (UCLA) and Texas Children's Hospital to name a few. In addition, CTIP assists many start-ups that have spun out of academic institutions in Southern California and beyond.

Continued on Page 7
Through these outreach efforts, a community of pediatric innovators is converging around a common passion for delivering creative technological solutions to pediatric patients. A culture of innovation is in motion and is galvanized by a growing sense of confidence that the challenging legacy of lackluster pediatric device commercialization can be overcome. For meaningful progress to occur toward the development of valuable medical devices for children, however, our industry partners’ perceptions of pediatric markets must undergo a profound shift. It is incumbent upon us, the Pediatric Device Consortia, to convince our industry partners that pediatrics is a rich opportunity for collaboration, investment and success. While changing such perceptions is far from easy and will take time, CTIP has begun to tackle this in a number of ways.

1. Engaging a Community of Innovators

We provide companies and academically based technologists with opportunities to explore pediatric applications of their technologies by engaging an audience of subspecialists and hospital administrators during our Med-Innovation Rounds. These Rounds enable collective discussion and brainstorming on how to adapt developing technologies towards pediatrics, and have resulted in a number of successful collaborations. In addition, we host larger events that highlight pediatric innovation and bring together hundreds of attendees including engineers, clinicians, researchers, entrepreneurs, investors, students and hospital staff. In 2014, our CTIP symposium titled “A New Era in Pediatric Innovation: Smarter Technologies for Unique Patient Needs” covered three topics: growing up in the genomic era, therapeutic and diagnostic gaming, and 3D printing. In 2015, our CTIP symposium titled “Dr. CPU: Is Machine Learning the Final Frontier?” will bring together industry players in artificial intelligence and machine learning with clinicians, behaviorists and ethicists to understand how computing will change the future of pediatric care. We believe that by engaging pediatric clinicians and engineers with entrepreneurs and inventors, we can build a community of innovation in our region with a focus on pediatric device development.

2. Developing a Successful Portfolio through a Focus on Commercialization

In order to reach promising pediatric device development teams, CTIP relies on word-of-mouth referrals, networking and referrals from academic institutions’ technology transfer offices (TTOs). CTIP is operated through the Center for Innovation at CHLA (formerly CHLA’s Office of Technology Transfer), and a commercialization focus is emphasized from the onset in the appraisal of pediatric device opportunities. Not surprisingly, pediatric-focused technologies developed at academic institutions often take a back seat to adult-focused devices when it comes to efforts and resources offered by the TTO. CTIP can provide TTOs no strings-attached services to help their innovators commercialize pediatric technologies, in some cases providing them a lifeline by helping overcome lack of experience getting pediatric projects off the ground, especially those targeting rare populations. In its first year of operation, CTIP advised 35 distinct pediatric device project teams.

3. Defining a Clear Value Proposition

The projects in our portfolio compete for the same external funding as technologies at similar stages of development which target adult markets. Therefore, we must approach investors and licensees with a deep and validated understanding of the market drivers and regulatory requirements in order to overcome their typical reservations about pediatric markets. Significant due diligence along with a creative and strategic mindset enable us to determine the full market potential of a particular pediatric technology. To underscore this style and approach, we have launched an Entrepreneur in Residence (EIR) program that invites experienced entrepreneurs to work collaboratively with our teams to articulate the product's value proposition. Without a clear demonstration that these opportunities have the potential to generate revenue, even the best idea is unlikely to make any headway due to the clearly recognized complexity of navigating device development. Therefore, establishing the health economic benefit, sizing the potential markets and understanding the drivers of clinical adoption are essential early steps in our evaluation of a novel pediatric device. CTIP empowers its EIRs to quickly tease out a technology's value proposition by gaining rapid access to CTIP's established network of clinical, technical, regulatory and business advisors.

Our strategy at CTIP is to pair seasoned entrepreneurs with domain area experts that have both deep expertise and a

Continued on Page 8
personal commitment to advancing the pediatric market. We believe that this combination of know-how and passion will be the key to achieving our goals.

Given the limited financial success stories in pediatrics to point to, any pediatric device – particularly early-stage devices – will need a convincing value proposition and risk assessment to compete in the challenging medical device landscape. We now are able to efficiently gain those critical market insights by tapping our growing engaged community of clinicians and technologists, and the rich network of entrepreneurs and investors from San Diego to San Francisco and beyond. Catalyzed by the FDA's Pediatric Device Consortia program, a uniquely collaborative model for research, development and commercialization is emerging, which we believe will profoundly improve the odds for advancing pediatric innovation.

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**How the Pediatric Device consortia are Changing . . . Continued from Page 7**

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**Brief Meeting Reports from Europe**

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Two meetings were recently held in Europe that focused on the development of pediatric therapeutics that may be of interest to SOATT members.

The Paediatric Drug Development Conference was held in Budapest, Hungary on Oct 28-29, 2014. First day speakers included a Hungarian member of the EMA's CHMP and pediatric committee (PDCO) Agnes Gyurasics, MD, PhD who gave a regulatory (EMA) perspective on pediatric trials and the EMA Scientific Officer Peter Karoyli, MD who presented an update on the EC Guideline on the format and content of pediatric investigational plans (PIPs). Practical, operational challenges in conducting pediatric trials were discussed by Dr. Frank Verheggen, Clinical Program Management Director at Astellas Pharma Europe. The opportunities for pediatric devices was illustrated by a presentation on acute care neonatal aerosol drug delivery given by John Power, Chief Executive & Managing Director, Aerogen Ltd and a presentation on “The Rare Disease Bonanza” by Martin Austin, CEO, TransformRX. I (Philip D. Walson, MD, FAAP) gave a presentation entitled “From research to bedside: challenges for academic researchers” summarizing some academic drug and device successes and failures and Jane Lamprill, RN, RSCN, FICR summarized the ethical barriers and the need for smoother pediatric clinical research review processes. The second day started with a presentation by Elin Haf Davies on the need for parent/patient involvement in the process. Otto Skoran, MD; CEO; Svabhegy Children's Hospital then summarized the state of pediatric trials in Hungary, Miklos Garami, MD, a pediatric oncologist at the Sammelweis University Hospital described the Hungarian Pediatric Oncology Network of Excellence, and finally Wouter Wijker, PhD gave a presentation on the future of pediatric clinical research from the perspective of a Hungarian CRO.

The meeting was held in the historic Hungarian Academy of Science building in the beautiful center of Budapest. There was ample opportunity for networking and interactions between speakers and attendees as well as a wonderful social program including a dinner on the Danube.

Paediatric and Rare Diseases Drug Development: the Way Forward was held at the University Children's Hospital in Basel (UKBB), Switzerland on Feb 3-4, 2015. The conference was hosted by John van den Anker, MD, PhD Co-Director of the newly established Paediatric Pharmacology and Pharmacometrics Research Center at UKBB, and Klaus Rose, MD, CEO klausrose Consulting, Pediatric Drug Development & More, Basel, Switzerland. The meeting was opened with a welcome followed by Dr. Conrad E. Müller, CEO UKBB who gave a short history of the Center and its funding by the Eckenstein-Geigy Foundation. Dr. Koenraad Norga from Belgium who is Vice-Chair of EMA's PDCO then summarized his view as a regulator of the achievements and limitations of the current European pediatric legislation. Dr. Klaus Rose then presented a rather critical assessment of the EU pediatric legislation. I then discussed the academic challenges involved in moving from bench to bedside and some factors that limit the ability of academic investigators to actually develop pediatric drugs and devices and Dr. van den Anker gave an overview on Clinical Pharmacology and the need for better medicines for children. Martin Austin; CEO, TransformRX then presented the case for the de-demonization of commercial drug development:

*Continued on Page 9*
why more entrepreneurs are needed and how to do this and Carlos Camozzi; Orphazyme, DK gave a presentation on the limitations and challenges of gene therapy in the pediatric population. After these presentations attendees were divided into groups to discuss suggestions for a) how to improve the EU pediatric legislation, b) which incentives are needed for development of orphan and pediatric drugs, c) how the academic system could produce more and better direct bedside therapy, and d) how to deal with the problems of developing pediatric drug formulations. Summaries of these breakout group discussions were then presented and discussed by all participants followed by an open discussion of charity funded research. The first day was concluded by a panel discussion that included a controversial and open discussion of potential positive and negative outcomes of the EU pediatric legislation.

The second day of the conference started with a presentation by Christina Bucci-Rechtweg, MD from Novartis of how big pharma views the EU pediatric legislation and pediatric drug development followed by a presentation by Dr van den Anker on pharmaceutical challenges in neonatology. John Power, Chief Executive & Managing Director, Aerogen Ltd then discussed the possible use of neonatal aerosol drug delivery to administer acute care medications. Natalie Seineuret described how the Innovative Medicine Initiative (IMI) was fostering collaboration to address pediatric drug and device development challenges and Frank van den Ouweland, MD, PhD discussed how SwissMedic was working to improve pediatric drug development. Finally, Dr. Stefan Rose-John described the development of agents to selectively block soluble interleukin-6 receptors for the treatment of juvenile idiopathic arthritis as an promising example of a potentially successful pediatric drug development program.

The meeting was held in the new UKKB in the center of Basel. There was ample opportunity for networking and interactions between speakers and attendees as well as with the children’s hospital staff. Selected presentations from the conference will be available as a future, special edition of the journal Children (see http://www.mdpi.com/journal/children/special_issues/Paediatric_Rare_Diseases).

Potential Conflict of Interest Disclosure: I helped organize and (as described above) spoke at both of the meetings discussed.
Innovation in Pediatric Health Care and Children's Hospitals: Current State-Of-the Art and Future Directions

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Nothing can stop an idea whose time has come.
-- Victor Hugo, French poet and novelist

Introduction

The word innovation is derived from the Latin noun innovatus, meaning renewal or change. Although companies such as Google and Apple are nearly synonymous with innovation, virtually all sectors in our current lives are imbued with yearn for innovation. This has lead to organizational focus on innovative strategies as well as recruitment of chief innovation officers and teams in many organizations. At times the word innovation seems like a cliché as there are now more than 5,000 books in print with the word “innovation” in the title.

More recently, innovation has garnered significant attention in health care. The future of health care has to innovate on a large scale in order to deliver sustained value for an overall transformative care. To date, there are no published reports on the state-of-the-art in innovation in pediatric health care and in particular, children's hospitals. This report will summarize the progress of pediatric innovation to date.

Pediatric vs Adult Innovation: Differences and Possible Solutions Differences

There are five distinct differences between adult and pediatric health care innovation with possible solutions:

Less Innovation Activities in Hospitals: According to the American Hospital Association, there are many more adult hospitals with significant innovation activities than children's hospitals. In the U.S., there are 5,686 hospitals of which only about 200 are pediatric centers (or about 3.5%). This vast difference may turn out to be an advantage for pediatric hospitals as the logistics of forming an innovation coalition may be more feasible.

Smaller Market Share: Pediatric patients have a much smaller share of the market for health care resources (it is estimated to be about 6%). This deficit in resources hinders research and development for this smaller population. One possible solution is to convince policymakers as well as industry that research and development for children can have adult dividends. In addition, parent advocacy groups along with pediatric subspecialists and pediatricians can collaborate to promote pediatric innovation efforts.

Large Age and Size Range: Pediatric patients range tremendously in both age and size, from the in utero fetus to the adult with pediatric disease (such as adults with congenital heart disease). This wide range in both age and size creates a daunting challenge in innovation areas, particularly medical device development. Again, miniaturization of such devices may be directly beneficial for adult patients as well.

Rare Diseases: Pediatric patients have more undiagnosed diseases than adult patients, who often are afflicted with diseases that are related to poor health habits (such as smoking, overeating, etc.). These rare diseases have relatively small numbers even in multi-institutional collaborations and create research and development voids.

Parental Advocacy: Pediatric patients, in addition to themselves, have powerful advocates in their parents. Parents can often affect policy change in health care, as exemplified recently by the pulse oximetry screening mandates in various states.

Continued on Page 11
Innovation in Pediatric Health Care: Current Status

The following is a brief summary of the significant activities to date in the realm of pediatric innovation:

The Pediatrics2040: Trends and Innovations in the Next 25 Years Symposium (October, 2013, in Anaheim, CA). This inaugural meeting on all aspects of pediatric innovation gathered over 400 attendees from close to 100 pediatric institutions. The curriculum was a comprehensive review of the pillars of medical innovation with some highlights from the various subspecialties. There is ongoing planning for the next meeting in early 2016.

The Pediatric Innovation Leadership Forum (June 2014, in Dana Point, CA):

The leadership in pediatric innovation that gathered for the above meeting reconvened in June of 2014 to better acquaint with each other and to share experiences and insight. Centers and programs were initially queried on the Internet with several search engines and yielded a list of more than 20 pediatric centers around the world with significant innovation activities. The 21 pediatric institutions also included four from cities abroad: Barcelona, Rome, Toronto, and Shanghai. The two-day agenda included individual hospital presentations on their innovation history and projects as well as several round tables on all aspects of innovation.

During this gathering, an alignment optimization project was executed with several significant findings: 1) the single most important element agreed upon by the innovation leaders was to achieve multi-institutional collaboration; 2) most of the centers represented resembled the innovation mindset of the California centers (5 were represented) and the Northeastern U.S. centers were found to be more conservative in innovation elements.

Other Pediatric Innovation Meetings: Other important meetings during 2013 that had a focus on pediatric innovation included the annual Pediatric Surgical Innovation meeting sponsored by Children's National Medical Center in Washington DC as well as the annual Pediatric Innovation Summit sponsored by Boston Children's Hospital in Boston.

Innovation in Pediatric Health Care: Future Directions

With this inexorable enthusiasm and esprit de corps from the pediatric innovation leadership group, several future activities and strategies are being discussed and organized:

The international Society for Pediatric Innovation and Intelligence (iSPI): The leadership group has had frequent and active discussions amongst the members about forming a coalition or society to promote innovation activities in pediatric health care in both children's hospitals and pediatric primary care. The group has also advocated a concomitant promotion of data science and artificial intelligence in this innovation effort.

Collaboration with Other Organizations: Both Institute for Pediatric Innovation (IPI) and Network for Excellence in Health Innovation (NEHI) have consolidated their innovation efforts and there are plans for a joint meeting of the aforementioned nascent iSPI group with this IPI/NEHI group in June of 2015 at the Health Care Innovation Summit in Chicago. (http://www.healthcareinnovationsummit.org/)

Additional Pediatric Innovation Strategies: Future collaborative endeavors will also involve both the Children's Hospital Association (CHA) and the American Academy of Pediatrics (AAP).
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Sheikh Zayed Institute for Pediatric Surgical Innovation
Part of the Children's National Health System
Meet the iCAN / KIDS Staff:

Nick Frederico (iCAN Coordinator)

I am an aspiring medical student who just graduated with a Biology degree from the University of Connecticut in Storrs, CT (December ’14). Before I went to UConn, I earned a Bachelor's degree in Aeronautical Science from Embry-Riddle Aeronautical University in Daytona Beach, FL (class of ’12). Right after graduation, I took a job as an intern in the corporate flight department of a large energy company in Charlotte, NC. I really enjoyed that job, but by then I had already made up my mind to pursue a career in medicine, so I applied to UConn while I was in North Carolina and started taking prerequisite classes as soon as my internship ended. I’ve been carving my own, unique path to medical school since then. Even though I’m no longer pursuing a career as a pilot, I still have a passion for aviation and I continue to fly recreationally in small aircraft.

I started working with iCAN in the beginning of January 2015. The breadth of the network impressed me when I first took on the job, and I continue to be impressed as I see new possibilities for growth and collaboration every day. Outside of work, I am an EMT with the volunteer fire department where I live, in a small town in Connecticut. Lately much of my remaining free time has been devoted to studying for the MCAT which I am taking in May. I’m happy to chat with anyone about the iCAN network or anything else, so please feel free to contact me any time: nick.icanresearch@gmail.com or 860-977-9206.

Hayleigh Thompson

Hadleigh is the Development Intern for iCAN. Hadleigh is a junior at Mother of Divine Grace School (Connecticut) and has been very active in growing both the KIDS and iCAN projects from their inception. Hadleigh is also the President of the KIDS Connecticut Team. As an intern, she will be assisting Nick and other leaders across the consortium to move iCAN to the next level. Hadleigh can be reached at DevelopmentIntern@icanresearch.org.

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We’re New and Need You!

How to Join . . .

It’s easy! There are NO DUES to join the SOATT.

Send an e-mail to Jackie Burke at jburke@aap.org to request to be added to the Section.

Also, please see the Message from the Membership Committee on page 18 for more information.
KIDS Update
Nick Frederico
iCAN Coordinator
nick.icanresearch@gmail.com

KIDS stands for Kids and Families Impacting Disease through Science. KIDS is an advisory group of children, young adults and families focused on understanding, communicating and improving medicine, research and innovation for children. The program is a collaboration between local AAP chapters, children's hospitals, schools and the AAP Section on Advances in Therapeutics and Technology. Since its inception in 2013, KIDS has established chapters in Connecticut, Georgia, Missouri, Ohio and Utah, and there are more chapters on the way in Illinois, D.C., Indiana, Florida, Michigan, New Jersey, New York and Houston.

In addition to its broad presence in the United States, KIDS is expanding internationally to Australia, France, Italy, Spain, and Germany. KIDS also collaborates with Young Person Advisory Groups in the U.K. and Scotland as well as the KIDSCan group in Toronto, Canada. To keep such a large international presence in order, we have developed the International Children's Advisory Network, or iCAN. This network has been slowly rolled out over the past few months, but it will officially launch in June 2015 at the first annual iCAN Research Summit in Washington, D.C.

The purpose of this event is to allow the iCAN members to meet one another and generate excitement about moving the network forward, as well as to begin collaborating as a team. The Summit will be attended by 100 - 150 KIDS members, parents and team leaders. There will be a kickoff and team-building session, then the kids will tour the Children's National Medical Center and take part in interactive activities there. The following day, the teams will meet with representatives from the FDA, EMA, Health Canada and NIH. Then, they will learn about legislative processes related to clinical trials. Their third and final day will be spent on Capitol Hill meeting with representatives from NORD, NCD Child, and the AAP Federal Affairs. The kids will write invitations to their Senators and Representatives to meet them at a reception in the Capitol Visitor Center, then they will tour the Capitol and return to the hotel for a final closing ceremony which the kids will be planning themselves.

Here is a glimpse of the exciting things KIDS has been up to:

• First Annual iCAN Research Summit to take place in Washington, D.C. June 22-26, 2015
  ○ International Children's Advisory Network (iCAN) official launch
  ○ Attended by 100 - 150 children, parents, and KIDS team advisors
  ○ Engaging, interactive sessions with one another, regulatory bodies, researchers, hospitals, non-profit and legislative bodies

• New iCAN Coordinator, Nick Frederico began working with the network in January 2015. Major responsibilities include:
  ○ Planning for the 2015 iCAN Launch and Summit in Washington, D.C.
  ○ Standardization across the network
  ○ Meeting with researchers and developers to plan consults with KIDS teams

• New iCAN Development Intern, Hadleigh Thompson, who is also the President of KIDS Connecticut, began working with the network in January 2015. She is working on:
  ○ Integrating KIDS teams into My Big Campus, an online learning community to house all of the organizations in the network and communicate across the network
  ○ Working on developing an iCAN Newsletter between teams

• Abstract accepted at ESPR and PAS - “Assent in Pediatric Clinical Trials: An International Children's Advisory Network (iCAN) Survey”
  ○ Based on research conducted by KIDS members at previous conferences

• 2015 PAS Annual Meeting in San Diego, CA - KIDS members from CT, MO, GA and OH will work together to staff a booth

Continued on Page 15
The International Children's Advisory Network is an exciting initiative with limitless possibilities. KIDS chapters are being established at an extraordinary rate, and their members are already beginning to realize the benefits of being part of this unique program. They are participating in high-profile events and providing a voice for children in research and medical innovation across the globe. KIDS objectives include:

- Learn, teach and advocate for medicine, research and innovation that improves the health and well-being of children and young adults
- Collaborate on projects and consult with hospitals, researchers, and others
- Provide input on research ideas, innovative solutions, and unmet pediatric needs
- Contribute to the design and implementation of clinical studies for children and young adults (e.g., assent, monitoring tools, schedules, etc.)
- Serve as a critical voice for children, young adults and families in the medical, research and innovation processes

KIDS membership normally includes children and young adults age 8-18 years, and their families, who have an interest in medicine or research, experience being in a clinical trial or using hospital services, or who have a chronic medical condition.

For more information about the iCAN network or KIDS teams, please visit icanresearch.org. If you have any questions or would like to start a local KIDS team, please email info@icanresearch.org
Thank you, Charlie. And thanks to the Section on Advances in Therapeutics and Technology. I am deeply appreciative of this honor. And I realize how truly fortunate I have been in my career. 40 years of experience in academic pediatrics and clinical pharmacology, the pharmaceutical industry, and at the FDA has provided a great deal of perspective. I can honestly say that I have experienced miracles during my brief time in pediatric therapeutics, remarkable advances in our understanding of the pathogenesis of disease, and conversion of that knowledge into real world treatments. Imagine the AIDS epidemic if it had begun in only 50 years before 1981; there were missteps, tragedies, and yet we were able to figure out the cause, develop drugs to treat it, and in perhaps the only true miracle of the ongoing epidemic, to prevent vertical transmission from mothers to newborns. Yes, we saw perhaps the most rapid advance of therapeutics down to our smallest, most vulnerable patients. And now we are seeing targeted therapies for a wide range of diseases, from cancer to cystic fibrosis. I remember how wise we felt when we changed the name “mucoviscidosis” to cystic fibrosis; I also remember being in the elevator at Hospital for Sick Children in Toronto with Dr. Lap-Chee Tsui, when he told me they had “found” the CF gene. I see with joy our son, David, now in his pediatric pulmonary fellowship having tools to treat CF that were but a dream when I began my time in pediatrics. And so much more. International legislative and regulatory initiatives to drive pediatric medical product development, pediatric advocates in all critical aspects of the process- academia, industry, regulatory agencies, and the encouraging and wise rise of patient/family advocacy to keep our focus where it needs to be, on children in need. Having been a witness to all this, and to help play a small part to the evolution of medical science and improved lives for our patients has been more than reward enough. Your recognition is a tribute to all who have worked so hard and long in this field, and I hope an inspiration to those who will carry this joyful task forward.

Stephen P. Spielberg, MD, PhD
Session Description/Objectives: This abstract and research session will cover research topics in the areas of pediatric innovation, therapeutics and technology. The program will also include the inaugural Section Award for Innovations in Pediatrics.

Proposed day: Monday, October 26, 2015
Noon – 2 PM

Noon – 12:05 PM       Welcome
12:05 – 12:40 PM      Top Three Research Paper Presentations (podium)
12:40 – 1 PM          Section Award Presentation
1 – 2 PM              Research Poster Q&A and reception
2 PM                  Adjourn

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If you are interested in joining the Listserv,
email tcoletta@aap.org
A Message from the Membership Committee

Seth Toback, MD, MMM, SOATT Membership Committee Chair

I am pleased to announce that since our last newsletter of this year our section has grown to 495 members. We are one of the few sections in the AAP that are currently growing in size and we have you to thank for it. Our grass roots membership campaign is really getting the word out about our section. Our number of affiliated members also continues to grow with 13 members from diverse backgrounds such as non-AAP medical doctors, PhDs and PharmDs. Thank you for discussing the section with your colleagues and co-workers and sharing our newsletters with potential new members.

Who Can Join?

Membership in the section is open to Fellows, Specialty Fellows, Candidate Members, Post Residency Training Members, Honorary Fellows, Emeritus Fellows, and Corresponding Fellows with an interest in advances in therapeutics and technology. Also now any Affiliate Member can join. Affiliates are those who are not eligible for membership in the AAP and hold a Masters degree or Doctorate (or equivalent) in pharmacy or other health science concentration. Affiliates must submit an application and have a signed letter of support from an AAP fellow in good standing. There is no fee to join the Section as a regular member and a $40 fee for affiliate members.

How To Join

If you are already a member of the AAP and would like to become a SATT member, join online by:

1. Going to Member Center of the AAP website and use your AAP login and password.
2. Click on “Join a Section or Council” under Member Community
3. Choose “Advances in Therapeutics and Technology”, answer a few questions, and click “Submit”.

Membership applications can be found at:

Members: http://www.aap.org/moc/memberservices/sectionform.cfm

Affiliates: https://fs25.formsite.com/aapmembership/affiliate/secure_index.html

If you have any questions about membership please contact Seth Toback, MD, FAAP at Seth.Toback@gilead.com or staff at jburke@aap.org.
Welcome New Members
(August 2014 to March 2015)

Samer Abu-Sultaneh, MD, FAAP
Amina Ahmed, MD
Fadiah Salman Alkhattabi IV, MD
Yossef Alnasser
Farranaz Alvarez Nunez, MD
Ronald L. Ariagno, MD, FAAP
Jeffrey R. Avner, MD, FAAP
Onsy S. Ayad, MD, FAAP
J. Randolph Bak, MD, FAAP
Krisztina Judit Balazs, MD, FAAP
Cristy Lynn Baldwin, MD, FAAP
Greg Alcantara Barretto Jr., MD, MS, FAAP
Alsan James Bellard Jr., MD FAAP
Kristin Ann Benson, MD, FAAP
John W. Berkenbosch, MD, FAAP
Abhik Kumar Biswas, MD, FAAP
Benjamin T. Black, MD, FAAP
Kathryn Bohannon
Grace Brouillette, DO, FAAP
Oscar ‘Skip’ Wharton Brown III, MD, FAAP
Bryan L. Burke Jr., MD, FAAP
Gina Marie Calarco-Smith, RN, MPH
Teresa de Jesus Carrion, MD
Ashley Case, MD
Jose L. Castaneda, MD
Brian Martin Cavagnari, MD, PhD
Valerie E. Charlton, MD, FAAP
Benjamin Choi, MD, FAAP
Enrique G. Cifuentes, MD, FAAP
Margaret Bradley Clarke, MD, FAAP
Joel Brian Cochran, DO, FAAP
Reuben Cohen, MD, FAAP

Andrew Jordan Collins, MD, FAAP
Katharine Suzanne Cox, MD, FAAP
Jeanne Annette Craft, MD, FAAP
Paul Herbert Dahm, MD, FAAP
Scottie Brian Day, MD, FAAP
Peter J. Di Rocco, MD, FAAP
Fatmeh Diab, MD, FAAP
Gina M. Dieudonne, MD, FAAP
Parvin C. Dorostkar, MD, FAAP
Kevin Dufendach, MD, FAAP
Susan Jane Duffy, MD, FAAP
Charles J. Dunn Jr., MD, FAAP
Gabriela Maria Echenique Subervi, MD
Guliz Erdem, MD, FAAP
Laura Farach, MD, FAAP
Erin R. Stucky Fisher, MD, FAAP
Prem Fort, MD, FAAP
Brandy Bromagen Fouch, MD, FAAP
Mary Fraga, MD
Anne B. Francis, MD, FAAP
Wayne H. Franklin, MD, MPH, MMM, FAAP
Lourdes M., Frau, MD, FAAP
Janet Hope Friday, MD, FAAP
Roger John Garceau, MD, FAAP
Deborah Marie Ghazoul, MD, FAAP
Sean Patrick Gleeson, MD, MBA, FAAP
Jonathan Goldenthal, MD, FAAP
Jose Luis Gonzalez, MD, JD, MSEd, FAAP
Carol Joy Green, MD, FAAP
Bram Greenberg, MD, FAAP
Hermila Tavares Vilar Guedes, MD

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Welcome New Member  Continued from Page 19

Robert Carl Gunther, MD, MPH, FAAP
Vineet Kumar Gupta, MD, FAAP
James Hobart Hanson, MD, FAAP
Noel Rebecca Harbist, MD, MPH, FAAP
Bradford D. Harris, MD, FAAP
Sara A. Hasan, MD
Mark Haupt, MD, FAAP
Wendy Henriquez, MD
Hector L. Hidalgo, MD, FAAP
Shane Philip Hoffman, MD, FAAP
Melissa Peta Holmes, MD, FAAP
Claudia Keidl Hoyen, MD, FAAP
Sonia Obermeyer Imaizumi, MD, FAAP
Carden Johnston, MD, FRCP, FAAP
Melissa Jones, MD, FAAP
Steven William Kairys, MD, MPH, FAAP
Sonal Kalburgi, MD, FAAP
Daria Manouso Karos, MD, FAAP
Jessica Haran Katznelson, MD, FAAP
Priyanka Kaul, MD, FAAP
Karen Cecilia Keough, MD, FAAP
Steven Killough, MD, FAAP
Eric Steven Kirkendall, MD, MBI, FAAP
Thomas A. Lacy, MD, FAAP
Carla Magnolia Laos, MD, FAAP
Tracy Lynn Lawrence-Black, MD, FAAP
Russell Clark Libby, MD, FAAP
Donald E. Lighter, MD, MBA, FAAP
Euldricka Bernadine Lindsay-O’Reggio, MD, FAAP
Sandra Leticia Lopez, MD
Lia H. Lowrie, MD, FAAP
Jennifer Ann Lowry, MD, FAAP
Angela Kumari Lumba-Brown, MD, FAAP
Gregg C. Lund, DO, FAAP
Kristin D. Lynch, DO
James Paul Marcin, MD, MPH, FAAP
Michael Scott Martin, MD, FAAP
Hilary McClafferty, MD, FAAP
Susanna A. McColley, MD, FAAP
Elizabeth Meade, MD, FAAP
Brock Harrison Medsker, MD, FAAP
Carmen Rafaela Mejia-Carvajal, MD, FAAP
Andrew Duncan Joseph Meyer, MD, FAAP
Genevieve Celine Michaud, MD
Karl Migally, MD, FAAP
Melvin Medina Mingoa, MD
Vicki Lee Montgomery, MD, FAAP
Claudia Regina Morris, MD, FAAP
Mohammed Najjar, MD, FAAP
Polya I. Ninova, MD
Mara Elida Nitu, MD, FAAP
Corina Noje, MD, FAAP
Natan Noviski, MD, FAAP
Anne-Claire Paquet-De Varennes, MD
Robert C. Pascucci, MD, FAAP
Anand Champak Patel, MD, FAAP
Faisalmohumed N. Patel, MD, FAAP
Robert Fraser Patterson, MD, FAAP
Christopher B. Peltier, MD, FAAP
Toni M. Petrillo-Albarano, MD, FAAP
Joseph Piacentine, MD, FAAP
Melissa Bays Porter, MD, FAAP
Kevin Powell, MD, PhD, FAAP
Puthenmadam Radhakrishnan, MD, MPH, FAAP
Jose Ramirez, MD, FAAP

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<table>
<thead>
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<th>Welcome New Member Continued from Page 20</th>
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| Brooke Ballantine Redmond, MD |
| Luis Antonio Reyes, MD |
| Robert Thomas Rohloff, MD, FAAP |
| James S. Roloff, MD, FAAP |
| Sarah Delores Ryan, MD, FAAP |
| Elizabeth (Tess) Vickers Saarel, MD, FAAP |
| Denise A. Salerno, MD, FAAP |
| Nadine Tenn Salle, MD, FAAP |
| Janet Lynn Schairer, MD, FAAP |
| Gail Ann Schonfeld, MD, FAAP |
| Charles Alexander Scott, MD, FAAP |
| Daniel J. Sedillo, MD, FAAP |
| Esam Fathy Ibrahim Sefein, MD |
| William Selby, DO, FAAP |
| Gerald A. Serwer, MD, FAAP |
| Neel Shah MD |
| Mahesh Sharman, MD, FAAP |
| Carolyn Feltes Shelak, MD, FAAP |
| Robert Leo Sheridan, MD, FAAP |
| Paul Michael Shore, MD, FAAP |
| Simran Sierra-Kjinserdahl, MD |
| Lawrence Tse Siew, MD, FAAP |
| Arlene B. Silverio, MD, FAAP |
| Douglas Harley Slater, MD, FAAP |
| Sara Slovin, MD, MSPH, FAAP |
| Sharon Roberta Smith, MD, FAAP |
| Hayley Sookmarine, MBBSCh |
| Hyndhavi Srigiriraju, MD, FAAP |
| Odett R. Stanley-Brown, MD, FAAP |
| Martha Molly Wood Stevens, MD, FAAP |
| Andrew Wesley Stubblefield, MD, FAAP |
| Wendy Sue Lewis Swanson, MD, MBE, FAAP |
| Geert W. ‘t Jong, MD, PhD |

| Aydin Tabrizi |
| Saurabh Talathi, MD |
| Sharief Taraman, MD |
| Mohammad H. Tcharmtchi, MD, FAAP |
| Aleksey Tentler, MD, FAAP |
| Adalberto Torres Jr., MD, FAAP |
| Robert R. Toscano, MD, FAAP |
| Balagangadhar Rao Totapally, MD, FAAP |
| Michael Joseph Verive, MD, FAAP |
| Nathalia Fernandes Vianna, MD |
| Shayan Vyas, MD, FAAP |
| Jonathan Burton Wagner, DO, FAAP |
| Robert Marshall Ward, MD, FCP, FAAP |
| Matthew John Weidman, MD, FAAP |
| Miles M. Weinberger, MD, FAAP |
| Eric J. Werner, MD, FAAP |
| Mary Anne Whelan, MD, PhD, FAAP |
| Mariusz Wojnarski, MD, FAAP |
| Elizabeth H. Yen, MD, FAAP |
| Jennifer Shin Zank, MD, FAAP |
| Christine Ann Zawistowski, MD, FAAP |
| Samuel Lewis Zuckerman, MD, FAAP |
Announcements from the AAP

Update on the AAP Pediatric Clinical Trials Stakeholder Forum

On November 4-5, 2014, the American Academy of Pediatrics (AAP) convened key stakeholders to discuss the feasibility of accelerating medical advances for children by creating an independent, global Pediatric Clinical Trials Network. The participants’ task was to address the challenges currently posed by the U.S. and global clinical trial systems with respect to testing and disseminating drugs and devices for pediatric patients — and thereby to improve the safety and efficacy of pediatric drugs, biological products, and medical devices.

The Forum brought together an unprecedented number of leaders with diverse backgrounds and interests, including clinicians, academicians, regulators, patient advocates, parents, AAP leadership, and representatives from the pharmaceutical industry and other focused disease Networks.

Among the participants, there was wide agreement about the need for:

• An improved, innovative approach to planning pediatric studies and the commensurate pediatric clinical trial infrastructure to perform those studies.
• Timely development of age-appropriate formulations, evaluative tools, and biomarkers for the pediatric population’s developmental continuum.
• Reduction of administrative barriers that hamper safe and efficacious products being assessed through clinical trials and accessed by the patients who need them.
• More robust, publicly available data that demonstrate the safety and efficacy of drugs and devices used in children, and that are communicated in a timely manner.
• Shorter time frames between adult and pediatric labeling.
• More integrative work across a variety of stakeholders.

The Forum offered a unique opportunity for stakeholders to address these needs by sharing ideas and mapping a vision to enable change through the formation of a global Pediatric Clinical Trials Network. The Network is anticipated to improve the current landscape by providing a central infrastructure spanning all pediatric sub-specialties, and fostering access to dedicated staff providing clinical research sites with scientific, medical, and operational support. In turn, a Network would facilitate the development and availability of innovative, high-quality therapies to help extend and enhance the lives of neonates, infants, children, adolescents, and young adults.

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The Forum participants expressed a strong interest in the formation of such a network and conveyed a clear sense of urgency to proceed. Despite much progress — with over 500 products now having been studied in children — drugs and devices are still often coming to market without adequate pediatric indications, particularly in the areas of neonatology and rare diseases. This has negative effects on children and their families. It behooves the community to support this effort and strive together to create and implement a Network.

The Forum closed with the development of a consensus statement about the participants’ shared vision for a Network and their commitment to implementing such an entity in the near future.

Funding for this Forum and meeting proceedings was made possible by an unrestricted contribution from The Pharmaceutical Research and Manufacturers of America (PhRMA)

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Miss the SOATT Webinar?
Watch SOATT’s Pediatric Product Development Processes: FDA and Globally Webinar On-Demand!

Faculty: Dianne Murphy, MD, FAAP and Lynne Yao, MD, FAAP

This Webinar took place on Monday, December 8th and was hosted by the AAP Section on Advances in Therapeutics and Technology.

Objectives:

Develop a framework concerning types of pediatric programs and processes for pediatric product development

Provide information on the resources and processes involved in global pediatric trial development

Advance understanding of the interactions that are necessary for product development trials between FDA, sponsors, Investigators and sometimes NICHD

Alert physicians to current changes and challenges in pediatric product development and how they may relate to them.

Watch it at your convenience at the SOATT Web page at: https://attendee.gotowebinar.com/register/200000000028567058;jsessionid=abc2Ln3ztIKNR8nyC3YhVu

***

Section on Advances in Therapeutics and Technology announces Section Election Results

The Section on Advances in Therapeutics & Technology closed their Section’s election on Monday, March 31, 2015. The following individuals will join the SOATT executive committee on November 1, 2015:

Continued on Page 24
Thank you to each person who voted in the election. The new terms will commence November 1, 2015 and each person will serve a three-year term.

If you have any questions about the election or future leadership openings for the Section on Advances in Therapeutics and Technology, please e-mail our staff at jburke@aap.org

Thank you to Lisa Mathis, MD, FAAP and Mitchell Goldstein, MD, FAAP for serving on the Section's nominations committee.

* * *

Implementing Mental Health Priorities in Practice: Strategies to Engage Patients and Families


Pediatricians are, and will continue to be, an important first resource for parents who are worried about their child's health concerns. Early intervention with families who have mental health concerns is critical.

Engaging families to uncover and clarify mental health needs requires skill and practice. Implementing Mental Health Priorities in Practice: Strategies to Engage Patients and Families is an innovative program designed to leverage the techniques of motivational interviewing, along with the power of video-based learning, to provide pediatricians with the practical skills needed to elicit accurate information and create behavior change in their patients.

This resource consists of 6 videos demonstrating examples of patient/family encounters. They encompass the most difficult conversation areas in the area of mental health, including the following topics: depression, disruptive behavior, inattention/impulsivity, social-emotional health, substance use, and suicide/self-harm.

For more information and materials on mental health, visit: www.aap.org/mentalhealth

Supported by the American Academy of Pediatrics Friends of Children Fund