The Section on Nephrology develops a yearly strategic plan to optimize our focus on key initiatives for the forthcoming year. In our last newsletter, we highlighted several main objectives for 2016, including developing educational articles for the AAP parent website, HealthyChildren.org. Thank you to Alyssa Riley and John Foreman in developing a new parent article regarding chronic kidney disease that will also be featured in an announcement in the March edition of AAP News highlighting World Kidney Day. This information can be found on page 5.

Another area of interest has been in the development of practice guidelines for pediatric nephrologists and all pediatricians regarding two areas, the management of hypertension and fluid disturbances.

The hypertension guideline development, co-chaired by Drs. Joseph Flynn and David Kaelber, is a joint effort between the AAP and the American College of Cardiology (ACC) and the American Heart Association (AHA). The subcommittee is currently completing their critical appraisal of the evidence and will begin drafting evidence tables. The projected publication date at this time is the summer/fall of 2017.

In addition, the section, in collaboration with the Section Cardiology and Cardiac Surgery, initiated an Education in Quality Improvement for Pediatric Practice (EQIPP) MOC part 4 module in June, 2015 regarding “Hypertension Identification and Management”. The main objectives of the course are to provide general guidelines for pediatric hypertension identification and management, outline policies for coordination of care among all caregivers, and use the guidelines to enhance delivery of care. This course was developed in response to our query of AAP members about which topics would be of interest and value to them. The response in the community has been overwhelming. As of February, there were 1042 subscribers for the course, including 399 general pediatricians and 124 subspecialists who had already started the course. The section is encouraged that the utilization of the course is trending
well and is among the more highly accessed online AAP EQIPP courses. For comparison, the asthma course had enrolled 1,719 participants and 370 for the medical home course. As with all AAP EQIPP courses, the pediatric hypertension course is part of your AAP membership (including for trainees) and has tracks that are appropriate for either general pediatricians or subspecialists. Subscribers can gain 27.5 CME credits, and the course is available until May 14, 2018. This course can be accessed on the EQIPP site.

In collaboration with the Section on Hospital Medicine, the SONp submitted an application to develop a clinical practice guideline on fluid therapy in children. The application was approved by the AAP Executive Committee. The two sections sought to engage experts in the field of fluid management and are grateful to have received the commitments of Dr. Leonard Feld (Chairperson) and Dr. Michael Moritz (SONp representative). Thus far, the workgroup has identified several key topics for inclusion in the guideline, and has plans for a face-to-face meeting in April, 2016. Finally, the workgroup plans on writing a point-counter point article for Pediatrics in Review based on the article: Read-Adam J and Adam H. “Hyponatremia”, Pediatrics in Review, 34:9, 2013.

Another of the section's continuing goals is to enhance our engagement of young physicians. In 2015, the SONp received an award for its efforts to include a training fellow on the Executive Committee. The training fellow is fully engaged in all SONp activities and attends the yearly Executive Committee meeting. Our success with incorporating our first training fellow (Nicole Christin) into the section was followed by approving a second fellow (Lyndsay Harshman) this past year. Drs. Christin and Harshman have provided excellent clinical contributions to our work product while establishing a link with our young fellows and faculty.

Finally, the SONp is working to broaden the reach of pediatric nephrology by working with other sections in the AAP. This enhances collaborations and provides our members with knowledge across a broad spectrum of expertise. For example, this year the SONp is participating in the Section on Hospital Medicine Section program at the 2016 AAP National Conference Exhibition (NCE) in San Francisco and we are exploring such collaborations with other groups in the years ahead. The NCE is the major AAP educational meeting in which a broad range of topics are presented for general pediatricians, subspecialists and other health care providers.

Thank you for your ongoing membership in the AAP and the SONp. As always, we appreciate any feedback or suggestions that you have regarding the content of the newsletter and your interest in volunteering within the Section.

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MOC Part 2: PREP Nephrology

This intensively peer-reviewed state-of-the art new online self-assessment program is developed by leading pediatric nephrology specialists and is designed for specialists. Case-based questions will challenge your knowledge in the extensive scope of this specialty. Thorough explanations of preferred responses are included with the most up-to-date references available for your review. Important points are highlighted with abundant graphics and charts. Questions and critiques are based on content specifications from the American Board of Pediatrics (ABP) MOC examination.

Your PREP® Nephrology subscription offers:
- 96 questions per year (8 questions/month)
- A maximum of 24.00 AMA PRA Category 1 Credits™ per year
- A maximum of 20.00 MOC Part 2 Points

Start your free trial or subscribe now!
2016 SONp Henry L. Barnett Award Recipient

The Section on Nephrology Henry L. Barnett Award recognizes lifetime achievement in pediatric nephrology, especially in the areas of: dedication to teaching nephrology, contributions to advocacy for children and distinguished service to the field of pediatric nephrology. The SONp Award Committee and Executive Committee is pleased and proud to announce that Dr. Barbara Fivush will receive the 2016 Henry Barnett Award.

Dr. Fivush is one of our communities’ most dedicated advocates who has served continuously in numerous leadership positions. Her contributions to nephrology education, training of fellows and faculty, advocacy for children with kidney disease, and scholarly initiatives are numerous. Many of those who were mentored under her guidance have assumed major leadership roles in pediatric nephrology both nationally and internationally, and she has been an outstanding example of a true dedicated mentor.

Dr. Fivush was formally the Chief of Pediatric Nephrology at the Johns Hopkins Children’s Center for twenty two years and remains a Professor of Pediatrics at the Johns Hopkins University School of Medicine. She is an active member of the American Society of Nephrology (ASN), the Renal Physician’s Association (RPA), the American Society of Pediatric Nephrology (APSN), the American Academy of Pediatrics (AAP) and the International Pediatric Nephrology Association (IPNA). She had been on the council of the American Society of Pediatric Nephrology (APSN) and had been the co-chair of the ASPN clinical affairs committee for over ten years. She was also elected as a council member of the IPNA.

Her early research interests centered on pediatric chronic kidney disease (CKD), and she was instrumental in setting the guidelines for immunization of pediatric CKD patients. Additionally, Dr. Fivush has been a collaborator and investigator on many national clinical trials. From 2003 to 2007, she served as a principal investigator for the NIH Funded “Chronic Kidney Disease in Children” study. Dr. Fivush is also a co-principal investigator on the NIH funded “Randomized Intervention for Children with Vesicoureteral Reflux” study (RIVUR). Dr. Fivush has published an extensive body of work.

Among her most distinguished contributions to the field of pediatric nephrology has been in her advocacy for the development of outcome measures for all pediatric patients, and those with kidney disease and ESRD. She was the head of the pediatric committee of the CMS clinical performance measures project from 2000 to 2006. In 2002, Dr. Fivush was invited to chair the ASPN clinical affairs committee and continued in that role until 2010. In 2005, due to her interest in measure development, she was asked by APSN to represent them on the AMA Physician Consortium for Performance Improvement (PCPI), and the Kidney Care Quality Initiative (KCQI). In 2008 and again in 2010, she was asked by ASPN to co-chair the Pediatric ESRD Measures Group for the AMA-PCPI. Under her guidance, three pediatric physician level measures were developed and endorsed by the AMA-PCPI. Several of these measures have been in the PQORI system for physician reporting.

Dr. Fivush has also been a long-standing member of the RPA since 2003, and was on the RPA board from 2007-2010. She continues on the RPA quality, safety and accountability committee. Recently due to her expertise in the area of guidelines and measures, Dr. Fivush was asked by the RPA to co-chair a pediatric work-group to submit a chapter for the 2010 RPA Guideline: Shared Decision Making in the Appropriate Initiation and Withdrawal from Dialysis. This guideline is published and has been well received. Dr. Fivush has been a member of the American Academy of Pediatrics (AAP) and has served on their measurement subcommittee between 2006-2012. Lastly, Dr. Fivush was nominated and selected to serve on the National Quality Forum (NQF) Panel to evaluate new ESRD faculty level measures in 2010.

Dr. Fivush pursued a new academic path in 2008 in the Dean's Office of Faculty Development as the Director-Office of Women in Science and Medicine, and from 2011 to present she has been the Associate Dean of Women in Science and Medicine. Her skills have been directed at continued mentoring of women in academic medicine at any stage of their career, a highly important mission that could not have found a more qualified leader. Dr. Fivush remains active with the ASPN Public Policy Committee, measure development, and most recently on the ASPN Foundation Board and the ASPN Leadership Development program. All of these commitments are significant to the continued success of pediatric nephrology.

Please join us in congratulating Dr. Fivush and this achievement. The award presentation will occur in conjunction with the Pediatric Academic Societies (PAS) annual meeting in Baltimore, Maryland on Saturday, April 30, 2016 as part of the American Society of Pediatric Nephrology Awards luncheon.
Fellow Corner

Integrative Research Pathway – Utilizing Research Training Tracks for Those Interested in Academic Pediatrics

Lyndsay Harshman, MD
SONp Training Fellow Liaison
lyndsay-harshman@uiowa.edu

Like many medical students, when I entered medical school I was looking for opportunities to tailor my education in a way that was “right for me”. But, nearly every step of the way there were few occasions to customize my medical training. One of the early ways that I was able to do so was by completing a year-out research fellowship (the Doris Duke Clinical Research Fellowship). From my undergraduate experiences, I knew that I loved clinical research and wanted an opportunity to experience more of it. After completing this year-out experience, coupled with amazing pediatric opportunities during my clerkships, I knew that a career in academic pediatrics was for me.

When I began my search for residency programs, one of my mentors suggested that I consider pursuing the “Integrated Research Pathway” option for my residency training (https://www.abp.org/content/integrated-research-pathway-irp). That was a rather life-changing moment for me. The Integrated Research Pathway (IRP), as it turns out, became a way for me to choose that path which was “right for me.” The IRP is designed for residents who have an MD with substantial research experience (e.g., formal year-out research fellowships, Master’s degree programs) or an MD/PhD and are committed to an academic research career.

Participants in the IRP receive 24 months of clinical training and up to 11 months of formal, mentored research training during their three years of residency. Mentorship is a central component to resident success in the IRP and the American Board of Pediatrics (and frequently the individual residency program itself) requires residents completing the IRP to establish a supervisory oversight committee in addition to a primary research mentor. At Iowa, where I completed residency, the residency program director and program staff have worked hard to encourage success in the IRP by being flexible with the research experience. For example, I was able to focus research time over blocks of 3 months duration which were interspersed between my core clinical rotations. While working on the IRP, I met frequently with both my mentorship team and my general pediatrics residency director to ensure I was on track for achieving specified clinical and research goals.

As with any non-traditional training pathway, there are conceivable negatives that a trainee should weigh when deciding whether the IRP is right for them. For example, residents completing this research pathway are not eligible to take their general pediatrics board exam until completing an additional 12 months of clinical training in a fellowship program – so, no general pediatrics boards in your first year of fellowship like a traditional general pediatrics graduate. Similarly, when considering the IRP, a candidate needs to be aware of the pathway at the outset of residency as residents must apply for the pathway within the first 9 months of the PL-1 year.

Many times medical students and first-year residents do not know that options such as the IRP exist. As we work to strengthen the workforce in pediatric nephrology and bring the best trainees available into our field, it is essential to communicate these opportunities beginning in medical school and extending through residency.
World Kidney Day takes Pediatric Focus in 2016

“Kidney Disease & Children; Act Early to Prevent It” is the theme of World Kidney Day (WKD), which is on March 10, 2016. The day aims to increase public awareness about and provide education regarding kidney diseases. It also draws recognition to the tremendous psychosocial and economic burdens on children and families with chronic kidney disease (CKD).

Pediatric CKD has become more prevalent in the last 20 years. Data collected from the North American Pediatric Renal Transplant Cooperative Study database shows that about 5,600 children in the USA have chronic kidney disease (CKD). Globally, the rates of pediatric CKD are about 18.5-58.3 per million children. However, the actual number of cases of pediatric CKD in the United States and globally may be significantly higher due to underreporting. In addition, approximately 2,000 children are receiving chronic dialysis in the United States, while 716 received kidney transplants in 2014.

It is important that health care professionals make the general public aware that kidney disease affects millions of people worldwide, including many children who may be at risk of kidney disease from an early age. Moreover, there is an increasing incidence of kidney disease in the lower socioeconomic population globally. It is therefore crucial that we encourage and facilitate education regarding: 1) early detection of kidney disease, 2) preventable causes of acute kidney injury, 3) a healthy life style starting in childhood and continuing through to older age, to combat the increase of preventable chronic kidney damage, and 4) optimal treatment of children with congenital and acquired kidney disorders.

There is more information about WKD on their website. For additional patient education resources view:

AAP HealthyChildren.org: Chronic Kidney Disease
National Kidney Foundation: Children With Chronic Kidney Disease: Tips for Parents
National Institute of Diabetes and Digestive and Kidney Diseases: Children and Kidney Disease

MOC Part 4 Activity:
EQIPP Course to Improve Identification & Management of Hypertension
(Subspecialist and General Pediatrician tracks)

Just a small change in your pediatric hypertension care could significantly improve the quality of care patients receive. EQIPP: Hypertension – Identification & Management delivers information and resources general pediatricians and pediatric specialists need to improve their ability to identify pediatric hypertension and better manage the condition, working with patients, family and other providers. The course is included with AAP membership so that there is no additional cost while the cost is $199 for nonmembers. This course helps satisfy MOC Part 4 requirements and helps programs satisfy QI requirements. More information: http://bit.ly/hypertensionQI
Clinical Feature: Nephrotoxic AKI

Jason Misurac, MD, MSCR, FAAP
Pediatric Nephrology Faculty
University of Iowa Children's Hospital

Case Presentation
A 17 year old boy with cystic fibrosis (CF) and CF-related diabetes was admitted for intravenous antibiotics to treat an exacerbation of his CF. He received intravenous (IV) tobramycin and meropenem for resistant pseudomonas infection. The serum creatinine (SCr) was 0.8 mg/dL on admission and was ordered at a frequency of twice per week during his hospital stay. On hospital day 10, SCr was 1.3 mg/dL. In response to this change, the patient was started on IV fluids. The serum creatinine improved to 0.8 mg/dL the next day and he was discharged home.

Introduction
Acute kidney injury (AKI) is defined as an abrupt decline in glomerular filtration rate (GFR), though definitions have been variable. Recently, criteria have been developed which stage AKI based on the magnitude of the change in estimated GFR (eGFR) or SCr. AKI staging based on this concept has been shown to be predictive of short- and long-term outcomes, with larger changes in SCr predictive of higher mortality and longer length of stay in certain situations.1, 2 Some examples of such criteria that stage AKI include the RIFLE/pRIFLE criteria and AKIN/modified AKIN criteria.2 These have helped to better define AKI and have provided important insights into prognosis, both short and long term.

Another important recent development in the understanding of AKI is the novel concept of renal angina.3 Renal angina can be understood as a pre-AKI state. Just as the diagnosis of pre-hypertension stimulates early intervention to prevent progression to a riskier clinical condition, a patient meeting the renal angina threshold should prompt early intervention to attempt to prevent or ameliorate AKI. The threshold for renal angina is described as the risk of AKI multiplied by the evidence of AKI.3 The concept of renal angina is based on the conclusion that in patients with a high risk for AKI, small changes in serum creatinine and urine output are often significant. Recognition of these early changes should prompt the clinician to minimize unnecessary nephrotoxic agents and to maintain circulating fluid volume, among other important disease-specific measures to prevent AKI.

Most AKI in developed nations occurs as a secondary effect of treatment for other diseases. The most common causes of AKI include sepsis, ischemic injury, and nephrotoxin exposure. The predominance of these etiologies is in contrast to previous eras in which primary renal diseases such as hemolytic uremic syndrome was the most common cause of AKI in hospitalized patients.4 The reasons for this change include improved support for seriously ill patients and increasing development and utilization of nephrotoxic medications over time.

Pathophysiology of AKI
While the distinction between prerenal and intrinsic renal disease is a useful tool to classify the cause of AKI, the progression from prerenal AKI to acute tubular necrosis (ATN) is better conceptualized as a continuum. In the setting of decreased renal perfusion, the kidney's autoregulatory mechanisms maintain the pressure gradient across the glomerular capillary bed through intra-renal production of prostaglandins and direct tubuloglomerular feedback, resulting in vasodilation of the afferent (preglomerular) arteriole. These mechanisms counteract the vasoconstrictive effects of endogenous catecholamines and angiotensin II, which are produced during states of decreased renal perfusion. GFR is further maintained by angiotensin II-dependent constriction of the efferent (postglomerular) arteriole. In addition, decreased urine flow rate results in the ability to maximally concentrate urine and conserve electrolytes.

With continuation of low renal perfusion pressure, autoregulatory mechanisms decompensate and GFR begins to decline. This results in medullary and tubular ischemia. Renal ischemia leads to ATP depletion, inflammation, necrosis, and apoptosis. Subsequent reperfusion causes generation of reactive oxygen species (ROS), tubular damage (including loss of tubule cell polarity), and inflammation by recruitment of activated leukocytes and release of cytokines by damaged tubular epithelial cells.5 Although proximal tubule cells in the outer cortex begin cellular repair soon after perfusion is restored, cellular injury continues in the thick ascending loop of Henle, the S3 segment of the proximal tubules, and endothelial cells due to surrounding inflammation and the continuing effects of prior insults. This causes GFR to further decrease and results in acute tubular necrosis.5, 6

AKI in hospitalized children is frequently multifactorial. Worsening illness severity, volume depletion, and receipt of

Continued on Page 7
nephrotoxic agents all increase the risk for AKI. This was recently illustrated in a retrospective study of children receiving vancomycin at a tertiary care children's hospital. The study included 284 patients who collectively received a total of 391 courses of vancomycin. Forty nine (17.2%) children developed AKI. The factor most strongly associated with development of AKI was receipt of at least two nephrotoxic medications (OR 2.2, CI 1.3-3.9). Interestingly, the study also found that patients with a blood urea nitrogen (BUN)/SCr ratio >20 prior to vancomycin administration had an independently higher risk of AKI development (OR 1.9, CI 1.3-3.3).

We performed a retrospective study of children with non-steroidal anti-inflammatory drug (NSAID)-associated AKI. Patients receiving other nephrotoxic medications were excluded, as were neonates. Twenty-seven patients with NSAID-associated AKI were identified; nearly all were previously healthy and received the NSAID prior to admission. NSAIDs were used for a median of 4 days; 75% of patients received normal, recommended doses. The most common presenting features of AKI were vomiting, abdominal pain, and decreased urine output. Volume depletion was present in 18/27 (67%) on admission. Younger patients were more severely affected, with 4/4 patients under 5 years of age requiring acute dialysis, while 0/23 patients 5 years of age or older required dialysis. Follow-up SCr was available in 23 of 27 patients (median 272 days after discharge); 6/23 (26%) had CKD stage II and 1/23 (4%) had CKD stage III.

**Long-term consequences of AKI**

It is increasingly recognized that patients with AKI are at higher risk for late-developing complications, including hypertension, proteinuria, and decreased GFR. A recent retrospective cohort study evaluated the risk of development of CKD in adults after a hospitalization with or without AKI. Patients with AKI were included only if there was full recovery from AKI by hospital discharge. To be included, patients needed to have a normal pre-hospitalization serum creatinine and sufficient long-term follow-up post discharge. During the hospitalization, 719/3,809 patients (19%) had AKI by AKIN criteria while 3,090/3,809 (81%) did not develop AKI (cohort controls). After a median follow-up of 2.5 years, incident CKD stage III or worse occurred in 15% of those who had AKI and 3% of patients who did not have AKI. This difference remained significant in propensity score-stratified analyses, with a HR of 3.82 (95% CI 2.81-5.19) (9). Thus, even in adults who appear to initially recover from an episode of AKI, there is a significantly higher risk of subsequent and significant CKD development.

Information about long-term sequelae of pediatric AKI can be drawn from two instructive groups: neonates and survivors of pediatric cancer. In both groups, patients are frequently exposed to nephrotoxic agents and ischemic insults.

Renal function in pediatric cancer survivors has also been followed in long-term cohort studies. A recent study assessed glomerular function in 1,122 survivors of childhood cancer a median of 21 years post-treatment. Mean eGFR declined in all groups during longitudinal follow-up. In patients treated with potentially nephrotoxic chemotherapy and/or nephrectomy, eGFR was significantly lower (eGFR <90 mL/min/1.73 m²) and continued to more rapidly decline over time. (10) As noted above, nephrotoxicity is an increasingly prevalent cause of AKI, especially in pediatric oncology patients. With the increasing rate of AKI in these patients, it will be important to follow this group longitudinally to examine CKD and ESRD risk. New studies of pediatric and neonatal patients with AKI aim to do just that, and will provide valuable information about short and long-term sequelae of AKI.

**Prevention of AKI**

As AKI results in short-term increases in mortality and long-term risks of CKD, its prevention should be a focus of clinicians. When considered within the framework of renal angina, a small increase in SCr should be considered significant in patients with a high pre-test probability of AKI. In these patients, consistent daily measurement of SCr would be important. However, as illustrated by the case presentation, clinicians may be reticent to monitor daily SCr in stable patients. This can lead to late recognition of AKI.
The Nephrotoxic Injury Negated by Just-in-time Action (NINJA) project has expanded from a single-center quality improvement initiative to a multicenter project which focuses on a simple recommendation: daily measurement of SCr in patients with high exposure to nephrotoxic medications. In the original institution, this approach resulted in a 42% decrease of AKI rate in exposed patients. Presumably, this decrease was due to clinicians responding to changes in SCr by eliminating unnecessary nephrotoxic medications and paying close attention to achieving and maintaining euvoolemia in exposed patients.

Another quality improvement initiative in a large tertiary care institution focused on implementation of a shock bundle for emergency department treatment of children with septic shock. Patients suspected to have septic shock were rapidly triaged and received goal-directed fluid resuscitation, IV antibiotics, and vasoactive infusions when appropriate. The bundle was successfully implemented, significantly decreasing time to first bolus, time to third bolus, and time to first antibiotic. An analysis compared 98 children in the pre-bundle group with 104 in the post-bundle group. Patients with CKD or ESRD were excluded from the analysis. The post-bundle group had a lower incidence of AKI (29% vs 54%, P < 0.001), fewer patients requiring renal replacement therapy (0 vs 4, p =0.04), and lower mortality (3% vs 10%, p = 0.037).

Conclusion
AKI in children is commonly multifactorial. Ischemic injury and nephrotoxicity frequently interact to cause AKI in children. In the short term, increased morbidity from AKI is apparent, and evidence is mounting that AKI and fluid overload contribute directly to the increased mortality. In the long term, pediatric AKI frequently leads to development of CKD, hypertension, and proteinuria. The prevention of AKI should be a goal of clinicians, given the short- and long-term consequences.

References:
AAP Role in OPTN/UNOS & Current Public Comment Opportunity

The Organ Procurement and Transplantation Network (OPTN) brings together medical professionals, transplant recipients, and donor families to develop organ transplantation policy and help ensure the success and efficiency of the national organ transplant system. The primary vehicle that the OPTN uses for conducting this work is through OPTN/United Network for Organ Sharing (UNOS) committees and the Board of Directors. OPTN/UNOS committees are charged with improving bylaws and policies that directly impact procurement, allocation and distribution of organs, patient safety, quality improvement, and the rights and obligations of all members.

UNOS has elected the American Academy of Pediatrics (AAP) to membership within the UNOS Medical/Scientific Organization category and the AAP has appointed Dr. Jaimie Nathan (Section on Surgery) and Dr. Vikas Dharnidharka (Section on Nephrology) to serve as the organizational representative and alternate, respectively. The representative is responsible for reviewing UNOS policies as they are presented at the meetings and sending comments to the AAP leadership if there are pediatric specific issues that require comment during the comment period. The representative may vote on behalf of the AAP at UNOS Regional Meetings. There is also the opportunity to serve on OPTN/UNOS Committees that meet in person 2-3 times per year, typically in Chicago, Illinois and by conference call, as necessary.

Most recently, the AAP submitted a letter that provided support for a proposal to establish pediatric training and experience requirements in the bylaws. The proposal was also supported by several organizations including ASPN, RPA and ASN. The UNOS Board approved this proposal and the bylaws now require pediatric experience and training for kidney, liver, and heart transplants. Pediatric expertise will now be formally recognized as necessary for the key personnel (primary surgeon and physician) for a center to perform transplants in patients less than 18 years old.

OPTN/UNOS sent out another call for public comment on January 29, 2016 regarding nine proposals. These proposals were developed by OPTN/UNOS committees. When the public comment period ends on March 25, 2016, each sponsoring committee will review the feedback it received and consider modifications to the original proposals. Two proposals, kidney allocation system (KAS) clarifications and simultaneous liver-kidney allocation 2016, may be of specific interest. The OPTN/UNOS Board of Directors may then review and vote on these proposals at its meeting on June 6-7, 2016. Please click on the following link to provide your comments no later than March 25, 2016. For general questions about the proposals, please contact your Regional Administrator at (804) 782-4800.
Welcome to our New SONp Members

If you know of others who might be interested in joining the Academy and the Section, please have them call 1-800-433-9016 ext. 5885 or go to www.aap.org. The link entitled Member Benefits will take them to an application. Current Academy members may join the Section by accessing the online application (member ID and login required) at: http://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Pages/Council-Section-Membership.aspx

AAP Fellows

| Sabahat Afshan, MD, FAAP       | Leo Levin, MD, FAAP            |
| Flowood, MS                   | Toronto, ON, Canada           |
| Thomas Davis, MD, FAAP        | Rene VanDeVoorde, MD, FAAP    |
| St. Louis, MO                 | Cincinnati, OH                |
| Oliver Fremont, MD, FAAP      | Darcy Weidemann, MD, FAAP     |
| Portland, ME                  | Kansas City, MO               |

A special welcome to training fellows who were added to the Section.
(As of July 1, 2012, Section dues for pediatric nephrology training fellows were eliminated.)

| Kathleen Altemose, MD         | Ali Kurady, MD                |
| Baltimore, MD                 | Brooklyn, NY                  |
| Reshma Bholah, MD, FAAP       | Rachel Millner, MD            |
| Henrico, VA                   | Burlington, VT                |
| Neha Dhimgra, MD, MD          | Arwa Nada, MD, FAAP           |
| Columbus, OH                  | Dublin, OH                    |
| Maria Domingo, MD, MD         | Lydia Pecker, MD, FAAP        |
| Los Angeles, CA               | Washington, DC                |
| Anuradha Gajjar, MD, FAAP     | Katherine Westreich, MD, FAAP |
| Philadelphia, PA              | Chapel Hill, NC               |
| Sean Herbert, MD, MD          | Megan Yanik, MD, FAAP         |
| Manvel, TX                    | Hoover, AL                    |
| Anne Kouri, MD, FAAP          | Indianapolis, IN              |
Join the AAP Council on Quality Improvement and Patient Safety

2015–2016 COQIPS Executive Committee
Wayne Franklin, MD, MPH, MMM FAAP
Chairperson
Joel Tieder, MD, MPH, FAAP
Vice Chairperson
Terry Adirim, MD, MPH, FAAP
David Bundy, MD, FAAP
Laura Ferguson, MD, FAAP
Michael Leu, MD, MS, MHS, FAAP
Brigitta Mueller, MD, MHCM, FAAP
Ricardo Quinonez, MD, FAAP
Michael Rinke, MD, PhD, FAAP
Elizabeth Vickers Saarel, MD, FAAP
Hsiang Yin, MD, MS, FAAP

Mission
To support the mission of the American Academy of Pediatrics in obtaining optimal health for all children. To accomplish its mission, COQIPS will define, promote, improve, measure, educate, and advocate for quality improvement and patient safety.

Member Benefits
Quality Connections — Receive the COQIPS Newsletter, published quarterly
E-mail List — Direct access to over 500 QI and patient safety experts and colleagues to share experiences and ask questions
Networking Opportunities — Network with colleagues and external organizations at the COQIPS section (H) program at the AAP National Conference & Exhibition
Leadership Opportunities — Participate in committee work on essential projects focused on policy and advocacy, guideline development, membership, education, implementation, patient safety and measurement

GET INVOLVED!
We are looking for members who are interested in:
- Spearheading the development of COQIPS policy and review of other AAP policy
- Developing COQIPS education programs for the National Conference & Exhibition
- Creating programs and materials for new and existing members
- Responding to requests for public comment from federal entities and national organizations about important quality and patient safety issues affecting pediatricians

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Call for Applications to APPD Leadership in Educational Academic Development

APPD is excited to announce that the call for applications to APPD Leadership in Educational Academic Development (APPD LEAD) is now open. Application information, instructions and online forms can be found on APPLY2LEAD.

Are you involved in medical education leadership and want to advance your educational development to improve yourself and your residency or fellowship program? APPD LEAD can help you meet those goals.

APPD LEAD is an approximately nine-month educational program that provides outstanding training for educators aspiring to develop the knowledge and skills needed to advance leadership skills in medical education. The program features:

- Three educational conferences
  - Curriculum focusing on organizational leadership, competency-based curriculum development, faculty development, residency and fellowship program administration and scholarship and career development
  - Nationally recognized faculty with significant experience in program leadership and medical education
  - Peer group activities and support
  - A mentored educational project
  - Certificate given at the completion of all program-required elements

The application process is web-based and requests:

- Applicant contact information
- Description of educational role(s)
- Personal Statement addressing career goals in medical education and how participation in APPD LEAD could help meet those goals
- Statement of commitment to participate actively and complete the program
- Curriculum vitae
- Statement of Support from Chair of department
- Letter of recommendation from a more senior individual involved in medical education at your institution
- Recent photograph

Application timetable

- February 5, 2016 Application system opens
- April 30, 2016 Application deadline
- May 13, 2016 Applicants notified of status

Complete application instructions and requirements, FAQs, meeting dates and more are available by clicking on APPLY2LEAD. For further information, send an email to LEAD@appd.org.
Upcoming Meetings

Renal Physicians Association Annual Meeting
March 17 – 20, 2016
Phoenix, AZ

National Kidney Foundation - 2016 Clinical Meeting
April 27 – May 1, 2016
Boston, MA

2016 Pediatric Academic Societies Meeting
April 30 – May 3, 2016
Baltimore, MD

European Renal Association-European Dialysis
and Transplant Association – 53rd Congress
May 21-24, 2016
Vienna, Austria

2nd International Symposium on AKI in Children
June 24- 26, 2016
Cincinnati, OH

17th Congress of the International Pediatric Nephrology Association
September 20-24, 2016
Iguacu, Brazil

AAP National Conference & Exhibition
October 22-25, 2016
San Francisco, CA

Kidney Week 2016
November 15-20, 2016
Chicago, IL

50th Annual Scientific Meeting of the European Society of Pediatric Nephrology
September 7 -9, 2017
Glasgow, Scotland
For Upcoming Newsletters . . .

We welcome your input and encourage you to submit ideas or information by email to Doug Silverstein, MD at dsilverstein2001@yahoo.com or Suzanne Kirkwood at skirkwood@aap.org for future issues of the newsletter.