Happy New Year!

As some of you have noticed, the face in the corner has changed. Let me introduce myself. I am a practicing general pediatrician in a small central New Hampshire community. I have been an active member of the AAP since residency, and look forward to continued involvement throughout my pediatric career. I am thrilled to begin this year as the new Chair of the Section on Young Physicians.

As the New Year began, I worked through the timely tradition of new goals for my professional and personal life. It’s likely that you have done the same and that we share some similar goals of young physicians; balancing work and life, reconnecting with friends, improving health and fitness. I share these with you because it is a reflection of the uniqueness of our section. Together, we are young pediatricians facing new challenges. Let’s continue to share our experiences together, so that we may learn from one another and encourage one another along our journey in this wonderful profession.

Let’s also tackle our 2014 section’s goals as a team. The SOYP strategic plan includes the following:

1. Improve the connectivity of our members within our section and the Academy; improved communication, news sharing, and growing our social media presence.

2. Be a resource and provide guidance for the challenges of our members in the pathway of finance, contracts, and promotion by providing online resources, educational sessions, or recommended mentors.

3. Find a way for members to share trials and experiences of balancing a new career with a growing family, busy relationships, and physical fitness.

4. Grow and develop leaders within our section to be key members of the Academy’s future success.
cont. From the Chair

It’s a new year and SOYP will continue to bring fresh ideas, new initiatives, and continued commitment to our long term section goals. I look forward to hearing about your successes in the coming year. When our members stretch for the stars, the SOYP hopes to be a part of your community that contributed along the way. Wishing you loads of success and growth in 2014!

Ashley

Editor’s Note

Jennifer Wolford, DO, MPH, FAAP
SOYP Newsletter Co-Editor

Best wishes for a fantastic 14!

Together, the Editor team of “SOYP SOAP Notes” is excited to bring you our Section’s first newsletter of 2014. It’s no surprise that this newsletter is full of new opportunities from the Academy to grow and learn from.

As with each New Year, I expect you’ve made goals for both yourself and our family. In this newsletter, there is great information to help further you along to those goals. There are reminders of funding opportunities, such as Visiting Professor Grants, online resources, and updates on clinical guidelines.

Possibly, you are still searching for the next challenge for your professional steps in the coming year. Inside this newsletter, I hope that you experience some reflections and shared moments from our colleagues, ideas for new directions for you to challenge yourself and photo reflections from our time together. Perhaps reading about another SOYP member’s PROS experience or Shot@Life involvement will inspire you with new areas to push yourself.

The Section’s goal is to be a specific professional launch pad for “early” FAAPs as we move through the challenges of first job negotiations, contracts, promotions, and new professional endeavors. Early in a new year is the ideal time to reacquaint yourself with the great opportunities that the SOYP and the Academy offer you. I hope this edition of the newsletter is just the start of your exploration into the New Year with SOYP.

The Editors Team can’t wait to write about your 2014 successes! Best of luck!

Jennifer
The 2013 American Academy of Pediatrics National Conference Experience in Orlando was “Magical.” As the conference with record attendance came to a close, everyone returned from the magical land to their practices rejuvenated and equipped with new knowledge and practice changes to implement. Through the conference lectures, attendees learned how to promote early brain development, address challenging behavioral issues, deal with new and emerging infections, treatments and vaccines, and assess the needs of special pediatric populations and their families. Below are some highlight photographs from the 2013 National Conference. We hope to see you in San Diego as we Explore New Horizons.

Walking the Red Carpet at Disney's Hollywood Studio®

Pediatric Bowl

Young Physician's Reception
Evaluating for Bleeding Disorders in the Setting of Possible Abuse

Jennifer Pierce, MD, FAAP
Jim Anderst, MD, MSCI, FAAP

A three-year-old is brought to your clinic with significant, but non-patterned, bruising on his neck, back, and abdomen. The mother tells you that the child was recently “playing rough” at daycare and must have sustained the bruising there. You are concerned that the bruising may have been caused by abuse. You remember that children with bleeding disorders can present in ways that may be confused with abuse. Which tests should you obtain to evaluate for a bleeding disorder in the setting of possible abuse? Why would you choose those tests?

Pediatricians may encounter children with bruises or intracranial hemorrhage (ICH) concerning for abuse in their clinical practices, and may be faced with uncertainty regarding how to proceed. A recent presentation at the 2013 American Academy of Pediatrics (AAP) National Conference and Exhibition given by Drs. Jim Anderst, Shannon Carpenter, and Mary Clyde Pierce provided guidance for pediatricians evaluating children with bleeding/bruising concerning for abuse. Key points in this presentation included approaches to distinguishing accidental from inflicted injury and specific recommendations for testing for bleeding disorders in such situations.

Bruising is the most common form of physical abuse, and is the most important overlooked injury in the abused child. Failure to identify abuse as the cause of bruising places the child at great risk of further injury and/or death. The presenters highlighted literature indicating that the identification of bruises in young, non-ambulatory infants or bruising in concerning locations (torso, ears, neck, buttocks, in addition to patterned bruising) should raise suspicion for abuse, regardless of the social setting of the family.

Subdural hemorrhage (especially interhemispheric or convexity), multiple intracranial hemorrhages (ICHs), history of apnea, and associated findings of hypoxic ischemic encephalopathy or retinal hemorrhages are significantly associated with abusive head trauma (AHT) in young children. However, studies establishing this did not include systematic evaluations for bleeding disorders. ICH is a well-recognized finding in physical abuse, but is also a known complication of certain bleeding disorders. Additionally, bruising is a common presentation of both physical abuse and bleeding disorders. In some circumstances, bruising and/or ICH is accompanied by other clearly abusive findings, such as fractures, abdominal injury, burns, and/or obviously object-patterned bruising. Such situations generally do not necessitate an evaluation for bleeding disorders. Conversely, bleeding disorders can present in a fashion that is essentially indistinguishable from child abuse, such as non-patterned bruising or ICH without fractures. The presenters recommended that evaluations for bleeding disorders and for child abuse be conducted simultaneously in such circumstances.

Some bleeding disorders are relatively common in the population, while others are quite rare. Each disorder has a unique population prevalence, disease severity, and risk of ICH. Based on these components, the authors provided recommendations for evaluation of bleeding disorders in children with bruising or ICH concerning for abuse.

In children with concerning bruises, testing is recommended for bleeding disorders with a population prevalence of at least 1 in 500,000. Recommended studies include: CBC, PT, aPTT, Factor VIII and IX levels, and von Willebrand Factor antigen and activity level. Children do not require assessment of bleeding status when there is a history of accidental injury which clearly explains the bruising, other medical findings of abusive,
Evaluating for Bleeding Disorders in the Setting of Possible Abuse

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patterned bruising, or independently witnessed injury. Alternatively, some physical findings, such as petechiae or bruising at sites of clothing or object pressure, may indicate the need for testing for platelet disorders.

Children with ICH may also require assessment for bleeding abnormalities. The authors recommended testing for conditions with a probability of causing ICH in the general population of at least 1 in 5 million. Recommended testing includes: CBC, PT, aPTT, Factor VIII and IX levels, fibrinogen, and D-dimer. In children with a verifiable history of trauma (abusive or accidental) and children with other medical findings of abuse, further work-up is not needed. In the case of positive results, or if further testing is desired, consultation with a pediatric hematologist is recommended.

The evaluation of an injured child can be challenging, and the implications of the diagnosis of abuse are significant. A missed diagnosis or an incorrect diagnosis of abuse when there was none may have devastating consequences. Consideration of the possibility of a medical condition causing bleeding or bruising is essential. Further information on this topic may be found in recent AAP Clinical and Technical Reports:

http://pediatrics.aappublications.org/content/131/4/e1314.abstract?rss=1
http://pediatrics.aappublications.org/content/131/4/e1357.abstract

To see the full Powerpoint presentation, visit http://www2.aap.org/sections/childabuseneglect/.

References


Pediatric Emergency and Disaster Readiness—Making a Difference as a Child Advocate and Leader

Sean Diederich and Laura Aird, Staff
American Academy of Pediatrics

At the 2013 National Conference and Exhibition (NCE), Steven E Krug, MD, FAAP, Disaster Preparedness Advisory Council Chairperson, presented on how he has become a child advocate and leader in pediatric emergency and disaster readiness. Below is a summary of the presentation.

Since children cannot vote, pediatricians need to advocate strategically on their behalf on issues that are important to their health and well-being. Pediatric emergency care and disaster readiness are excellent examples of how advocacy can make a difference. The legislation that authorized the Emergency Medical Services for Children (EMSC) program was developed in response to the recognition that existing emergency care and emergency medical service (EMS) systems were not meeting the needs of children. Pediatricians (and others) played a pivotal role in making this a reality. Today, nearly 30 years later, the EMSC program is the single largest source of funding for clinical advances, education, and research in pediatric emergency medicine.

Although pediatric emergency readiness has come a long way, there is still a lot of work to do. Children account for about ¼ of all emergency department (ED) visits nationwide, yet most general EDs and EMS agencies do not require specialized pediatric training for their clinical staff. Children are not small adults; unique vulnerabilities, specialized care resource needs, development and mental health, and family issues, are all examples of why children require different emergency care considerations from adults. In the event of a large-scale emergency, it is crucial to have plans in place to care for sick or injured children.

Steps have been taken to improve all-hazard disaster readiness for children. The Pandemic & All-Hazards Preparedness Act of 2006 required that all state disaster plans must now contain considerations for “at risk populations,” which includes children. Although this was a step in the right direction, there were few pediatric patient-specific requirements included, no pediatric-specific performance measures or targets, and predictably, pediatric care components within disaster plans varied greatly by state. Due to effective advocacy by members of the American Academy of Pediatrics (AAP), The Pandemic & All-Hazards Preparedness Reauthorization Act (2013) has addressed some of these concerns. The reauthorization created a National Advisory Committee on Children and Disasters and increased the development and labeling of pediatric medical countermeasures.

The AAP has taken many steps to promote awareness of the unique needs of children and advance pediatric readiness. The AAP has supported the inclusion of pediatricians on several federal advisory bodies including the National Biodefense Science Board and the Federal Emergency Management Agency National Advisory Council. The National Disaster Medical System (NDMS) is directed by a pediatrician, and pediatric preparedness positions have been initiated within the Centers for Disease Control and Prevention (CDC) and the US Food and Drug Administration (FDA). The AAP has partnered with the CDC on bioterrorism and pandemic guidance for pathogens including influenza, anthrax, smallpox, and botulimum, and has collaborated with the FDA on pediatric medical countermeasures. The AAP is also assisting with the development and dissemination of a “Pediatric Regional Network Survey Project (http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Disaster-Networks-Survey-Project.aspx),” that will identify formal and
cont. Pediatric Emergency and Disaster Readiness—Making a Difference as a Child Advocate and Leader

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Informal networks among agencies and organizations that collaborate on disaster-related efforts. The AAP also created a Pediatric Preparedness Resource Kit [http://www.aap.org/disasters/resourcekit](http://www.aap.org/disasters/resourcekit) to promote collaborative discussions and decision-making among pediatric and public health leaders about pediatric preparedness planning.

Perceived barriers to becoming an advocate for children were discussed. Some examples included: no time, no experience, not sure where to go or who to partner with; people may not like you or may not listen, and you may be uncertain about the outcome. The benefits of becoming an active AAP member include: access to 60,000+ pediatrician colleagues, attendance and networking at the annual meeting, state chapter participation, section and council participation, committee work, and many opportunities as an Academy member to advocate for children and their families.

Networking and teamwork are important first steps to becoming an advocate and leader in pediatric emergency and disaster readiness, or for any issue pertinent to the well-being of children. Engaging in advocacy will eventually pay off for the kids, and for pediatricians who are willing to do this, advocacy will contribute tremendously to personal growth and career satisfaction.

For more information, visit the AAP Children and Disasters website [www.aap.org/disasters](http://www.aap.org/disasters) or e-mail DisasterReady@aap.org.

Dr. Steven Krug
Talking to SOMSRFT members about disaster preparedness at the 2013 NCE.
Like most people, I am a member of dozens of listservs that send countless e-mails weekly. I was not familiar with Shot@Life before I saw the name on one of those e-mails. The name intrigued me. Was it true that $20 could provide a child with lifetime protection against some of the crippling and deadly diseases? I read more and learned the American Academy of Pediatrics (AAP) was a partner within this campaign. I knew I wanted to get involved, but was not quite sure how until I received another e-mail promoting small grants to raise awareness about global immunizations, sponsored by the AAP. In my home country, India, I led polio camps, worked closed with the Rotary Club, and championed the PULSE POLIO campaign. I knew the devastating effects of polio, and I remember when the last polio patient was treated in India, over two years ago. But, prior to Shot@Life, I was unable to make these diseases relevant to communities in the United States. Everything seemed like it was there, not here.

It was great to learn that non-profit organizations, physicians, and other institutions in the United States are actively involved in global vaccinations. I applied for the grant because I wanted to educate my colleagues as I had been able to learn first-hand about the global impact of these diseases and the importance of discussing the benefits of vaccination with patients, families, and the community.

I started with a grand rounds to over 50 community physicians, family physicians, nurse practitioners, residents, and students. I also wanted to deliver the health message through a pro-health behavior. We hosted the “Run to Give a Shot@Life” One Mile Run at Michigan State University. It was a great event that included prizes and educational materials for the participants. Finally, I wanted to get the larger community outside the university involved, so we participated in the annual “Teddy Bear Picnic”, a community event that brings out over 400 families. Children bring their teddy bears to get checked out by pediatricians, surgeons, and other doctors. We set up a Shot@Life booth, with some pediatricians and medical students, and talked to families about global immunizations and many of the diseases we do not think about in the United States that are still hurting children around the world. Families were given the opportunity to donate directly to the campaign. I enjoyed this event because the awareness building did not end with the families; I was proud to help tomorrow’s doctors appreciate the value of global immunizations.

I look forward to continuing to serve as a Shot@Life AAP Global Immunization champion in the coming year. Oftentimes, we get lost with the e-mails, paperwork, endless appointments. This opportunity reminded me the impact that I can make on children’s health across the world. Shot@Life helped me connect my past experiences in India to the families I see in Michigan today.
Why Should You Care About Effects of Media on Children & Adolescents?

Vic Strasburger, MD

I know – you are busy, you are dating or starting a family, you have student loans. Plus, you have old academic fogeys like me telling you what you need to do in your eight-minute well-child visits. Bicycle helmets, Reach Out & Read, child-proofing the house, secondary smoke, guns in the home –- the list is nearly endless and could take up all of your eight minutes and more if the parents dare to ask any questions. So why should you care about media effects?

1. The media affect virtually every concern that pediatricians and parents have about child and adolescent development -- obesity, sex, drugs, language development, school performance, sleep, and more. Media effects are not the leading cause of any health problem in the United States, but they can contribute significantly. (see Strasburger VC, Jordan AB, Donnerstein E:  Health effects of media on children and adolescents. Pediatric Clinics of North America 2012; 59(3): 533-587).

2. Kids spend more time with media -- 7-10 hours/day -- than in any other activity but sleeping. Children spend more time with media than in school. It is their leading leisure-time activity.

3. You can make a difference. Several studies show that just a minute or two of office counseling about media can change parents' behavior.

So what should you be doing? The American Academy of Pediatrics (AAP) recommends that you simply ask two questions at every well-child and well-adolescent visit:

1. **How many hours per day do you spend on entertainment screen time?** The AAP recommends less than two hours/day. This means time spent watching TV, movies, videos, and playing video games. This does not include schoolwork. The AAP does not have recommendations about limiting texting (except while driving) since there are no data yet on the behavioral impact of a lot of texting.

2. **Is there technology in the bedroom?** If so, get it out of there!

If you have any questions, please feel free to e-mail me:  vstrasburger@salud.unm.edu.

Vic Strasburger, MD is a distinguished professor of pediatrics at the University of New Mexico School of Medicine.
Office Interventions for Poverty: Child Health

Julia Morinis, MD, FRCPC, MSc
Andrea Feller, MD, MS, FAAP, FACP M

You are a family physician in a busy suburban clinic. You see a family that is relatively new to your practice: Melanie is a 19-year-old single mother of two children — Seth (age three) and Jake (age one month). She lives in her aunt’s cramped one-bedroom apartment. Melanie’s source of income is Ontario Works (welfare) and the Ontario Child Benefit, from which she receives $1,194 per month. You recognize that Seth has limited language that is difficult to understand, and he appears to have significant dental caries. Melanie tells you that he is home with her all day and that he spends four hours or more per day watching television. She is suffering from depression and they rarely leave the home. She is struggling to make ends meet. Seth has very limited socialization with other children. There is likely more going on in Melanie’s life than you know about, but you have only 15 minutes and you don’t have more time to spend on the social stressors.

Introduction
The first two articles in this series (which appeared in the October 2013 OMR, accessible at www.oma.org outlined the strong links between the social determinants of health and health outcomes, and the importance of interventions into poverty as a health risk. This article focuses on the role of physicians in addressing these issues when it comes to children, and highlights how small interventions within the office setting, and navigation of community resources, can have a large impact in practice.

Social Determinants of Health
The social determinants of health are the conditions into which people are born, grow, live, work and age, and include income, employment, education, early child development, nutrition, social support, and health care access. These social issues powerfully shape children’s development and physical well-being.

Currently in Canada, nearly one in six children lives in a low-income household. Research has shown that these children are at higher risk than their more affluent peers for negative health outcomes, such as low birth weight, learning difficulties, mental health problems, micronutrient deficiencies, asthma, burns and injuries, obesity and hospitalization. Infants living in poverty have a 60% higher mortality rate before the age of one year. Children are particularly vulnerable as they are largely dependent upon their families for basic needs, social support, socialization, and the development of life skills.

“It is easier to build strong children than to repair broken men.”
Frederick Douglass (1817-1895)

Background
Early childhood exposure to poverty has been shown to lead to adult chronic disease through epigenetic changes, stress dysregulation and perpetuation of poverty. Exposure to prolonged stress is known as toxic stress and can negatively impact physical, social and cognitive development. The number of social risk factors and length of exposure demonstrate a cumulative increased vulnerability to poorer health status over the years that most impact “life-course developmental health.” Trying to lessen the negative health impacts of social determinants of health at an early age is essential to improving the health of all Canadians.

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The American Academy of Pediatrics and Canadian Pediatric Society (in press) recommend expanding the role of health providers for children to include screening, assessment, and referral of parents for social problems, and to urge practitioners to look beyond their offices and medical teams to include community resources in routine care. Early identification and recognition within the office setting is essential in order to minimize the negative outcomes seen among these children. This approach includes:

a) Screen for social risk.

b) Provide appropriate intervention and referrals to community resources.

c) Ensure follow-up and support.

Screen

The use of screening tools may increase screening rates and identification of social problems. For example, Kenyon, et al., created the IHELPL mnemonic —income, housing, education, literacy, legal status, and personal safety — to assist practitioners with the social history in day-to-day practice. Garg, et al., recommends conducting routine screening with initial intake, and at all well-child visits, with increasing screening based on burden of psychosocial issues in the community. However, in order for screening to be beneficial, effective interventions must be available to address identified problems. Although there is a paucity of randomized controlled trials evaluating programs that address the social determinants of health, other studies have suggested beneficial effects in many domains.

Refer

Research has highlighted key areas for intervention that can make a difference in health outcomes among low-income children. Simple actions such as regular referrals of children to quality childcare, Public Health departments, libraries or Early Years Centres in Ontario, as well as for hearing tests and routine vision and dental care, have been shown to make a significant difference in health outcomes. Referring these patients, as well as maintaining close follow-up and support, is essential for success and clinical improvement.

1) Vision and Hearing

Poor vision has detrimental effects on both social and educational development. Screening can improve the detection of visual problems. Studies are ongoing to assess in-school interventions to increase the rate of glasses use, however, screening in primary care, referral and follow-up is paramount. Hearing difficulties are also linked to deficits in communication and literacy. Hearing screening can improve the identification of hearing problems, and interventions to improve hearing are linked with better school and language outcomes.

2) Child Care and Education

As many children spend a large proportion of their time in non-parental care, child-care centres and preschool programs present an important setting in which to promote early childhood education, and can buffer the negative effects of poverty on school readiness. High-quality childcare has a beneficial effect on behavioural and cognitive outcomes, and structured preschool programs have shown consistent short-term and long-term outcome benefits, including improved IQ, school achievement, increased employment, and higher socioeconomic status.
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3) Language and Literacy
Comprehensive literacy promotion programs, such as the Reach Out and Read program, have shown positive effects on reading and development. These programs involve anticipatory guidance, the provision of age-appropriate books, and literacy-rich waiting rooms. The beneficial effects are highest in the most impoverished families.

Don’t Play “Wait And See”
Watchful waiting is often utilized in pediatrics to assist in the diagnosis and treatment of undifferentiated or seemingly minor concerns. However, this approach should not be employed for developmental concerns. This is especially important for children with a high social burden, including a history of poverty, time in foster care, or other social instability.

Back To The Case
You immediately refer Melanie to Public Health and speech and language supports, ensuring the phone call is made before she leaves. You then see Melanie at Jake’s two-month visit. You reiterate the importance of library visits and daily programming at the local Early Years Centre for both children. You provide Melanie with information to sign up for a daycare subsidy in addition to audiology assessment and a referral to a developmental pediatrician. You give her a collection of children’s books to read to Seth at home, and discuss the importance of vision and hearing screening. Three months later, Seth has gained a tremendous amount of language through socialization and Melanie has established a community through the Early Years Centre. In addition, Melanie has also continued to breastfeed Jake, saving money on formula, and qualifying her for the Pregnancy/Breastfeeding Nutritional Allowance ($40 per month).

Conclusion
Identification of, and intervention into, social determinants of health with children is essential to improving their health trajectory. Identification of social determinants through screening tools and simple actions such as advocating for quality childcare should be a routine part of child health visits.

As our understanding of the mechanisms and impact of social factors on healthy development deepens, the role of the clinician in promoting the physical, mental, and social health of children at social risk must also evolve.

Overall series editor: Dr. Andrea Feller. Series editorial committee: Dr. Andrea Feller, Dr. Gary Bloch, Dr. Michael Rachlis.
The editors would like to thank Dr. Lee Ford-Jones for her support, and Kathryn MacKay, Ontario Medical Association, for her assistance with the final preparation of the articles.

Dr. Julia Morinis is a staff pediatrician at the Hospital for Sick Children and a post-doctoral research fellow at the Centre for Research on Inner City Health, Li Ka Shing Knowledge Institute, St. Michael’s Hospital; Dr. Andrea Feller is Associate Medical Officer of Health in Niagara Region, and is board-certified in both pediatrics and preventive medicine.

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**Child Health Resources**

211ontario.ca  Index of community and social services in Ontario (phone 211): http://www.211ontario.ca/

Ontario Child Care Subsidy  Provides financial assistance for child care: http://www.edu.gov.on.ca/childcare/paying.html#subsidy


Ontario Drug Benefits (Trillium Drug Program)  Provides financial assistance for households that spend a large portion of income on prescribed drugs: www.health.gov.on.ca (search “trillium”)

Canada Revenue Agency (CRA)  Provides financial assistance, including the universal child care benefit and children's special allowances: www.cra-arc.gc.ca/bnfts/menu-eng.html


CanadaBenefits.gc.ca  Searchable and customizable index of federal and provincial government benefits: http://www.canadabenefits.gc.ca/

Ontario Early Years Centres (OEYC)  Provides information and supports for parents and children: www.ontarioearlyyears.ca/

Special Services at Home  Information on services for parents of children with a disability: http://www.children.gov.on.ca/ (search SSAH)

- end -
As our Legislators Vote - How Will Children Fare?

Donald Schiff, MD, FAAP

As government crises (Government Shutdown) follow one after another (problematic rollout of Affordable Care Act), seemingly as predictable as natural disasters, pediatricians and the American Academy of Pediatrics (AAP) pursue opportunities to protect and support the cause of children and their families. Our daily contact with families gives a true face to the stressful challenges which families and their children are facing and the subsequent effects on their lives.

Pediatricians have recognized for some time the marked increase in interest in the broad field of Neuroscience. The term toxic stress has been applied to the delineation of the biochemical changes which occur as a result of a number of different types of stress. The effects of these stresses have been observed as occurring across the entire pediatric age range from prenatal through adolescence. These effects include prematurity, congenital and chronic disease, surgery, hospitalization, drug abuse, medications, and dysfunctional families.

On Monday, October 28, 2013 at the AAP annual business luncheon, incoming AAP President Jim Perrin gave his inaugural address, in which he brought to our attention the critical importance of poverty, the stress which it creates for family and children, and the efforts which pediatricians and the AAP have expended to minimize these damaging effects. The rate of economic recovery following the recession of 2008 has been slow and has not enabled millions of families to regain a sturdy, reliable financial status.

The Academic Pediatric Association (APA) Task Force on Childhood Poverty has provided data on the scope of the problem by stating “one in five children live below the poverty line in the United States, and almost one in two are poor or near poor and are the poorest members of our society.” Although as pediatricians we are primarily concerned about the health of children, our broader view of health and wellness is reflected in the APA description of the “consequences of poverty which may change their life trajectories, lead to an unproductive adult life, and trap them in intergenerational poverty.”

Recognizing poverty as one of many societal elements to be changed as part of our efforts to improve the health of our nation’s children should not be misunderstood as a political position by our organization. Our primary responsibilities are in health, but as an organization whose mission for children is broad, we must examine what we can accomplish ourselves and what will require vastly larger coalitions to achieve.

Our efforts to improve the quality of health care for children through education and research is well established and recognized. Our support of legislation which expands quality, accessibility and affordability of care through the ACA, Medicaid, CHIP, and private insurance has met with significant success. There are numerous bills, proposals, and initiatives that can have far reaching effects on children, their families and the family’s health and stability.

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As our Legislators Vote - How Will Children Fare?

Controversy over the proposed annual farm bill persists at this time. This legislation, which generally provides very large subsidies to farmers, large and small, also is the funding vehicle for the Supplemental Nutrition Assistance Program (SNAP), commonly known as the food stamp program. Republicans, in their attempt to cut the budget, have recommended a $40 billion cut in this item. It is obvious that a reduction of this magnitude will add to the unyielding prevalence of hunger, malnutrition and food insecurity in children’s lives.

Many view the legislated basic minimum wage as a critical aspect of the battle against poverty. A newfound political will to take on this issue has arisen in a number of states. California has recently raised their state requirements to $10/hour. New Jersey has gone up to $8.25/hour, and a community near Seattle is at $10/hour, hoping to go to $15/hour. The federal minimum wage remains at $7.25, although President Obama has called for legislation to raise the level to $10/hour.

These proposed improvements will not become a reality without struggle. Forty-six and a half million Americans who are struggling with food insecurity, housing instability, and struggling to make ends meet for entire families’ stability need all of our help. Your voice can make an enormous difference to our nation’s children.

As always, your thoughts and comments are appreciated. Please e-mail me at donroschiff@comcast.net.

Pattie Quigley, Allison Housman and Kelsey Logan
SAVE THE DATE! Quality Improvement & Patient Safety at NCE 2014

Cathleen Guch, Staff
American Academy of Pediatrics

Join the Council on Quality Improvement and Patient Safety (COQIPS) at their inaugural Section (H) program at National Conference and Exhibition 2014 in San Diego!

COQIPS will host a full day program on Monday, October 13, 2014. The morning of the program will be dedicated to abstract presentations, poster presentations, and a networking reception. COQIPS encourages the SOYP to submit quality improvement and/or patient safety abstracts for consideration. More details and the official call for abstracts will become available January 2014: https://aap.confex.com/aap/2014/cfp.cgi.

Dr. Thomas K. McInerny, American Academy of Pediatrics (AAP) Immediate Past President, will kick-off the afternoon activities with a presentation on the future role that QI and patient safety will play for the AAP, members, and most importantly, the children and families we serve.

The remainder of the afternoon will introduce practical techniques for applying QI science and methodology to a timely topic in ambulatory patient safety. Participants will be equipped with tangible tools, tips, and resources to implement these methods in practice. Join COQIPS For Free!

COQIPS believes in mentoring the next generation of QI and patient safety leaders and offers many opportunities for general pediatricians and subspecialists with all levels of QI and patient safety experience to become involved.

COQIPS memberships will be free to AAP members through June 2014. Contact Vanessa Shorte at vshorte@aap.org with questions or visit the following link to join: http://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Membership-Criteria/Pages/Quality-Improvement-and-Patient-Safety.aspx.

To learn more about COQIPS, visit: http://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Council-on-Quality-Improvement-Patient-Safety/Pages/default.aspx.

District VI
Young Physicians at the NCE Young Physician Reception
AAP Practice Excellence Program (APEX)

Bradley Rysz, Staff
American Academy of Pediatrics

The American Academy of Pediatrics Practice Excellence (APEX) program has been designed to provide practices with the necessary tools to transform into the Medical Home model of care. APEX offers webinars, workshops, and a web-based software application, the Digital Navigator, to meet your practice needs. Join us in March to view the following webinar.

Effective Collections Strategies for Your Pediatric Practice will be presented by renowned speaker Elizabeth W. Woodcock, MBA, FACMPE, CPC, on Thursday, March 13, 2014 at 1 PM ET. During this webinar, attendees will learn to:

- Describe how to improve time of service collections and eliminate billing altogether.
- Determine tips for improving patient collections after the service is provided.
- Define standards for training reception staff so they know how to establish payment expectations with families and follow through by using effective collection techniques when patients receive services.
- Discover new ways to collect what families owe - from writing collections letters that get results to improving the effectiveness of your patient statements.

To learn more about this webinar, or to register, click here.

For more information on APEX and its service offerings, click here or e-mail apex@aap.org.

District IV Young Physicians at the NCE Young Physician Reception
Educational Programs from the Council on Clinical Information Technology (COCIT)

Cathleen Guch, Staff
American Academy of Pediatrics

COCIT educational program at the 2014 National Conference & Exhibition (NCE) Sunday, October 12, 2014
9:00 AM - 5:30 PM

The COCIT educational program at the 2014 NCE will provide participants with practical tips for how to prepare for and manage the difficult transition of changing EMRs.

COCIT also accepts podium and poster abstracts on pediatric informatics research including projects on the use of information technology in child health. Research in the following areas will be considered: clinical practice, health services delivery and/or public health (including the use of IT by patients). The official Call for Abstracts announcement will go live in January 2014: https://aap.confex.com/aap/2014/cfp.cgi.

Check out the COCIT Educational Programs page for more details about the COCIT 2014 educational program: http://www2.aap.org/informatics/COCITEducationalPrograms.html.

The Technology Virtual Grand Rounds – NEW TOPIC

The Technology Virtual Grand Rounds were developed to provide on-demand, asynchronous learning opportunities on topics in telehealth and health information technology (HIT) relevant to the profession of pediatrics.

The newest topic is titled Telehealth in the School Setting: Focus on Telemental Health.

View the activity here: http://www2.aap.org/informatics/VirtualGrandRounds.html.

2014 AAP Visiting Lectureship Program Grants

Janet Brishke, Staff
American Academy of Pediatrics

The Julius B. Richmond Visiting Lectureship Program provides grants of up to $3,000 to support two-day, customized, educational meetings aimed at protecting the health of children and families by controlling tobacco smoke exposure. The lectureships are designed to promote secondhand smoke (SHS) exposure control and to integrate tobacco control and prevention into medical education, health departments and state or national pediatric organizations, both in the U.S. and abroad. The deadline for submissions is February 18, 2014 and awards will be made in April 2014. The Call for Proposals is posted on the Richmond Center website.
Award-Winning Autism Book for Parents
Enjoy 3 Chapters of the Book as a Sneak Preview!

Stephanie Mucha, Staff
American Academy of Pediatrics

The American Academy of Pediatrics Council on Children with Disabilities Autism Subcommittee was integrally involved in the development of a new parent book, *Autism: What Every Parent Needs to Know*—with Drs Alan Rosenblatt and Paul Carbone serving as co-editors. Since its release in October 2012, the book has won numerous awards:

- Silver EXCEL Award from the Association Media & Publishing awards competition in the non-technical book category
- Silver Award in the Independent Book Publishers Association Benjamin Franklin Awards in the Parenting & Family Issues category
- Medical Book Award in the Public/Healthcare Consumers category from the American Medical Writers Association
- ForeWord Reviews 2012 Book of the Year Award: Honorable Mention in the Family & Relationships category.

To celebrate these awards, here is a sneak preview (3 chapters) of the book!

If you'd like to purchase a copy, click here: [www.healthychildren.org/AutismBook](http://www.healthychildren.org/AutismBook).

For more information on autism: [www.aap.org/autism](http://www.aap.org/autism).

About the book: *Autism Spectrum Disorders: What Every Parent Needs to Know* is an invaluable resource for parents and caregivers of children who have been diagnosed with an Autism Spectrum Disorder (ASD). This resource was prepared under the editorial direction of two distinguished pediatricians and autism experts (one author is also the parent of a son with autism). This book helps parents understand how ASDs are defined and diagnosed and provides information on the most current types of behavioral and developmental therapies. It also helps parents understand what they can do to help promote a smooth transition from adolescence through the teen years and into adulthood.

About the editors: Alan I. Rosenblatt, MD, FAAP, is a neurodevelopmental pediatrician and teaches general pediatrics at the Ann & Robert H. Lurie Children's Hospital of Chicago. He has combined patient care, advocacy, and teaching throughout his career in a variety of clinical settings in the United States and abroad and has received awards for clinical excellence and for his advocacy efforts. He has held professional leadership positions at the local, state, and national levels, including on the Autism Expert Panel of the American Academy of Pediatrics. Dr. Rosenblatt lives in Chicago, Illinois.

Paul S. Carbone, MD, FAAP, is a general pediatrician with an interest and experience in the area of autism spectrum disorders and related developmental disabilities. He is an assistant professor of pediatrics at the University of Utah in Salt Lake City and a coordinator for the autism program of the Utah Regional Leadership Education in Neurodevelopmental Disabilities Program. He is a current member of the Council on Children with Disabilities Autism Subcommittee of the American Academy of Pediatrics. Dr. Carbone lives in Salt Lake City, Utah.
Are you missing something in your life? I was, but thankfully, through some research, I have found it.

About six months after completing residency and about three months after taking boards, I was really enjoying life. With my training complete, I finally had the opportunity to relax and reap the benefits of my hard work. I was settling into the rhythm of primary care. My job was fabulous. I had so much control over the course of my day to day schedule. Most nights I actually got to sleep in my own bed. I enjoyed attending several family functions and reconnecting with friends and family that I had not seen since this journey began in college.

Despite all of my free time to spend with loved ones or curled in front of the fire with a good, completely non-medical book, I was missing something. I completed most work days with the nagging sensation that I was missing something. Unfortunately, I could not quite put my finger on the source of my angst.

Enter the Section on Young Physicians. In an e-mail from the AAP's Young Physician group, I saw a request for a young physician liaison to Pediatric Research in Office Settings (PROS). I had never heard of PROS, but began to do some research and what I discovered was very exciting.

PROS was established in 1986. Its mission is to improve the health of children by conducting collaborative primary care practice-based research. PROS recognizes the gap in the research available on children's health care, because many studies are based in academic and hospital settings.

The PROS network is committed to generating new knowledge about basic pediatric issues of prevention and medical effectiveness -- knowledge that can have a significant impact on the health of children. Ideas for studies come from a wide range of sources, but most importantly, from primary care providers. PROS recognizes that primary care physicians are quite busy so studies are designed with that in mind. Participating practices can select from several studies based on interest level, patient population, and time commitment required.

PROS filled an empty spot in my professional life. It satisfied my need to be involved in office-based research and to advance the practice of medicine. I feel strongly that PROS can do the same for you! Want more information? Visit https://www2.aap.org/pros/index.htm.

District X Young Physicians at the NCE Young Physicians Reception
2014 Call for Nominations – AAP Tobacco Consortium Membership

Janet Brishke, Staff
American Academy of Pediatrics

The AAP Julius B. Richmond Center of Excellence announces a Call for Nominations for AAP Tobacco Consortium Members.

The Tobacco Consortium serves as a forum for scientific exchange and research-in-progress presentations between established and newer investigators who are committed to tobacco control and prevention affecting children, youth and families. The Consortium uses a participatory process to set its agenda, and provides opportunities for members to meet and share cutting edge research that advances child and adolescent tobacco control and prevention.

AAP members and non-members interested in scientific research in child and adolescent tobacco prevention and control are invited to nominate themselves or be nominated for membership positions on the Consortium.

Nominations should include:
1) Brief Fact Sheet (describing scholarly activities and interest)
2) Biosketch
3) Letter of recommendation (optional)

Nomination forms and more information about the Consortium and the Call for Nominations are available on the Richmond Center web site. Applications should be submitted by e-mail to richmondcenter@aap.org by March 3, 2014.

To learn more about the AAP Richmond Center, please see www.aap.org/richmondcenter or contact the Richmond Center’s Director, Jonathan D. Klein, MD, MPH at jklein@aap.org or 847-434-4322.
Update on The Pediatrician Life and Career Experience Study – PLACES
Electronic Communication with Families
Ashley Miller, MD, FAAP
PLACES Project Advisory Committee

Over the past decade, there has been an increase in electronic communication between physicians and their patients, but less is known about such communication among young pediatricians. Do younger pediatricians communicate with their patients or their patients’ families in an electronic way?

According to new data from the AAP Pediatrician Life and Career Experience Study (PLACES) 2013 annual spring survey, 42% of the PLACES participants report current use of email, text, or other digital technology to communicate with their patients or their patients’ families. Electronic communication varies by current position, with participants in hospitalist positions reporting the lowest use (see Figure 1). Use of electronic communication is similar for men and women and race/ethnicity but varies by work area and setting. Pediatricians working in suburban areas report the highest use (50%), and those in urban, inner city areas report the lowest use (34%). Full or part owners report higher use (60%) than employees (41%) or independent contractors (12%). Among those who are not currently in fellowship training, pediatricians who graduated residency 2-4 years ago were less likely than those who graduated 9-11 years ago to report electronic communication with patients or their families (36% and 47%, respectively).

Among the participants who report that they communicate electronically with patients or their patients’ families, the majority use email (68%) and patient portals (52%), while less text (15%). Pediatricians who reported use of email and patient portals vary by position type (see Figure 2). Those in fellowship training are most likely to use email (88%) and least likely to use patient portals (32%), while those in general pediatrics are most likely to use patient portals (61%) and least likely to use email (58%). Lower reported use of texting was consistent across all positions.

The majority of young pediatricians do not communicate electronically with patients or their patients’ families. Email and patient portals are used by the majority of pediatricians who do communicate electronically. PLACES will be able to track the use of such modes of communication across time.

About PLACES: PLACES is a longitudinal study of early career pediatricians that tracks their work and life experiences and is unique because of its longitudinal design, inclusion of both AAP member and non-members, and the range of content included on the surveys (e.g., work, satisfaction, personal dimension). PLACES was launched in 2012 and includes over 1,800 pediatricians in two cohorts: 1) recent residency graduates (most graduated residency in 2009 – 2011) and 2) early career (most graduated in 2002-2004). Participants are asked to complete 2 surveys each year: a longer survey in the spring and a shorter one in the fall. More than 9 in 10 participants (93%) completed the 2013 spring survey. Thanks to those of you who continue to participate in PLACES!
cont. Update on The Pediatrician Life and Career Experience Study – PLACES Electronic Communication with Families

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For more information, check out the October Issue of the PLACES newsletter, “GOING PLACES,” visit the PLACES website, or email places@aap.org. We will continue to share PLACES results and updates in this newsletter.

Figure 1 – Current Use of Email, Text, or Other Digital Technology to Communicate with Patients/ Patients’ Families by Current Primary Position (N=1666)

Source: AAP PLACES Annual 2 (2013) Survey
**cont. Update on The Pediatrician Life and Career Experience Study – PLACE**

**Electronic Communication with Families**

*Cont. from page 25*

**Figure 2 – Method of Electronic Communication by Current Primary Position (N=680)**

![Graph showing communication methods](image)

Source: AAP PLACES Annual 2 (2013) Survey
You CAN get “Medicaid Health Insurance!”

Help Spread the word! Youth who have recently aged out of foster care (<26 yrs old) will be eligible for Medicaid starting January 1, 2014! Help spread the word, the American Academy of Pediatrics has created a web badge that links to [www.aap.org/alumnihealth](http://www.aap.org/alumnihealth), where alumni can find more information on how to sign up. Please help by posting the web badge to your website, sending it to a email distribution list, posting it on social media platforms (e.g., Facebook), and/or printing it out and posting at sites where alumni might see it.

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Pediatric Research in Office Settings (PROS) is the American Academy of Pediatrics’ practice-based research network, where pediatricians partner with researchers to develop and conduct research studies aimed at improving the health of children. Our mission is to improve the health of children and enhance primary care practice by conducting and fostering national collaborative practice-based research.

To learn more about PROS opportunities, please contact:

Alison Bocian, MS  
Sr. Research Associate  
Email: abocian@aap.org  
Phone: 800/433-9016 x 7620  
Please visit our website at [http://www2.aap.org/pros/](http://www2.aap.org/pros/)
Subspecialist Web Site Member Benefit

Visit the latest addition to AAP.org! This Web site is designed specifically for pediatric subspecialists and surgical specialists, aims to enhance professional development, provide opportunities to interact with other pediatricians, assist with work-life balances, and encourage communication between subspecialists and surgeons who understand the concerns faced in practice. Following is a glimpse of what is included:

- Advocacy
- Education
- Maintenance of Certification
- Patient Management
- Policies and Publications
- Professional
- Quality

View testimonials here. Tell us what you think here!

NCE 2013
Dr. Nadine Burke Harris recipient of the Arnold P. Gold Foundation Humanism in Medicine Award
Drs. Perrin, Harris, Alden and McInerny
1. Who are you?

My name is James (Jimmy) McElligott, and I am an academic general pediatrician at the Medical University of South Carolina (MUSC). I graduated from the University of North Carolina (undergraduate), Wake Forest (medical school) and MUSC (residency, chief residency and academic generalist fellowship). My interests include telehealth, health disparities, vaccine delivery, and global health. I currently have the role of Medical Director for Telehealth at MUSC, and I am also active in our South Carolina Pediatric Practice Research Network. I live in Summerville with my wife and two kids. I play soccer and am in a band and playing guitar, mostly originals, but Irish tunes lately.

2. Who or what influenced your career?

I grew up in a large family of seven kids, which greatly influenced my decision to go into pediatrics. I find my gratitude from helping those most in need, which has led me down the path of health disparities, and surprisingly to the application of telehealth technology.

3. How did you become involved in the American Academy of Pediatrics?

I have been involved since residency and am active in advocacy efforts with the residents, so have remained involved with the AAP.

4. What is your favorite book and/or favorite travel destination?

I am enjoying Hemingway these days. I am intrigued by the way he described the world. I would say ‘for Whom the Bell Tolls’ if I was pressed. I love going home to Ireland, where my parents and two youngest siblings live.

5. What is your favorite developmental milestone?

After watching my son develop, I would have to say I really enjoy watching his perception of the world take off. Not sure where that falls in, but perhaps the ‘follow two step command’ kind of stuff, but that really does not describe the amazing process.

6. What is the best part of your job?

Feeling good about what I do is the best part of my job. I often tell the medical students debating between family medicine and pediatrics that there are different types of gratitude you get from your job. In family medicine, they get lots of cakes and old folks who love them no matter what they do, but parents are different and tend to be more anxious about the care because it involves their kids. I take pride in helping a family because I have the patience to do it and do not need the immediate gratitude, all though I could use some cakes.

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District VI

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1. Who are you?

My name is Dipesh Navsaria, MPH, MSLIS, MD. I am an assistant professor of pediatrics at the University of Wisconsin School of Public Health and Occasional Children’s Librarian.

2. Who or what influenced your career?

Quite simply: who or what *didn’t* influence my career? To quote Tennyson "I am a part of all I have met."

3. What’s the best part of your job?

Serious answer: making a meaningful difference in the lives of children whether that is directly through clinical care or by training others and setting up systems that will do the same.

Silly answer: Making booger jokes in a professional setting.

District VIII

1. Who are you?

My name is Milette Oliveros, MD and I am a neonatologist at the Kapiolani Medical Center for Women and Children. I am currently the Secretary and Young Physician representative of the Hawaii Chapter of the American Academy of Pediatrics. I came from the Philippines and did my pediatric residency and neonatology fellowship at the University of Illinois at Chicago.

2. Who or what influenced your career?

My parents were very influential in convincing me to become a doctor. They did this with a lot of love and support. Pediatrics was the right specialty to suit my personality and as a resident I thoroughly enjoyed my NICU rotation that I envisioned myself doing for the rest of my life.

3. How did you become involved in the American Academy of Pediatrics (AAP)?

As a pediatric resident, the AAP provided me with journals, books and preparatory materials for the boards. I continued to be a member to utilize all these perks, but I soon realized that there was so much more to the organization.
I became a local chapter member as soon as I moved to Hawaii to meet the pediatric community. I learned about the various activities that the AAP was involved in to advocate for pediatric health. It was important for me to get young pediatricians aware by becoming active members. With the help of Gary dela Cruz, another young physician serving on the board, we were able to hold fun activities targeting young pediatricians in the community to promote engagement. These activities include the 5-minute speed meeting, annual summer social and educational dinners.

4. **What are your favorite books and/or favorite travel destination?**

My favorite travel destination is Palawan, Philippines. I still love going back to the Philippines. Although there are areas of chaos, there are certainly areas of great beauty. This particular location has gorgeous beaches, rich marine life, and spectacular rock cave formations. Life in this region is simple and it enables one to self-reflect in a tranquil environment.

5. **What is your favorite developmental milestone?**

My favorite developmental milestone is the social smile. It is wonderful to elicit such a positive learned human response from a baby. It creates a special bond between the parent and child since it is such an enjoyable early form of communication.
MEET YOUR SOYP EXECUTIVE COMMITTEE

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Interested in writing an article?
Email the editors.
We welcome your submission!

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NEWSLETTER EDITORS

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

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