At last month’s AAP National Conference and Exhibition (NCE), I had the pleasure of meeting with the AAP Section for Senior Members executive committee. Many people may think that it is odd for the chair of the Section on Young Physicians (SOYP) to meet with pediatricians at the other end of the career spectrum, however, the SOYP has a long and productive history of collaboration with the Senior Section.

At this meeting, the subject of changes in clinical care came up. When asked why she still practices general pediatrics after all these years, Iris Snider, MD, told a story about diagnosing a case of measles. Surprisingly this did not happen decades ago, this happened a week prior to our meeting! One of her patients has a case of post-vaccination measles which she was quickly able to recognize and diagnose. Dr. Snider’s excitement about her job was infectious (cont.)

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(pardon the pun). This story led to a discussion about my experiences, or lack thereof, diagnosing vaccine preventable diseases like measles, varicella, and polio.

A few hours later, I was discussing my meeting with the SOYP executive committee. One of our committee members told a story about how a more seasoned pediatrician in her practice was able to show her how to feel the elusive “olive” described in patients with pyloric stenosis.

So many of our clinical skills have been augmented or replaced by medical testing and technology. In my own practice, the implementation of electronic medical records has drawn my focus away from the patient and more towards the computer---though I hope this is only temporary.

During the meeting with the Senior Section, I also found so many things our sections have in common. We all struggle with work-life balance. Many of us wish we were better business people and that it was easier to navigate the constantly changing healthcare system. We also talked about career choices and my decision of going into academic medicine versus a traditional private practice, as well as the inability for most pediatricians today to be a solo practitioner.

I left this meeting energized. Our groups can learn so much from each other. I encourage you to seek out more senior pediatricians in your hometowns and build a mentoring relationship. This connection can be a two-way street with you also serving as a mentor—in areas such as social media, incorporating technology into practice, etc. (If you have been watching Grey’s Anatomy, you have seen a bidirectional mentoring relationship between a young surgeon and her senior colleague---and we all know our lives are just like on Grey’s!)

In this newsletter, you will find articles written by our section members that will also energize and inspire you. As always, I encourage you all to write about what you are doing in your practices and communities. We would love to include your stories in our next newsletter. If you have any questions about how to become more involved in the SOYP or in the Academy, feel free to contact anyone on the SOYP executive committee. We would be happy to help you navigate the system or connect you with members in your area of interest.

Sincerely,

Rachel Dawkins, MD, FAAP
Editor’s Note

Tyler Smith, MD, MPH, FAAP
SOYP Newsletter Co-Editor

Who dat? Who dat? I said who dat dere that's gonna advocate for kids?! OK, this may not be my best catch phrase, but you get the point :O)! The American Academy of Pediatrics (AAP) held its annual National Conference and Exhibition (NCE) in the “Big Easy,” Nawlins, Louisiana. The young physicians (YPs) were present in full force with Mardi Gras beads and warm beignets. The YPs conducted a joint program with the Section on Administration and Practice Management with sessions about quality improvement projects, employee relations and managing staff, and marketing a pediatric practice. Keynote addresses at the NCE were given by AAP President Robert W. Block, MD, Pulitzer Prize Winner in Journalism, cartoonist Walt Handelsman, and political analysts as well as husband and wife, James Carville and Mary Matalin. A true highlight of the NCE was the New Orleans Experience at Mardi Gras World. While dining on jambalaya and other New Orleans inspired cuisine, attendees were able to see firsthand where Mardi Gras floats were designed and created. Brass bands, clowns, magicians, and stilt walkers created the ambiance for a magical night with children decorating umbrellas and adults dancing the night away to a local New Orleans band. And who could forget the great food and fellowship at the YP reception with an iPad given as a door prize!

On another note, I was well into the holiday season as it is one of my favorite times of the year. My wreath and stockings were hung and the tree was decorated with glittery ornaments. I was uncertain of my favorite parts of the winter holidays. Was it the hustle and bustle of holiday shopping? Was it sipping hot cocoa with extra marshmallows and whipped cream? Was it singing my favorite holiday songs? Or was it watching “Rudolph the Red Nose Reindeer” or “Charlie Brown Christmas” or “How the Grinch Stole Christmas” for the umpteenth time (Yes, I still watched these holiday favorites!)? I think it was the happy spirit of the season all wrapped into one big ball of gooey happiness!

I travelled back to my home state of New York and got into the holiday spirit walking the avenues and streets of New York City. I was brought back to my childhood marveling at the holiday tree in Rockefeller Center, viewing the intricacies of the holiday windows at Macy's and Saks Fifth Avenue, and enjoying the bright lights of Times Square. For my first time ever, I attended the Radio City Music Hall Christmas Spectacular featuring the 85th anniversary of the world renowned and iconic Rockettes. I think I was more excited to see the performance than the kids who sat with me in the audience!

As much as I enjoyed the holidays and my brief time in New York City, I was reminded that I also needed to remember my pediatric patients. Children and adults alike could easily get caught up in the commercialism of the holidays, but it was important be mindful and remember the joy of the season in counting our blessings while spending time with family and friends. For some of our patients, this was a very challenging time of the year. This was the first holiday after the loss of a family member, close friend, or even a beloved pet. This was the first holiday after a major life change such as the birth of a sibling or moving to a new home. With the recent devastation of Hurricane Sandy along the eastern seaboard, some of our patients and colleagues were still working to bring normalcy back to their lives and did not spend the holidays in a comfortable or familiar environment. It was my hope that we as pediatric providers were mindful of this wonderful, but sometimes difficult, time of year. I hope as providers we checked in with families and colleagues to be sure they were okay and knew that someone cared during the holidays. Thoughtful words with a warm and friendly smile could have made a huge difference to the holiday season!
Standing Up for Immigrant Children and Families

Lase Ajayi, MD, Fellowship Trainee
Council on Community Pediatrics Immigrant Health Special Interest Group

I am new to the San Diego area, having only moved here a couple of months ago. Because the majority of my immigrant patients are from Mexico, I recently realized that the first thing that comes to my mind when I hear “immigrant health” is “Mexican immigrant health.” I sometimes forget that there are so many more immigrants in the United States than those coming from Mexico. This point was recently driven home when I had the opportunity to meet and fall in love with a family from Thailand.

This young couple recently immigrated to the United States as Burmese refugees because they were told that America would hold a cure for their son. In Thailand they gave birth to two beautiful twin boys at 26 weeks gestation. One passed away shortly after birth, but the second twin survived. Upon discharge from the hospital, they were told that their surviving child had a small brain, two small kidneys, and would have some problems eating. They took their baby home and managed intermittent apneic episodes at home without any medical intervention. When a neighbor and family friend told them that America would have a cure for their son, they sold everything they owned and used the last of their money to come to the United States. Within two days of their arrival in San Diego, they took their child to the emergency room, and he was admitted to the hospital. But instead of receiving the cure they were so desperate for, they received the devastating diagnosis of congenital encephalomalacia and a prognosis of less than two years to live.

A couple of months later I met this couple while doing a home visit. The mother was depressed and lonely. She was barely able to speak or read English and spent most of the day alone with her son who she feared would choke and die at any moment. Her husband worked for most of the day and stayed out at night because he found the house too depressing. The mother told me that she planned to kill herself when her son died because there would be no reason for living. Her dreams for her child were shattered. She felt utterly alone, hopeless, and trapped. As a pediatrician, I was overwhelmed.

This is just one of the many stories that I, and I am sure many other pediatricians can tell about our immigrant families. Many of the immigrant families we serve are facing difficult economic and social challenges in a new country. Many have arrived with incredible hopes and dreams for America and American health care. As pediatricians, we are often at the forefront of their lives as new Americans. But it can be difficult for us to access the quality comprehensive health care they need, because they are poor or excluded by public policy. Cultural and linguistic barriers can also prevent the delivery of timely, quality care. Therefor, it is our duty to recognize these issues and stand up for our immigrant patients.

The AAP is standing taller for immigrant patients through the Immigrant Health Special Interest Group (SIG). Run by the Council on Community Pediatrics, the Immigrant SIG focuses on advancing pediatric practice and advocacy to support immigrant child health. Filled with the stories and commitments of pediatricians around the nation, the SIG is growing in membership and activity. The group is standing up for immigrants through federal advocacy for immigrant inclusion in health care reform implementation, and other policy issues. The SIG has started the development of a toolkit to ensure practicing pediatricians can provide culturally and linguistically effective care, and recently hosted educational sessions at the AAP National Conference and Exhibition. And as a group filled with stories, the Immigrant SIG is developing an online story bank to capture the triumphs and challenges of our patients and profession.

I hope that you will join us. Tell us your story and get involved. When we stand together we have a voice that will be heard, and it will ensure that all children have a path to their best potential health. For more information visit www2.aap.org/commpeds/cocp/ or contact cocp@aap.org.
Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

Martin Luther King, Jr.

Health care disparities have burdened Native American populations in the past and still are major obstacles for medical providers working in the Indian Health Service; however, this gap has narrowed for Native American children who are living on the Navajo reservation. After visiting several of the health care facilities, I witnessed several positive changes that pediatricians are making to improve the health status of children on the reservations.

As a fellow liaison to the Committee on Native American Child Health (CONACH), I was able to participate in the yearly pediatric consultation visits to an Indian Health Service (IHS) health care facility. The IHS is a comprehensive community-oriented health service delivery system that serves American Indians and Alaska Natives. The goals of the CONACH consultation visits are to strengthen the ties with American Indian tribes, understand and appreciate the medical issues facing Native American children, and develop policies and programs to improve the health of Native American children. The committee makes consultation visits to Indian health care facilities across the United States and this year’s visitation site was on the Navajo reservation.

The Navajo reservation is the largest Indian reservation in the United States, covering 25,000 square miles in Utah, Arizona, Colorado, and New Mexico, which is approximately the size of West Virginia. Given the remoteness of Indian reservations, access of care is often limited by poor infrastructure such as, unpaved roads and absence of public transit. The populations are often burdened with high poverty levels, lack of traditional plumbing, and poor access for heating, often having to use wood for basic heating. The major medical issues for the pediatric population that were identified were overweight/obesity, early childhood dental caries, elevated risks of depression and suicide, and type 2 diabetes.

The visit included an informal dinner with a group of pediatricians at local restaurant that provided an opportunity for the CONACH participants and local pediatricians to learn about each other’s needs and goals for the visitation and also to cultivate stronger interpersonal relationships. The following day was spent at the health care facility with presentations that described the medical services, challenges and strengths of their clinical practice. The day also included a tour of a comprehensive community health care service that includes outpatient and inpatient services, newborn nursery, surgical, and emergency room facilities. The day ended with a tour and overview of school-based clinics.

The pediatricians have integrated a unique Family-Centered health care system that incorporates partnerships with the tribe and the community. The foundation of their medical delivery system is based on the community, family, and patient being treated as a partner in care decisions that may include western medicine practices, traditional Native American practices or combination of both. Their efforts have been evident with improved preventive care strategies and prevention outcomes. The Navajo reservation has one of the highest immunization delivery rates, low asthma exacerbations, and low tobacco usage. The hospital implemented a “baby friendly hospital” with early infant-mother interactions and promotion of early breastfeeding.

The pediatricians have also implemented various community-based early intervention programs. The extension of the medical home has been bridged with school-based health care clinics that provide comprehensive care to the adolescent population, home visitations to provide care to families without transportation, and a mobile-clinic trailer that is able to extend medical services. Public health initiatives such as injury prevention were recognized with road-side billboards increasing infant car seat education and promoting awareness about decreasing texting on cell phones while driving a motor vehicle.
**cont.** Perspectives on Native American Children Health Care Status: CONACH Consultation Site Visit

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The pediatricians that I met on the Navajo reservation were a spirited and motivated group, who embrace the Native American culture and created unique programs to bridge western medicine and traditional Native American medicine. The medical-home models implemented on the reservations are outstanding programs that should be recognized by other care facilities across the nation. There continues to be significant health disparities facing Native American communities, but the medical providers working in the Indian Health Service have made significant steps eliminating these discrepancies for Native American children.

Damon Dixon, MD, is a second-year pediatric cardiology fellow at the University of Minnesota. He is a Native American physician, who is enrolled in the Hopi tribe. Write to him at db-dixon@hotmail.com.

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**Book Review**

*Randi Teplow-Phipps, MD, FAAP*

*Title: Prescription for the Cure*  
*Author: Jeffrey M. Lobosky, MD*

The hype of the presidential debates and election presented the perfect opportunity to discuss a book on health care in America. We have seen dramatic changes in the governmental approach to health care from the dispute over “Obamacare”. As physicians, and often patients ourselves, we experience the frustrations of the American healthcare system regularly. Dr. Lobosky, a neurosurgeon from California, wrote this book as a catharsis to address his dissatisfaction as he dissects the issues of American health care in a humor-filled readable manner. He begins with a reality check that American health care, despite being the most expensive, is not nearly the best care in the world. He delves into the history of the insurance companies and the development of managed care. He points out the good intentions of these companies when they started, but shows how they devolved into the disrepair of today. He criticizes the American reimbursement system where volume and procedures are valued more than bedside manner and thoughtful medicine. He addresses the pharmaceutical industry and traces how our trillions of dollars are spent and why medication costs are astronomical in the United States. He discusses the shift of health care into emergency rooms and urgent care centers, and how this has caused the system to become overwhelmed forcing changes in the way medicine is practiced. Public hospitals often are forced to absorb costs of the uninsured and simultaneously suffer low reimbursement rates for Medicaid and Medicare patients. Dr. Lobosky believes that there will be a shortage of doctors and that we will rely mostly on physician extenders, such as physician assistants and nurse practitioners, to provide primary care for the aging baby boom population. Finally, he raises the issue of how often the patient themselves, while playing the part of the victim, continue to contribute to the breakdown of the system.

While reading this book, I had flash backs to the Michael Moore movie “Sicko.” Most of this book, while true, seems to be one-sided about the problems in this country. He even comments how Moore’s films are too unilateral, but he falls into the trap himself. In his final chapter, he attempts to provide solutions to our broken system, yet many of them are too extreme for the American public to seriously consider, such as changing presidential and congressional term lengths. He promotes equality for all American citizens, recommends universal health care, and believes that care should be a basic right for everyone.

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**cont. Book Review**

**Title: Prescription for the Cure**

He discusses how the original healthcare plan proposed by President Obama could have solved many of the nation's problems, but how the final bill became a watered down version due to lobbyists as it passed through congress. To Dr. Lobosky and the President's dismay, the current plan barely resembles the original idea. He challenges all physicians to take a stand and not remain among the silent majority who allow the broken system to continue. Dr. Lobosky's book is provocative and his ideas are strong as he tries to ignite a movement for change. He urges the reader to think about the issues, to be involved, and at the very least, to become an informed consumer and provider in the great American Health Care System.

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**Title: The Story of Beautiful Girl**

**Author: Rachel Simon**

Set in 1968, during one of the darkest moments of American history, when state-run mental health institutions treated patients inhumanely and locked them away as if they were prisoners. This is a story of how love was still able to bloom. They were an unlikely pair; Lynnie, a young girl with mental disability and Homan, an African American deaf male. Despite being unable to communicate verbally, they managed to develop a deep love and understanding for one another. When the unthinkable violation happened to Lynnie and she became pregnant, Homan helped her escape in time to deliver the baby. On that fateful night, they sought refuge at Martha's house, a retired school teacher and childless widow, who opened her door in the pouring rain. Knowing nothing of Martha, they entrusted her with the duty of hiding the infant and eventually raising their daughter. When the authorities came looking for the couple Homan was lucky enough to escape. We followed his travels across the country as he learned how to become integrated into society and grew as an independent person. Yet despite his freedom, for decades to come he continued to pine for Lynnie. Unfortunately, Lynnie was forced to return to the institution where she was treated more like a prisoner than someone with a disability. As Lynnie worked to overcome some of her limitations and cope with the trauma she experienced, she never once stopped hoping for the day she would reunite with Homan.

Through the various voices and experiences of the characters, we learn of the horrors of state-run institutions in the 1960s and the total disregard for human lives. As time progresses through the book, we see some of the positive changes implemented as Americans finally recognized that treating the disabled in such a disgraceful manner was unacceptable.

Rachel Simon, the author, became interested in the history of state institutions when she traveled the country discussing her prior book about growing up with her mentally disabled sister. She was touched by the stories of her readers and their family's struggles with the state institutional system. She recognized that many disabled people fought to retain the right to make decisions about their own lives, which she intricately ties into this book. The author's other main inspiration for this book came from a true story re-created by Dave Bakke of a young deaf man found wandering the alleys of Illinois in 1945. Known only as John Doe Number 24, since his signing could not be understood, this young man was deemed feebleminded and sent to an institution for the remainder of his life. Simon, troubled by this young man's lost identity, wrote this work of fiction to pay tribute to his life. In this book, she successfully discusses the struggles of those with disabilities, both as individuals and with outside forces.
A New Course on Pediatric and Adolescent HIV Care for Pediatric Residents and Fellows in Memphis!

Rana Chakraborty, MD, PhD, FAAP
Course Director and Chair of the Committee on Pediatric AIDS

Ellen Cooper, MD, FAAP
Course Director

Pat Flynn, MD, FAAP
Course Director and Past Chair of the Committee

The Committee on Pediatric AIDS (COPA) at the American Academy of Pediatrics (AAP) is delighted to offer the inaugural training course on HIV management in children and adolescents to all pediatric residents and fellows, nationwide. This course will take place annually and will comprehensively educate participants on all aspects of HIV management in infants, children, adolescents, and young adults. The course will be undertaken in collaboration with the Pediatric European Network of Treatment of AIDS (PENTA) and the European Society for Pediatric Infectious Diseases (ESPID), which already provides established courses in Europe, Africa, and Brazil on pediatric and adolescent HIV care. Other partners include the Pediatric Infectious Diseases Society and St. Jude’s Children’s Research Hospital. The COPA course will follow on from the annual St. Jude/PIDS research conference in Memphis, TN, which takes place on February 22 - 23, 2013.

The COPA course will be taught by pediatricians who are internationally recognized experts in HIV care from the United States (US) and Europe over three days (February 23 – 25, 2013). The course offers pediatricians’ structured didactic lectures combined with informal workshops. The content includes topics on global and international child health using the most current evidence-based medicine for pediatric and adolescent HIV care, by renowned teachers who themselves are principal investigators for these international trials. At the same time lectures on current practice in the US will be presented by the same faculty who also serve as medical directors of pediatric and adolescent HIV clinics within their respective institutions and who also develop and contribute to HIV management guidelines for the US, Europe and the World Health Organization (WHO). The COPA course will enable the participant to become familiar with the essential concepts of HIV management in the above age groups in both resource-rich and resource-poor settings. In addition to serving a national need for improvement in HIV care in children and adolescents, the COPA course will comprehensively address pediatric HIV management as part of a global health initiative at a time when many US-trained junior pediatricians work outside the country for variable periods of time in resource-poor settings where HIV infection may be endemic.

Background

Globally, HIV has infected more than 40 million people worldwide; approximately 2 million include children under the age of 15 years [1]. An estimated 1,800 children are newly infected each day, with the majority of cases attributed to mother to child transmission (MTCT). Nearly two thirds of all HIV-infected children do not have access to life-saving antiretroviral therapy (ART). Without effective treatment, approximately half of all perinatally HIV-infected children will die by their second birthday [2,3]. In contrast, data from Western Europe and North America have documented an 80-90% decline in HIV-associated morbidity and mortality in HIV-infected children and adolescents, achieved when ART was successfully administered [4]. However, pediatric HIV care remains complex and continues to present great challenges, despite the consequential advances witnessed over the last two decades. Domestically, there has been a sharp increase in newly diagnosed HIV infection among adolescents and young adults (AYAs). In 2006, an estimated 5,259
A New Course on Pediatric and Adolescent HIV Care for Pediatric Residents and Fellows in Memphis!

AYAs aged 13-24 in 33 states were diagnosed with HIV/AIDS, representing 14% of all persons diagnosed with HIV in the US that year [5]. Many clinics providing care for HIV-infected children have adapted their practice to include older patients infected horizontally. With the roll out of ART globally, there are concerns on the emergence of drug-resistant HIV. At the same time there are new classes of antiretroviral drugs that are available for children. The field is therefore as dynamic as it is challenging, but professionally very rewarding when a practitioner is able to successfully make a difference in the lives of the individuals and families he or she serves.

Target Audience – You!

Given the considerable trend of United States-trained junior doctors working outside the US for variable periods often-times in resource-poor settings, the proposed course is both timely and relevant to meet their academic and professional needs. In 1984, only six percent of graduating US medical students had participated in international health electives. In 2004, 22% had done so [6]. Furthermore, a recent study documented that 52% of pediatric residency programs offered a global health elective [7]. In light of this marked increase in the recognition of the importance of global health, there appears to be a corresponding shortfall in postgraduate medical training addressing international medical experiences [8] when such endeavors require a greater knowledge of global health issues on the part of the resident particularly in a field as dynamic and changing as pediatric and adolescent HIV care [9]. Therefore COPA and the AAP encourage pediatric residents and fellows especially those wishing to embark upon subsequent or concurrent careers in infectious diseases, immunology, pathology, adolescent and adult medicine, epidemiology, or global and international child health to enroll in the COPA course. At the same time, we hope the topics covered will both inform and update the experienced practitioner serving HIV-infected and exposed infants, children and adolescents within and outside the United States.

How Do I Sign Up?

The link to register for the course is www.stjude.org/HIV-AIDS-training-course. For more information, a course brochure and/or registration please contact Anjie Emanuel at 847/434-4979 or by email at aemanuel@aap.org. The St. Jude's/Pediatric Infectious Diseases Society research conference takes place just before the COPA training course at the same venue in St. Jude's Children's Research Hospital. The link to this conference is: [http://www.pids.org/images/stories/programs/StJude_PIDS_13program_9.26.12.pdf](http://www.pids.org/images/stories/programs/StJude_PIDS_13program_9.26.12.pdf).

We look forward to meeting you in Memphis this coming February, and welcome your input and future collaboration as trainees new to HIV care or as experienced specialists.

Warm Regards,

Rana Chakraborty, MD, PhD, FAAP
Course Director and Chair of the Committee on Pediatric AIDS

Ellen Cooper, MD, FAAP
Course Director

Pat Flynn, MD, FAAP
Course Director and Past Chair of the Committee
A New Course on Pediatric and Adolescent HIV Care for Pediatric Residents and Fellows in Memphis!

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References


Making a Difference by Going for the Low-Hanging Fruit

Elizabeth Mack, MD, MS, FAAP, AAP Section on Young Physicians
Pediatric Intensivist and Director of Quality at Palmetto Health Children's Hospital in Columbia, South Carolina

In residency and fellowship training, I was surrounded by people who were passionate about providing consistently excellent care to patients. My mentors taught me to think on a systems level, not an individual level. They were “doers” rather than complainers. Thus, my introduction to quality improvement was not formal or fancy, but it had a huge impact on me. And slowly in my career as a junior faculty member (with the help of many folks), I have initiated a variety of multidisciplinary initiatives merely based on experience with inefficient or suboptimal delivery of care (i.e., my “pet peeves”). It is easy to get excited about turning things that really irk us into productive initiatives.

I was taught early on to go for the “low-hanging fruit.” For example, including a pre-checked “asthma education” on the asthma admission order set ensures all patients receive an order for asthma education prior to discharge; or satisfying a Joint Commission/Centers for Medicare and Medicaid Services requirement to have an order/reason for restraints by using a simple addition to order sets. These are easy fixes for major issues – very satisfying.

Smart use of data is another way to address the low hanging fruit. Through the implementation of the Institute for Healthcare Improvement’s trigger tool, we found that both narcotics and naloxone were being ordered in inappropriately high doses. Thus, we created order sets with suggested maximum doses and corollary orders with appropriate doses of naloxone. Providers have been happy with the incorporation of this into their workflow and the ease of ordering, and patients are happier now that we use less naloxone.

We have encouraged our peers and trainees to choose a quality improvement project that is simple to implement and easy to measure, and they have come up with some really great stuff! For example, one of our residents is assessing whether infants’ sleep practices while they are in the hospital comply with American Academy of Pediatrics recommendations on sleep practices (“Back to Sleep”)? If the answer is no, the intervention will be additional education for parents and staff. In this way, residents will merely walk around while on call at night and note whether patients sleep practice is compliant with AAP recommendations. Easy, free, and important!

I want to encourage all young physicians to find the thing that drives you and your patients crazy and approach the issue from a multidisciplinary, systems-based perspective. That way you are guaranteed to be passionate about and committed to the project. Pick a bite-sized project, look for low hanging fruit, and be sure the baseline and outcomes are easy to measure. Take the challenge on – your work life and your patients’ lives will greatly benefit from your efforts!
Thinking Outside of Our Borders: Global Immunization Advocacy

Gitanjli (Tanya) Arora, MD, DTMH, FAAP
Children’s Hospital of Los Angeles/Peds

Globally, one in every five children does not have access to vaccines. I have always had an interest in vaccine preventable diseases. My earliest childhood memory is of being in a hospital waiting room as my infant brother struggled with respiratory syncytial virus (RSV). I desperately wanted him to be well, and when the pediatrician came to tell us that my brother would be ok, I knew I wanted to be just like this doctor when I grew up. The desire to care for children was reinforced by summer vacations in India seeing kids, who looked just like me, by the roadside unable to walk or play because they had been afflicted by polio. At that age, it was difficult for me to understand the inequity that existed in my two home countries. My father grew up in India and contracted small pox as a child. He explained that this was a terrible disease and he was lucky to be alive, although he would carry the stigma of pox virus scars on his face for life. From early on, I learned how lucky I was to grow up in a time and in a country when my parents did not have to worry about life-threatening illnesses each time I had a fever. I also learned that it was just a twist of fate that separated my life from the lives of the children by the roadside and I had a responsibility to use my skills, the opportunities I had been given, to help children regardless of where they lived.

Shortly after residency, I signed up to work internationally with Doctors Without Borders in South Sudan. Here I found myself caring for children with diseases that were entirely preventable. Never did I think I would see tetanus, polio and meningitis - things my mentors back home had never seen. Vaccines in South Sudan are only made available to children less than one year old and because of the poor health care infrastructure, most children remain unvaccinated. In the 52 bed unit hospital where I worked, I had nine beds that were always full of infants and children with tetanus. They would spasm with the slightest sound or touch. Two afternoons a week, when the airplane bringing much needed medical supplies would land at the field nearby, all nine children would go in to simultaneous spasm. The other beds were filled with patients with diarrhea, pneumonia, pertussis, and a few with meningitis. Most of the hospitalizations and most of the subsequent deaths could have been prevented with vaccines. Given the tenuous political state of South Sudan during the time I was there, it was clear to me that if our hospital was not there then children with diseases such as diabetes, tuberculosis, and severe burn injuries would certainly die as there was no other health infrastructure to support sick children. But nearly two-thirds of my pediatrics ward was filled with children whose illnesses could have easily been avoided. If they had access to vaccines then they would not have become sick and would not needed hospitalization. I cannot state strongly enough the impact that vaccination would have in this unstable community.

By the time I left South Sudan, I had become sickened with myself for having said to parents again and again that there is nothing I can do for their child's breathing problem, brain infection, seizures, dehydration, and spasms for tetanus. After all, there is something that could have been done. These children should have all been vaccinated. No parent should ever have to expect that one in four of their children are destined to die. I am still unable to reconcile the inequity of knowing that more than one out of four children in so many places in the world will not make it to their 5th birthday with knowing that in my hometown of Los Angeles we live in such safety and comfort that parents feel comfortable actually refusing life-saving vaccines for their children.

In June of this year, the American Academy of Pediatrics (AAP) offered me the chance to share my experiences with senators and representatives in Washington, DC. I had the good fortune of being paired with Dr Yvonne (Bonnie) Maldonado, Chief of Pediatric Infectious Diseases and Professor of Pediatrics and of Health Research and Policy at Stanford. We went from office to office sharing our personal stories of caring for children whose illnesses were entirely preventable. In total, AAP representatives met with the staff of 46 offices from 13 states demonstrating the Academy’s commitment to global child health. Currently, the federal government is operating under a continuing resolution that will keep

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initiatives, such as the CDC global vaccination program, operating at previous year’s levels until March 2013. When Congress revisits the budget process in 2013, the AAP will continue to be a voice for children’s health both here and abroad.

The story of my brother with RSV ends well. He is now a healthy adult and is expecting his own child this spring. He plans to ensure the best care possible for his child, ensuring full vaccination in accordance with the AAP recommended immunization schedule. We feel tremendously fortunate to have access to these life-saving vaccines. To help all parents care for their children, pediatricians can support global vaccination and eradication efforts by continuing to assure high levels of immunization coverage in their patients and by partnering with others in their community such as Rotary Clubs and the United Nation Foundation’s Shot at Life Campaign to help promote global vaccination efforts.

For more information, visit the AAP global immunization webpage: http://www2.aap.org/international/immunization/default.html.
Do you hire based on the candidate’s ability to smile?

Brandon Betancourt, MBA
Pediatric Practice Managers Alliance Leadership Team Member

If you are like most people, you probably do not even notice if a candidate smiles spontaneously. During interviews, most of us are so consumed with the candidate’s skills, and finding out if they can do the job, that we often overlook important aspects that in many cases may be more important.

The funny thing is that you can teach people most any skill, but you cannot teach them to smile. And for people in the service industry, smiling is probably the most important skill of all.

While researching a talk, I came across this little story that Tom Peters told in one of his presentations. I once said to a Starbucks regional manager, “I am stunned that almost all of your store people, from the United States to Saudi Arabia, always sport a smile. What is your secret?” She smiled as she answered: “We hire people who smile!” And to keep them smiling? “We promote the ones who smile the most.”

Could it be that simple?

I can see some people saying, yeah, but Starbucks is different than a medical office. Oh yeah, how so? Whether we want to admit it or not, those of us that work in private practices, we are in the service industry just as much as Starbucks is. If anything, we ought to be more emotionally connected with patients, than Starbucks is with their customers, yet we are probably the industry that hires less on smiles and more on skills.

Smiling is the only expression I can think of that is understood by everyone despite culture, race, or religion. It is a sign of pleasure, joy, happiness, or amusement. It is also an inviting expression; one of welcoming or politeness and friendliness. In fact, research shows that smiling correlates with greater trust, greater financial earnings, and increased interpersonal cooperation.

We are not hiring right now, but when we do, I am going to make sure I look for that smile before I evaluate their skills. We can always teach them how to do things in our office, but we cannot teach people to smile spontaneously. That comes from within.

The Pediatric Practice Managers Alliance: Beside every successful Pediatrician is a very skilled Practice Manager

Jose F Lopez
Manager, Practice Management
American Academy of Pediatrics

The Pediatric Practice Managers Alliance (PPMA) is a subcommittee of the Section on Administration and Practice Management (SOAPM) created with the purpose to empower pediatric practice administrator and managers to overcome many of the day-to-day challenges of running a medical practice. By using the collective knowledge and available resources of pediatric practice managers around the country, the PPMA can help medical groups to become more effective, efficient and profitable.

Members of the PPMA have access to the brightest minds in pediatric practice management, the most creative and effective techniques to improve profitability, up-to-date information on health care related issues, as well as many educational opportunities to help practice managers or administrators grow professionally. Some of the resources available to PPMA members include:

- Access to the Practice Support Web Site, an online resource with hundreds of articles, resources, guidelines and protocols on how to manage a practice.
- Webinars that address current and relevant practice management issues. For example, health insurance contract negotiations techniques and physician compensation models are just a couple of topics that has been presented in the past.
- Access to the PPMA and/or SOAPM LISTSERVs, an electronic mailing list of medical group practice managers and pediatricians, which is used to share practice management and administrative ideas. Members can post questions to the listserv and obtain free consulting advice as well as other resources such as forms, protocols or advertising ideas.
- Opportunities for networking with hundreds of other pediatric practice managers from around the country. Being linked to like-minded practice managers, one is able to better recognize, create and even act upon business opportunities and to cultivate productive relationships.

Membership to the PPMA is open to all practice managers by joining the SOAPM as an affiliate member. For more information on the PPMA, including information on how to join, please visit http://www2.aap.org/sections/soapm/ppma.htm. If you have any questions, feel free to contact Jose Lopez at jlopez@aap.org.
Baby Educational TV. An Oxymoron?

Ari Brown, MD, FAAP
Lead Author of 2011 AAP Policy Statement Media Use By Children Younger than 2 Years

The AAP has discouraged media use in young children since 1999 (pre-dating most forms of portable screens like iPads and smartphones). It was based on limited data, but we believed that there were more potential negatives of media than positives in this age group. And since 1999, the policy has taken flak from parents, industry, and even some pediatricians. Many ask, “Where’s the harm?” if a baby is entertained by a video so a parent can make dinner or take a shower.

But, the concerns raised are even more relevant today. Screens are everywhere, and 90% of 0-23 month olds watch at least an hour of televised programs a day. So we decided to take a fresh look at the scientific evidence and see if our concerns were still valid. Here are the key questions and answers we found:

1. Do infant/toddler programs have any educational value for kids under 2?
Nope. There is a digital developmental divide. Video gets “lost in translation” for children under 1.5—2.5 years old. They cannot figure out the content or context to actually learn from televised programs. While a few 18 month olds might “get it,” the majority of kids do not have that skill until they are at least two years-old. Entertaining? Yes. Educational? No. Young children learn best from real people and playing with real objects. Kids over age two years-old can learn language and social skills from high quality shows.

2. Is there any harm in children under 2 watching televised programs?
There are 3 concerns here.
A. Short-term language delays. Young children who watch televised programs may have delayed language skills.
   Why? We do not know. One concern is that parents talk less to their kids when the TV is on, and that “talk time” is critical for young children to learn language. We do not have any long-term studies to see how this plays out, but the short-term effects are concerning.
B. Less quality and quantity of sleep. Up to 1/3 of American kids under age three have a TV in their bedroom and up to 30% of parents admit to using TV as a sleep aid for their child. However, this backfires as kids go to bed later and have more disrupted sleep when they go to bed with the tube on.
C. Time well spent? We know you cannot play with your child 24/7, but letting your child have unplugged, unstructured, independent playtime while you cook dinner is really valuable! It fosters your child’s problem solving skills and their imagination—important life tools. That is time better spent than being entertained by a program. (Check out the tips below for what your little one can be doing while you are busy doing something else.)

3. Does secondhand TV (programs intended for adults that are on when a child is in the room) affect young children?
Yes. It is distracting for parents, who are talking less to their child when their shows are on. And it is distracting for the child. Even if the show is over a child’s head, he will be less focused on his activity if he is playing nearby with the TV on. And many parents say their TV is always or often on, even when no one is watching it (which begs the question, WHY?). Our advice: turn the TV off if you are not watching, and watch your own shows later.

We know you cannot keep your child away from screens 100% of the time, and we know you cannot play with your child 24/7, but this updated statement is meant to make parents more aware of the impact of media on young children so that they will thoughtfully consider the whole family’s media use and make a plan how to manage it!

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**cont. Baby Educational TV. An Oxymoron?**

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Here are some ideas for simple, inexpensive activities that your infant or young child can do without your participation. Remember that as your baby starts to crawl, use a portable playpen or safety gates to keep your child in a safe area if your eyes are distracted. Parents should make sure that all toys are too large and impossible to swallow or chew.

**Sensory Activities**
- For young infants, offer interesting items like colorful or high-contrast toys or mobiles to look or follow with their eyes.
- Let your baby listen to music. Let your older baby or young child play with rattles, or child-friendly music boxes.
- Offer safe objects or toys that are touchable with different textures.
- Offer large plastic toys, wood, or plush toys without small removable pieces to grab, manipulate, and mouth.

**Cognitive/Language**
- Let your baby explore hard cardboard books that are bite and rip-proof.
- Offer “cause and effect” toys. Let your baby figure out how to make an object light up or make noise or move.
- Toys that can be filled and dumped are also popular with young children.

**Social**
- Let your baby play with a plastic mirror to look at their image.
- Offer pretend play props to children over age one (pretend food, picnic ware, teacups, a grocery cart, baby doll, or baby carriage).
- Let your child participate in activities of daily living. While you are cooking, let your baby “cook” his own meal on the floor with pots and pans. While you are cleaning up, let him “clean up” with his own towel.

**Large and small muscles**
- Infants as young as three months can play with an activity gym to bat/grab objects.
- Offer old measuring cups, plastic food containers, pots, pans, and wooden spatulas to explore.
- Let your older baby play with a big ball to roll, kick, or throw.
- Stacking cups or “nesting cups” are good for using small muscles and figuring out how to stack. Shape sorters (cylinders with plastic shapes and matching holes in the top) are another classic toy for toddlers to encourage eye-hand coordination.
A special something extra was having Dr. Rachel Dawkins, Chair of the SOYP, join the executive committee of the Section on Senior Member’s discussion on membership issues at our meeting on October 21 during the NCE in New Orleans.

Drs. Ken Slaw and Tom Tryon and Ms. Terri Howard of the Department of Membership were also participants in the discussion. Membership is a significant concern currently in almost all similar entities, whether the AAP, AMA, religious communities, or other non-mandatory bodies.

During residency young physicians have their AAP membership funded by their residency programs, so it is a financial shock to most when completion of residency poses confrontation with candidate member dues, in addition to repayment of educational loans, costs of establishing practice, etc, etc. This is a period of vulnerability and potential loss of affiliation with the AAP, which should be seen as the guild or professional advocate for all pediatricians, as well as for children. As the 4th largest section within the Academy, the SOYP is comprised of pediatricians from completion of their residencies until they reach age 41. Once affiliated, young pediatricians appreciate the major value of advocacy as well as of continuing medical education and help with practice management information offered by the AAP.

Maintenance of membership again becomes an issue as pediatricians age and contemplate retirement or part time practice. Many AAP Fellows are surprised that one becomes eligible for membership in the Section on Senior Members at age 55. Rachel suggested, mostly in jest, that the AAP should just have a continuum of membership in our mutual sections, so there’s not a ten year “identity gap.” Perhaps it is worth considering. We know that active affiliation within Sections promotes maintenance of affiliation with the Academy, but a larger membership worry looms on the immediate horizon. Dr. Slaw and Ms. Howard again described the impact that the ongoing effect of aging out of the “baby boomers” (i.e., those born in the years after WWII), as older fellows of the AAP retire, elect emeritus membership, or simply die. Whatever the cause of attrition, it is clear that the AAP has other sources of support than merely membership dues, but the issue is crucially important, and Dr. Tom Tryon, new Chairperson of the Committee on Membership described ongoing discussion within executive leadership and the AAP Committee on Membership regarding need for overall review of our dues structure. This is likely to have most impact on senior members, especially those who elect the option of emeritus or retired membership.

This executive committee meeting was my last as Chair of the Senior Section, and one of the accomplishments of our Section during my tenure of which I am most pleased is the collaboration we have had between our two sections. Our teleconferences and question sessions with the nominees for AAP President Elect is one example and our mutual contributions to our respective section newsletters is another.

So, a final serving of lagniappe: When Dr. Toni Eaton suggested about 12 years ago that I run for the executive committee of SOSM, I was practicing fulltime and responded: “Surely, I’m not old enough.” Toni responded, “Well, I checked and yes you are!” Time has a way of flying past whether we are having fun or not. It goes much more quickly than most of us realize until we have been in practice for 30 or 40 years and stop to realize that we might just be old enough for membership in the Senior Section.
Pediatrics offers so much variety and challenge that we should never allow ourselves to be bored, but weeks of seeing children with otitis media and influenza and children with pertussis whose parents refused immunizations can be trying. So, make time for your practice-family-personal interests and also find your passion within pediatrics! I would suggest child health advocacy. If you have not done so already, join the AAP FAAN club (Federal Advocacy Action Network) and you will have all the tools you will need to champion important advocacy issues within your practice, your community, and the Academy. That is what maintains membership and makes us realize that we have the best profession in the world and, well, it keeps us young, despite our age!

The complexity both of medical knowledge and the efforts required to deliver quality health care continue to grow, and so does the need to focus on delivering safe, effective, and cost-effective care. The American Academy of Pediatrics (AAP) has many sections, committees, and councils working diligently to produce guidance for generalists and specialists in an effort to facilitate our collective provision of excellent health care for children. Members of AAP Section on Epidemiology (SOEp) facilitate these efforts with their clinical and methodologic expertise.

The SOEp was founded in 1988 by Dr. Ruth Etzel, an internationally-renowned environmental health specialist who chaired the section until 1992. The section now includes hundreds of pediatricians and scientists from all pediatric disciplines with a background in epidemiology, including public health, evidence-based medicine (EBM), and clinical research.

The mission of the SOEp is to “improve the health of children through mentoring and educating pediatricians on the use of epidemiologic principles in the practice of pediatrics and public health.” The primary means of accomplishing this mission is by working with other groups in the AAP to develop clinical guidance and policies using methodologically-appropriate approaches to interpretation of data and formulation of decisions. SOEp members work in four major areas: advocacy, education, service, and global activities.

Advocacy activities focus on expanding the use of evidence-based medicine (EBM) methodologies in AAP continuing medical education activities and clinical publications, including many practice guidelines and Bright Futures. SOEp members often participate in other groups such as the EBM Special Interest Group (SIG) of the Academic Pediatric Society, the AAP Prevention and Public Health SIG, the American Public Health Association, the Society for Pediatric Epidemiology Research, and other national groups.

SOEp members serve as a primary source of “methodologists” for formal clinical practice guidelines produced by the AAP. The SOEp offers seminars and workshops on epidemiology and EBM for attendees at AAP national meetings and the Pediatric Academic Societies annual meeting. Members serve as resources to help pediatricians understand how and when to interact with state and local health department staff. Members also work in various capacities to provide education and guidance on high quality methods for pediatric research and public health for pediatricians outside the field.
**cont. Section on Epidemiology**

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the United States. Members are able to volunteer for projects as they wish based on their interests and time constraints.

For a young physician with methodological expertise, membership in the SOEp is a chance to contribute to the care of children at a national or international level. And membership is free! To learn more about the SOEp or to become a member, go to [http://www2.aap.org/sections/epidemiology/default.cfm](http://www2.aap.org/sections/epidemiology/default.cfm) or contact Caryn Davidson at cdavidson@aap.org.

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**Update on The Pediatrician Life and Career Experience Study – PLACES**

*Ashley Brunelle, MD, FAAP*

*PLACES Project Advisory Committee*

The American Academy of Pediatrics (AAP) launched a longitudinal study of early career pediatricians - **The Pediatrician Life and Career Experience Study (PLACES)** to understand the changes, successes, and satisfaction that pediatricians experience in their personal and professional lives.

The first annual PLACES survey was fielded in late spring/early summer, 2012. The response was amazing - 93% of the pediatricians who were initially enrolled in PLACES completed the survey. **Thanks to all of you who completed the survey!**

PLACES is unique because of its longitudinal design, inclusion of both AAP members and non-members, and the range of content included on the surveys (e.g., work, satisfaction, personal dimension). There are two important cohorts with almost 900 participants in each of the cohorts: 1) recent residency graduates (~ 1 to 3 years post-residency), and 2) early career (~ 8 to 10 years post-residency).

Approximately 68% of the participants in the recent residency graduates cohort are working full-time (56%) or part-time (12%), and about 30% are in fellowship training. Nearly all of the early career cohort participants are working full-time (69%) or part-time (28%), with varied clinical time spent in general and subspecialty pediatric care and inpatient and outpatient care (see Figures 1 and 2). Almost 60% of the early career participants spend the majority of their clinical time in general pediatric care while 32% spend the majority of time in subspecialty pediatric care. Seventy-one percent of the early career participants spend the majority of their time in outpatient pediatric care, while 20% spend the majority of time in pediatric inpatient care.

The majority of PLACES participants in each of 3 groups (recent residency graduates-in training, recent residency graduates-post training, and early career) report that they are satisfied with their career as a physician, would recommend their specialty to a student seeking advice, and find their present work personally rewarding (see Figure 3).

For more information, check out the first PLACES newsletter, “Going Places” visit the [PLACES website](http://www.aap.org/sections/epidemiology/default.cfm), or email places@aap.org. We will continue to share PLACES results and updates in this newsletter.

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Update on The Pediatrician Life and Career Experience Study – PLACES

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Figure 1 - Proportion of Early Career Cohort Participants who Spend the Majority of Clinical Time in General and Subspecialty Peds

![Bar chart showing 59% in General Pediatrics and 32% in Subspecialty Pediatrics.]

Figure 2 - Proportion of Early Career Cohort Participants who Spend the Majority of Clinical Time in Outpatient and Inpatient Peds

![Bar chart showing 71% in Outpatient Pediatrics and 20% in Inpatient Pediatrics.]

Figure 3 - Proportion of PLACES Participants Satisfied with Their Career, Specialty, and Job (Reported “Strongly Agree” or “Agree”)

![Bar chart with satisfaction levels for Recent Grads in Training, Recent Grads Post Training, and Early Career. Dashes indicate satisfaction levels across different categories.]
Canned sardines, outdated cereal, and TV dinners comprised my typical diet as a child. These fine eating habits and my love of fast food, fried food, and sugar food led me on my way to being known by my peers as “Natalie Fatalie.” Like 9 million children today, I was an obese kid.

My early struggles with obesity and the challenging process of adopting healthier habits and achieving a healthy weight compelled me to become a pediatrician. During residency, I worked with countless children and families who now face a similar struggle that I did, but their challenges are more pronounced. Access to healthy food is limited. For many low-income families, opportunities for physical activity are hard to find. Children and their parents often have little support or access to culturally-appropriate information to help support healthy habits. As such, over 60% of children in my continuity clinic – a large community clinic of mostly Spanish-speaking families – were overweight or obese. Parents often commented that they had a difficult time affording healthy foods, preparing them in a way that their children like, and making time to eat meals together. To respond to this need, two colleagues and I wanted to develop a program that not only teaches families about healthy eating, but actively involves them in the process and empowers them to directly apply what they have learned to their everyday lives.

The Community Access to Child Health (CATCH) program allowed us to do just that. We had heard about CATCH from our mentor, who on many occasions shared how uncomplicated it is to apply for and implement a CATCH grant. The CATCH program espouses that “one pediatrician can make a difference.” To back that belief, the program provides applicants and recipients with extensive support. CATCH deploys an enthusiastic staff and a committed group of member pediatricians -- Chapter CATCH Facilitators, District CATCH Facilitators, District Resident Liaisons, and National Resident Liaisons – to provide technical support from the time an applicant starts an application until the project is implemented and the final report completed. CATCH wants pediatricians to succeed.

My colleagues and I applied for and received a resident CATCH grant for “The Little Chef” Cooking School. Our bilingual program offered low-income parents and their young children an opportunity to spend time together learning how to cook healthy foods in a delicious yet inexpensive way. Last May, our CATCH grant culminated in the publication of a book – “Eat Your Vegetables!” and Other Mistakes Parents Make: Redefining How to Raise Healthy Eaters.

I was so inspired by my experience with the CATCH program that I applied to become a National Resident Liaison. In that role, I was given the opportunity to learn more about the program and not only how straightforward it is to complete the application for residents but also for practicing pediatricians. (Residents can apply for $3,000 grants while practicing pediatricians can apply for $12,000 planning and/or implementation grants.) Few programs provide such an accessible source of seed money for practicing pediatricians to implement projects in their communities.

The CATCH program offers pediatricians a phenomenal opportunity to work with stakeholders to improve the health of children in the community and to be effective child advocates. This program effectively achieves its goal to support community pediatricians in creating secure medical homes and healthy communities through teamwork, networking, and ongoing community asset-building and collaboration.

My residency training and two-year term as national resident liaison have both ended. Now, as a young physician, I reflect on how meaningful my experience with CATCH has been in shaping my career path and beliefs. I embrace the belief that, while the power of the one-on-one patient-physician interaction must not be underestimated, only when we look at our patients as part of a larger community will we be able to successfully change behaviors and optimize children’s health. My experience with CATCH has informed my decision to both practice general pediatrics serving patients from all socioeconomic backgrounds and work with a nonprofit organization, the American Council on Exercise, to engage in the large-scale public health effort to promote healthy nutrition and physical activity.

I am excited to continue my involvement with CATCH and share how accessible this program is for young physicians.
cont. Community Access to Child Health - CATCH Program

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who are committed to contributing to healthy changes in their communities. If you have an idea for a project linking community changes to promote improved health and access to a medical home, please consider applying for a CATCH grant to support your efforts. The CATCH call for proposals is now open at http://www2.aap.org/catch/funding.htm. The CATCH network is standing by to help you get started.

Introducing the Provisional Section on Tobacco Control!

...tobacco is the only legally available consumer product which kills people when it is used entirely as intended. – The Oxford Medical Companion (1994)

Tobacco continues to be one of the leading causes of death and disability in the United States and across the globe. Since 2006, the American Academy of Pediatrics (AAP) Julius B. Richmond Center of Excellence strives to protect children from tobacco and secondhand smoke. The Richmond Center offers tools and resources to help clinicians and communities, as well as supports research and policy development to create a healthy environment for children, adolescents, and families.

In 2012, the Academy launched the Provisional Section on Tobacco Control (PSOTCo) to ensure the mission of the Richmond Center reaches more pediatricians, more effectively. The purpose of the Section is to educate pediatricians and other health care professionals about all aspects of tobacco prevention and control, including how to counsel patients and families, offer treatment and/or referral for tobacco dependence, and advocate for public policies necessary to reduce tobacco dependence and exposure to tobacco smoke.

Why should I join PSOTCo?

What do you do when you encounter a child exposed to secondhand smoke? How do you assist an adolescent who wants to quit smoking? What are the Academy recommendations on preventing tobacco use and exposure to youth?

Tobacco use and exposure can be a perplexing health issue for a pediatrician, as a clinician, advocate, and citizen. As a young physician, your contributions to the new Section can truly shape its success. Play a role in the revision and development of AAP policy statements, run for Section Executive Committee positions, and help influence the Section’s future goals. Section members can also help plan, develop, and provide educational programs at the National Conference and Exhibition and other AAP meetings. The Section is an excellent platform to network and collaborate with others who share your interest in tobacco control.

The Provisional Section on Tobacco Control aims to provide pediatricians with the knowledge, skills, and resources to reduce children’s exposure to tobacco smoke and reduce youth rates of smoking and tobacco use initiation. Additionally, the Section will foster collaboration and networking between pediatricians, pediatric sub-specialists, other colleagues and professional health care organizations to maximize and synchronize efforts. Members will gain skills to serve as a resource for patients, parents, families, and communities to find creative ways to eliminate involuntary tobacco smoke exposure, reduce adolescent smoking and tobacco use initiation, and figure out ways to treat tobacco dependence.

How can I join PSOTCo?

Membership for PSOTCo is now open, and is FREE to join. To join the Section, individuals must complete a membership application and a tobacco disclosure statement. More information is available on the web site (http://www2.aap.org/richmondcenter/psotco/HowToJoin.html). Questions? E-mail us today notobacco@aap.org.
Pediatric Care Online™ trial subscriptions available

Pediatric Care Online™ is one integrated resource for expert help with your primary care information needs. Access continually updated content and tools from the American Academy of Pediatrics, online or on your mobile device. And an improved search function, including Medline, makes Pediatric Care Online better than ever.

Residents receive one complimentary access card each year of residency; pediatricians receive 3-month trial subscriptions. Access cards are available from your Mead Johnson representative, or by calling 888/363-2362.

For more information, visit www.pediatriccareonline.org.

Download the Free AAP App!

Centralized app with single sign-on gives you access to all your AAP online resources and free or purchased apps, including:

- Red Book
- Pediatric Care Online
- AAP eBooks
- IronKids
- And many more

- Updates, messages, and new apps from the AAP delivered right to your mobile device
- Apple version includes free calculators for APGAR, BMI, Bilirubin, and Growth Charts

To get your free AAP app and see the whole suite of available apps, visit www.aap.org/mobile.
New Medical Home Video Tutorials

The National Center for Medical Home Implementation (NCMHI) has developed 2 new video tutorials to help users navigate the MedicalHomeInfo.org Web site and Building Your Medical Home toolkit.

What Can You Find on MedicalHomeInfo.org?

The NCMHI Web site is the clearinghouse for information and tools regarding the medical home approach to care in the pediatric setting. This brief video tutorial has been developed to help you understand all there is to find on the Web site. It describes the 6 sections of the Web site, as well as the practical resources available for primary care providers and families.

Learn How the Building Your Medical Home Toolkit Can Work For You!

This video tutorial walks users through the 6 building blocks of the Building Your Medical Home toolkit, as well as the various tools available. The toolkit is FREE and can be accessed online at www.pediatricmedhome.org. Set up a user account today! Developed via a cooperative agreement between the American Academy of Pediatrics and the Maternal and Child Health Bureau, the toolkit supports the primary care practitioner's development and improvement of a pediatric medical home.

National Center staff is always available to help you find what you need to ensure that every child and youth has a medical home. Fill out the Contact Us form for assistance.

Pre-Conference Session at the San Diego International Conference on Child and Family Maltreatment

The Role of Pediatrician Partnerships in Identifying and Caring for Children and Adolescents Exposed to Multiple Types of Violence

National experts will provide current research, best practices, and facilitated discussion with participants during this session on Sunday, January 27th, 2013 (8:30 am – 4:00 pm). Cost is $75. Register here. For more information, contact Heather Fitzpatrick (hfitzpatrick@aap.org).

This pre-conference session is being coordinated by the American Academy of Pediatrics under award #2012-VF-GX-K011, awarded by the Office for Victims of Crime, Office of Justice Programs, United States Department of Justice. The opinions, findings, and conclusions or recommendations expressed during this conference are those of the contributors and do not necessarily represent the official position or policies of the US Department of Justice.
Section of Hospital Medicine Mentorship

The AAP Section on Hospital Medicine's Resident and Young Hospitalist subcommittee continues to provide a mentorship program available to young physicians. New hospitalists are encouraged to take advantage of this program that pairs mentees with seasoned practitioners who act as mentors and provide valuable advice. Pairs are made based on similar interests, ranging from quality improvement to education to career advice and networking tips. The program also hopes to develop a network of practicing veterans that can provide young careerists with ideas and recommendations, and to create a source of knowledge regarding issues such as preparing for jobs after residency, goals for the first 5 years in a new position, and opportunities to get involved.

Our program has a strong foundation with over 30 mentors who practice at community and tertiary institutions across the nation with interests that range from resident education to family centered rounds. We are currently trying to increase young physician involvement in our mentorship program, and encourage you to visit our website and complete a brief application such that you can take full advantage of the experience and wisdom that our mentors have to offer.

Additional information can be found at our SOHM Mentorship website: http://www.aap.org/sections/hospcare/residents_subcomm/residents-mentorship.htm or you can email earagona13@gmail.com for more information.

Community Access to Child Health (CATCH)

Applications for $12,000 CATCH grants for pediatricians to address child health issues in their community are now available. Submissions will be due Thursday, January 31, 2013. For more information, or to apply, visit www.aap.org/catch and www.aap.org/commpeds/grantsdatabase. If you have questions, please contact catch@aap.org.

Join the Section on Oral Health

The American Academy of Pediatrics Section on Oral Health works to improve oral health for children through medical and dental collaboration. Becoming a member will afford you opportunities to work interprofessionally and to combat the number one children's chronic disease, dental caries. To join the Section or ask a question, simply email oralhealth@aap.org. Membership for pediatricians in good standing is free. Visit www.aap.org/oralhealth for more information.
New 2nd Edition!

Autism: Caring for Children With Autism Spectrum Disorders: A Resource Toolkit for Clinicians

Updated and expanded—now including many tools in Spanish!
The newly updated toolkit has been developed to assist clinicians in the recognition, diagnosis, and management of children and youth with autism spectrum disorders. It delivers content in one quick access resource including expert guidelines, developmental screening tools, interactive algorithms, visit preparation and tracking aids, clinician fact sheets, coding guidance, family handouts, and much more.

For more information contact Marirose Russo at mrusso@aap.org or to order, visit http://tinyurl.aap.org/pub199384.

Practical Pediatrics CME Courses are Practical for You

William Hennrikus, MD, FAAOS, FAAP
Chairperson, Practical Pediatrics Course Planning Group

It is ironic, really. As a young physician, one of the first things you learn when you are done with your formal education is that you are not done learning – you are never done learning. Changing pharmaceuticals have you questioning which treatments are best for ADHD and depression, you are not sure which sports injuries you can treat and which you should refer, and your patients are presenting with rashes you do not recognize and fevers you can not explain. And then there are all those questions from parents about poop.

AAP Practical Pediatrics CME courses (PPCs) are just right for you. With the emphasis on “practical,” these courses offer answers to the kinds of issues all of us face in our daily practice. Each course features 6 expert faculty discussing both the common problems and hot topics that challenge all of us, and each course provides general session lectures and breakout seminars to ensure you have direct access to the course faculty and their expertise.

Practical Pediatrics CME courses also offer a practical way for you to combine CME with R&R. Scheduled with half-day sessions over 3 to 4 days in vacation destinations, PPCs are designed to give you the best and most practical pediatric CME while also providing you and your family with a relaxing getaway. Whether you enjoy the beach, the ski slopes, theme parks, historic landmarks, or world-class cities, there is a PPC course to meet your educational and recreational needs.

Do not just take my word for it. See what your colleagues had to say about our most recent PPCs.

“The instructors were all excellent and entertaining. I always leave with pearls and improvements to my practices. I am always ‘better’ when I leave.” Lucille E. Kanjer Larson, MD; Clinton, MA. “The course was a concise update of some of the most recent changes in standards of care...a must for a busy practitioner. The scheduling allowed free time to
**cont. Practical Pediatrics CME Courses are Practical for You**

*Cont. from page 27*

refuel both professionally and personally.” Damea Bourne Benton, MD; Hattiesburg, MS.

“The name says it all - practical pediatrics. Knowledge gained can be used in daily practice.” Parimal Parekh, MD; Freeport, IL.

“A wonderful way to combine great CME with family-inclusive fun.” Michael Jaczko, DO; Carlton, OR.

So whether you are looking to fill gaps in your training or learn about emerging issues, PPCs are the practical choice for your continuing medical education. I encourage you to attend a PPC course or two in 2012.

Remember to register early to lock in early bird registration rates for any of the following outstanding course locations:

- **Vail, Colorado**  
  January 17-20, 2013

- **Paradise Island, The Bahamas**  
  February 22-24, 2013

- **Orlando, Florida**  
  March 15-17, 2013

- **New Orleans, Louisiana**  
  April 12-14, 2013

- **Hilton Head Island, South Carolina**  
  May 23-25, 2013

- **Breckenridge, Colorado**  
  June 21-23, 2013

- **Washington, DC**  
  August 30 - September 1, 2013

- **Scottsdale, Arizona**  
  November 8-10, 2013

- **Williamsburg, Virginia**  
  December 13-15, 2013

You can find more information and register online at [www.pedialink.org/cmefinder](http://www.pedialink.org/cmefinder). We look forward to seeing you soon.

The American Academy of Pediatrics (AAP) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The AAP designates these live activities for a maximum of 33.25 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Yale Primary Care Pediatrics Curriculum

Do you teach students or residents? Do you want a source for quick review of core topics in general pediatrics? The Yale Primary Care Pediatrics Curriculum serves as a guide for organized, case-centered, evidence-based discussions of 84 topics in outpatient pediatrics as well as issues relating to the ethical, legal, and business aspects of healthcare. The curriculum is used by dozens of residency programs and practices nationwide. For information visit http://pcpc.yale.edu.

AAP Provisional Section On Obesity

Stephen Pont, MD, MPH, FAAP
SOYP member & Chair, AAP Provisional Section on Obesity

Helping kids achieve a healthier weight, healthier built environments, decreasing misleading “health” advertising, advocating that obesity office visits with YOU BE reimbursed... interested? Then please consider joining the provisional, brand new, Section on Obesity. Membership is free, so check the box on the My AAP page and you are good to go. Questions? If so, please let me know!

Email: SJPont@seton.org
Twitter: @DrStephenPont

HealthyChildren.org Now Available On-the-Go as a Mobile App

With the new HealthyChildren.org app, parents can look up age-by-age health information for their children, check immunization schedules, access first-aid how-to information and much more. Automatic updates to the app will keep parents informed of new features, including Healthy Children e-magazine, an ADHD Tracker app, an IronKids strength training app, and an upcoming car seat checker app. Download the HealthyChildren app on the iTunes and Google Play stores.
Coming Soon: HealthyChildren.org en Español

Since the launch of our award-winning website for parents, HealthyChildren.org, many AAP members have expressed strong interest in seeing the site’s content available in Spanish. The team at HealthyChildren.org is happy to announce that the development of HealthyChildren.org en Español is underway! The site will launch in spring of 2013, but we encourage you to begin letting families know about the site now by sending them to www.healthychildren.org/Espanol. Here they can sign up to receive an email announcement when the site has launched.

New Resource: AAP Tobacco Coding Fact Sheet

Kiran Patel, MPH
Tobacco Prevention Coordinator
American Academy of Pediatrics

The AAP Tobacco Coding Fact Sheet is a helpful tool for pediatricians and pediatric health care providers and staff to ensure appropriate coding for their work in tobacco prevention and control counseling. Created by American Academy of Pediatrics coding experts, this fact sheet offers CPT codes for inpatient and outpatient settings, as well as ICD-9-CM codes for medical diagnoses, comorbid diseases, and related supplemental codes. At the end of the coding section are six short scenarios with applicable codes and diagnoses. Download the fact sheet at http://www2.aap.org/richmondcenter/pdfs/TobaccoCodingFactSheet2012.pdf

Medicolegal Issues in Pediatrics

Medicolegal Issues in Pediatrics offers a wide range of medicolegal topics that affect the practice of pediatrics from residency through retirement. This newly updated resource provides detailed information on common pediatric malpractice claims and risk management strategies. It explains in simple language the anatomy of a malpractice lawsuit, guidance for coping with malpractice litigation stress, and the basics of professional liability insurance for pediatricians.

For more information, contact Marirose Russo at mrusso@aap.org or to order, visit http://tinyurl.aap.org/pub169532.
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