Chair’s Welcome
Kelsey Logan, MD, FAAP—Chair, SOYP

In the SOYP, we are enjoying the chance given us by the Wakefield autism press to further discussion on vaccines with our parents and patients. Things are going our way! The AAP has done a great job promoting pro-vaccine press, literature, and statements. Please let us know how you are doing with vaccine awareness and discussion with your patients. This is a great opportunity to share successes and find ways to further improve dialogue and education. Thank you for all you do to provide optimal health for your patients.

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Cont. Chair’s Welcome

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We are working on a mentoring program for the AAP. I encourage you to send us stories about successful and unsuccessful mentoring efforts you have been involved in, as all experiences help us in development. We aim to make mentoring available for all SOYP members, whether you are in academic or private practice, subspecialty or general practice, and whatever geographic area you call home. Please contact me (and visit all the other fun blogs and discussions) at our YPConnection site (it’s like Facebook for YPs!).

Editor’s Note

Elsa Vazquez-Melendez, MD, FAAP—SOYP Newsletter Co-editor
Assistant Professor of Medicine & Pediatrics
University of Illinois College of Medicine

Hello everyone! I am very excited about this opportunity to share editorial responsibilities for the SOYP Newsletter with Aimee.

Please allow me to start my first note with a brief introduction. I was born and raised in my grandfather’s coffee farm in the hills outside Ponce, Puerto Rico. I went to medical school in the Dominican Republic and completed Med-Peds residency at the University of Illinois, where I have remained on faculty as an assistant professor of Medicine and Pediatrics. My husband is an Infectious Disease physician who is occasionally accused of impersonating Dr. House with disturbing realism. We have three children: an overly competitive hockey player, an overly precocious 2 ½ year old girl, and a just plain overly hefty 10 month-old boy. I enjoy teaching and mentoring residents and medical students. My professional pursuits include curriculum development and clinical research.

In this winter’s edition of the SOYP newsletter, you will read about the maternal inclinations of a new pediatric hospitalist on a teaching service managing not only her patients, but her residents as well. Dr. Elizabeth Mack makes a convincing case that quality improvement research does not need to be rocket science. Do not be afraid to pick the low hanging fruit that is already at your fingertips. We also have the honor of a first-hand account of the fascinating life and adventures in medicine of Dr. Blanche Bourne, a senior diplomat of the American Board of Pediatrics. These are just a few examples of the insights in store for you in the pages that follow, so please read on and enjoy.

I look forward to sharing the next two years with all of the SOYP newsletter readers. Please do not hesitate to drop me a line anytime. Even if you don’t have a finished work for publication, I would be happy to toss ideas back and forth, or collaborate on an article with you.
**District IX Update**

*Christina Vo, MD, FAAP*

*District IX SOYP Representative*

**My time is almost up!** I will no longer be your district representative in October of this year.

**It’s time to vote!** The next California AAP Young Physician Representative will be elected by the California members of the SOYP this March. Be sure to look for the online ballot. We have two great candidates: [Kate Roberts](mailto:), from Orange County and [Tracy Zaslow](mailto:), from Los Angeles. Click on their names to read their profiles! They will be blogging on YPConnection throughout February and March. Go to [http://ypn.aap.org](http://ypn.aap.org) and join the District 9 (California group) to hear from them!

**Californians Making Change:** California pediatricians submitted 19 resolutions (I think that it is a record for the district!) for the upcoming Annual Leadership Forum! Two were submitted by young physicians: one on organic foods submitted by myself and one on creating a Section on Immigrant Health submitted by Ricky Choi. At the [Annual Leadership Forum](http://www.aap.org/moc/alf), any pediatrician can submit a resolution to effect change in the AAP. The top 10 resolutions go immediately to the AAP Board of Directors. Want to submit a resolution? Ask me (christinavomd@gmail.com) or Donald Miller, our ALF Rep (title is actually CFMC rep - dtmiller@aap.net) for help.

**Legislators of the Year:** AAP-CA will be awarding two legislators the Legislator of the Year Award. Juan Arambula (Ind) for AB 354, the bill requiring TdaP for school entry for 7th through 12th graders. This bill also allowed for future vaccines to become school requirements with only one vote through the legislature, a huge win for the case for vaccine preventable disease! For more information on the Tdap requirement, see the California Department of Health page. [http://www.cdph.ca.gov/HealthInfo/discond/Pages/Pertussis.aspx](http://www.cdph.ca.gov/HealthInfo/discond/Pages/Pertussis.aspx)

The second Legislator of the Year award will go to Manuel Perez (D) for AB 2093, the bill which supported minimum payment for vaccine administration codes. Although this bill was vetoed by Governor Schwarzenegger, it was a huge step in legislation for fair payment to physicians.
The National Conference and Exhibition (NCE) in October 2010 was a fantastic experience for young physicians. The American Academy of Pediatrics’ (AAP) NCE is on my calendar every year. I value it highly for the incredible opportunity this conference provides for education, networking, and fun.

During this year’s conference, I had the opportunity to learn about new research and review important topics. My favorite aspect of the experience was networking with my fellow pediatricians, including the opportunity to meet and learn directly from our AAP President, Dr. O. Marion Burton. I particularly enjoyed the chance to consult with other young physicians who share my areas of interest or live in my area.

The Academy has a designated program for the Section on Young Physicians, wherein we prepare a topic that focuses on young physicians’ areas of interest. This year the SOYP focused on advocacy. The director of the AAP Department of Federal Affairs, Mr. Mark Del Monte, spoke about his role as an advocate on the Federal level. He also gave us an update on current issues and reforms, including Medicaid reform, and provided practical guidance on how we young physicians can better advocate for the children we serve. Other speakers emphasized that a group of people with a common goal can make a strong impact on policy. A young physician from Washington, D.C. shared his strategy to involve residents and young physicians by educating and training them in practical advocacy techniques.

We also had time to have fun! Each year, at the end of the conference, we have a wonderful reception for young physicians and resident physicians. This year we did something new. Each district representative wore a distinctive shirt, and we divided the time between networking with our district members and sharing ideas from our subcommittees. Our keynote speaker at the reception was AAP President Dr. O. Marion Burton. He has been very supportive of the section and our needs. Nestle Nutrition Institute supported this event and gave a present to all the participants--we even had a raffle for a new iPod and a free year of AAP membership!

I hope you will consider joining us at the NCE next year, in Boston, Massachusetts on October 16, 2011. You can be part of the amazing educational and networking opportunities the NCE provides. And don’t forget to join us at the super fun SOYP reception!
~ WHAT’S ON YOUR MIND ~

Board Fever
Bahareh Keith D.O. – Clinical Instructor
and Elizabeth Paulk M.D.—Assistant Professor
University of Florida, Department of Pediatrics, Division of Hospital Medicine

You may think I am exaggerating, but the Pediatric Boards are notorious for making people sick. Knowing my own weakness for this particular type of disease (I am a terrible test taker), I planned to start studying early for my Pediatric Board Exam in 2010. While on maternity leave at the start of my third year in residency, I scoured the market of endless studying resources. I even turned to the supreme source: Google. As I viewed online conversations about the boards, I became distraught. Countless people gave accounts of their studying efforts and subsequent failure. My stomach began to turn. Other people exclaimed that their passing score was a miracle, and then gave detailed oratories on why the test was nothing short of ridiculous. I concluded that the boards are nothing like real life. Because the questions were brief they left out key information a physician would have in real life. Furthermore, the boards love the “zebras.” Why do they test on so many “zebras” if in real life you should look for “horses” first? Then the worst piece of information was burned into my brain: the pass rate on the Pediatric Boards was around 75%. This gave me momentary respiratory arrest.

Perhaps I was the victim of a case of too much information, but I took advantage of the fire to fuel my studying. I tried to read two hours a night at least three nights a week. According to Laughing Your Way Through The Pediatric Boards, there needs to be balance and your schedule should be reasonable. Somehow it doesn’t seem quite enough to read 10 large font pages a night, especially when it’s an 800 page book. What did they expect a third year resident to be able to get through before falling asleep? Most of my work days were around fourteen hours. Did I also mention that I had a newborn who was teaching me first-hand what nursing every three hours really meant?

Thankfully, residency ended and the baby started to sleep through the night. However, that sick feeling only grew stronger as the boards got closer. I made a pact with a friend and got motivated by her very “hard core” schedule. She scared me into submission by telling me horror stories about the boards and the ridiculously large amounts of material that people had to study in order to pass. I felt like I was on a on a fad diet of First Aid, PREP questions, and Laughing Your Way Through The Pediatric Boards. Everyone I spoke to said you HAD TO do at least five yrs of PREP questions. Even after studying diligently, I still wondered whether I was doing enough. Should I spend thousands of dollars to travel to a board preparation course? I was overwhelmed by the sheer amount of information.

I cannot imagine accomplishing this task as a new subspecialty fellow or a novice in a busy full time practice. I was fortunate to have tremendous support. My accommodating department scheduled me for only light clinical duties. My office mate—a fellow board applicant--had already read through the med study books. When a concept didn’t make sense, I picked her brain and she did the same with me. Somehow, suffering with someone else is nicer than suffering alone.

In the three months before the boards my fever heightened, my heart rate was always elevated, my appetite very poor, and I did not sleep much. First I read through all of Laughing Your Way Through The Pediatric Boards while simultaneously doing PREP questions. When I felt I needed more detail I turned to First Aid For The Pediatric Boards. I also reviewed most of the iconic Zitelli’s Atlas of Pediatric Diagnosis, reading parts I thought were interesting. Occasionally, I actually enjoyed the studying. Some of the information helped me make sense of what I had done as a resident and some made me excited to learn more details on a particular subject about which I had not had time to read before. The rest just made me tired because I felt that I would forget it the second I turned the page. 

Cont. page 6
In the last month I studied for no less than eight hours a day. I felt so guilty missing play time with my son. My husband had to pick up the slack at home while also having an unhappy me to cope with. I would lock myself in a library study room and time myself doing question after question. I had been told to aim for 75% but I never got there. Moreover, I am a slow test taker and I was barely getting the questions done on time. The fever was taking over and I was sure I would not pass the boards.

As the dreaded day drew closer the world seemed to get darker. On test day the fever peaked, and the anticipated pre-exam gastrointestinal overstimulation was earlier than usual. I went through all the rituals that I had done in the past, truly believing each would help me do better on the test. I had to have a good high protein dinner to have good energy reserves. (This had been advice I was given by my Kaplan teacher when I was preparing for the MCAT.) The same was supposed to apply to breakfast, but I was so nauseated by then I had trouble finishing a simple piece of bread. Still I took comfort in my ear plugs, my back up protein bars, and the joy of being allowed to have food in the testing room for the first time.

One of the most painful parts of the exam was waiting through the long line to get into the door. Then waiting while everyone else filed in and the slow instructions were given. I used the time wisely and scribbled the estimated time of start and what question I should be at for every fifteen minutes. When I finally opened the book I found I knew the answer to the first few questions and the details that were missing did not bother me because I was glad to be able to do the question in a timely manner. I grew confident. Of course, that feeling faded as the test questions got more vague and the answer choices did not seem to include what I thought was the right answer. Before I knew it I had twenty minutes left and forty questions. Somehow in the haze of a test day when they notified us we had an hour left I had mistakenly thought I had one hundred minutes instead of sixty. My body was in full shock.

First, I bubbled in what I had answered. Then I just skimmed the questions and picked the most likely answer. There was no time to watch out for board tricks, no time to pick out the one word that truly changed the meaning of a question--there was simply no time. I had to bubble in “B” (the first letter of my first name) for fifteen of the questions. I worried that the difference between a great score and failing could be as few as fifteen questions. Even more frustrating, the last ten questions were one-liners. The lunch break can only be described as me in a deep depression.

Despite my teary eyes and the certain feeling that I had flunked, I went back in with a plan. The second half was a race to the finish line from the start. I did not even read the more verbose questions, I just skipped them. There were also a lot of questions I might have gotten right if I had a few more seconds to think. In the end it was worth it because this time I only marked “B” on five questions. I made it through the test but was unsure of most answers. Afterwards, instead of feeling relief, I was even more anxious. Would I lose my job if I failed? I had two months to wait for the score.

Interestingly, I did not let this mortifying experience shake my confidence as a clinician. As I both treated patients in the hospital and taught the residents, I was more and more convinced that this test had little to do with clinical skill or actually taking care of patients. As I correctly nailed diagnosis after diagnosis and saw more and more satisfied looks on parents’ faces, I realized that even if I had failed the exam, I was still a capable and caring pediatrician. I recognized that the real test of a good pediatrician is in the outcome of her patients and families.

When the score came out in December, I did feel a small recurrence of the fever. Feeling clammy, I checked my score. This time I had momentary cardiac arrest. I passed! The fever was finally really gone—at least for seven years when I have to re-certify.
We have all either seen or been that mother at the grocery store. She is the colonel of a small brigade. With her four little children, grocery shopping (which would otherwise be a simple task) grows into a battle to be fought. She wipes snotty noses, secures the baby safely into the cart, ignores temper tantrums, listens to requests—all while navigating a huge cart full of groceries in a crowded store. Oh, and she must accomplish the bottom line of actually finding and buying the correct groceries. In this situation, most moms are exasperated. There are only a few who handle themselves with grace. This scenario is similar to my experience as a new ward attending. Although I attempted to be graceful, at first, I was the exasperated mom.

Initially, I was overwhelmed by the team’s sheer size. My charges included two senior residents, two pediatric interns, one family medicine intern, one fourth year medical student, three third year medical students, and a nurse practitioner. The first day, we crowded into a patient’s room, barely fitting. The third year medical student presented a patient with meningitis. “This patient is a 39 day old ex-preemie admitted for a rule out sepsis.” This inaccurate assessment irritated me, especially since not only was meningitis written in the last note, but the CSF had 1,000 WBC and 10 RBC. Hoping he would be corrected by the senior, I lowered my eyes, avoiding eye contact with the student. Because the senior did not correct the student, he kept presenting to me, not her. I asked, “This child has been on antibiotics for how many days?” Awkward silence. I wished I could be like the mom in the grocery store, deftly managing her children’s behavior, praising the good, and ignoring the bad. I did not want to be the screaming parent.

Not only must I manage the little chicks, but I also needed to pick out the correct groceries. What kind of follow-up head imaging should this child receive? When should he be imaged? Further, when the residents and students fell short of my expectations, how should I react? How could I encourage the senior to step up and take the lead?

As the attending, I was no longer the oldest child in the grocery cart. I was the mom. Though the oldest child may help, as the mom I was responsible for not only the behavior of my children but also for anything they broke. Sometimes, they broke a jar of pickles (started the wrong antibiotic). Other times, they fell and hurt themselves (they forgot their bedside manner and were yelled at by a parent). Occasionally, they forgot to help me when I asked them to put the bread in the basket (did not give an asthma action plan prior to discharge). No matter what they did or did not do, it always came back to me. As a new attending, this accountability stressed me to a level with which I was unaccustomed. However, I quickly learned that my senior attendings could help shoulder the load. Their experience, insight, and advice enabled me to transition from constant feelings of insecurity to a sense of mastery.

I soon realized why the medical student missed the meningitis diagnosis—he did not know how to systematically review the patient’s chart. I also realized why the senior did not speak up—she was an introvert and needed encouragement. After I suggested some approaches to each, they improved their performance. The medical student carried a card with the pertinent patient information. He now knew all of the patient’s medications and active problems. The senior spoke up during rounds if I sat down.

My grandmother has sardonically said, “If you don’t expect anything you won’t be disappointed.” If residents and students knew it all, they would not be residents and students: Medical education exists for a reason. I am not suggesting that standards are unrealistic. What I am suggesting is that we should expect everyone, attendings included, to fall short of the standard periodically. However, if the standard is not communicated clearly, it is unlikely to be met. So what is my advice to young attendings? Make your expectations clear. However, when they are not met, do not be surprised or annoyed. Like the graceful mom, expect the kids to throw tantrums in the grocery store. Expect them to beg for a cookie. They are kids and that is what they do. They need you to teach them. And sometimes, in order to really learn, they need freedom to make mistakes. I don’t have any biological children, but when anyone asks me if I have kids, I always say yes.
You have finished residency and are embarking on your career as a pediatrician. Maybe you are deep into fellowship and enjoying the challenge of academic life. Maybe you are comfortably settled into a group practice and building relationships with your patients and their families. Maybe you are trying to find your passion and traveling around as a locum tenens physician. And maybe, despite feeling accomplished and relieved that you are finally out of training, you ask yourself, “What now?”

After finding myself in that exact position in 2007, I came across an advertisement for the Pediatric Leadership Alliance (PLA). At the time, I was struggling with how to make a name for myself in academic pediatrics as a young physician. I was intrigued by the opportunity to network with leaders in the field of pediatrics in such an informal environment and to be able to practice leadership skills in a practical, hands-on format. After attending the PLA, I possessed a renewed sense of confidence and felt part of a larger community of pediatricians who had the same values and drive to succeed. More importantly, I had the tools to channel my energy into a productive and exciting career path.

Over 3,000 pediatric professionals have attended the PLA and 79% of PLA alumni advanced into greater leadership roles within the Academy (including myself!), as well as in hospital, medical association, government and corporate environments following their training. Another PLA session is being offered March 23-25th, immediately before the Annual Leadership Forum (ALF) at the Schaumburg Renaissance in Schaumburg Illinois. The PLA is specifically designed to provide real-life scenarios in order to practice skills and learn from one’s colleagues. Sessions include “Strategy Development: Charting Your Course” and “Dynamics of Change: Moving People & Culture”. A dynamic keynote speaker, Dr Lewis First, (Editor-in-Chief, Pediatrics) will describe his leadership journey and how leadership skills learned were embedded in advancing into more key roles in the profession of pediatrics. To promote networking among participants, the PLA has dedicated time for casual conversation during the reception, dinner and workshop meals. It was during this “downtime” that I was able to really form relationships with the other participants and facilitators. More than enjoying the company of my colleagues, I was inspired by the different people I met and by the work that they were doing.

In addition to the foundation for leadership formed at the conference, the participants will be encouraged to sustain their development through long term follow up and goal setting. Although a critical component of the workshop, the follow up is entirely personalized and voluntary - the support is provided by the PLA staff and the AAP as a whole but it is up to the individual to follow through on the goals set during the conference. This was the most difficult part for me personally, sustaining the momentum I gained at the PLA, but I was able to refer back to the PLA website and workshop materials including the book The Leadership Challenge by Kouzes and Posner. A full 13 hours of CME credit can be earned by attending this influential conference. Early registration (before Jan 30, 2011) is $395. Housing at the Schaumburg Renaissance is approximately $300 total for both nights. For more information visit www.aap.org/pla/Agenda.pdf or email PLA@aap.org.

Please challenge yourself to answer the question, “What now?” Consider sharpening your leadership skills with a group who pledges to “enable pediatricians to become effective learners and leaders to advance their profession, and to care and advocate for children.”
When I was a Resident...

Rachel Dawkins, MD, FAAP
Assistant Professor of Clinical Pediatrics, Associate Pediatric Program Director
Louisiana State University

Since the new resident work hour rules for 2011 were announced by the Accreditation Council for Graduate Medical Education (ACGME), common comments from pediatricians both in the academic world and in private practice have been along the lines of “When I was a resident I practically lived in the hospital. That’s why they called us house officers.” So why is the ACGME changing the duty hour rules yet again?

The primary reasons for changing the work hour rules are patient and resident safety. The number one reason is to improve patient safety in teaching hospitals. Numerous studies have shown an increase in errors when novice providers are toward the end of a traditional call period. The second reason is to provide a safe and effective learning environment for residents. The old culture of “I did it and so should you regardless of the cost” is no longer viable. Physicians need to learn to recognize signs of fatigue in themselves and their colleagues. Aside from committing medical errors, residents who have worked long hours, such as a 24 hour shift, are more likely to be involved in a motor vehicle collision.

What are the changes exactly?

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<td>Maximum hours of work per week</td>
<td>80 hours, averaged over 4 wks</td>
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| Maximum Duty Period Length     | 30 hours (admitting patients up to 24 hours then 6 additional hours for transitional and educational activities) | • PGY-2 and above: 28 hrs (admitting patients for up to 24 hrs, plus 4-hr remaining hrs for transition and educational activities)  
• PGY-1: 16 hrs |
| Maximum in-hospital on-call frequency | Every third night, on average             | Every third night, no averaging  |
| Minimum time off between scheduled duty periods | 10 hours after shift length          | • PGY-1 should have 10 hrs; must have 8 hrs  
• Intermediate-level should have 10hrs; must have 8 hrs. Must have 14 hrs after 24 hrs on in-house duty  
• Final years: exceptions made by RRC |
| Maximum frequency of in-hospital night float | Not addressed                          | • 6 consecutive nights          |
| Mandatory time off duty        | • 4 days off per month  
• 1 day (24 hours) off per week, averaged over 4 weeks | • Same                          |

*Thanks to Dr. Bonnie Desselle, Pediatric Program Director-Louisiana State University New Orleans, for this table*
Cont. When I was a Resident...

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What will the new regulations mean to you?

In the short term, those of you who interact with residents on a daily basis will notice changes to how the residents are educated. The goal is quality of patient interaction, not necessarily quantity. For some of you it might mean reductions in the number of beds the residents cover in your hospitals. Conversely it may mean residents are covering more patients per resident. The residents will be going toward a shift work schedule. This will lead to multiple patient hand-offs and less continuity between the residents and their patients and attendings. Practicing pediatricians do not have any duty hour rules to protect them. Will they, therefore have to “pick up the slack?”

With a major reduction in number of hours worked, there is concern that future residents will not be prepared for the “real world.” The number of patient encounters will be greatly decreased and residents will have fewer opportunities to follow a patient throughout their illnesses because of the limited numbers of continuous hours of duty. Will this result in less competent or less prepared physicians? How will residents deal with working long hours in private practice? Or taking call? Should we be worried?

The change in work hour rules will certainly shift how we train residents. Residency programs have been focusing on teaching proficiency in the 6 core competencies: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and system based practice. Improving the quality of the time the residents spend in the hospital and clinic will undoubtedly improve their overall educational experiences.

In essence, pediatrics is a specialty of lifelong learning. Residency is just the beginning of the continuum. By promoting resident well-being and improving patient safety, the hope is this change in resident duty hours will improve not only the practice but the culture of medicine.

So what is my opinion as an associate program director and a person not too far removed from residency? Truthfully, I am not sure. It is so easy to say, “when I was a resident,” and complain about how residents these days have it too easy. When I look at the studies on resident fatigue and patient safety, I agree that the old way may not be the best way. I can think of quite a few times where I fell asleep at a red light on my way home from a thirty hour shift. What kind of medical decisions did I make in the couple of hours prior? Who else, beside myself, was I putting in danger on my ten minute drive home?

However, as an attending, I know that my job is not protected by work hour rules. No one is worried about my strategic naps---except for me of course! And the many patients I was able to care for during my three years of residency have shaped the pediatrician I am today. I was ready to be an effective and efficient upper level on the wards because of the patients I helped to admit as an intern at three in the morning or the urgent calls from nurses that woke me up at 4am. Occasionally mistakes were made. It was part of how we learned. But I hope I never endangered a patient due to fatigue.

Eventually, the ACGME will study the effects of changing the work hour rules on resident education. Will this lead to an extension of residency? Will residents be prepared to enter into the “real world?” This all remains to be seen. Hopefully patients will be safer and residents, while still receiving a great pediatric education, will be happier and well-rested.
In the Wake of Wakefield

Christina Vo, MD, FAAP
General pediatrician in private practice in Berkeley and Orinda, CA

Recently the British Medical Journal published an article disparaging Andrew Wakefield for falsifying data in his study which showed that vaccines caused autism. (BMJ BMJ 2011; 342:c7452) http://www.bmj.com/content/342/bmj.c7452.full. Since then, the media seems to have finally jumped off the vaccines-and-autism bandwagon in support of vaccine safety. In the past few weeks I have already seen a change in the questions that patients ask me. The families that want to vaccinate but are confused by the media hype against vaccines no longer ask, “should we be worried about vaccines?” but instead ask, “is this good news?”

“Yes!” I tell them. This is good news because it means that we can spend less energy on trying to defend the safety of vaccines and more energy on trying to find the true cause of autism. What I do not tell them (or maybe I should) is that I personally get to spend less energy on discussing vaccines and more energy on discussing their child’s health, development and behavior. Parents’ attitudes are not going to change right away, but this is a great opportunity for us as pediatricians to once again promote vaccination according to the AAP/ACIP recommended schedule.

My practice Web site (www.eastbaypediatrics.com) has a “Hot Topics” page on which I can post information for parents about topics such as H1N1, the recent Tylenol recall, or pertussis in California. Our Web site focuses on vaccine-preventable diseases in the vaccine section and on presenting research on the cause of autism in an autism section. I added resources for parents who support vaccines so that they feel more comfortable talking to other parents about vaccines. I added links to websites of groups which support vaccine research.

Here are a few resources which might help you in your discussions with your patients:

- http://www.aap.org/protecttomorrow -- AAP’s public service announcement regarding vaccines
- http://www.aap.org/immunization -- AAP’s Immunization page
- http://www.cdc.gov/vaccines/spec-grps/parents.htm -- The CDC has its own site designed for parents.
- http://www.immunize.org/catg.d/p2068.pdf -- The Immunization Action Coalition has a great article by Dr. Ari Brown regarding vaccine safety. Dr. Paul Offit has written several excellent books and article about vaccines and the myths which have surrounded them in recent years.

The SOYP Executive Committee submitted a letter in January 2010 to the AAP Executive Committee requesting more guidance from AAP leadership regarding the recent publicity surrounding vaccines and Wakefield’s controversial claims. This letter and the AAP response epitomize the ongoing struggle that we physicians have in communicating regarding these issues. The efforts of our AAP and SOYP executive committees provide us with the leadership we need as we face the “future of pediatrics.
Quality Improvement—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
Palmetto Health Children's Hospital in Columbia, South Carolina

In residency and fellowship 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. 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 QI 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 AAP recommendations on sleep practices (“Back to Sleep”)? If the answer is no, the intervention will be additional education for parents and staff. Then residents will merely walk around at night while on call and note whether patients’ sleep practice is compliant with AAP recommendations. Easy, free, and important!

I would 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. Then take the challenge on – your work life and your patients’ lives will greatly benefit from your efforts!
It’s as Simple as “1-3-6”

Every day, 33 infants are born with some degree of hearing loss. The Early Hearing Detection and Intervention (EHDI) program outlines the following three goals (1-3-6) to address hearing loss in children:

- **"1"** - All infants are **screened** for hearing loss no later than 1 month of age, preferably before hospital discharge.
- **"3"** - All infants who do not pass the screening will have a **diagnostic** audiological evaluation no later than 3 months of age.
- **"6"** - All infants identified with a hearing loss receive appropriate **early intervention** services no later than 6 months of age.

While universal newborn hearing screening has been successful in screening 97% (2007 CDC statistic) of infants at birth or before 1 month of age, many that fail the initial screen are lost to follow up or documentation. Screening is only the first step to a successful outcome for a child with hearing loss. It is equally important that medical home providers obtain newborn screening results and provide families with the necessary information for early intervention and follow-up. To learn more about the EHDI program at the AAP and available resources contact Faiza Khan at fkhan@aap.org and visit [http://www.medicalhomeinfo.org/how/clinical_care/hearing_screening/ehdi.aspx](http://www.medicalhomeinfo.org/how/clinical_care/hearing_screening/ehdi.aspx).

Evidence to Practice: Improving Care for Children with Hearing Loss

Susan Wiley, MD, FAAP

In 2008, more than 50 experts gathered for two days to review and prioritize existing newborn hearing screening, diagnosis and intervention recommendations, to identify the most effective of these recommendations, and to create a plan for incorporating evidence-based recommendations into practice.


Newborn hearing screening has become successful over the last decade. Currently, more than 95% of newborns are screened for hearing loss. However, diagnosis and intervention rates are lower: less than 60% of newborns who do not pass their screening have a documented diagnosis and only 77% of those diagnosed with hearing loss receive intervention services by 6 months of age.

Workshop participants used a modified Delphi process to identify the top five existing recommendations for each of the following key areas: diagnosis, treatment, parental and public awareness, and continuous quality improvement. For example, participants indicated that using outreach to ensure at-risk families seek follow-up was the top priority for the diagnosis category. In addition, ensuring infants have hearing aids within one month of diagnosis was the top priority for the treatment and intervention category; providing special resources to minority and non-English speaking parents was the top priority for the parental and public awareness category; and expanding state data
**Evidence to Practice: Improving Care for Children with Hearing Loss**

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management and tracking systems was the most important recommendation for continuous quality improvement.

Participants also made choices for organizing a stewardship group with public-private oversight funded and organized by the federal government as the top priority.

Participants divided into four breakout groups that corresponded with the four areas of focus for further discussion about action steps and organizations that could take responsibility for implementing recommendations.

“More infants are being screened early for hearing loss, but the extent of essential diagnostic follow-up and treatment is variable, and there is concern that not all children are receiving the best available, evidence-based care. The outcomes of infants identified with early hearing loss and their families can be improved by efforts to accelerate evidence into practice and to continuously monitor access, quality, and outcomes of services,” concluded the authors at the end of the supplement article. To access the supplement in its entirety on the Pediatrics Web site go to: [http://pediatrics.aappublications.org/content/vol126/Supplement_1](http://pediatrics.aappublications.org/content/vol126/Supplement_1).

In 2001 the American Academy of Pediatrics (AAP) implemented a program, *Improving the Effectiveness of Newborn Hearing Screening, Diagnosis, and Intervention* through the Medical Home, focused on increasing the involvement of primary care pediatricians and other child health care providers by linking follow-up services more closely to the newborn's medical home. As part of Early Hearing Detection and Intervention (EHDI), the Academy has worked to identify one pediatrician in each chapter to “champion this cause.” Since 2001, more than 60 chapter champions have been identified and are actively participating in the program at the national and state/chapter levels. To obtain the name and contact information of your EHDI Chapter Champion, learn more about the EHDI Program, or for technical assistance please contact Faiza Khan, MPH, AAP Program Manager, at fkhan@aap.org or 847/434-4924. Also be sure to visit [http://medicalhomeinfo.org/how/clinical_care/hearing_screening/](http://medicalhomeinfo.org/how/clinical_care/hearing_screening/) to access a number of resources related to newborn hearing screening.

**The Need for Education and Training in Fetal Alcohol Spectrum Disorders (FASDs)**

It is known that fetal alcohol spectrum disorders (FASDs) are the leading preventable causes of developmental disabilities with serious permanent consequences, yet 13% of women in the US continue to drink alcohol during pregnancy. The study *Fetal Alcohol Syndrome: Knowledge and Attitudes of Family Medicine Clerkship and Residency Directors* examined the knowledge, skills, and practices of family medicine residency and clerkship directors and assessed the time devoted and format of FAS curricula in the programs. The results of the study indicated that there is a high level of of knowledge about FASD and alcohol counseling for pregnant women in both groups, but it also made apparent the need for FASD education and physician counseling training in all residency curriculums. FASDs is one topic area addressed as part of the *Program to Enhance the Health and Development of Infants & Children (PEHDIC)* cooperative agreement between the AAP and the
Cont. The Need for Education and Training in Fetal Alcohol Spectrum Disorders (FASDs)

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CDC National Center on Birth Defects and Developmental Disabilities. An FASDs factsheet is now available to download at http://www.medicalhomeinfo.org/about/PEHDIC/fasdfactsheet.pdf. To learn more about the larger program, contact Faiza Khan at fkhan@aap.org.

Fetal Alcohol Spectrum Disorders (FASDs) Factsheet Now Available

Did you know that a small head size, low body weight, lower than average height, poor coordination, vision or hearing problems, along with a number of other signs and symptoms can be indicators of a child with a Fetal Alcohol Spectrum Disorder (FASD)? Would you be able to recognize it? Fetal alcohol spectrum disorders (FASDs) is a term that encompasses the range of conditions that can occur in a person whose mother drank alcohol during pregnancy. These effects can include physical, mental, behavioral and/or learning problems. Often, a person with an FASD has a combination of these.

While, we do not know exactly how many people have an FASD, CDC studies have shown that 0.2 to 1.5 cases of fetal alcohol syndrome (FAS) occur for every 1,000 live births in certain areas of the United States.1, 2, 3, 4 Other studies using different methods have estimated the rate of FAS at 0.5 to 2.0 cases per 1,000 live births. Many children with FASDs remain undetected because there is a lack of accurate, routine screening in prenatal clinics and pediatric settings. Thus, current prevalence figures underestimate the magnitude of these disorders because of inconsistent documentation of prenatal exposures or symptoms characteristic of prenatal alcohol exposure.

Diagnosing FASDs can be difficult because there is no medical test for it and other disorders, such as ADHD (attention-deficit/hyperactivity disorder) and Williams syndrome, display similar signs and symptoms.

To diagnose FAS, look for:
- Abnormal facial features (e.g. smooth ridge between nose and upper lip)
- Lower-than-average height, weight, or both
- Central nervous system problems (e.g., small head size, problems with attention and hyperactivity, poor coordination)
- Prenatal alcohol exposure; although confirmation is not required to make a diagnosis

Pediatricians should consider FASDs when evaluating children with developmental problems, behavioral concerns, or school failure. Like other children with complex medical or behavioral disabilities, children with FASD need a pediatric medical home to provide and coordinate care and ensure necessary medical, behavioral, social, and educational services.

FASDs last a lifetime and there is no cure. However, early intervention and adequate treatment can significantly improve an affected child’s life. No one treatment is right for every patient. Successful treatment plans will include close monitoring, follow-up care, and changes as needed. Evidence-based interventions for children with an FASD are available. For more information about these interventions, visit www.cdc.gov/fasd. Also, remember, fetal alcohol spectrum disorders are 100% preventable if a woman does not drink alcohol while she is pregnant.

FASDs is one topic area addressed as part of the Program to Enhance the Health and Development of Infants & Children (PEHDIC) cooperative agreement between the American Academy of Pediatrics (AAP) and the National Center on Birth Defects and Developmental Disabilities of the Centers for Disease Control and Prevention (CDC). Recently the AAP, in collaboration with the CDC, developed an FASDs factsheet which contains information about types
Cont. The Need for Education and Training in Fetal Alcohol Spectrum Disorders (FASDs)

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of FASDs, ways to diagnose, treatments, web resources and the CDC-funded FASD Regional Training Centers. To download a copy visit, http://www.medicalhomeinfo.org/about/PEHDIC/fasdfactsheet.pdf and to learn about the program, contact Faiza Khan, MPH, Program Manager, AAP Division of Children with Special Needs at 847/434-4924 or fkhan@aap.org.


~ SOAPM CORNER ~

(Section on Administration and Practice Management)

Communication Among Clinicians—Aims and Means

Budd N. Shenkin, MD, FAAP
SOAPM Member

I like the size of our practice—35 clinicians in 10 offices—but I have to admit, communicating was much easier when we were just two staff members and me. Even though we had a small practice, I still had to write things down to avoid, “Don’t you remember? This is what we decided!” With a bigger group, communicating is both more difficult and more important.

The Range of Technologies
Initially, our mode of communication consisted of meetings, phone calls, and letters. Technology evolved from pagers that beeped to pagers with messages to answering machines and voice mails. Then came faxes, e-mails, cell phones, and web sites. Now, private intranet has helped us connect among offices, clinicians, and staff in a more secure way. With all these choices, we can now fine-tune which modality we use and for what purpose. Electronic medical records will probably be the next technological upgrade in our practice communications.

Principles of Choosing Which Mode to Use
Communication should transmit objective information clearly and efficiently. It should initiate and spread easily within the group, provide room for interaction and feedback, and it should be readily available for retrieval. Getting things done relies on clarity and efficiency. But as important as those aspects are, I think that the subjective aspects of communication are even more important. The feelings of group members lurk beneath the surface—their attachment to one another, their esprit de corps, their agreement on practice philosophy, their feelings of autonomy, their pride in the group. Lack of good communication may lead the group to become dysfunctional. Leadership can breed resentment instead of inspire support. Individual offices and practitioners can become rivals instead of comrades.
Cont. Communication Among Clinicians—Aims and Means

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Emotional distance can increase. Groups can break up. So communication need not only to transmit objective information back and forth clearly and efficiently, but should also foster group satisfaction and cohesion. It is a tall order.

It can be tough to figure out how to combine clarity with warmth. See the table in Appendix (there is a link at the end of the article) for many of the tasks of communication within the group, and the various means available.

How We Move and Sit
Our clinicians practice in 2 different offices. In each office they sit in a common room, in which they can interact with each other. Comfortable informal relationships and communications are crucial to a group. At the cost of privacy, this arrangement promotes interaction, understanding, mutual case consultation, viral news and gossip, and friendship.

Meetings
With all of our technology, is there any role for meetings at all? You bet! I doubt that even holograms will ever substitute for the in-person meeting. Meetings provide body language, nuance, feelings, and instant feedback. Long-distance relationships are just too hard to maintain, and most doctors are not great writers. We can more easily and fully express ourselves with direct, verbal contact.

In our group, we meet for business, clinical policy, education and pleasure. When we meet we generally eat. In my opinion, meeting without eating is barbaric. Groups need to eat together to stay together. Each clinical office has 3 mandatory-attendance meetings each year. In each meeting, we try to cover as many topics as we can. We explore what is and is not working in the office, introduce new items for evaluation such as tuberculosis screening questionnaires, teen depression screens, and quality improvement (QI) projects. We discuss where we are in the world of pediatrics and managed care and listen to concerns of physicians. We take notes and follow up what we say with the time-tested new business/old business format. The meetings are warm with a high clarity.

We meet monthly in our 2 divisions for educational purposes and have group discussions about clinical cases and documentation issues. We discuss presentations of conferences we have been to, or invite specialists to share their experience with us. Once a year we have a steak house dinner with a guest speaker followed by a class picture. For special purposes or counseling, individual clinicians meet with our clinical leadership. Meeting personally is a sign of respect and cannot be ignored.

E-mail and Practice Listserv
How did we exist without e-mail, I ask you? I simply do not remember. We use it for everything, as I am sure everyone does. We have not solved how to sign out and discuss cases in a Health Insurance Portability and Accountability Act-protected mode, but we are working on it. We have also constructed a practice Listserv on Yahoo which serves to discuss cases, ask for advice, cite interesting articles, ask for input in developing handouts and forms, pass on billing tips, announce new babies of our prolific clinicians, and much more. While not so warm as meeting in person, a style of cooperation can compensate for that.

Cell Phones and Telephones
Phone calls are still great for many purposes, especially for communications where it is useful to have no written record. A phone call is usually warmer than an e-mail. In addition, we have recently added a pediatric surgeon and an allergist/immunologist/rheumatologist to our group. We call their cell phones for instant consultations. Warm and efficient.

Our Web Site
Our Web site portrays us to patients, but also to ourselves. We have a thoughtful mission statement, our history and
Cont. Communication Among Clinicians—Aims and Means

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philosophy, an account of our QI projects, and all our educational material (BaysideMedical.com). This helps us to all be on the same page, literally. Highly efficient.

Our Intranet

We have our own intranet that gives us an opportunity to ensconce and transmit the knowledge of the ages. It includes but is not limited to, personal pearls and protocols we have devised for our benefit. With the intranet we can also do practice business. Our intranet is highly objective, very efficient—but not the place to exchange feelings. So far, here is what we have been posting:

- Group announcements
- Resources for daily practice
  - References and links
  - Office forms
  - Coding and documentation resources
  - Public health reporting forms
  - Referral and community resource information
- Clinical pearls
- On-call, rounds, and vacation schedules
- Practice statistics—e.g. all clinicians separately on bar graphs, on selected issues

A practice will have choices in how to communicate many items. Techniques are new, but people are as they have always been. We need information, but we also need human contact and appreciation. Attending to both is key to practice health. See our table of communication methods in the appendix for more information.

SOAPM Membership Drive

Seth Toback, MD, FAAP
SOAPM Membership committee co-chair
Betsy Peterson, MD, FAAP
SOYP liaison and SOAPM Membership committee co-chair

The membership committee for the Section on Administration and Practice Management (SOAPM) is excited to announce the first ever Free One Year Membership Drive. The SOAPM executive committee and the AAP have approved opening up all the benefits of SOAPM to any AAP fellow who is not a current SOAPM member. This offer begins March 1, 2011 and ends February 28, 2012.

In an effort to attract more young physicians to the section, SOAPM is offering a fabulous SOAPM t-shirt to the first 30 SOYP members who take advantage of the free membership. The shirts are 100% cotton, have the AAP logo on the front and the SOAPM tagline “The curbside consult on practice management” on the back. The shirts are to be handed or mailed out at the time of the NCE in October.

Joining is easy. Just go to our membership page (https://www.formrouter.net/forms01@AAPED/SOAPM.html), enter your AAP ID number and password, then click ‘Join a Section or Council’. Administration and Practice Management is right on top!

So take advantage of all that SOAPM has to offer and join today!
A diplomat of the American Board of Pediatrics, Blanche Bourne began her practice in Cincinnati, OH at St Louis, MO before joining the faculty at the Howard University College of Medicine. She retired in 1957 and accepted a position in the DC Department of Public Health; her second retirement was as deputy administrator of Community Health and Hospitals and deputy director of Public Health. Dr Bourne’s honors include an Award of Merit—Howard University Centennial (1967), and the Distinguished Service Award—Howard University College of Medicine (1982). Her personal narrative follows:

I was born in Frederick, MD, attended the public schools there, and left with memories of a happy childhood in a small town. My father was a general practitioner of medicine and made house calls all over the county in that era of the “country doctor.”

I went with him on many of his house calls. Surprisingly, the majority of his patients were white, and in the days of segregation, contentedly sat in his non-segregated waiting room. They called him to their homes, where he attended them and delivered their babies at home or at one hospital where he could do so.

These experiences with him had an influence on me from early in my childhood. He was my idol together with my lovely mother who encouraged and supported my dreams. So, a medical doctor I became, but my career carried me in a direction away from that of a “country doctor.”

College years were spent at Morgan State College, now Morgan State University, Maryland, in preparation for medical school. My entrance into Howard University College of Medicine marked the beginning of years of serious study, fun, and experiences that are remembered as one of the happiest periods of my life.

There were five women in my class of 1941. That was unusual for the time and did cause some comment. However, it never seemed strange to us. We were fully accepted by fellow students and by faculty. I have no recollection of any bias on the basis of sex throughout all these years. I never expected to be treated any differently because I am female, and I have not been conscious throughout my career of sex discrimination personally directed to me.

Our class was small and there was a camaraderie that has manifested itself each time we have the opportunity to be together. We had a marvelous faculty during those years in medical school. Throughout all of my years of association with other physicians from schools all over and outside the country, I have felt proud of my educational training received at Howard...that education has enabled me to continue to learn and grow in any desired area.

Upon graduation from HUCM, I interned at Homer G. Phillips Hospital in St Louis, MO. This was followed by two years of residency in pediatrics at the same institution. I married a physician, Dr. C. Raymond Merry, who was in surgery; we moved to Cincinnati to establish a private practice. I limited my practice to pediatrics and was accepted on the staff of Children’s Hospital, where I could admit and treat my patients and attend staff conferences. We had the beginning of a successful practice but my husband became ill with tuberculosis. We went back to St Louis for him to enter a tuberculosis hospital there, and I began a pediatric practice. However, my husband did not like the hospital, so I made arrangements to take him to Freedman's Annex in Washington, DC.

In order to do so, I applied for a position on the pediatrics staff at the College of Medicine at Howard. Fortunately, I was accepted in the position of instructor in pediatrics. This move back to Washington marked the beginning of another phase in my career and profession. I found that I truly enjoyed working with the medical students (13 women in my first class), interns, residents and staff. The care of patients in the hospital and clinics was important to me also.
I embarked upon a referral and consultative practice. It has been a joy through the years to see so many of my students become truly great physicians. I feel such pride in them and am happy for their successes. Also, so many of their children had been my patients and I was and am thankful for the privilege of being their pediatrician.

Although my years as a faculty member at Howard were stimulating and important to me, I decided to leave after ten years of service. My husband had died in 1952.

My second marriage in 1954 was to Harold B. Jordan, administrative assistant to the dean of HUCM. He was most supportive of any decision that I made about my career. I felt that I had to make money as the university salaries were then very low.

Dr Ella Oppenheimer, chief of the Bureau of Maternal and Child Health in the DC Department of Public Health had frequently invited me to work with her. So I finally applied for a position of medical officer in public health. Upon acceptance I began a career in public health that extended over a period of 22 years.

These years are filled with memories of many glowing accomplishments as well as many gloomy defeats. Rather than giving specifics, I share spare the details and give the positions occupied with some highlights of these service years.

I began as a medical officer and worked in various child health clinics and many other areas of maternal and child health. This gave me experience with all facets of the Bureau.

I was then appointed as chief health officer at the Gales Health Center. My duties were part clinical in child health clinics and in the specialty clinics, together with major administrative responsibilities. In 1961, I was appointed chief of the School Health Division, where I was responsible for 40 physicians and the medical programs in the schools. Then I was promoted to coordinator of the DC School Health Program. This provided for the coordination of all health department programs and activities in the schools and for working with the superintendent and many of the educators and school nurses to coordinate programs to meet many needs. It was a most challenging position and one that I filled with interest and enthusiasm.

About 1971 a departmental reorganization resulted in a change in public health. The department became an administration in the new Department of Human Resources. My role and position changed.

The director of the department sent me to the Federal Executive Institute in Charlottesville, VA for an intensive two month course in executive development for top-level government employees. Class members came from many federal agencies throughout the country. It was a wonderful experience for which I was ever grateful. This opened new vistas and more challenging goals in the administrative process for me. Subsequently, I became the director of a new office, the Office of Child Development. Further re-organization led to a position as consultant, School Health Program, and then to chief of the Bureau of Clinical Services in the Community Health and Hospital Administration (CHHA).

In this position, I reported to the administrator of CHHA, who was also the director of Public Health. The incumbent in that position, (the late) Dr Raymond Standard, ('52) had been a student in my pediatric classes, and it was a most compatible association as I moved into my new position – deputy administrator and deputy director of public health.

These were years filled with work, frustration, some progress, some regression and much responsibility – recognized and unrecognized. Yet, I always found my work in public health to be a satisfying endeavor with enough visible positive results in programs to keep one stimulated to continue aspiring for further successes.

During my years of service in public health, I was appreciative of various recognitions received; one was an “Award of Merit” from the Medical Women’s Centennial Committee of Howard University in April 1976.
The other significant honor was the “Federal Women’s Award” founded in 1961. Six women from a variety of professional disciplines and background received this coveted award for 1976 and I was one of them. It was established to “provide special recognition to women who have made significant contributions to the efficiency and quality of the career system of the federal government.” Personal quality of dedication, leadership, integrity, and judgment are also considered. Unfortunately these awards are no longer given. However, I think those of us fortunate enough to be selected are proud of the honor and were inspired to continue to try to accomplish even more.

By 1978, my decision to retire was finalized in the view of the vast changes in the department and the political climate. Also, I wanted to have more time with my husband of 24 years. We had a great life together and were planning to build a new home in Florida. We also wanted to do more traveling in the states as most of our fairly extensive travel had been out of the country. Hence, I put in my retirement papers and on November 30, the staff gave me a tremendous and memorable luncheon. On December 1, I went to the office to finish clearing out desks, concluding details and to attend a final small office party. My husband did not arrive. I went home to find him peacefully sleeping on the sofa—only it was the sleep of death.

Dr Ray Standard would not accept my resignation for he correctly believed that I should have something to occupy my grief-filled days. I returned to work in January 1979 and worked about four months and then left quietly with Ray’s blessing. He let me go when I told him I was going to be a consultant to the maternal and child health program in the Department of Health, Education, and Welfare.

My period providing consultation was a short one of about one year’s duration. However, it was filled with interesting experiences and contacts. I reviewed maternal and child health programs in the states of New Jersey, Kansas and Montana, as well as some assignments at the DHEW. Upon meeting my present husband and marrying in 1981, I decided to retire altogether.

The final honor I received in 1982 is another of great value and it is greatly appreciated. This is the Distinguished Service Award from HUCM, presented at its dinner during the annual National Medical Association convention in San Francisco that year.

After retirement, I decided to leave Washington and return to the area I was born. I live in a village in Frederick County Maryland where the inhabitants are active, independent seniors. Although most are retired, some are not. All of us seem to enjoy this village life with our security, attention to grass-cutting or snow removal and the activities of our club house, with swimming pool, tennis courts and planned recreation. I lived here prior to meeting and marrying “Chris” Tyree, but the attraction of this place captured his heart too.

I have retired completely from medical activity except for some brief time with the Public Health Department. This consisted for review of specific health records and committee activity. Other volunteer work included my appointment on various boards: Board of Associates of Hood College, Community Foundation of Frederick County, Delaplaine Visual Arts Education Center, The Family Life Center, Good Will Industries, and other organizations.

For three years I was co-host of a program at the local TV station entitled “Young at Heart.” This was an enjoyable period. Upon leaving the show I continued as a member of the advisory committee. The show was discontinued when Comcast bought the station.

At present, I am fortunate to be enjoying life in a more tranquil but satisfactory manner. This involves good friends and enough activity to keep life interesting.
Did you know? Cigarette smoking and exposure to secondhand smoke are the leading cause of preventable mortality in the United States. According to the Centers for Disease Control and Prevention, each day in the United States, approximately 4,000 adolescents aged 12-17 try their first cigarette.

The AAP Julius B. Richmond Center of Excellence is dedicated to eliminating children’s exposure to tobacco and secondhand smoke. The Richmond Center needs dedicated physicians to help decrease these statistics and work to create healthy, tobacco-free environments for children, adolescents, and families.

Opportunity for Involvement
There are a number of opportunities to get involved in tobacco prevention and control efforts at the community, state, and chapter levels. The Richmond Center of Excellence received funding under the American Recovery and Reinvestment Act (ARRA) Communities Putting Prevention to Work (CPPW) initiative to partner communities, chapters, and pediatricians in an effort to effect social, environmental, and systems change around tobacco prevention and control. The Richmond Center is actively seeking pediatricians interested in becoming Tobacco Champions. As a Champion you will serve as a tobacco advocate on behalf of children and will have the opportunity to educate others utilizing your influential perspective as a child healthcare provider. If you are interested in learning more about the CPPW initiative or becoming a Tobacco Champion in your own community please contact us at richmondcenter@aap.org.

Upcoming Educational Webinars
Keep an eye out for the upcoming Richmond Center of Excellence webinar series! The webinar series is intended for practicing pediatricians and chapters with topics focusing on advocacy, hot topics in tobacco prevention and control, communication with patients and families, best practices, and point of care issues.

Stay Connected to the Richmond Center
Be the first to hear about tobacco prevention and control information. Join the AAP Julius B. Richmond Center of Excellence E-mail List! As a subscriber, you will receive up-to-date information from the AAP regarding tobacco and secondhand smoke initiatives including funding opportunities, upcoming meetings and conferences, research tools, and more! Join the email list by contacting: richmondcenter@aap.org

Resources for Tobacco Prevention and Control
The Richmond Center website is regularly updated with resources and information to help support your tobacco prevention and control efforts. Whether your interests lie in bettering the clinical setting, improving reimbursement, or locating funding and advocacy opportunities, this website will have the tools to get you started. Visit us at http://www.aap.org/richmondcenter/

As a young physician, you play a critical role in advancing the AAP Julius B. Richmond Center of Excellence's mission. Numerous physicians have already made the commitment to become active against tobacco use and exposure and you too can make a difference in your community and practice. The Richmond Center continually looks for ways to highlight dedicated young physicians for their work in the tobacco control and prevention arena. We would like to hear how you are making a difference! Please share your stories with us at richmondcenter@aap.org
New Vaccine Codes
AAP Resources to Advocate for Payment on New Immunization Administration Codes

The American Academy of Pediatrics (AAP) has developed new CPT codes for reporting immunization administration (IA) in the pediatric patient population. The new codes became effective on January 1, 2011 and replaced codes 90465-90468. The new codes are reported based on the number of vaccine components rather than the number of injections/administrations. These codes are as follows:

- **90460** Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component
- **90461** Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (list separately in addition to code for primary procedure)

Several issues have been reported with implementation of the new codes. To address inadequate payment of the IA codes, members can download an appeal letter to send to payers at: [http://www.aap.org/securemoc/reimburse/InadequatePayIA.pdf](http://www.aap.org/securemoc/reimburse/InadequatePayIA.pdf) (requires member log in).

To report any problems with payment for the new codes, visit the Hassle Factor Form on the AAP's Member Center home page or go to [http://www.aap.org/moc/reimburse/hasslefactor/](http://www.aap.org/moc/reimburse/hasslefactor/). AAP staff are monitoring submissions and following up with payers.

2012 CATCH Planning Funds Program Call for Proposals

Applications available May 2, 2011—submissions due July 29, 2011
Applicants notified December 2011—projects begin January 2012

For the 18th consecutive year, the American Academy of Pediatrics is offering pediatricians an opportunity to put their ideas into action by taking advantage of the funding available through the CATCH Program. The CATCH mission and the focus of the Planning Funds grants are to enable pediatricians to plan innovative community-based child health initiatives that increase access to medical homes or specific health services not otherwise available. A pediatrician must lead the project and be involved in the proposal development and project activities.

The grants are awarded in amounts from $5,000 to $12,000 on a competitive basis for planning activities such as needs assessments and community asset mapping, feasibility studies, community coalition/collaboration meetings, focus groups, and development of grant proposals for project implementation after the planning phase is complete.
**Cont. 2012 CATCH Planning Funds Program Call for Proposals**  
*Cont. from page 23*

Project activities should include developing broad-based collaborative community partnerships. Priority is given to projects that will be serving communities with the greatest health disparities.

All applications must be submitted online. More information is at [www.aap.org/catch/planninggrants.htm](http://www.aap.org/catch/planninggrants.htm), e-mail catch@aap.org, or call 800/433-9016, ext 4916 or 847/434-4916.

Join more than 1,000 pediatricians who, through their CATCH projects, have learned that local child health problems can be solved locally, often using local resources.

One pediatrician *can* make a difference!

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**Practical Pediatrics CME Courses are Practical for You**

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

Congratulations. You have made it through medical school, residency, maybe a fellowship or two. You are done learning, and you are ready for practice.

Not so fast! 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. Black-box warnings have you questioning which treatments are best for asthma, 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 cannot 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 six 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 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's a PPC course to meet your educational and recreational needs.
Cont. Practical Pediatrics CME Courses are Practical for You  Cont. from page 24

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 2011.

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

Hilton Head Island, South Carolina
May 26-28
Seattle, Washington
May 27-29

Hershey, Pennsylvania
June 24-26

Chicago, Illinois
September 2-4

Amelia Island, Florida
November 4-6

Anaheim, California
December 9-11

You can find more information and register online at www.pedialink.org/cmefinder. We look forward to seeing you soon!
Transforming Pediatric Residency Training to Improve Care for Underserved Children: A Team-based Approach

Re: Request for Applications NOW OPEN
Deadline: March 16, 2011 2 PM CDT
The call for proposals is now open for Transforming Pediatric Residency Training to Improve Care for Underserved Children: A Team-Based Approach Grant. The goal of this grant is to help residency programs improve their community pediatrics and advocacy training. Programs selected will create sustainable strategies to implement change to enhance residency training in community pediatrics and advocacy.

Grants of up to $30,000 will be awarded on a competitive basis to 7 pediatric residency programs for activities to be completed over the course of 2 years. A pediatric faculty member with AAP national and chapter membership must lead the project.

Application and guidelines are available online at:
www.aap.org/commpeds/cpti/opportunities.htm

Applications must be submitted by e-mail to cpti@aap.org in a Word or PDF file by 2pm CDT March 16, 2011. For more information, please contact us at: cpti@aap.org or 800/433-9016, ext 7397.

Learn the Pediatric Coding Success Secrets of Today’s Top Pros.

The AAP Coding Webinar Series includes 1-hour live events filled with pediatric-specific coding insights and information you can’t afford to miss. Here is the help you need to meet your most complex pediatric coding and billing challenges.

Everything You Always Wanted to Know About RBRVS and RVUs But Were Too Busy to Ask!
RBRVS and RVUs
This fast-paced webinar will introduce the Resource-Based Relative Value Scale (RBRVS) and explain how RBRVS can benefit your practice. You will learn how to identify the elements of RBRVS—physician work, practice expense, and professional liability insurance and how RVUs are converted into dollar amounts and what those amounts look like in 2011.
Cont. Learn the Pediatric Coding Success Secrets of Today’s Top Pros.

Navigating Neonatal Concurrent Care Concerns
Newborn and Neonatal Hospital Coding
Learn valuable explanations and updates on the who, what, when, and where of newborn coding—plus the latest code changes and the new AAP neonatal coding algorithm.

For: Neonatologists, hospitalists, pediatricians, critical care and transport care physicians, coders
Presenter: Rich Molteni, MD, FAAP
Date & Time: April 21, 2011 12:00 pm–1:00 pm CT
Cost: $134.95

How to Code When the Kid Isn’t There
Non-Face-to-Face Coding
Here’s how to code when the kid isn’t there—including advice, consultation, and evaluation and treatment via e-mail or phone. This fast-paced webinar will review guidelines and AAP services for appealing payment denials.

For: Physicians, care providers, Medicaid directors, carriers, transition care specialists, coders
Presenter: Richard Tuck, MD, FAAP
Date & Time: June 7, 2011 12:00 pm–1:00 pm CT
Cost: $134.95

Register today at www.aap.org/webinars/coding.
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Visit us on the YoungPeds Network
www.aap.org/ypn OR
the YPConnection http://ypn.aap.org.

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Interested in writing an article - email one of our newsletter editors!
SOYP Letter to AAP Re: Wakefield

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

January 20, 2011

TO: O. Marion Burton, MD, FAAP

FR: Section on Young Physicians Executive Committee

RE: Follow-up to Wakefield publicity

During our winter meeting, the Section on Young Physicians (SOYP) Executive Committee has been charged with creating action items related to the Vision of Pediatrics 2020 Megatrends. Once again, we focused on consumer driven medicine. In light of the media on the British Medical Journal’s recent article on Andrew Wakefield and his work on autism, we, as the SOYP Executive Committee, are concerned that the AAP did not choose to make a public response. The AAP should take advantage of opportuniteve like this to help pediatrician members respond to parent inquiries. We as pediatricians can further our positive relationships with families struggling with difficult decisions by helping them digest the information they are bombarded with in the lay media.

Many of us talk to parents about vaccines every day. Some ask questions about whether they are safe or whether they will cause autism. Some ask questions about whether other unvaccinated patients put their children at risk. After the media blasts about Wakefield, many parents ask, “Is this good news?” Individual pediatricians lack an official response from the AAP.

We would like to see the AAP respond positively in the following ways:
- Issue a short guideline to the AAP membership with a summary of developments regarding Wakefield’s study retraction.
- Offer AAP members guidelines on how to advise their patients about vaccines in light of this latest media topic.
- Release press supporting the use of vaccinations.
- Provide a statement or advertisement in lay press for parents summarizing the issue and supporting vaccine use.

While we understand the issue of making AAP statements is very complex, we think this is an easy way to underscore the importance and safety of vaccines to our patients without “playing into” the media hype. These suggestions are a great way to show pediatricians the value of their AAP membership.

Thank you for the opportunity to voice our concerns.

Kelsey Logan, MD, FAAP – Chair. District V
Amy J. Sturner, MD, FAAP – District I
Rhonda Graves, MD, FAAP – District II
Laurel Ongojdum, MD, FAAP – District III
Elizabeth Mack, MD, FAAP – District IV
Bryan Wohlwend, MD, FAAP – District V
Rachel Davkins, MD, FAAP – District VII
Alex Cvejimovic, MD, FAAP – District VIII
Christina Vo, MD, FAAP – District IX
Cristina Pelaez, MD, FAAP – District X
AAP Response Re: Wakefield

Kelsey,
Thank you for this very thoughtful response. Much of its content is extremely pertinent to this issue. Please be assured that your Executive Committee, Board of Directors and senior staff AAP leadership are consistently monitoring the best approach to take. There are a number of considerations that come into play when deciding when and how to respond.
In the years when defending immunizations was not as popular as it is today, the AAP boldly, consistently and without hesitation took the "road less traveled" and was very visible in promoting the safety and effectiveness of immunizations and announcing caution regarding research that could not be validated. Now almost every media outlet in the country is "doing our heavy lifting" for us. It is important now that we make the right statement at the right time and in the right way rather than just "piling on" the Wakefield episode as many are doing. This could not be as effective as we would hope and also could have negative aspects. Be assured we are trying to do what is best for all children and our members.
O. Marion Burton, MD FAAP
AAP President

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