According to Wikipedia, strategic planning is defined as “an organization’s process of defining its strategy, or direction, and making decisions on allocating its resources to pursue this strategy. In order to determine the direction of the organization, it is necessary to understand its current position and the possible avenues through which it can pursue a particular course of action.” So imagine the Section on Young Physicians’ (SOYP) executive committee’s excitement when told that the major topic of our January meeting was reviewing and revising the section’s strategic plan. Many cups of coffee, diet Coke or other caffeinated beverages were going to be necessary to complete this task. Surprisingly, however, the strategic planning process was informative, energizing and, dare I say, fun!

The major items we focused on during the strategic planning session were the purpose of the SOYP, where the section is within the Academy, what we would like to accomplish and how to get there. The SOYP aims to be the professional home (within the AAP) for pediatricians post residency and fellowship training especially in the areas of leadership training, mentoring, and networking with the ultimate goal of helping to advance child health. We want to serve the interests of physicians early in their careers and to position them to best serve children.

For the past few years we have been debating a name change for our section--- since the phrase “Young Physician” seems to confuse most. Maybe the name of the section should be “Early Career Pediatricians” or “Physicians Early in Practice.” Whatever the name, the section needs to do a better job of highlighting our role in developing pediatricians both within the AAP and in their careers.

To this end, we established six major topic areas for the SOYP.
executive committee to focus on over the next five years. Within each topic area we identified desired outcomes and approaches to reaching these outcomes. Some of the topic areas are internal-to better connect members with AAP benefits, through better communication and improving member value. Other areas are broader and apply specifically to the young physician demographic. These topics include work/life balance, personal financial planning, leadership development, and pediatric workforce.

Over the next few months, the group (with the help of Ken Slaw and Julie Raymond) will refine our goals and further delineate our desired outcomes. Overall, the strategic planning process invigorated our executive committee. We were able to get a better grasp of our purpose within the Academy and where we can best utilize our resources-namely our motivated and energetic members-to accomplish our goals.

Many thanks to Ken Slaw for guiding us through this process, to Julie Raymond for being our mentor and to Dr. Pam Shaw for giving us valuable feedback from a Board perspective-we could not have done this without your help!
Hello Young Physicians!

On behalf of the Editor, Tyler Smith, MD, MPH, FAAP and our fabulous AAP Staff Member, Barb Miller, I am thrilled to share the 2013 Spring/Summer SOYP Newsletter – SOYP Notes. I am Jennifer Wolford, DO, MPH, FAAP, and have recently joined the team as the new Assistant Editor.

This newsletter is 30+ pages of inspiration. Inside, you will find articles by our colleagues from all over the country. I was inspired to learn about the amazing work that our fellow young FAAPs are leading in the Member Spotlights. It’s exciting to see what we can do and who and what these young physicians cite as important factors in their career path. Be inspired to use your resources. Nearly every page has an announcement of Academy resources to assist you in your work day. We preview practical tools on vaccine storage to larger clinical guides, including caring for survivors of cancer in your office. Be inspired to take your practice to the next level. In this edition, you can learn about the new user-friendly Digital Navigator to turn your practice into a Medical Home.

Be inspired to keep learning. Some of the great assets of the AAP that were so valuable as a resident can continue to be available to you as a Young Physician. Please look inside to learn more about Pediatric Care Online and the deep resource of Pedialink for Young Physicians after residency. Every pediatrician can learn more about a trauma informed approach to patient care. Please check out the information included in the newsletter about this great resource.

Most importantly, be inspired to be mindful of the tender moments of your day. Enjoy the reflections of some of our colleagues and share their journey of advocating for children’s health. Some have shared their gratification of advocating on Capitol Hill while others have shared the humbling memories of realizing our limitations as healers. For wherever you are today, in the busy clinic lunch room, the PTA meeting, or stealing a quiet late minute on your couch – we hope you’ll be inspired by our fellow Young Physicians striving toward a better tomorrow for children. We certainly are!

Jennifer Wolford, DO, MPH
Speaking Up For Kids  
Karen Maule, MD, FAAP  
Council on Injury, Violence & Poison Prevention

A year ago, I was listening to Dr. Garry Gardner, the primary care pediatrician who drove an hour every Tuesday morning from the suburbs into Chicago to teach in our little residency clinic. I was a month away from graduation and about to start my first real job in Rhode Island as a primary care pediatrician. While I was obsessing about Lyme disease, Dr. Gardner was reminding me, as he often did, about the big picture. “The greatest gift that you can give is the gift of time,” he said. Listen to your patients, he would say with his stories, and speak for them when they need help being heard. So I start every office visit the way that he started his: “I have some questions for you, but first, what questions do you have for me?”

Amid the questions about sleepless nights and terrible diets of chicken nuggets and juice, parents would tell me about bringing their children to emergency departments (ED) after falls, ingestions, or car crashes. They would say, “I feel so lucky that my children are okay.” I would protest, safety was not only about luck. Rearrange the furniture so it is not close to a window. Keep medicine out of reach. Get a car seat. This burden should not be shouldered by the parents who already have their hands full. Pediatricians should educate parents about window guards. Medicine should not be packaged like candy. A stop sign should be placed at that busy intersection.

During residency, Dr. Gardner and I worked with an amazing team of child advocates to decrease button battery ingestion injuries. When I was a resident, a two-year-old boy had been seen at our ED with a sore throat, and 16 hours later, a 20-mm lithium button battery was removed from his esophagus. Button batteries, I learned, produce hydroxide ions at the anode that result in caustic (alkaline) tissue injury within two hours of ingestion (1). The anode of the battery that he had swallowed had been facing anteriorly and had eroded into his trachea. He left our pediatric intensive care unit with a trach.

Every three hours, an ED in the United States is caring for a child with a battery-related issue (2). More consumer products are using button batteries that are more powerful and 20 mm in size, which is the perfect size for lodging in the cricopharyngeal angle of the esophagus close to the trachea and aorta. Battery button compartments are not all childproofed. Ingestions are often not witnessed. Symptoms can be absent or similar to a cold. X-rays of button batteries can look like coins, if you do not know to look for the halo or step-off that are signs of a battery. As a result, complications from ingestions have increased 6.7-fold in the past 20 years (3).

I tell my patients’ parents to make sure that products like remote controls that use button batteries are securely closed and that loose batteries should be safely disposed or stored out of children’s reach. With all of the children with cold symptoms I see in my office, I am dreading the day that I send home a child who ingested a button battery. That day does not have to come.

A few years after we started the project and many e-mails later, industry leaders, physicians, public health
**cont. Speaking Up For Kids**

*Cont. from page 4*

workers, and government representatives have been working together
to make one less tragic story of button battery ingestion injury. Energizer
has produced a new childproof package for its button batteries. In-
creased awareness has led to improved reporting to the National Battery
Ingestion Hotline, and the AAP Annual Leadership Forum voted button
battery ingestion prevention as one of its top 10 leadership resolutions.
Horizontal industry standards for two-action compartment security are
being developed, so that all products that use button batteries are child-
proofed.

Advocacy is a process, and the rate of button battery ingestion compli-
cations has not decreased yet. Being a part of this effort has been tre-
mendously rewarding for me, a constant reminder that any young physi-
ian can make a difference with just a little time. Find any issue that you care about and speak up. It could
be as simple as a conversation, an e-mail, or a story for the SOYP newsletter. You never know who is listen-
ing. If you are feeling overwhelmed, find a mentor like Dr. Gardner who is willing to give you the greatest gift
of all to help you find your voice.

For further information on preventing button battery ingestions, please check out [www.poison.org/battery](http://www.poison.org/battery) and [thebatterycontrolled.com](http://thebatterycontrolled.com).

2. Sharpe SJ, Rochette LM, Smith GA. Pediatric battery-related emergency department visits in the United

The Possible Pathways of Hospitalist Training and Certification: An Evolution in Progress

*Gabrielle Hester, MD, FAAP*

Residents, fellows, and young physicians in pediatric hospital medicine (PHM) may have heard a buzz lately
regarding potential changes in the pipeline for how PHM physicians are trained. In April 2013, 18 pediatric
and hospital medicine leaders met with representatives from the American Board of Pediatrics (ABP) to discuss
two questions: 1) What is the best way to improve the care of hospitalized children? 2) What is the best way
to ensure the public trust? After 2 days discussing potential answers, consensus was reached by PHM leaders
to petition the ABP to recognize hospital medicine as a new subspecialty by providing certification in the disci-
pline. The leaders agreed that a two-year accredited fellowship in PHM would be the optimal route to insure
**cont.** The Possible Pathways of Hospitalist Training and Certification: An Evolution in Progress

*Cont. from page 5*

acquisition of clinical and scholarly skills needed to be eligible for certification in the future.

As Dr. Gail McGuinness, Executive Vice President for the ABP, noted at a panel discussion at the Pediatric Academic Society (PAS) conference in May 2013, the road to providing certification in a new subspecialty is long. She stated that the process varies depending on the circumstances, but an average time between a new petition and the first board exam in the subspecialty is five to seven years. The ABP also develops a ‘practice pathway’ for new subspecialties with criteria that physicians would need to meet in order to take the exam (“grandfathering”). For example, Dr. McGuinness stated that a clinician might have to practice x% of time in PHM over the preceding x years, or have completed a non-accredited fellowship program. For the first three exams (given every other year) any physician meeting the practice pathway requirements would be allowed to apply for the exam. Once approval is granted, the physician has seven years to pass the exam. And the good news is perhaps no more memorizing the Denver II Development Milestones (I hope!) as hospitalists passing the PHM subspecialty boards may not be required to maintain General Pediatrics specialty boards, although that decision would not be made until a petition is submitted and reviewed by the ABP. Once the ABP agrees to offer a certificate in a new discipline, a petition will be sent to the Accreditation Council for Graduate Medical Education (ACGME) to accredit training programs. The ABP then sets a date in the future designating when individuals must enter accredited training programs. This typically occurs 18 months to two years after the first programs are accredited by ACGME.

More good news is that the creation of a certification process, subspecialty board exam and accredited PHM fellowships would recognize, as Dr. McGuinness stated, “the evolution of a discipline over time.” As Dr. Joe Gilhooly (chair, Pediatric ACGME) stated at the PAS panel, “the goal of pediatric residency is not to train hospitalists.” Hospitalized children are increasingly complex in their chronic medical needs and new training options must be created to meet these demands. Dr. Karen Wilson (Assistant Professor, Hospitalist Section Chief and PHM Fellowship Director at Children’s Hospital Colorado) noted that PHM requires a diverse set of skills across community and academic settings; including leadership and communication skills, clinical proficiency and research or scholarly expertise. As a participant on the PAS panel, she advocated for accreditation of a PHM fellowship as a way to train physicians in these domains.

The road to certification in PHM and accreditation of fellowships will not be without hurdles. There are questions on who will bear the costs of fellowship training, possible recruiting bottlenecks, the challenge of developing standardized curriculum while still preserving the unique areas of expertise that different fellowship programs offer and how to adequately meet the needs of hospitalists with varying career goals.

PHM physicians should rest easy that certification in the subspecialty and the accreditation of training programs is many years away and requires final approval by both ABP and the American Board of Medical Specialties (ABMS) and the ACGME. Approval is not always granted, but if it is the “grandfathering” process will mean that most physicians will be able to attain certification if they pass the exam. While medical students and residents considering PHM as a career will likely not be required to pursue PHM fellowship for many years, the discussions surrounding creation of a PHM subspecialty highlight the increasingly complex skill sets required by pediatric hospitalists. Further training (through current non-accredited PHM fellowships) can only hone a skill set and increase the attractiveness of a job candidate. Many academic programs are already prioritizing candidates with fellowship training when recruiting new faculty.
**Child Sexual Abuse Prevention: Addressing Personal Space and Privacy in Pediatric Practice**

*Martin A. Finkel, DO, FAAP*

The practice of pediatrics has changed considerably since I was a resident. Most apparent are the shifts from acute care pediatrics to an increasing emphasis on helping caretakers address the emotional/behavioral/learning challenges of childhood to assure optimal development in these domains. We now have an opportunity to play a more integral role in helping parents address issues that can be much more difficult than caring for an acute disease and require a different set of skills. This shift is most apparent when one looks for a moment at the list of issues that pediatricians now address during routine health care in the form of anticipatory guidance to assure well being and safety.

Pediatricians routinely address with new parents the importance of back to sleep and car safety. As children develop, the scope of anticipatory guidance expands to address issues such as bicycle, water and fire safety as well as domestic violence, suicide prevention, and environmental hazards. We believe that the time we take to deliver each of these messages helps to reduce risk for children. There are many potential bumps in the road that can interfere with the healthy development of children. One such issue that can halt or significantly interfere with healthy development is the sexual victimization of children.

I would ask why we do not routinely provide anticipatory guidance to parents and children about a child’s right to personal space and privacy (PSP). Our failure to routinely address PSP is not because we are unaware of the issue of child sexual abuse (CSA), but possibly because we find the topic unpalatable, do not have comfortable language to address this topic, and maybe unsure of the effectiveness of this messaging. Since CSA affects approximately one in four girls and one in seven boys, it is time that we add this issue to our prevention repertoire! Even if we cannot “immunize” every child against the possibility of CSA we can likely help protect some from experiencing sexual abuse by enhancing their knowledge and skill.

So you may be asking, if I were to deliver anticipatory guidance regarding PSP when do I start, how often do I need to deliver the message, and how do I deliver the message? We know that we cannot just tell kids to wear their seat belts one time and expect that we have successfully addressed car safety. We have to begin by delivering these messages early in childhood and continue to deliver these simple safety messages over and over again in a developmentally appropriate manner reinforcing the information. This same concept equally applies when delivering the message of PSP.

Some very basic principals if followed may reduce vulnerability to children experiencing inappropriate sexual experiences. 1) Messaging PSP must begin early and be repeated frequently over time in a developmentally appropriate manner. Begin messaging at three-years-old and incorporate as a part of the annual health assessment. 2) Allow children to have as much independence regarding their own genital/perianal care and bathing that is developmentally appropriate. 3) Introduce the concept of private parts, parts covered by their bathing suit or underwear, and teach children the appropriate names for their private parts so they have the language to communicate. 4) Limit the number of individuals who participate in a child’s genital/perianal and bathing care. 5) Teach children about okay and not okay touching and who is allowed to touch their private parts and under what circumstances. 6) Educate children that it is never okay to have a secret and if they are told to keep something a secret or think they should they need to tell a parent and a teacher. Surprises are
cont. Child Sexual Abuse Prevention: Addressing Personal Space and Privacy in Pediatric Practice

Cont. from page 7

fine because we find out, secrets are not. 7) Emphasize that if someone does something okay or makes them do something that is not okay it will not be their fault, they need to tell and will not be in trouble.

Much of the national efforts within the community at large have been focused on offenders and school-based education programs which fulfill only a part of the patch quilt of prevention. Now is the time for pediatricians to assume an import role by providing universal anticipatory guidance regarding PSP that is developmentally appropriate throughout the lives of children from toddlerhood through adolescence to further reduce the risk of sexual victimization. It is up to this latest generation of pediatricians to delivery this important message!

*Editors’ Note – Martin A. Finkel, DO, FAAP is an expert regarding child abuse and neglect in the New Jersey area having served on numerous national boards and committees.

Growing Up
Jennifer Kett, MD, FAAP

Early in my medical training, I admitted a teenage boy with an unusual rash. The rash was painful and unsightly, and had gotten worse over several days. In addition, he was feeling unwell, with a high fever and the chills. Since I was new to medicine, I enjoyed using fancy words to describe it: He had a vesicular rash in a dermatomal distribution, and was febrile with rigors. He was lethargic and suffering from malaise. In my freshmen enthusiasm, I was unreasonably excited to see him. I knew what this rash was and where it had come from! Shingles! His rash was the result of chickenpox infection that laid dormant in his nerve cells. Although I felt for this young man’s suffering, I was extremely pleased to be able to demonstrate my newly honed clinical skills! Because shingles is a bit unusual in healthy teens, we asked a number of subspecialists to evaluate him. Each service asked for a panoply of tests, including a test for HIV.

Late that night, I was making my rounds and looking forward to a nap in the call room. I stopped to check on him. “You have had a busy day,” I said, “I just wanted to check on you.” “I am fine,” he said, with a typical adolescent shrug. “Ok, then, goodnight,” I said, and went to make my exit. His mother looked up abruptly and stopped me. “Doctor, wait, he is worried about something,” she said. A rapid nonverbal discussion was conducted in eye gestures between mother and son.

“What is it?” I interrupted their silent dispute. “Ask me anything.” After a long and uncomfortable pause, his mother said. “Well, doctor, he is worried about the HIV test. Why are you doing that? Do you think he has AIDS?” She sat back nervously in her seat. “Oh!” I thought to myself, “I have got this!” I was so relieved. I had been afraid they were going to ask me something that I could not answer, like, “How long he will be in the hospital?” or “How well will the rash heal?” I knew the answer to this question and rushed in to deliver it. “Oh, no!” I said with a comforting smile. “We don’t think he has AIDS. The HIV test is one of many that the specialists recommended to be complete. We do not expect it to be positive and we really did not mean to

Cont. page 9
Growing Up

Cont. from page 8

scare you. I am so sorry that we made you so upset." The tension in the room evaporated. I left the smiling family and I headed to bed feeling like an excellent doctor.

After rounds the next day, I went home for my “golden weekend.” When I returned, well-rested, several days later, I was surprised to find that he was no longer admitted. His HIV test had come back positive. He had HIV. His rash was a result of acute seroconversion syndrome from primary HIV infection. The HIV team had met with him and disclosed the results. The boy and his mother had been devastated. His rash had improved, and he had been discharged home. He would follow up with the HIV team in several days. Despite extensive questioning, no source for his HIV infection had been identified. He denied ever having been sexually active, using drugs, or being abused.

I do not know what happened to that boy, but I think of him often with a deep sense of shame. I know, now, that the tentative question delivered through his mother was a call for help. This was a missed opportunity. He was looking to divulge something that was weighing on him heavily, and I did not permit him to do so. Perhaps he was struggling with questions about his sexuality, or a history of abuse. Perhaps a well-timed question would have allowed him to reveal himself. Perhaps unloading this information would have made him feel less alone or would have made his diagnosis easier to bear, but perhaps not. Rather than rushing to answer his question with my own relief and paltry reassurances, I should have answered his question with my attention and more questions. Rather than thinking about myself, I should have been thinking about him.

Perspectives on Advocacy - Annual CONACH Legislative Visit on Native American Children's Health

Damon Dixon, MD, FAAP

As the fellow liaison to the Committee on Native American Children Health (CONACH), I had the opportunity to participate in the annual CONACH legislative visit to Washington, DC. The agenda for the legislative meeting involved discussions on Native American child health issues, an opportunity to meet with United States Representatives and Senators, and sponsorship of a congressional briefing.

CONACH is an American Academy of Pediatrics (AAP) National Committee that develops policies and programs to improve the health of Native American Children. The members are committed to increasing the awareness of health care issues facing Native American children and advocating for legislation that ensures Native American children have access to high quality health care. CONACH also conducts annual pediatric consultation visits to Indian Health Service (IHS) and tribal health care facilities to promote the development of programs that support healthy lifestyles and optimal physical, mental, and social health in Native American children.
The Indian Health Service is a comprehensive community-oriented health care delivery system that serves American Indians and Alaska Natives (AI/AN). The IHS was established by treaties and trust agreements to provide basic health care needs to AI/AN by the United States government. AI/AN have longstanding treaty rights with the U.S. government that guarantee federal provision of health care services, dating all the way back to the Constitution. IHS serves 2.1 million American Indians and Alaska Natives and is the primary source of basic health care services on Indian reservations.

Meeting in downtown Washington, DC, CONACH members discussed several issues, including actions to improve medical provider’s recruitment and retention, coalition building with other health professional groups, updates of Reach Out and Read (ROR) programs in IHS clinics, and updates of area IHS health care facilities. The meeting was highlighted by a tele-conference meeting with the current IHS Director, Dr. Yvette Roubideaux. Dr. Roubideaux discussed the current state of affairs and reviewed IHS four priorities, which are commitments to strengthen partnerships with tribes, bring reform to the IHS, improve the quality and access to care, and ensure that its work is transparent, accountable and fair.

The legislative agenda focused on the recent federal sequestration and proposed spending cuts on the IHS. Other health care programs such as Social Security, Medicaid, the Supplemental Nutrition Assistance Program and Veteran’s health care program were exempted from the proposed budget cuts. AI/AN children suffer from significant health disparities compared to other children in the general population. A Native American child born today has a life expectancy four years shorter than that of the general population; moreover the rate of obesity and Type 2 diabetes is epidemic in Indian Country. IHS provides primary preventative care to a vulnerable population with unique health care needs.

Members of CONACH also had the opportunity to meet with United States Congressional representatives to discuss and advocate support for federal policies that would protect AI/AN children from the budget cuts under sequestration. The AAP also sponsored a Hill briefing on the importance of transportation infrastructure and transportation safety issues on the Indian reservations. Motor vehicle crashes are the leading causes of injury-related deaths for a Native American 19 years old and younger.

The AAP has collaborated with the IHS for 48 years and has played an important role in the improvement of Native American health care. CONACH is an example of the AAP’s commitment to expanding its efforts to raise the status of Native American children’s health. Being a member of CONACH has strengthened my commitment to the IHS and has rekindled my passion for advocacy.

* Damon Dixon, MD is a Native American physician and is currently a 3rd year pediatric cardiology fellow at the University of Minnesota-Amplatz Children’s Hospital.*
Discussing Death and Dying with the Parents of Pediatric Patients

Alexandra Milloff Butler, MD, FAAP

“Dr. Butler, you are the first person who has told us that our daughter is going to die.”

These are not words I ever expect to hear, but I did hear them back in December. Honestly, I do not usually have conversations with my patients or their families about end of life. As a pediatric hospitalist, most of my patients are generally healthy, and are only hospitalized for short and isolated periods of time. I had taken care of children who faced end-of-life issues before, but this was not something I was very practiced in since I had graduated residency.

Nonetheless, I found myself on that day in December standing next to the parents of my three-week-old patient, a girl who was born with severe hydrocephalus and who was neurologically devastated, talking with them about her death. Unfortunately, this was not the first child with this condition these parents had nurtured-- their other affected child had passed away several years ago at 10 months of age. By prenatal ultrasound my patient had seemed more affected than her sister, and because the prenatal prognosis was so poor the family had not been prepared to bring their daughter home. She had done better than expected and her family was now putting together a nursery as we made plans for discharge. I could see how happy these parents were to care for their baby, but also how worried they were about what would happen once they left the hospital.

As I got to know this family, they told me about their first daughter. They told me about how she had undergone numerous medical interventions as her condition progressed, and they had hated seeing her suffer. They told me how they put her to sleep one night, and then when they had gotten up in the morning they found that she had passed away. “Just like that.” Quickly. Silently. After everything they had gone through in the past, they had a different outlook now: a do not resuscitate (DNR) order had been placed on my patient’s chart days ago. They knew that the prognosis was bleak. However, as I watched the patient’s father peering over the crib railing at his daughter, I could see the hope and joy he had now that he was a father again. He was simultaneously feeling capable and ready to go home, but also overwhelmed. As he and his wife continued to talk with me, their fears became more solidified: What if everything they did was not enough? What if their daughter died? Would they have failed her?

When I heard them expressing these fears, I felt a natural urge to try to make them feel better, reassure them that everything would be all right. But instead, I said that someday they could be doing everything right, but their daughter still might die. She was very sick, and nothing we could do would make her better. We were going to make her comfortable. It was obvious that her parents were going to love and take care of her impeccably. However, someday this might not be enough—and when that day came, it would not be their fault. As I laid out this scenario, I could see the weight of the world start to come off of their shoulders. They had, like parents do, taken on the full responsibility for their daughter’s well-being. Hearing that everything was not going to be in their control, and that that was OK, was the first step in allowing themselves to believe it. I by no means was the only one who had discussed the expected outcome of their daughter’s disease, and I by no means told them with any certainty when or how their daughter would die. Using those specific words, “die” and “death”—without initially knowing the impact it would have, I was able to provide comfort while being realistic. When they turned and told me that I had been the first person to say this out loud to them and they were appreciative. I was not going to sugarcoat the truth, but together we would find relief by acknowledging that sometimes even when we do our best, the outcome may not be the one we would have chosen.
Caring for Cancer Survivors: The Important Role of Pediatricians

Ana C. Xavier, MD, PhD, FAAP

It is estimated that over 8,000 children are diagnosed annually with cancer in the United States. The use of aggressive multimodal therapy has fortunately led to high cure rates among children with cancer. More and more of these children will survive cancer and live happy healthy lives. Today, it is estimated that 1/640 people between the ages of 20 and 39 years will have survived some type of childhood cancer (1). However, this growing population is under an increased risk of developing significant long term comorbidities that are directly related to cancer or its therapy. Survivors will face debilitating and chronic physical, cognitive, and psychological conditions and will require continued specialized medical follow up through adulthood.

For instance, among 10,397 long term pediatric cancer survivors, close to 70% reported having at least one chronic medical condition and almost 30% of them reported having at least one medical condition considered severe or life-threatening (2). Chemotherapy regimens can affect hearing, heart function, kidney function, pulmonary function, and fertility. Radiation therapy may affect growth, learning abilities, and hormone production. Survivors will also have more learning and memory difficulties, anxiety, depression, and other complications that can severely compromise their quality of life and ability of functioning as expected in society. Many of these effects will not appear for several years after completion of therapy.

Careful clinical observation during and after cancer treatment may lead to early recognition of medical problems and may potentially minimize unwanted side effects. Although most pediatric oncology centers follow patients for at least five years after completion of treatment, less than 20% of long term cancer survivors receive follow up care at a specialized center (3). Additionally, patients exclusively followed by an oncologist are less likely to receive preventive care (4).

Therefore, a significant proportion of survivors will rely solely on the care provided in general practice offices. Pediatricians are in the front line of care of this special group of patients and need to be alert to the potential toxicities faced by this group of children and adolescents. In many instances, cancer survivors will depend on general pediatricians to provide anticipatory guidance, to offer appropriate surveillance based on individual's diagnosis and treatment, and to transition their care to adult health care providers.

Specific training in this area or significant exposure to this group of patients is usually not offered by general pediatric residency programs. So, how can general pediatricians lead and coordinate the care of cancer survivors? Proceeding with a careful history and physical examination at each visit will help detect specific problems and trigger appropriate intervention. Additionally, having a list of all the previous administered chemotherapy drugs or radiotherapy, as well as total doses and dates of administration will certainly guide the necessary screening for each group of patients. In addition, it will be very important for the primary care doctor to keep close communication with the oncologist to help identifying potential risk factors linked to therapy. To assist with these clinical practices, evidence-based screening guidelines have been established - such as the one developed by a Children’s Oncology Group consensus committee - and are available for anyone (website Survivorshipguidelines.org). Abnormalities detected with those screening tests should trigger immediate referral to appropriate subspecialist. In summary, pediatricians are the first line of defense for patients who underwent complex cancer therapy at young age. The ability of pediatricians to coordinate high quality, comprehensive care in an effective, conscious, and compassionate manner will guarantee that pediatric cancer survivors will live happy and long lives.

Cont. page 13
Caring for Cancer Survivors: The Important Role of Pediatricians

References:


Personal Reflections of Participation on AAP Work Group

Samantha Schilling, MD, FAAP

Hello! My name is Sam and I am a first year fellow in Child Abuse Pediatrics at Children’s Hospital of Philadelphia (CHOP). I recently had the amazing opportunity to participate in a work group sponsored by the American Academy of Pediatrics (AAP) Council on Foster Care, Adoption, and Kinship Care. Our goal was to promote trauma-informed care by developing a booklet for primary care pediatricians and an accompanying one-pager for families with a special focus on children who have been adopted.

I first learned about the project on the AAP website. The application invited young physicians to join the work group in the spirit of mentorship and encouraging growth and interest in important issues such as childhood trauma, foster care, adoption, and child abuse and neglect. This project resonated with my interests, focusing on areas I hope to understand better and to influence during my career. In addition, my participation in the work group allowed me to work alongside three wonderful pediatricians who care for maltreated, adopted, and foster care children. I learned how they use their experience and expertise to improve the life prospects of all children, including those with histories of child maltreatment and trauma exposure. Being involved with this project has been an incredible experience for me—I got to see what it is like to be on a work group at the AAP and it was a great opportunity for me to enrich my child advocacy efforts. The members of the work group are extraordinary teachers and mentors and it was a special treat to work with them towards a common goal and to share in their passion for improving the lives of children exposed to trauma. Their enthusiasm was contagious and their guidance and mentorship were critical to my role in the project. They taught me a lot at our first meeting at the Academy, and helped me generate ideas and edit my contribution to the project. Working with them was so inspirational that I have been informing many of my colleagues about the exciting content of our project, as well as teaching residents and medical students all about the importance of trauma informed care. Please consider joining AAP work groups when similar opportunities are made available to you. It is a great investment of time with much in return.
Will you be at the National Conference and Exhibition (NCE) this fall?

If so, come and check out, The Council on Communications and Media (COCM). We will be having a COCM Reception, Saturday October 26, 2013 evening for COCM members and those interested in finding out more about COCM. So come on out and see what we are doing. Stay tuned for time and location.

Learn more about communication and media while at NCE this year!
COCM talks will include:

I1038- Communication Challenge: What’s a Pediatrician to Do/ Say?
Fagbuyi, Daniel B. & Swanson, Wendy Sue Lewis
Are you passionate about issues affecting children's health? Are you eager to use the power of the media to reach parents, policy-makers, and the public? Learn from your pediatric colleagues how you can use radio, television, print media, and the Internet effectively to inform and advocate for children. Experienced peers teach attendees how to craft a message, illustrate that message, and avoid some of the common pitfalls of media engagement.

S1118- Your Child Has an iPhone….Now What? Helping Parents Negotiate the High Tech Worlds of Small Children
Christakis, Dimitri Alexander & Shifrin, Donald L.
Today’s parents are putting kids online and using mobile technology with kids younger than two years, regardless of AAP guidelines. Pediatricians need to understand the health and developmental issues involved to help families negotiate this tough territory. This session will provide pediatricians with approaches to quickly and effectively help parents of young kids make technology part of a healthy media diet so they can maximize their time, both plugged and unplugged. Pediatricians will also learn what issues might arise later and how to help families avoid them.

AND our H SESSION is open to everyone!
H2030- Most of the health problems we address as pediatricians -- diet, exercise, media use, and high-risk behaviors -- come down to a battle of messaging: ours versus corporate America's. Two executives with extensive experience at crafting positive health messages for corporate clients give pediatricians insight into how they do what they do. One of our own messaging masters will follow with an examination of health campaigning versus corporate messaging in an important area of work for the AAP: Tobacco prevention.

H Session Talks:
Dance, Dance Revolution - Designing Electronic Games to Reinforce Healthy Behaviors
Debra Lieberman, PhD, Director, Health Games Research, UC Santa Barbara
Free To Be You And Me - Teaching Cross-Cultural Communication in a White-Collar World
Tony Jenkins, Market President - Central and Northwest Florida, Florida Blue
Advice From Tobacco Opponents: A Case Study Of Successful Media Campaigns To Reduce Child Tobacco Use
Jonathan D Klein, MD, MPH, FAAP, Associate Executive Director, AAP
cont. Will you be at the National Conference and Exhibition (NCE) this fall?

Cont. from page 14

Lastly, Don’t forget to check out SOYP and COCM’s Joint Program
H2076- Practicing Pediatrics in 140 Characters or Less: How and Why to Use Social Media to Your Advantage
Brown, Ari | Hubbard, Susan Jeanne | Swanson, Wendy Sue Lewis |
Would you like to be able to use social media in your practice, but are concerned about how to use it and/or the ethical implications? Learn about how others have used social media to successfully engage their patients and their parents, as well as what not to do. Our interactions as pediatricians with the media can also play an important role in how we advocate for our patients. Learn some basics steps on how to effectively use the media to address child and adolescent issues.

Joint Program Talks:
How to Apply Social Media in Practice
Ethics and Social Media - How to Prevent Legal Problems
Media Training 1.0 - Insider Tips From the Mediatricians
ADVOCACY: Personal Reflections
Gerald S. Gilchrist, MD, FAAP

I am truly honored at being selected for this award and particularly at having been nominated by my colleagues in Minnesota. The Minnesota Chapter works tirelessly on behalf of the children and adolescents in the State of 10,000 lakes and I consider it a privilege to be able to work with them. I am particularly indebted to Anne Edwards, whose knowledge of the legislative process has quick-started my recent efforts.

Lucy Crain asked me to comment on what motivated some of my advocacy activities. That has caused me to reflect on the notion that advocacy comes in many forms and flavors and can result in both positive and negative outcomes. I will try to highlight examples from my own experiences, while being very conscious that all our colleagues are advocating for kids day in and day out in offices, clinics, hospitals and research laboratories. My earliest advocacy efforts actually predated my entry into the profession.

One thinks of advocacy as either promoting change or resisting it. Although promoting change has the more progressive connotations, in medical school in South Africa in the mid 1950s, many of my fellow students and I found ourselves resisting change. In this case, we pushed back against the increasingly rigid color lines being enforced on our universities by the Nationalist government, which had come to power in the previous decade.

I was in my fourth year of medical school, which was a six year course directly out of high school, when I was elected to the Students Representative Council, the body responsible for directing student activities and organizations around campus and the public voice of the student body both inside and outside the university. Unlike in the United States, medical students were undergraduates and very involved in university-wide activities including student politics and sports. The Nationalist government was pressuring South Africa’s two racially integrated universities, including the one I attended, the University of Witwatersrand, to no longer admit students of color. We student leaders were committed to our roles as advocates for justice. However, in spite of protests, marches, and entreaties to the government, apartheid laws were expanded and applied to our universities: It took forty years for them to be repealed.

Many of my fellow student leaders who stayed in South Africa and resisted endured profound political oppression. They took risks, made sacrifices and choices that I am thankful I was never faced with. One became a justice on the post-apartheid Supreme Court. More soberingly, another was executed for planting a bomb in the Johannesburg Railroad Station.

Cont. page 17
ADVOCACY: Personal Reflections

Cont. from page 16

Upon graduation, I reached my own personal crossroads. All post-graduate training and hospital staff appointments in South Africa were ultimately controlled by the government. As the curtain of apartheid descended upon the country, my antigovernment activities were not only a risk to my work as a physician, but also to my life, limb, and freedom. I considered changing careers to become a lawyer and, as such, to be somewhat protected against the government. However, the country’s increasingly bleak-looking future, which to me at the time held little prospect of a peaceful outcome, combined with my lack of appetite for another three intense years of study, pushed me to reject law and to leave the country–first to the United Kingdom in 1960 and then to the United States in 1962.

My interest in improving hemophilia care began when Denny Hammond, my fellowship director at Children’s Hospital of LA assigned me a case of hemophilia A in a female as my first project. It was not long after this, in 1965, that Judith Pool at Stanford identified the factor VIII-rich cryoprecipitate in human plasma. These two events spurred my career-long involvement in advocating at the local, state, and federal level for access to care for patients with inherited bleeding disorders. Success in these efforts allowed us to rehabilitate patients crippled by joint deformities, to facilitate outpatient and then home-based replacement therapy and prevent many of the life and health threatening complications.

In 1981 the “golden age” of hemophilia care came crashing down with the first recognition of HIV as a blood product contaminant and its devastating effect on our patients. Because of societal attitudes, infected patients were stigmatized and even isolated and quarantined. Overcoming governmental inertia and indifference required constant lobbying on behalf of patients, both in terms of meeting their medical and social needs, but also in pushing the pharmaceutical industry to develop safer blood products, including the much earlier-than-expected recombinant factor VIII.

After moving to Mayo in 1971 and as our subspecialty was maturing, I became increasingly concerned that pediatric subspecialists had a very little voice nationally. We were afterthoughts in the major specialty societies and, at the time, the American Academy of Pediatrics (AAP) was perceived as only representing the interests of primary care providers. Yet I saw the AAP’s potential as a compelling voice for both medical and surgical subspecialists, and this became another cause for advocacy. Over time, as I and my many like-minded colleagues were successful in raising the profile of pediatric subspecialties, we turned our attention to the rigid–almost impenetrable–barriers between sections, committees, and chapters. Our efforts culminated in the merging of some committees and sections and in the establishment of the Annual Leadership Forum.

Since retirement from Mayo, I have been active on the Public Policy Committee of the AAP Minnesota Chapter. In 2004, I was invited to attend a forum on early childhood education of which I knew close to nothing. Art Rolnick, then the director of research for the Minneapolis Federal Reserve, was the main speaker and presented his work on the economic, social, and educational benefits of preschool education. The event also introduced me to organizations and people working to improve education, including Reach Out and Read. To impact at least some of the unmet needs of disadvantaged kids, I began tutoring first graders at an inner city public school in Minneapolis. (Two years ago, I was moved up to the third grade, but do not anticipate

Cont. page 18
any further promotions!)) These kids, nearly all of whom are Native-American, have provided me with astonishing insight into life on the other side of our economic divide. Up until three years ago, when my wife and I began taking care of our first grandchild several days a week, I was spending virtually every morning one-on-one tutoring.

In tandem with these direct efforts in the schools, I joined the advisory board of Reach Out and Read Minnesota, and have had opportunities to testify before early childhood-related committees at the state legislature and to meet regularly with state lawmakers. Even in these very challenging fiscal times and polarized political climate, we have successfully turned back a number of attempts to scale back early childhood enrichment opportunities.

In my opinion we all have an obligation to our patients to work to ensure that our professional organizations and our public institutions are serving children of all ages as we strive to give our patients the best care possible. My more recent advocacy efforts, both within and on behalf of the AAP, have been truly rewarding and will hopefully serve as an example to younger colleagues in various branches of pediatrics. This award from my peers in the AAP is truly valued and enormously appreciated.
Birth of the Council on Quality Improvement and Patient Safety

Wayne H. Franklin, MD, MPH, MMM, FAAP

The American Academy of Pediatrics (AAP) has formed a new council, the Council on Quality Improvement and Patient Safety, which will officially launch in July 2013. The Council grew out of the ever-expanding work performed by the Steering Committee on Quality Improvement and Management (SCOQIM). “Quality Improvement has become integrated into the fabric of patient care,” stated Xavier Sevilla, MD, MBA, Chair of SCOQIM. “Quality is one of the pillars of the AAP and therefore this new council is going to be key in supporting this pillar.” The formation of a council easily allows the growth of members, generalists and sub-specialists who are interested in Quality Improvement and Patient Safety to become involved.

The Council on Quality Improvement and Patient Safety should be of great interest to many members of the Section of Young Physicians (SOYP). Greg Randolph, MD, MPH, who heads the education efforts for SCOQIM states, “It is essential that members of the Section of Young Physicians become active members in this new council. It fits perfectly with the SOYP’s mission to provide opportunities and resources for young physicians around leadership, mentorship, advocacy, and education. An added bonus is that initial membership will be free!”

SCOQIM was established in 2001 as a “mega-committee” in response to increasing national concern on the quality of health care and the Academy’s own identification of quality improvement (QI) as a strategic pillar. SCOQIM offered a more integrated voice for QI and enabled the Academy to support its members in providing the highest quality clinical care for children. The group is comprised of nine pediatricians with expertise in practice, technology, and evidence-based medicine and six liaisons from internal AAP groups as well as the Agency for Healthcare Research and Quality (AHRQ) and the Children’s Hospital Association. In recent years, SCOQIM has grown from its core group of 15 members and liaisons to a larger entity that includes subject workgroups on education, evidence, quality measurement, and patient safety totaling almost 200 members. Other workgroups are being established to address quality improvement implementation and collaboration with chapters and subspecialty sections. SCOQIM continues to grow these workgroups as AAP members express increased interest in contributing to and expanding the AAP’s quality improvement agenda.

SCOQIM has been functioning as a quasi-council for the past five years with multiple workgroups, liaison relationships, and other contacts with various AAP QI groups including the Chapter Alliance for Quality Improvement, Education in Quality Improvement for Pediatric Practice, Medical Home Project Advisory Committee, QuIN as well as the external organizations, AHRQ and CHA. SCOQIM also has developed more informal linkages with the American Board of Pediatrics, Centers for Medicare and Medicaid Services, and National Initiative for Children’s Healthcare Quality, frequently inviting guests to attend SCOQIM meetings.

Given SCOQIM’s growth, current structure, and the increased interest in QI, SCOQIM felt that the transition to a council would be an organic next step. The Council on Quality Improvement and Patient Safety will have initial membership derived from existing members from SCOQIM and its workgroups, other QI groups, and AAP members-at-large. A key group of individuals to join this council will be members of the SOYP who have been early adopters of QI into their practice.
Motor Delays: New Clinical Report, Algorithm and Video Vignettes

Rachel Daskalov, AAP Staff

Motor Delays: Early Identification and Evaluation and its accompanying clinical decision algorithm, were published in the June issue of Pediatrics.

Pediatricians often encounter children with delays of motor development in their clinical practices. Earlier identification of motor delays allows for timely referral for developmental interventions as well as diagnostic evaluations and treatment planning. Highlights of this report include suggestions for formal developmental screening at the 9-, 18-, 30-, and 48-month well-child visits; approaches to the neurologic examination, with emphasis on the assessment of muscle tone; and initial diagnostic approaches for medical home providers. Use of diagnostic tests to evaluate children with motor delays is described and the importance of pursuing diagnostic tests while concurrently referring patients to early intervention programs is emphasized.

This report* was written by Dr. Garey Noritz, Dr. Nancy Murphy, and the Neuromotor Expert Panel, led by members of the Council on Children with Disabilities, the Committee on Genetics, the Sections on Developmental and Behavioral Pediatrics, Neurology, and Orthopaedics, as well as leaders from Bright Futures Initiatives. In addition, the Panel included representatives from the CDC/National Center on Birth Defects and Developmental Disabilities and American Academy of Cerebral Palsy and Developmental Medicine.

Video Vignettes: Implementing the Neuromotor Screening Recommendations in Practice

Three physician members of the Neuromotor Screening Expert Panel discuss the ways in which primary care pediatricians can use Motor Delays: Early Identification and Evaluation and its algorithm to enhance developmental surveillance and screening for neuromotor impairment.

*Development of this clinical report was funded by the American Academy of Pediatrics through the Public Health Program to Enhance the Health and Development of Infants and Children (PEHDIC) a cooperative agreement with the CDC National Center on Birth Defects and Developmental Disabilities.

Click here for more information on Neuromotor Activities within the PEHDIC and here for Council on Children with Disabilities initiatives.
Digital Navigator

Bradley Rysz, Staff
American Academy of Pediatrics

Is your practice considering a transition to the medical home model of care? Have you already begun the process and are seeking guidance along the way? If you answered yes to either of these questions, the American Academy of Pediatrics (AAP) can help.

The family-centered medical home approach to primary care is not a new idea, but one that has gradually gained acceptance throughout the years and is becoming a proven model that can help a practice improve its patient care, while both increasing profits and reducing costs. Many practices are applying for medical home recognition from the various recognition programs available, such as the National Committee for Quality Assurance (NCQA). However, the application process and the transition to a new model of care can, at times, seem daunting and overwhelming. This is where the Digital Navigator may be of assistance to you and your practice.

The AAP is currently developing a web-based software application called the Digital Navigator. The Digital Navigator will guide users through the transformation process into the medical home model of care. This comprehensive and modular tool offers step-by-step assistance to enable the transition to a high-performing practice. The Digital Navigator provides clinicians the opportunity to scale their investment of time and resources into the family-centered medical home transformation process through a format that will allow them to implement each standard at their convenience.

The Digital Navigator is designed to be a team-based application, where both practicing physicians and office staff work together to achieve the practice’s desired results. Once your practice is signed up and your team is established, you will perform a baseline practice assessment that will help define your practice’s needs and see exactly where you stand in the medical home transformation process. The Navigator will take this information, build a detailed plan for your practice, and you are on your way!

The tool is broken down into six modules: Enhance Access & Continuity, Identify & Manage Patient Populations, Plan & Manage Care, Provide Self Care Support & Resources, Track & Coordinate Care, and Measure & Improve Performance. Within these modules are a detailed explanation of the task and task steps, sample reports, policies, templates, and forms to help you gather the necessary data for your NCQA application, and additional AAP resources such as journal articles, policy statements, and other relevant AAP materials.

While using the Digital Navigator, your practice team will constantly be uploading and saving documents to a feature called the Virtual Briefcase within the Navigator. If your practice has pre-existing documentation for any of the tasks, they can easily be uploaded to your Briefcase. When you are finished, you will have all your materials necessary to apply for Medical Home recognition, all in one convenient location.

The Digital Navigator also features an informative reporting page, which provides an up-to-date outlook on where your practice stands in the transformation process. You can see overall practice progress, individual team member information, where your practice stands in each module, a quick glance at how many Meaningful Use and Must-Pass Tasks have been completed, and a general estimation of how many NCQA points you would receive if you applied at that moment. Additionally, multi-practice users can see the overall progress of the entire network, as well as the progress of the individual practices included. These reports can be e-mailed amongst users, printed, and downloaded as a PDF.

Cont. page 22
**cont. Digital Navigator**

*Cont. from page 21*

Another added feature of the Digital Navigator is the availability of one free EQIPP course for each practicing physician at your practice. EQIPP is a unique online learning program that weaves improvement principles and concepts with pediatric-specific clinical content. With successful completion of an EQIPP course, you can earn valuable AMA PRA Category 1 Credit and also meet the American Board of Pediatrics Maintenance of Certification Performance in Practice requirements.

The Digital Navigator is a powerful application that can help any practice or organization meet their needs as they transform into the medical home model of care.

To view a demonstration of the Digital Navigator tool, please contact Brad Rysz, APEX Marketing & Sales Manager, at brysz@aap.org to set up a time that works for you!

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**Pediatric Care Online**

*Allison Pollock, MD*

*If* you love that papery smell of flipping through textbooks, but instead find yourself at the computer writing orders or pressing refresh to check labs on your iPhone, check out Pediatric Care Online (PCO). It is an application (app), a website, and a repository of helpful practical pediatric resources at your online fingertips.*

**Search**

Although PCO has direct links to the entire content of Bright Futures, the AAP Textbook of Pediatric Care, and Red Book, I would argue that the fastest way to get to the resource you want is through the PCO search bar. Just type in the name of a condition, symptom, sign, medication or whatever else you are looking for, and you will receive both a standard results list and a list sorted by category. After diagnosing a young boy with molluscum in clinic the other day, I typed “molluscum” into the search bar, zeroed-in on the Patient Handouts on the left-side of the screen, and instantly had a well-designed patient-friendly document printed and ready for my patient. I was not surprised when my patient and his mom did not like the idea of a prescription for the tincture of time. Next I zeroed-in on the Red Book search results from my “molluscum” search and made sure my thought to try a course of imiquimod was reasonable (in case you are wondering, per the Red Book, “imiquimod has been reported as a potentially effective topical treatment in several small clinical trials”).

**Tools**

Although searching is my preferred method of navigation, many people like to access their tools more deliberately. If you are trying to guess how premature a baby is, you can access the Clinical Calculators to find a link to the Ballard calculator. When you are talking with medical students about meeting Kawasaki criteria, you can open up the Kawasaki Algorithm Tool to walk them through a particular patient’s case. When a parent brings up concerns for Attention-Deficit/Hyperactivity Disorder (ADHD) during an acute illness visit, you can quickly print a Vanderbilt form for the family to take home. Finally, there is a Visual Library of graphics, charts, and photos that are great to reference for presentations and other projects.

*Cont. page 23*
Pediatric Care Online

Cont. from page 22

Pediatric Care Online is available as a stand-alone and mobile-friendly website, as well as a smartphone app (iPhone, iPad, iPod touch, Blackberry, Android, and WindowsPhone). For more information, go to www.pediatriccareonline.org, search for PCO in your app store, or email pco@aap.org.

*Editor's note: PCO is free to residents! This access for residents is supported by an educational grant from Mead Johnson.

Understanding the New Polio Eradication & Endgame Strategic Plan

AAP Global Immunization Team

We are this close

In 2012, the world saw the fewest number of polio cases in the fewest countries ever. This is a remarkable milestone as global incidence has decreased by 99% since 1988, and in 2012, only three countries were labeled as endemic: Afghanistan, Nigeria, and Pakistan. India has not reported a case in more than two years. As of June 5, 2013, there were 45 confirmed cases of polio globally in 2013; this is significantly lower than the 67 cases reported globally at this time in 2012. The public health community is now refueling its efforts to officially rid the globe of the last 1%.

The Global Polio Eradication Initiative (GPEI) recently released the Polio Eradication & Endgame Strategic Plan (2013-2018) in an effort to map out the plan to reach and sustain polio eradication by 2018. The GPEI is led by the World Health Organization, Rotary International, the Centers for Disease Control and Prevention, and UNICEF, with support from the Bill & Melinda Gates Foundation. The AAP is a civil society partner supporting GPEI and is a member of the GPEI Polio Partners Group, which has provided technical input and review into the Plan. The Plan provides a framework which simultaneously seeks to eradicate wild poliovirus (WPV) and eliminate circulating vaccine-derived polioviruses (cVDPVs). To facilitate this strategy, the Plan describes phasing out the oral polio vaccine (OPV) in the 144 countries currently using it and presents strategies to introduce the inactivated polio vaccine (IPV) within routine immunization systems. IPV eliminates the risk of vaccine-derived paralysis and cVDPVs. The switch from OPV to IPV must occur in to reach eradication goals.

The four primary objectives of the plan are:

- **Poliovirus detection and interruption**: Stop all WPV transmission by the end of 2014 and new cVDPV outbreaks within 120 days of confirmation of the first case
- **Immunization systems strengthening and OPV withdrawal**: Hasten the interruption of all poliovirus transmission and help strengthen immunization systems

**Containment and certification**: Certify all regions of the world polio-free and ensure that all polio-virus stocks are safely contained **Legacy planning**: Ensure that a polio-free world is permanent and that the investment in polio eradication provides public health dividends for years to come.
Trainee and Early Career Neonatologists
Krithika Lingappan, MD, FAAP
Trainee and Early Career Neonatologists (TECaN) Chairperson

In 2008, the American Academy of Pediatrics (AAP) Section on Perinatal Pediatrics (SoPPe) sought to develop leaders among young neonatologists. Drs. Judy Aschner and Linda J. Van Marter engaged a focus group of post-residency training fellows in neonatology, who shared their ideas of a group which would cater to the career and life of young physicians in neonatology. SoPPe now has a group for trainees and early career neonatologists (within seven years of their fellowship completion).

TECaN strives to engage, educate, and support young neonatologists as they advance through training, seek employment, evaluate professional positions, and progress along their career trajectories. To welcome fellows in neonatology to TECaN and the SoPPe, the SoPPe has waived its section membership fees for any trainee in an approved fellowship program. To be eligible, Post Residency Training Membership in the AAP is required, at annual reduced dues of $105.

Under the sponsorship of the section, TECaN members participate in section activities, including those related to Maintenance of Certification; maintaining and updating TECaN and neonatology-specific social media outlets; the addition of more “fellow-friendly” educational activities at section meetings; and participation in the Organization of Neonatal Training Program Directors (ONTPD).

Over the past five years, TECaN has grown steadily, increased its membership and added valuable resources to advance the career of fellows and early career neonatologists. With the help of their District and Program representatives, the focus was to get the message about the perinatal section and TECaN across to fellows and early career neonatologists throughout the country. TECaN has also been involved in educating pediatric residents and medical students about the subspecialty, and what a career in neonatology would mean for them. TECaN represented the subspecialty of neonatal-perinatal medicine at the SOMSRFT speed dating session at the AAP National Conference and Exhibition meeting held in New Orleans and met with residents and medical students. The Section leadership has involved TECaN at all levels with the goal to train and mentor the next generation of leaders and incorporate the ideas and suggestions from this group in the upcoming and ongoing projects of the section. One of our most important objectives was to add resources and improve our website (www.aap.org/TECaN) for trainees with relevant and valuable information. These include:

- Research Corner: created with the assistance of the National Institutes of Health, which contains information to help TECaN members get started in a research career, including grant writing and submission, sources of funding, key contacts, and examples of successful grants.
**cont. Trainee and Early Career Neonatologists**

*Cont. from page 24*

- Research Corner: created with the assistance of the National Institutes of Health, which contains information to help TECaN members get started in a research career, including grant writing and submission, sources of funding, key contacts, and examples of successful grants.
- Career Corner: guides members through the process of job search, interview skills, salary information, and career advancement either in private practice or an academic setting.
- Advocacy Corner: helps members pursue their advocacy goals by increasing their exposure to advocacy training opportunities, providing new ways to connect with the AAP's Washington office and their local, state, and federal representatives anywhere in the country, and share their stories with policymakers.
- Interactive Google Maps feature of Neonatal fellowship programs.
- Global Health Resources: information and training opportunities in the Helping Babies Breathe Program.

We are also in the process of launching a dedicated quality corner on the TECaN webpage with resources to access well-established quality improvement educational material and resources. TECaN is also building a partnership with the Vermont Oxford Network (VON) with the goal to achieve early engagement of fellows in the vibrant community of quality improvement that will set the stage for a lifetime of contribution to quality.

TECaN continues to grow every day and strives to become a community for trainees and early career neonatologists. TEncan offers opportunities to network and create lifelong professional relationships and collaboration, and is to become an indispensable resource in their fellowship and early career journey. The goal of TECaN is to become the portal for training the next generation of leaders at the perinatal section.

For more information and benefits of membership, please visit the AAP Perinatal Trainees website (http://www2.aap.org/sections/perinatal/trainees.html) to learn more about TECaN. Become a TECaN member at: http://www2.aap.org/sections/perinatal/tecan/feedbackTECAN.html.

TECaN is also represented on Facebook, Twitter and LinkedIn.

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Jane

Daughter of Kelsey Logan
2013 State Legislative Update on Gun Violence Prevention

Ian Van Dinther
Senior State Government Affairs Analyst

With the country’s attention focused primarily on the United States Senate’s failed attempt to pass modest reforms to the nation’s gun laws, numerous state legislatures this year took positive steps forward to protect children and families from gun violence. The American Academy of Pediatrics (AAP) state chapters have played a key role in a number of these important initiatives.

- **Colorado**, **Connecticut**, **Maryland**, and **New York** all enacted comprehensive legislation this year to require universal background checks, ban assault weapons or strengthen existing assault weapons bans, and limit high capacity magazines. **Delaware** also passed a universal background check bill. Other important state level actions are still pending: **Nevada**’s legislature passed a universal background check bill, which Governor Sandoval has vowed to veto.

- **New Jersey** Governor Chris Christie signed 10 of the 13 gun bills that were passed the state legislature. Included in the new laws are provisions that will increase penalties for certain gun offenses, improve mental health reporting to the National Instant Criminal Background Check System, and strengthening the state’s existing Child Access Prevention (CAP) law. Governor Christie vetoed provisions that would overhaul the state’s firearm ID cards system, include new weapons to the state’s existing assault weapons ban, and require state law enforcement to report lost or stolen firearms to a federal database.

**Illinois** Governor Pat Quinn signed legislation that will require universal background checks and reporting of lost or stolen firearms.

- **California** is also poised to enact firearms injury and violence prevention legislation this year. Proposed bills in the state senate would create a stronger background check system, restrictions on the types of offenses that warrant gun ownership prohibitions, and improvements in the existing assault weapons ban. The state assembly also passed a package of bills that would create stronger safe storage requirement (a key AAP policy recommendation to prevent unintentional gun injuries in children) as well as increased public health reporting of gun deaths. Nancy Graff, MD, FAAP, pediatric residency program director at the University of California-San Diego and a member of the Academy’s Committee on State Government Affairs, was part of the pediatric delegation that lobbied for passage of this bill, and Richard Pan, MD, MPH, FAAP, a state Assemblyman, was a key sponsor of the bills.

Additionally, AAP chapters were key players in a number of successful efforts to defeat bills that would prevent or restrict pediatricians from providing anticipatory guidance on firearms storage and safety. Bills in **Missouri**, **Kansas**, **Oklahoma**, **South Carolina**, and **West Virginia** were all defeated following successful coalition efforts with other physician groups. Similar bills have recently been announced in **Ohio** and **Wisconsin** and efforts are underway to stop them.

The national AAP supports the state advocacy work of chapters via the Division of State Government Affairs. Located in the Academy’s Elk Grove Village, Illinois headquarters, the Division works with state chapters to promote the Academy’s advocacy agenda in state capitals and advises the Academy’s committees, councils, sections, task forces, and leadership on the key state policy issues impacting pediatric practice and child health. To learn more about the Academy’s mission on the state level, visit [www.aap.org/stgovaffairs](http://www.aap.org/stgovaffairs) (MyAAP login required). Connect with the **AAP chapter** in your state and learn how you can get involved in their ongoing state advocacy efforts. **You can make a difference!**
Update on The Pediatrician Life and Career Experience Study – PLACES

A Look at Part-Time Physicians

Ashley Miller, 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) in 2012 and successfully recruited over 1,800 participants. PLACES is a major research initiative that tracks the work and life experiences of pediatricians. The second year of the project is starting, and participants were sent the second annual survey in the spring, 2013. Thanks to those of you who are participants of PLACES!

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 over 900 participants in each of the cohorts: 1) recent residency graduates (most graduated residency in 2009 – 2011 and includes 268 in fellowship training), and 2) early career (most graduated in 2002-2004).

Approximately 20% of the PLACES participants are working part-time, 28% of the early career cohort and 17% of the recent residency graduates cohort who are not in fellowship training. None of the recent graduates who are in fellowship training reported working part-time. For both cohorts, participants who are women, married, and have children are more likely to work part-time than men, those unmarried, and those who do not have children, respectively (see Table 1). General pediatricians are more likely to report part-time work than subspecialists and other specialists. For the early career cohort, physicians with a position in the suburbs are more likely to work part-time than those with positions in other areas.

A subgroup of the participants who work part-time answered questions on why they are part-time (see Figure 1). The two main reasons were for a child, spouse, or other family need and/or a personal preference. Other reasons selected include education or training and lack of finding a full-time position.

Part-time physicians are as likely as full-time physicians to report being satisfied with their career as a physician and current work, and more likely to be satisfied with their current work load.

For more information, check out the Spring Issue of the PLACES newsletter, “Going PLACES,” visit the PLACES website, or email places@aap.org. We will continue to share PLACES results and updates in this newsletter.
cont. Update on The Pediatrician Life and Career Experience Study – PLACES
A Look at Part-Time Physicians

Cont. from page 27

| Table 1 – Characteristics of PLACES Participants who are Working Part-Time |
|-------------------------------------------------|-----------------|-----------------|
|                                                  | Working         | % Part-Time    |
|                                                  | Recent Residency Graduates (excluding fellowship trainees), N=635 | Early Career, N=901 |
| All                                              | 17              | 28              |
| Gender                                           |                 |                 |
| Female                                           | 20              | 39              |
| Male                                             | 7               | 3               |
| Married                                          |                 |                 |
| Yes                                              | 20              | 31              |
| No                                               | 8               | 7               |
| Have Children                                    |                 |                 |
| Yes                                              | 25              | 32              |
| No                                               | 9               | 7               |
| Specialty                                        |                 |                 |
| General Pediatrics                               | 19              | 39              |
| Subspecialty/Other                               | 11              | 15              |
| Primary Practice Location                        |                 |                 |
| Urban, inner city                                | 20              | 21              |
| Urban, not inner city                            | 17              | 27              |
| Suburban                                         | 20              | 37              |
| Rural                                            | 13              | 24              |

Source: AAP PLACES Annual 1 Survey

Cont. page 29
**cont. Update on The Pediatrician Life and Career Experience Study – PLACES**

**A Look at Part-Time Physicians**

*Cont. from page 28*

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**Figure 1 – Reasons Why PLACES Participants Work Part-Time (N=293)*

<table>
<thead>
<tr>
<th>Reason</th>
<th>Recent Residency Grads</th>
<th>Early Career</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/spouse and/or other family need</td>
<td>74%</td>
<td>95%</td>
</tr>
<tr>
<td>Personal preference</td>
<td>52%</td>
<td>61%</td>
</tr>
<tr>
<td>Other</td>
<td>27%</td>
<td>13%</td>
</tr>
</tbody>
</table>

* Participants could select more than 1 reason

Source: AAP PLACES Check Point 1 Survey

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**Figure 2 – Satisfaction with Career as a Physician, Current Work, and Work Load For Part-Time and Full-Time Participants**

<table>
<thead>
<tr>
<th>Category</th>
<th>Part-Time</th>
<th>Full-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied with Career</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>Satisfied with Current Work</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>Satisfied with Work Load</td>
<td>77%</td>
<td>58%</td>
</tr>
</tbody>
</table>

Source: AAP PLACES Annual 1 Survey
New AAP Guide for Pediatricians on Addressing Trauma

In partnership with the Dave Thomas Foundation for Adoption and Jockey Being Family, the American Academy of Pediatrics (AAP) has developed materials for pediatricians on how to support adoptive and foster families by strengthening the abilities of pediatricians to identify traumatized children, educate families about toxic stress, and empower families to respond to their child's behavior in a manner that acknowledges past trauma. The guide is accompanied by a coding tip sheet, discharge form, and an educational handout for families. The materials can be downloaded from the Healthy Foster Care America Web site at www.aap.org/traumaguide.

A special thanks goes out to the AAP members who dedicated their time and expertise to developing these materials!

Heather Forkey, MD, FAAP
Andy Garner, MD, PhD, FAAP
Lisa Nalven, MD, MA, FAAP
Samantha Schilling, MD
John Stirling, MD, FAAP

LD Navigator

The American Academy of Pediatrics has partnered with the National Center for Learning Disabilities and the National Association of Pediatric Nurse Practitioners to develop the Learning Disabilities (LD) Navigator, a free comprehensive resource guide about learning difficulties and disabilities for pediatric healthcare professionals. The online hub is a unique and easily accessible way to navigate a child’s LD and delivers evidence-based tools and strategies into the hands of busy pediatric healthcare professionals.

Please visit http://www2.aap.org/sections/dbpeds/LDNavigator.asp.

Pediatric Preparedness Resource Kit

The American Academy of Pediatrics and the Centers for Disease Control and Prevention have created the “Pediatric Preparedness Resource Kit: Inspired by the H1N1 Pandemic: Strengthening Pediatric and Public Health Partnerships.” The purpose of the Resource Kit is to promote collaborative discussions and decision-making among pediatric and public health leaders about pediatric preparedness planning. To request complimentary print copies, please e-mail disasterready@aap.org, or visit www.aap.org/disasters/resourcekit to access the electronic copy.
PediaLink Promotion

If you liked PediaLink while a resident or fellowship trainee, you will love what PediaLink for Pediatric Professionals can do for you now. Tailored to meet the educational needs of busy pediatricians from their first year in practice to their last, PediaLink delivers everything needed to manage your continued learning needs including:

- Online continuing medical education (CME) courses that takes as little as 30 minutes. Choose from the largest selection of CME courses that will expand your knowledge and bring you up to date on the latest information and guidelines. Completion times range from 30 minutes to two hours, and most qualify for AMA PRA Category 1 Credits™. Members can access free CME courses, and receive discounts on all other PediaLink courses. And, follow us every Thursday on Facebook, Twitter and www.pedialink.org for our weekly THRIFTY THURSDAY discount offers.

- Resources that will improve your teaching and presentation skills. From teaching tips to basic procedure videos, the tools and resources in the PediaLink Teaching and Learning Center can help make you a more effective teacher. Access these free resources by logging into PediaLink using your AAP login and password.

- Transcript-management tool that record your learning activities. PediaLink tracks the credit(s) you have earned through AAP activities and self-claim credits so you do not have to. In one place, you can view, print and submit your transcript. Learning Plans: if you used PediaLink while a resident or fellow in training, you can easily pick up where you left off on your learning objectives. Your objectives carry over from year to year throughout your career.

- CME Finder that searches for AAP live, online, print and more continuing medical education activities. Just type in the topic(s) you are interested in and see a complete list of related AAP educational opportunities.

- Online search that quickly delivers the information you need—and can trust. Do not waste another minute sorting through online search results. Just type in your question into the PediaLink Internet Point of Care search feature. In minutes, you will view a list of AAP peer-reviewed resources directly related to your topic.

- EQIPP quality improvement courses that identify and close practice gaps. Improve your patient care and increase patient satisfaction by getting the information and tools you need to achieve measurable results. You will also earn CME credit. For more information and complete course list visit www.eqipp.org.

Access to PediaLink time saving features are FREE for members of the AAP. Get started with PediaLink now. Use your AAP Login and Password at www.pedialink.org. If you have any questions about using PediaLink, please contact pedialinkadmin@aap.org.
Experience the National Conference and Exhibition (NCE)

The American Academy of Pediatrics (AAP) invites you to be an active part of the AAP Experience! The AAP National Conference features educational sessions in nearly 60 topic areas to suit a variation of learning styles. Use our AAP conference planner to build an itinerary and view sessions/faculty handouts on your mobile device (laptop, tablet, or smartphone). Search sessions by keyword, ACGME competency/attributes, and topic area. To receive advance registrations rates, register before September 13, 2013 at www.AAPexperience.org/register.

New Resource Showcases Provider and Patient/Family Partnerships


Your Membership Matters Promotional Video

As part of the District and Chapter Recruitment Campaign the American Academy of Pediatrics (AAP) funded this year, Districts VI and VIII (thank you Dr. Yasuda and Dr. Shaw!) dedicated some of their allocated funds to create a video promoting the value of membership in the AAP. Many of the chapters have requested this type of promotional material, and the final video is now available for your use! The video has been reviewed and strongly endorsed by the Committee on Membership, and has also been previewed and received enthusiastically by the AAP Board, and the DVCs. Here is the link to the video: http://youtu.be/zFmmFCg6VdQ

At the end of the presentation the audience is directed to our new "Your Membership Matters" website landing page, where they can get all of their membership questions addressed with one stop, or join or renew membership.

We hope you find this useful to your recruitment and promotional activities. Please use it, take it out to meetings, share it with colleagues electronically and through social media to help spread the message that when it comes to advancing child health and the future of Pediatrics...Every Member Matters!
Vaccine Storage and Handling Resources

The American Academy of Pediatrics has developed new resources to help immunization providers practice safe vaccine storage and handling. They include information on using and purchasing equipment (refrigerators, freezers, and data loggers), a storage and handling checklist, tips for safe vaccine transport, and information to help you write your emergency vaccine storage and handling plan. View these resources at: http://www2.aap.org/immunization/pediatricians/storageandhandling.html.

Thank you!
District I

1. Who are you?

Susan Harp, MD, a pediatrician in private practice 3 years out of residency training

2. Who or what influenced your career?

One, the death of a sister of a very rare disease when I was very young instilled in me the importance of health care for children. Two, my father, who fostered in me a sense of wonder and awe, and took time to have really interesting conversations with me as a fellow human being, rather than a little kid, even when I actually was a little kid.

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

As a resident, I began using the resources available to young physicians, and as I continue on, I continue to use them not only as resources for parents, but as excellent supports for myself, especially the annual conference.

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

I like to travel anywhere and any time. Many books have captured my imagination, but my all-time favorite would either be Middlemarch by George Eliot or Watership Down by Richard Adams.

5. What is your favorite developmental milestone?

Reaching for things with intention between 2-3 months old is my favorite. You almost see the ‘light bulb’ go on, and the knowledge that you control your hands, and therefore the environment around you, is a profound leap of intellect for a being that has only been around for 8-12 weeks on this planet.

6. What is the best part of your job?

The best part of my job is being part of the joy and pride that parents have in their children. No matter the age, when parents share with me the amazing things that their children are accomplishing, I feel privileged all over again to be able to be in such an intimate and meaningful relationship with these families.

Cont. page 35
District III

Cont. from page 34

1. Who are you?

I am Marc Yester, M.D., a pediatrician originally from West Virginia, but currently practicing in a Pittsburgh, Pennsylvania suburb. I did my undergraduate and medical school training at West Virginia University (WVU) and my residency at Wake Forest. I am married to an obstetrician/gynecologist physician and we have two kids.

2. Who or what influenced your career?

My interest in medicine started with my mother who has been an operating room nurse for 35 years. Doctors Norman Ferrari, Martin Weisse, and Renee Saggio at WVU inspired me to go into pediatrics. Finally, the entire group of pediatricians at Wake Forest / Brenner's Children's Hospital made me into the doctor I am today. I could not be happier with the help I have received along the way.

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

I got involved with the AAP following my first year of general practice by attending the National Conference and Exhibition (NCE). The NCE is always so inspiring, and now I make sure to get there each year.

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

I cannot pick a favorite book. That is too hard. I will say that the last really good page turner I read was Gone Girl by Gillian Flynn. My favorite travel destination, however, is easy. Every year during the summer we rent a cabin on a lake in Northern Ontario. We fish, float, and just relax in general. The best part is no cell phones, TVs, or computers!

5. What is your favorite developmental milestone?

Ha! Great question! I guess with my own kids I find them pretty boring until they start really talking. So I would have to pick the 2 year-old language developmental milestone.

6. What's the best part of your job?

I prefer well checks when the kids are healthy and we get to talk about preventing illness. However, I feel most valuable when I am helping a family through a very serious illness or new diagnosis.
1. Who are you?

My name is Stephen Pont, MD and I am the dad of two busy boys, a husband, and a pediatrician. Within the AAP I have the great pleasure of serving as chair of the Provisional Section on Obesity - which we hope will become non-provisional/official on July 1st! Work wise, I serve as the medical director for the Texas Center for the Prevention and Treatment of Childhood Obesity at Dell Children's Medical Center in Austin, Texas, www.dellchildrens.net/healthyliving. I also work with Austin Independent School District’s Student Health Services.

2. Who or what influenced your career?

My mom always put others needs before herself as she worked with underserved folks, and so I have always tried to follow in her footsteps. Many friends and mentors along the way have played critical roles in my career development, and I would not be where I am now without the help and support of many. Many mentors from my pediatric residency (Arkansas Children's) and fellowship (Vanderbilt) days provided me with critical advice and training and fortunately I am still in regular contact with many of them. It would also be impossible to do my job without a lot of help from my wife who is also a neonatologist.

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

I became formally involved with the AAP as a resident through attending my first AAP National Conference and Exhibition where I became a Section on Residents District Coordinator during my PGY2 year. I then returned for another year as a District Coordinator during my second year of fellowship. During that time I was also able to attend my first Annual Leadership Forum (ALF), which exposed me to some of the inner workings of the AAP. AAP leaders have always been warm, friendly and encouraging, and so I hope that I can do the same for others who are less familiar with the AAP too.

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

I unfortunately do not get to read much, but the last book I read was the Nature Principle by Rich Louv http://www.childrenandnature.org/ (also author of Last Child in the Woods: Saving our Children from Nature Deficit Disorder), which describes how important it is for us and our kids to regularly spend time in nature. My favorite travel destination is anywhere south of Texas. I studied in Costa Rica for a semester in college and have travelled extensively through Mexico and Central America and I love to go back whenever I can. I currently go on a mission trip with a group from our church each summer to an orphanage in Guatemala City www.hogarmiquelimagone.com (Facebook: Miguel Magone Guatemala) and to a rural school, (no website, but Facebook: “San Bartolome Escuela Ong”). These have primarily been construction and clean water trips so far, but I am hoping to establish a medical partnership soon - perhaps through using the AAP’s Helping Babies Breathe curriculum.

5. What is your favorite developmental milestone?

Wow, after now having my own kids, there are a lot! There is something amazing about laughing, so your infant child laughing with you is a pretty special milestone. Getting out of diapers and being able to get
Cont. from page 36

yourself dressed are pretty big ones too! As for a less traditional milestone, my sons and I practice martial arts and so taking our first martial arts test together was pretty neat as well.

6. What is the best part of your job?

The best part of my job is that I am able to do a lot of different things to work to improve the health of kids. This ranges from clinic to research to community health campaigns to legislative advocacy and media interviews to spread healthy messages. While it has been a super busy time since starting my “real job” in Austin, it has been very rewarding as I do think that we are making a difference and improving the health of kids in Austin and around Texas.

District IX

1. Who are you?
My name is Dane Gehringer, MD and I am a pediatric chief resident.

2. Who or what influenced your career?
My parents influenced my career. Also life experiences made me hope to work closely with all types of people and people in need.

3. How did you become involved in the American Academy of Pediatrics (AAP)?
I became involved through residents and mentors during my training.

4. What is your favorite book and/or favorite travel destination?
I like to travel to the Northern Wisconsin lakes in the summer.

5. What is your favorite developmental milestone?
My favorite milestones are all of the language and communication skills that ramp up between one and two years-old.

6. What is the best part of your job?
The best part of my job is the fact that I like what I do, enjoy going to work, respect and enjoy interacting with my colleagues, and the amazing children with all of their wonderful differences. I feel that I can play a role in a stressful and important time of patients and families lives.
Opinions expressed are those of the authors and not necessarily those of the American Academy of Pediatrics. The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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