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Greetings! As I write this, we are wrapping up a fantastic Mardi Gras season in New Orleans. It will not be long until the American Academy of Pediatrics (AAP) descends on New Orleans for its National Conference and Exhibition (NCE). I cannot wait for all of you to experience the wonderful food, music, and culture my adopted city has to offer. Be on the lookout for information about registering for the NCE and reserving hotel rooms in early June.

The Section on Young Physicians (SOYP) has been busy over the past few months. As you can see by this great newsletter, young physicians have been active across the country both in their communities and as advocates at a regional and national level. In fact, the SOYP executive committee was recently able to take part in an advocacy day in Washington, DC organized by the AAP's Department of Federal Affairs. We visited our senators and representatives and discussed three key pieces of federal legislation effecting children and pediatricians. One of these topics was reauthorization and funding of children's hospital GME. CHGME is an important program that finances pediatric residency and fellowship training at 55 freestanding children's hospitals. These hospitals are not eligible for Medicare funding and without the program they would not be able to educate residents and thus, add to the pediatric workforce.

One of the things the SOYP executive committee has been working on for the past few years is getting young physicians involved across the AAP. You may see emails about openings on various AAP committees, sections and councils. If your interest is piqued, let us know and we are happy to recommend young physicians for leadership positions. We are also working on strengthening our YP speaker database. This database will be available to chapters, districts, and others who are looking for speakers for meetings and other events. So if you are passionate and well versed on a topic and would like to be a speaker, fill out this quick survey and become part of the database. https://www.surveymonkey.com/s/YPSpeakerDatabase2012

I hope you enjoy this newsletter. As always, I would love to hear your feedback about not only the newsletter, but about how the AAP SOYP can help you in your practice!
Hello! My name is Tyler Kimberly Smith, MD, MPH, FAAP and I am pleased to introduce myself to the readership of the Young Physicians (YP) Newsletter as the new co-editor working with Elsa Vazquez-Melendez, MD, FAAP. I have been actively involved in the American Academy of Pediatrics since my residency training at the University of Maryland Medical Center and throughout fellowship training at Johns Hopkins School of Medicine serving on the executive committee for the Section on Medical Students, Residents, and Fellowship Trainees. While on the executive committee, I was the Assistant District Coordinator and District Coordinator of the dynamic District III and also worked as the Section Secretary. While holding these positions, I received extensive training in newsletter preparation and editing. My hope is to utilize these skills and apply them to the YP Newsletter in providing the readership with valuable and useful information.

In light of recent events in pop culture with the untimely passing of superstar singer, Ms. Whitney Houston, I take pause to be “in the moment” and enjoy my surroundings. The journey to becoming a physician is a road filled with many challenges and sacrifices; however, the rewards of being a pediatrician are insurmountable. The priceless smile on a child’s face after receiving a new book during a well child visit or receiving a picture drawn by a young patient could melt even the Grinch’s heart.

I recently attended Disney on Ice and was reminded of the simplicity of childhood. I observed children taking in the awe and wonderment of the theatrical performance of their favorite Disney characters. As children ate cotton candy and held up “Incredibles” flashing lights, I was taken back to my childhood where my biggest worries were doing well in school and getting home before the street lights came on. I remember dreaming about becoming a pediatrician when I got older (I would say bigger, but I have been the same height since I was 12 years old!). Now that this dream has been achieved, I continue to create more dreams. I never want to lose the child spirit of having and making dreams. As pediatricians, despite our best efforts, we easily get caught up in the hectic schedule of being a physician and often bring our work home. We mull over clinical decisions made and contemplate if the 4:30pm patient should have gone to the emergency department. Let us be mindful that although we deal with life and death situations daily, we are still human and need to remember to be “in the moment.” We should strive to embrace and hold on to some of the innocence and simplicity of childhood.

My hope as co-editor is to assist with making the YP Newsletter a vehicle for practical information, but also a venue for sharing our enriching experiences as pediatricians. I thank you for the opportunity to be the newsletter co-editor and look forward to serving the readership.

Smiles,
Tyler
What's the best part of your job?
I have the best job on Earth! I give hugs to kids all day. What could be better? Also I love working with the residents. They keep me on my toes, constantly challenging me to stay up-to-date.

What kinds of activities are you involved in with the AAP?
Currently I am fortunate to serve as chair of the Section on Young Physicians. This is my third year being on the SOYP executive committee and I am proud of the work the section is doing not only on behalf of young physicians, but also for the AAP.

I am also on the executive committee for the Louisiana chapter. I think being involved in your chapter is important because so much of what chapters advocate for affects your practice directly. My chapter was very welcoming to me as a resident and I have stayed involved over the years.

Recently you attended an advocacy day put on by the DC office. What is it like visiting Capitol Hill on behalf of the AAP?
So amazing! I have been to visit my Senators and Congressman (and their legislative aides) a few times over the years. At first I was really intimidated. I kind of think of members of Congress like rock stars (yes, I'm a big political junkie). The AAP's Washington office prepares you well to talk about important federal legislation affecting kids. And then once you realize that the legislative aides are often much younger than you are (and they are intimidated by the fact you are a doctor), it is not quite so scary.

I would highly recommend the legislative conference or one of the DC Advocacy Day events. It is a great chance to learn how to be an advocate on the federal level.

What advice would you give to someone early in their career unsure about where they fit in the AAP?
Get involved! There are so many opportunities to get involved. Maybe you work closely with schools in your area. Or maybe you are passionate about obesity. Or maybe you have a strong business mind and are becoming an expert on meaningful use. Chapters as well as sections, councils, and committees are often looking for young physicians with interest in all kinds of areas.

A lot of people are worried about time commitments. I started out attending quarterly chapter advisory meetings. A couple of hours every three months was doable with my busy schedule and over time it has allowed me to network with pediatricians across the state who I would not have met otherwise.

Pediatricians are such a friendly and welcoming group, don't be afraid to reach out!
Book Review

Randi Teplow-Phipps, MD, FAAP

Cutting for Stone by Abraham Verghese

This epic book chronicles the lives of twin brothers, Marion and Shiva, as they grow up in Ethiopia. Their story begins when the twins are born to parents of an unlikely union, an Indian nun and a British surgeon. Abandoned by the death of their mother and the disappearance of their father, the twins grow up in a unique setting. They are raised as part of a rural, Ethiopian community hospital where they discover and explore their fascination with medicine. Their surrogate parents, both physicians, become their role models as they display compassionate care that exemplifies the richness of medicine. The book guides the reader through the ups and downs between the twins as the underlying bond of brotherly love continuously strengthens. Ultimately this unspoken closeness results in a true sacrifice. This story is not just about the love of family, it displays the breadth of the entire emotion of love. Marion’s infatuation with Genet, his childhood crush, resonates with the reader and the uncontainable devotion of a surgeon for the operating room shines through. As the twins mature and become physicians, their paths diverge and they come to develop unique styles. The reader, especially a physician-reader, can identify with the varied perspectives and approaches to medicine. More importantly, the reader can develop a new appreciation for the art of medicine. This well written book integrates medicine seamlessly into the detailed accounts of the twins’ lives and helps to define what it means to be a physician in the truest sense of the profession.

Moloka‘i by Alan Brennert

Rachel Kalama is a young girl living in Hawaii in the 1890s at the peak of the Leprosy epidemic. The reader experiences her strong spirit and positive outlook as she navigates the disfiguring disease that causes her to be taken from her family and isolated on a quarantined island. Leprosy, a disease that is still seen in the modern medical world, mostly in tropical climates, is often missed due to lack of physician awareness. Caused by Mycobacterium leprae, it is an illness involving the skin and peripheral nerves that is seen in two distinct forms: tuberculoid and lepromatous. Common symptoms include hypopigmented skin lesions with decreased sensation, muscle weakness, numbness, and large skin nodules. It is still uncertain how it is transmitted, but it likely occurs through respiratory secretions or via open wounds. According to the World Health Organization (WHO), at the beginning of 2011 from 130 countries and territories, the prevalence of leprosy was 192,246 cases worldwide. Currently the WHO provides multidrug treatments free of charge to all countries for those infected with Leprosy. The medicines used by the WHO for multidrug treatments are a combination of rifampicin, clofazimine and dapsone. The treatment course lasts for 6-12 months for those with tuberculoid disease and 24 months for those with lepromatous disease. The Bacillus Calmette-Guerin (BCG) vaccine has been shown to be effective in preventing both TB and Leprosy, and it is used in countries with a high prevalence of Leprosy.
**cont. Book Review**

*Cont. from page 5*

Luckily today there are effective treatments for leprosy, but in the 1890s these had not yet been discovered. Moloka‘i takes the reader through the turmoil of living with a chronic, stigmatizing disease. Rachel, the protagonist, is strong willed and determined to beat the disease. She subjects herself to experiments of new potential treatments and procedures for the hope of a cure. This book, while it discusses many of the medical complications of leprosy, is enjoyable to read and easy to follow. It is a beautiful story that remains with the reader far longer than any text book description of this often forgotten disease.

**Sources**


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**QI: Coming Full Circle**

*Amy Belisle, MD, FAAP*  
*Director, Child Health Quality Improvement, Maine Quality Counts*  
*Steering Committee on Quality Improvement and Management*

In 1998-2001, when I was a medical student and resident at the Barbara Bush Children’s Hospital in Portland, Maine, I was fortunate to witness the inception of the Asthma Health (AH!) Program. The program was led by Barbara Chilmonczyk, MD, a local asthma expert, who was trying to improve the quality of care for pediatric asthma patients. As a resident, we learned about asthma action plans, the proper use of medications and devices, how to help patients learn to use peak flow meters, and the importance of flu shots. Little did I know what a long-term impact this quality initiative would have on my work!

Soon after I left residency, I was assigned to improve the care of asthma patients at my military pediatric clinic in Japan, both in the clinic and in schools. I quickly contacted the AH! Program to get the materials to institute an asthma clinic and educational sessions for families, clinic staff, and schools.

Fast forward five years after the Japan experience and a return to my home state Maine. In the spring of 2009, I was asked to champion the Maine AAP Chapter’s Asthma Pilot with the AAP Chapter Quality. I agreed to be the champion, as long as our local experts, Dr. Chilmonczyk and Rhonda Vosmus, AE-RT, and the AH! Program would help co-lead the project. Maine was one of 4 states (along with OH, AL, and OR) chosen as a pilot site to work with the AAP and Quality Improvement (QI) coaches from Cincinnati Children’s Hospital to improve asthma care, as well as to develop a quality improvement infrastructure. For the AAP pilot, we had 12 practices and 50 pediatric providers participate in Maine in the year-long collaborative. We were fortunate because we were building on the work of two previous asthma pilots in the state led by the AH! Program within the past 8 years, so many groups were already familiar with the use of action plans, asthma control screening tools, and how to do asthma education in the office.

We saw some major improvements across the collaborative. For example, 91% of the pilot groups were using a registry at the end, up from 50%; optimal care scores increased from 45% to 75%; well controlled patients increased from 60% to 82%; and spirometry increased from 40% to 65%. One practice even increased their rate of spirometry from 0% to 70%.

*Cont. page 7*
### cont. QI: Coming Full Circle

*Cont. from page 6*

In addition to medical management of asthma, we worked with practices on QI methods and tools, such as PDSA (Plan-Do-Study-Act) cycles, and planned care approaches so they could build their internal infrastructure. We also started to engage health care system leaders to build pediatric quality improvement capacity and sustain the progress of the pilot.

This work has had other very positive spinoffs. One year afterwards, the Maine Chapter of the AAP was partnering with other groups in the state to build a Child Health Improvement Partnership in the state that will lead measurement-based efforts to improve the health outcomes of children. These groups were: Maine Quality Counts, MaineCare (Medicare), The Maine CDC, The Muskie School of Public Service, University of Southern Maine, health care systems, residency programs, the Maine Academy of Family Medicine, families, practices, and health care providers. Maine Quality Counts, and all the groups in the partnership, are currently working with MaineCare, who has a 5 year Children’s Health Insurance Program Reauthorization Act (CHIPRA) grant with Vermont, to lead a learning collaboration on improving immunizations rates and early preventive services.

My QI work has come full circle – and along the way, the impact of our asthma work has expanded greatly to benefit practices, health systems, trainees, and most importantly children and families. I hope many of you are fortunate enough to have similar opportunities as the QI “circle” expands nationally.


### Creation of a Pediatric Simulation Research Collaborative Built to INSPIRE

**Marc Auerbach, MD, MSCI¹,**
**Taylor Sawyer DO, Med² on behalf of the INSPIRE simulation collaborative**

1. Department of Pediatric Emergency Medicine, Yale School of Medicine, New Haven, CT
2. Division of Neonatology, Tripler Army Medical Center, Honolulu, HI

Over the past decade, pediatric simulation has evolved into an essential component of provider education and team training. Evidence to support its value as an adjunct to traditional methods of education is expanding; however, large multicenter studies are very rare. Simulation-based researchers face many challenges related to small sample sizes, poor generalizability, and paucity of clinically proven and relevant outcome measures. Over the past five years pediatric simulation researchers have created two collaborative research networks: EXPRESS (Examining Pediatric Resuscitation Education Using Simulation and Scripting) and POISE (Patient Outcomes In Simulation Education). Recently, members of these two networks have decided to combine forces and create a single all-inclusive network for collaborative pediatric simulation-based research. The name of the new network is INSPIRE (International Network for Simulation-Based Pediatric Innovation Research and Education). INSPIRE is a growing network of pediatric simulation-researchers from over sixty hospitals across six countries. A site map of the current institutions involved in INSPIRE can be found at [http://g.co/maps/h4tku](http://g.co/maps/h4tku)

*Cont. page 8*
**cont. Creation of a Pediatric Simulation Research Collaborative Built to INSPIRE**

*Cont. from page 7*

INSPIRE aims to improve the care provided to acutely ill infants and children by answering important research questions pertaining to resuscitation, technical skills, education, and simulation. In particular, INSPIRE aims to conduct robust, adequately powered and appropriately designed trials with an emphasis on simulation and multicenter collaboration. Through collaborative research the network will INSPIRE the academic growth of new investigators by exposing them to established mentors and nurturing the skills necessary to become successful researchers. Specifically, young investigators will be mentored through the process of selecting an appropriate research idea, developing objectives and specific aims, writing research proposals, applying for grant support, executing research protocols, presenting emerging data at national and international conferences, and bringing projects to print via peer-review publication. We anticipate a steady stream of grant support will help to promote the growth of INSPIRE in the coming years. Through this process, we expect to build expertise and knowledge that gains momentum for collaborative simulation-based research on an international level. For more information, or information on joining INSPIRE, please contact the INSPIRE leadership at inspiresimnetwork@gmail.com.

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**Hot off the press: 2010 PALS guidelines**

*Elizabeth Mack, MD, MS, FAAP*

*Executive Committee Member - District VIII*

*Pediatric Intensivist, Director of Quality, Palmetto Health Children’s Hospital*

*Disclaimer: You must take a PALS course to become (re-)certified.*

**Are you up to date on the new PALS guidelines? (See the end of the article for answers.)**

1. What is the recommended rate of compressions for a pulseless infant, child, or adult?
   
   A) 30/min  
   B) 50/min  
   C) 80/min  
   D) 100/min  
   E) 150/min

2. Which of the following is true regarding resuscitation of infants?
   
   A) AED should never be used in infants  
   B) Pulse should be checked over femoral artery  
   C) Depth of compressions should be 1/3 AP diameter of chest (~1.5 cm)  
   D) ETCO2 monitoring is not recommended in infants

3. Once circulation is restored, supplemental oxygen should be decreased to the lowest concentration that gives sat goal (any age) of:
   
   A) 85-90%  
   B) 88-92%  
   C) ≥ 90%  
   D) ≥ 94%  
   E) 100%

*Cont. page 9*
cont. Hot off the press: 2010 PALS guidelines

Cont. from page 8

4. Which of the following is TRUE about energy doses in pediatric defibrillation?
   A) Initial dose should be 0.5-1J/kg
   B) Subsequent doses should be 2J/kg
   C) All doses should be synchronized
   D) Subsequent doses should be 4J/kg and can reach up to 10J/kg

You may have heard that the old “ABC” and “Annie, Annie, are you OK?” are no longer. In fact, PALS has now gone back to the basics by focusing on basic life support (BLS). Quality (recoil, depth) and quantity (rate, avoiding interruptions) of cardiopulmonary resuscitation (CPR) are the most important parts of resuscitation. You may be thinking “whatever happened to respiratory issues being the most common cause of respiratory arrest.” As you know the AHA now allows “compression-only CPR” for adults so as not to delay resuscitation due to hesitation to deliver mouth-to-mouth or bag valve mask CPR. The odds of patients receiving bystander CPR (out-of-hospitals) is quite low (<1/3) and the quality of bystander CPR is often poor. Thus, these now BLS-heavy PALS guidelines were released by the AHA on 10/19/2010. See below for an overview.

Overview of pediatric BLS/PALS changes

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR sequence</td>
<td>ABC</td>
<td>CAB</td>
</tr>
<tr>
<td>Ratio</td>
<td>30:2 (single), 15:2 (2+HCP)</td>
<td>30:2 (single), 15:2 (2+HCP)</td>
</tr>
<tr>
<td>CPR depth</td>
<td>1/3 – 1/2 AP diameter</td>
<td>1/3 AP diameter</td>
</tr>
<tr>
<td></td>
<td>(1.5” infant, 2” child)</td>
<td>(1.5” infant, 2” child)</td>
</tr>
<tr>
<td>Pulse check</td>
<td>10s (default CPR)</td>
<td>10s (default CPR)</td>
</tr>
<tr>
<td>AED for &lt;1yo</td>
<td>No recommendation</td>
<td>Ideal: manual defib</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alt: AED w/ ped dose atten</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2nd alt: AED w/o dose atten</td>
</tr>
<tr>
<td>ETCO₂</td>
<td>Use to confirm ETT, in transport</td>
<td>Use to confirm ETT, in transport, and to guide CPR efficacy</td>
</tr>
<tr>
<td>Defib dose</td>
<td>Initial: 2J/kg</td>
<td>Initial: 2-4J/kg</td>
</tr>
<tr>
<td></td>
<td>Subsequent: 4J/kg</td>
<td>Subsequent: 4J/kg (max 10J/kg or adult max)</td>
</tr>
</tbody>
</table>
Changes continued...

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limiting O2</td>
<td>Avoid hyperoxia, no specific rec</td>
<td>After ROSC, titrate quickly to sats ≥94%</td>
</tr>
<tr>
<td>CHD</td>
<td>N/A</td>
<td>Recs for SV, BDG, Fontan/hemi-Fontan physiology, and PHTN</td>
</tr>
<tr>
<td>Def of wide complex tachy</td>
<td>QRS width &gt; 0.08s</td>
<td>&lt;4yo: QRS width &gt; 0.09s 4-16yo: QRS width &gt; 0.1s</td>
</tr>
<tr>
<td>Calcium</td>
<td>Routine use does not improve outcome</td>
<td>Not recommended unless documented hypoCa, CCB OD, hypoMg, hyperK; No benefit &amp; may be harmful</td>
</tr>
<tr>
<td>Etomidate</td>
<td>N/A</td>
<td>Not recommended in patients with septic shock</td>
</tr>
<tr>
<td>Post-arrest care</td>
<td>Therapeutic hypothermia (32-34°C) x12-24h may be considered if pt remains comatose after cardiac arrest</td>
<td>Therapeutic hypothermia (32-34°C) may be considered if pt remains comatose after cardiac arrest (esp adol OOH VF based on adult evidence)</td>
</tr>
<tr>
<td>Sudden death</td>
<td>N/A</td>
<td>PMH, FHx, prior ECGs, unrestricted complete autopsy by pathologist, preserve tissue r/o channelopathy</td>
</tr>
</tbody>
</table>
Hot off the press: 2010 PALS guidelines

Overview of 2010 guidelines

<table>
<thead>
<tr>
<th>Component</th>
<th>Adults</th>
<th>Children</th>
<th>Infants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition</td>
<td>Unresponsive, apneic, (or only gasping), no pulse within 10s (HCP only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPR sequence</td>
<td>C-A-B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compression rate</td>
<td></td>
<td>100/min</td>
<td></td>
</tr>
<tr>
<td>Compression depth</td>
<td>≥2 in</td>
<td>At least 1/3 AP diameter ~2 in</td>
<td>At least 1/3 AP diameter ~1.5 in</td>
</tr>
<tr>
<td>Chest wall recoil</td>
<td>Allow complete recoil between compressions HCP rotate compressors q2min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compression pauses</td>
<td>Minimize to &lt;10s for pulse/rhythm check q2min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio (no adv airway)</td>
<td>30:2 (1 or 2 rescuers)</td>
<td>Single rescuer: 30:2 2+ HCPs: 15:2</td>
<td></td>
</tr>
<tr>
<td>Ratio (w/ adv airway)</td>
<td>No synchronization 8-10 breaths/min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay resucuer</td>
<td>Compressions only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defibrillation</td>
<td>Attach and use ASAP Minimize pauses in CPR (resume CPR immediately after shock)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Reference
We asked a few SOYPs to give us their most useful apps and here are the results of our informal survey. We are not speaking on behalf of the AAP and have no disclosures to report. Updated 2/4/12, info subject to change. Contact us if you have other suggestions.

Medical Apps

<table>
<thead>
<tr>
<th>App</th>
<th>Cost</th>
<th>Platforms</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epocrates Rx</td>
<td>Free</td>
<td>I A B W P</td>
<td>Quick drug ref with interactions, pill ID, pediatric ref tables, formulae, calculators</td>
</tr>
<tr>
<td>AHRQ ePSS</td>
<td>Free</td>
<td>I A B P W</td>
<td>USPSTF recommendations for preventive services, customize by age, smoking status, gender, pregnancy status, sexual activity; Mostly adult recommendations; Gives levels of evidence (A, B, C, D, I) for recommendations</td>
</tr>
<tr>
<td>Lose It!</td>
<td>Free</td>
<td>I A</td>
<td>Log your food &amp; exercise daily, set your goals &amp; track your progress; motivating!</td>
</tr>
<tr>
<td>PALS advisor</td>
<td>$1.99</td>
<td>I</td>
<td>Real time practice algorithms, does not certify in PALS, updated in 2012</td>
</tr>
<tr>
<td>PALS Wiz</td>
<td>$0.99</td>
<td>I</td>
<td>Flash cards, does not certify in PALS, updated in 2012</td>
</tr>
<tr>
<td>AAP News</td>
<td>Free</td>
<td>I</td>
<td>Electronic version of the monthly AAP News</td>
</tr>
<tr>
<td>Travel vaccination guide</td>
<td>$0.99</td>
<td>I</td>
<td>Track your own vaccines, find vaccination clinics, and search by country (&gt;200 destinations) what vaccines you &amp; your patients need</td>
</tr>
<tr>
<td>SCAT2</td>
<td>Free</td>
<td>I</td>
<td>Sport concussion assessment tool for use in &lt;10yo; can use for pre- &amp; post-season testing for comparison</td>
</tr>
<tr>
<td>CR hospitals</td>
<td>$2.99</td>
<td>I</td>
<td>Consumer reports ranks &amp; compares hospitals by QI/safety metrics (overall pt experience, CLABSI, SSI, readmission rate)</td>
</tr>
<tr>
<td>BiliCalc</td>
<td>$1.99</td>
<td>I A</td>
<td>Based on AAP 2004 management of hyperbilirubinemia in infants &gt;35wks to calc threshold for starting phototherapy based on age, bilirubin level, neurotoxicity risk. Similar to bilitool.org</td>
</tr>
<tr>
<td>Pediatrics Digest</td>
<td>Free</td>
<td>I</td>
<td>Weekly offering of article summaries from Pediatrics</td>
</tr>
</tbody>
</table>

Cont. page 13
**cont. Cool, Useful, Cheap Apps for the Young Physician!**

*Cont. from page 12*

Medical Apps (cont.)

<table>
<thead>
<tr>
<th>App</th>
<th>Cost</th>
<th>Platforms</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medscape</td>
<td>Free</td>
<td>I A B</td>
<td>WebMD resource with drugs, calculators, articles, procedures, interactions</td>
</tr>
<tr>
<td>NEJM This Week</td>
<td>Free</td>
<td>I</td>
<td>Hot articles, images, audio summaries, videos of procedures</td>
</tr>
<tr>
<td>PubSearch</td>
<td>$4.99</td>
<td>I</td>
<td>Handheld version of PubMed; limited to 10 results</td>
</tr>
<tr>
<td>Dropbox</td>
<td>Free</td>
<td>I</td>
<td>Replaces your flash drive. Lets you bring your photos, docs, videos with you. Drag &amp; drop files from your computer so you can view them from your iPhone/iPad/other desktop or laptop. 2GB/mo free. Syncs between devices.</td>
</tr>
</tbody>
</table>

Personal Apps

<table>
<thead>
<tr>
<th>App</th>
<th>Cost</th>
<th>Platforms</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evernote</td>
<td>Free</td>
<td>I A B W P</td>
<td>Store photos, audio clips, text notes, etc. Great for to-do lists, grocery lists, procedures, supply lists, or anything. Also web-based version.</td>
</tr>
<tr>
<td>Mint</td>
<td>Free</td>
<td>I A</td>
<td>Popular budgeting tool, categorizes your spending, keeps track of retirement savings, bills, etc</td>
</tr>
<tr>
<td>MailStop</td>
<td>Free but see comments</td>
<td>I A coming 2012</td>
<td>Get rid of your junk mail (app for CatalogChoice.com); scan your catalog and they take care of the rest; get 5 free opt-outs and then others ($14.99 for 50 opt-outs; $1.99 for 5 opt-outs)</td>
</tr>
<tr>
<td>Award Wallet</td>
<td>Free</td>
<td>I A</td>
<td>Keeps track of your loyalty programs (airlines, shopping, hotels, group buying, etc) and get reminders about expiring points/miles; keep everything in one place</td>
</tr>
<tr>
<td>NPR</td>
<td>Free</td>
<td>I A</td>
<td>Great source for news, newscasts, human interest stories, playlists, stations</td>
</tr>
<tr>
<td>Gas Bag</td>
<td>Free</td>
<td>I</td>
<td>Helps you find the cheapest gas around your location; keeps track of fuel efficiency.; logs all entries</td>
</tr>
<tr>
<td>Pandora</td>
<td>Free</td>
<td>I A B P</td>
<td>Great free music source; choose your stations; ads in the free version</td>
</tr>
<tr>
<td>Amazon</td>
<td>Free</td>
<td>I A B W</td>
<td>Easy searchable format to buy books, e-books, music, etc</td>
</tr>
</tbody>
</table>
## Cool, Useful, Cheap Apps for the Young Physician!

*Cont. from page 13*

**Personal Apps (cont.)**

<table>
<thead>
<tr>
<th>App</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zinio</td>
<td>Free</td>
<td>I A N Green way to read magazines to which you subscribe without getting the paper version</td>
</tr>
<tr>
<td>Fandango</td>
<td>Free</td>
<td>I A B W P N See what movies are playing in theatres near you; check out fan reviews, trailers, etc</td>
</tr>
<tr>
<td>Babycenter My Pregnancy Today</td>
<td>Free</td>
<td>I A Enter your due date and learn what to expect, checklists, etc</td>
</tr>
<tr>
<td>Yelp</td>
<td>Free</td>
<td>I A B W P Search for restaurants, cafes, bars, banks, gas stations, drugstores, etc near you and see reviews by other users</td>
</tr>
<tr>
<td>Shazam</td>
<td>Free</td>
<td>I A B W Na Play a song and app provides title, artist, etc; Similar to Soundhound; 5 free song tags per day in free version; Shazam Encore &amp; Shazam RED upgrades are $5.99 each</td>
</tr>
<tr>
<td>Facebook</td>
<td>Free</td>
<td>I A B W P Na ‘nough said...like your friends, AAP News, AAP Grand Rounds, AAP Pediatrics, AAP Red Book, American Academy of Pediatrics, AAP Department of Federal Government Affairs, NCE, and various sections &amp; chapters</td>
</tr>
<tr>
<td>Twitter</td>
<td>Free</td>
<td>I A B Follow tweets (message &lt;140 characters) by your tweeps (twitter peeps); hashtags (#) indicate a keyword/phrase ex: #aapnce; users are mentioned by using &quot;@&quot; which provides a “handle” ex: @AAPNews, @Pedialink, @AAPExperieNCE, or chapters</td>
</tr>
<tr>
<td>Skype</td>
<td>Free</td>
<td>I A B Video chat with folks for free (Skype-to-Skype)</td>
</tr>
<tr>
<td>ESPN ScoreCenter</td>
<td>Free</td>
<td>I A B W Up-to-the-minute scores, plays, summaries, etc. Pick your favorite teams. Includes college &amp; professional sports. Includes auto racing, baseball, basketball, boxing, cricket, football, golf, hockey, lacrosse, MMA, rugby, soccer, softball, tennis, volleyball, water polo</td>
</tr>
<tr>
<td>Kindle</td>
<td>Free</td>
<td>I A B W Reader platform. No Kindle device required but if you do have a Kindle device your last page read, bookmarks, notes, &amp; highlights will be synced across devices.</td>
</tr>
</tbody>
</table>
**cont. Cool, Useful, Cheap Apps for the Young Physician!**

*Cont. from page 14*

**Personal Apps (cont.)**

<table>
<thead>
<tr>
<th>App</th>
<th>Price</th>
<th>Platforms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinterest</td>
<td>Free</td>
<td>I A W</td>
<td>Virtual bulletin board allowing you to “pin” anything you find on the web, upload, or repin from other users. Another social media site. Store anything from recipes to wedding planning ideas.</td>
</tr>
<tr>
<td>Groupon</td>
<td>Free</td>
<td>I A B W</td>
<td>Get discounted food, massage, gym membership, vacation, etc through the power of group buying. Many areas/cities included. Paperless.</td>
</tr>
<tr>
<td>Living social</td>
<td>Free</td>
<td>I A B</td>
<td>Similar to Groupon but with more of an East Coast &amp; indie business bias</td>
</tr>
<tr>
<td>Taxi magic</td>
<td>Free</td>
<td>I A B P</td>
<td>Hail a taxi using this app which is integrated with taxi dispatch systems. Track the arrival of your taxi. Charge the ride to your card &amp; get an expense receipt for $1.50. Available in major metro areas.</td>
</tr>
<tr>
<td>Kayak</td>
<td>Free</td>
<td>I A B W</td>
<td>Handheld version of the website; search hotels, flights, car rentals, vacation packages. Also get price alerts, flight tracker, airline fees, airport info, currency converter, etc.</td>
</tr>
<tr>
<td>iAnnotate</td>
<td>$0.99</td>
<td>I</td>
<td>Select or take a photo, add drawings or text to your photo, save to your album, and share by email or Facebook. With the iPad version, make notes and doodle all over your pdfs and save as an annotated version.</td>
</tr>
<tr>
<td>OpenTable</td>
<td>Free</td>
<td>I A B W</td>
<td>Perfect for foodies. Make instant restaurant reservations and accrue dining rewards points redeemable for Dining Cheques good at OpenTable restaurants.</td>
</tr>
</tbody>
</table>

I = iOS  
A = Android  
B = BlackBerry  
P = Palm  
W = Windows  
N = Nook  
Na = Nokia
Keeping your business healthy should include a review of your fee schedule, at least annually. You should pay particular attention to the following issues: creating a meaningful fee schedule platform, monitoring the actual payments you receive as compared to the amount of fee schedule billed, and closely watching vaccine costs versus payments. You cannot afford not to pay attention to these details. If you do not have the time, delegate this to a trusted staff member and then review their report. This is not a complex task once you have a basic understanding of best practices, and how these can benefit your own practice.

Many practices have a historical fee schedule and just periodically increase their numbers. This approach may not necessarily take into account the actual value of your services, and may also miss or undervalue new services. While this is an easy way to manage the fees, there are better and more realistic approaches. Most insurers calculate claims payments and contract terms based on a percentage of the Medicare (CMS) fee schedule. The Medicare fee schedule is a good platform on which to base your practice fee schedule, since these payments are based on RVU (relative value units) for each service, multiplied by a set dollar amount. RVU values exist for every CPT code (except vaccines, and the dollar multiplier is set by the government at least once a year. More information on CMS payments can be found on the CMS website (http://www.cms.gov/PhysicianFeeSched). A good spreadsheet for use with these numbers can be found at http://www.pedsources.com/chipsblog/2012-free-rbrvs-calculator with instructions for use. As a benefit of your AAP membership, the AAP provides resources including an RBRVS Conversion Spreadsheet through Practice Management Online. Once you have this data, you can base your contracts with insurers to get paid X% of a particular year’s CMS fee schedule.

After you have chosen a platform for your fee schedule and have put the numbers in your billing system, you should monitor what percentage of your fee schedule each one of your insurance companies is paying. If any payer is giving you 100% of your fee schedule, it is time to raise the fees! You are potentially leaving money on the table and the insurance companies may be willing to pay you more. Alert your billing department to let you know if this ever happens. This should not wait for your annual review. If your best payer is only paying you 50% of your fee schedule, then it may be time to take a closer look at your fees (are you being unrealistic?), or renegotiate your contracts.

Vaccine costs and payments can make or break the financial success of your practice. Next to salaries, vaccines have the second highest impact on your practice finances. Through Practice Management Online, the AAP provides resources on The Business Case for Pricing Vaccines and Immunization Administration. All vaccine fee schedules should start with the CDC Private Sector Cost/Dose. You can subscribe to email update alerts at http://www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm. This website is updated frequently as pharmaceutical companies raise their vaccine prices. Studies have shown that you should be getting paid a minimum of 17-28% above the cost of the vaccines in order to break even. Therefore, you should negotiate your contracts and set your prices to achieve at least a breakeven on your vaccines. Also, remember to specify in your contract’s language that the insurer must respond PROMPTLY to any manufacturer price increase. If the insurer does not raise what they pay you for many months, you will be stuck paying more while receiving a lower fee.

Know what your fee schedule is. Know what you are being paid. Set thoughtful pricing and create a culture of quality monitoring and improvement of the business side of your practice. Quality improvement is not just about improving care for your patients. It is also about improving the financial health of your practice. If you are not already a member, join the Section on Administration and Practice Management and learn why the motto “No Margin, No Mission” is critical to the long term survival of pediatric practice.
Get Paid For EVERYTHING You Do

Jesse M. Hackell, MD FAAP
Susan Kressly, MD FAAP
Section on Administration and Practice Management

Most of the things that pediatricians do in their offices consist of procedures which fall into the Evaluation and Management code section of the CPT Manual. These include both well care visits and illness visits, and codes associated with them, including Physician Office Lab (POL) codes and the various codes pertaining to immunizations, both for the product and for the administration and counseling associated with immunizing our patients.

These codes comprise just a very small section of the CPT Manual. The bulk of that weighty tome consists of thousands of codes for procedures that most pediatricians do not even consider to be part of their office practices—mostly surgical procedures, but also advanced or specialized medical procedures in which pediatricians have not been trained, and for which their patients have little to no need.

If you think that way, however, you may be significantly undervaluing the work that you do, and cheating yourself out of significant revenue. For example, treatment of a radial head dislocation in a toddler (aka “nursemaid’s elbow”) is a common and simple procedure done by pediatricians everywhere on a regular basis. If you code that visit with a simple E/M code (like 99213, for example), with a diagnosis of the subluxation (832.00), you will be paid for the E/M only. However, since the child is often in pain for no apparent reason, or refusing to use the arm, and you take a history, make a diagnosis, reduce the subluxation, and instruct the parent on after-care, you are entitled to also bill for the “reduction of radial head dislocation”, with CPT code 24640. Note that the 99213 has a RVU of 1.39, while the 24640 is valued at 4.85; all other things being equal, you will be paid over three times as much for the reduction as you would for the E/M. Plus, if the injury was not witnessed, you can bill BOTH an E/M (with a -25 modifier) AND the reduction. After all, you did all the work of first making the diagnosis, and then treating the condition. The same goes for splinting simple finger or toe fractures, clavicle fractures and so on. (The relevant CPT and ICD codes can be found in the respective code books, available from the AAP and many other sources.)

Another simple example is the two week old infant whose umbilical cord has fallen off, but who has significant oozing from the umbilicus. On examination, you note a granuloma within the umbilicus, and you cauterize it with silver nitrate. CPT code 17250 (“chemical cauterization”) can be billed IN ADDITION TO the visit code, whether well or sick, and should be paid. After all, you did the work.

Treating warts, draining subungual hematomas, removing foreign bodies from orifices...the list of procedures which pediatricians do every day goes on and on. And don’t forget in-office testing—labs, pulmonary function testing, hearing, vision, and developmental screenings. Each one is billable (you may need to add a modifier, either -25 to the E/M code or -59 to the procedure code), and payable, often at rates which dwarf those paid for the office visit. You are doing the work—make sure you get paid for it.

For other tips on how to optimize your practice, both financially and functionally, consider joining SOAPM—the Section on Administration and Practice Management. It is a large and active section, with members from all areas of the country and all styles of practice. Pointers and practical tips are always being discussed on a very active discussion board, and posting a question usually generates numerous responses with helpful information.
Mind and Body Working Together: Baby steps toward integrated healthcare

Jeanine M. Swenson, MD, FAAP, FACC, LMFT
Children's Hospital of Wisconsin
Milwaukee, Wisconsin
Council on Communication and Media

From my little corner of the world next to Lake Michigan, it seems that every aspect of American life continues to evolve, develop, and progress at a breakneck speed and with dizzying complexity. So much is changing, yet can we strive to blend old and new solutions as a way to ensure progress for patients, families, and communities in our twenty-first century world. This may go a long way in managing stress, and ensuring that it does not change us.

One critical and ethical consideration here may be that the individual or group with the most power in a system is also responsible for the direction of change.

As relationship experts, pediatricians understand that fundamental bonds start from individual to individual, but in our world today patients are now expected to trust whole entire systems. We all send our children to school and the fragile bonds of trust and connection have the possibility of birth. We meet our primary care providers and the opportunity of conveying our unique family story grows. In my short experience, I have noted that every family has a great story; some just need a little help, guidance or healing during the difficult chapters of their life.

Have you noticed that with technological advance, it also seems that many interactions are becoming increasingly indirect and unsatisfying? So much can go unnoticed and unspoken when around 90% of communication is lost electronically. It seems that we still need old-fashioned, face-to-face interaction to convey the most important messages.

Many of our care systems (i.e. - education, medicine, families) function as hierarchies and their traditionally provider-focused, top-heavy structures have made progress and reform difficult. In fact, I have noted how often so many of these structures are said to be in “crisis.” It is not difficult to appreciate the potential for miscommunication and breakdown, as each interaction may be fraught with unspoken expectations, affective baggage, communication missteps, and even cultural clash. As a family care provider, I have seen the world change greatly even over the last decade. And as an artist and systemic thinker, I also appreciate how communication, relationships, and emotional management remain key players in bringing beneficial and lasting improvement in many arenas, both at home and in the workplace.

But, you may ask, why is change necessary? In the primary care setting, the teeter-totter of behavioral change and resistance to it plays out across the spectrum of daily life for all participants in many interactions. But sadly, engrained patterns of relating and old scripts have made change difficult. Impatience and time pressure may be motivating some out-dated strategies about direct advice giving and “educating” patients and families before critical bonds are established or when energy for power struggle remains low. One great loss in this speeded up process is the chance for providers and patients to get to know each other to a level that engenders trust.

A new blend of medicine, called integrated care, is growing and includes both doctors of the body (primary care physicians) and professionals of the mind (family therapists). Ideally these helpers are available in the out-patient setting together, where they can truly work as a team.

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**Mind and Body Working Together: Baby steps toward integrated healthcare**

This team can bring their knowledge and understanding of the mind, body, families, and communities to the table as a way to a different future. This new idea will be difficult and arduous as very old legacies about mind/body split and covert misunderstanding and fear of mental illness have hindered growth, just when we need to embrace the emotional components of illness and the blocks to health both interpersonally and systemically. The addition of mental health care professionals (LMFT’s) to primary care as part of the team is an idea that is catching on in Wisconsin and nationally.

Psychotherapy and its diverse uses remain somewhat of a black box for many individuals who are not familiar with its long history or established effectiveness. Family therapists’ critical and deep understanding of the diagnostic criteria of the DSM-IV TR will go a long way in making sure that patients are being served appropriately. But we must quickly switch from problem-based to solution-focused thinking with many families. Their ability to shift the spotlight from the individual to the system and context in which they live and work will be invaluable in bringing in the big picture to many cases.

Working and communicating our family systemic principles within traditional medical setting may be the nonlinear break that shifts many concerns forward toward change and empowerment. With our help, medical systems can shift the power, decision-making abilities, and authority from the old guard (insurance companies and providers) to the place it may do the most good (patients and their families). We can move the family to the center of the care system. Not only does this sound like a breath of fresh air, it may be the very thing patients have been wanting for a long time. Happy integrating!

For more information please contact Dr. Swenson at jswenson@chw.org.

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**Advice on Media During a Well-Child Check Visit**

*Corinn Cross, MD, FAAP  
Council on Communication and Media*

With the well child exam already jam packed with topics to hit upon in an increasingly shortened visit, the general pediatrician may be inclined not to address the new realm of cyber-life and the issues it has created for our patients and their parents.

However, there are some quick questions we can ask and words of wisdom we can provide, which can be worked into the visit without much additional time or effort.

1. **How many hours of sleep do you get a night? Do you keep your cell phone or computer in your bedroom while you are sleeping?**

   Many kids and teens charge their cell phones and laptops in their rooms overnight. Parents may complain that their children are up to the wee hours of the morning playing games or chatting with friends. Some parents may be unaware that their child is getting texts or calls during the night awakening them and interrupting their sleep.

   We can empower parents to take control of this behavior by instituting a curfew for these devices as well as a designated place for them to charge, such as a common room in the house or in the parent’s bedroom.

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2. Do you communicate with your friends on-line? Have you ever felt harassed, bullied, or teased by someone on-line?

Many children and teens do not understand that everything they post on the internet will live on as a digital footprint which may come back to haunt them years later, such as at a job or college admission interview. Children need to be taught where the appropriate boundaries are for on-line communication. In addition, cyber-bullying is increasingly common and can have devastating effects on the recipient.

Encourage parents to open an account on their children's social network site and “friend” them, so that they can monitor their virtual world and help them learn how to live in it safely.

3. How much time do you spend in front of a screen, such as a TV, computer, or smart phone a day?

According to the AAP, children and teens should not spend more than two hours a day in front of a screen and should get a minimum of one hour a day of physical activity.

Advise parents to set rules in their homes encouraging children to get their one hour of outdoor play or physical activity before they can use their two hours of screen time.
Update from the Resident and Young Hospitalist Subcommittee

Dr. Elena Aragona
Section on Hospital Medicine
Resident and Young Physician Subcommittee

The Resident and Young Hospitalist subcommittee of the AAP Section on Hospital Medicine distributed its first bi-annual newsletter in November 2011. The Pediatric Hospitalist Q&A column contains brief surveys completed by two pediatric hospitalists – one from a tertiary care center and one from a community hospital. The purpose of this section is to demonstrate to residents and young physicians interested in pediatric hospital medicine the breadth of clinical duties and non-clinical responsibilities that different hospitalist positions entail. Please see the excerpt below and visit the SOHM Residents and Young Hospitalists webpage for additional information at http://www2.aap.org/sections/hospcare/residents_subcomm/default.htm

Pediatric Hospitalist Q&A: Academic, Tertiary Care Hospitalist
Dr. Derek Justin Williams, MPH, MD

1. Where do you work and how long have you been there for? What type of hospital is this?
   Vanderbilt University School of Medicine and the Monroe Carell, Jr. Children’s Hospital at Vanderbilt. The Children's Hospital is a tertiary care academic medical center located in Nashville, TN. I have been here for 4 years.

2. A career as Pediatric Hospitalist encompasses a wide spectrum of possibilities (i.e., NICU coverage, ED shifts, teaching, administrative meetings). Can you please describe the different roles that you perform during a typical year?
   I spend the majority of my time engaged in research. I also spend several weeks per year attending on the hospital medicine inpatient services caring for patients and working with medical students and residents.

3. To display the variation of pediatric hospital medicine career duties, could you briefly list a few activities you have done today?
   My typical day usually involves several meetings and/or teleconferences, overseeing our research study teams, a bit of writing, and brainstorming for future projects. When I am on service, I spend the majority of my time in the hospital taking care of patients and teaching.

4. Why/How did you decide to become a Pediatric Hospitalist?
   I knew I was a generalist early during residency, and I enjoyed the inpatient setting much more than the clinics. This made hospital medicine the natural choice for me.

5. Did you have any additional training after residency before you became a Pediatric Hospitalist?
   I completed a fellowship in Academic General Pediatrics during which time I also obtained a Masters of Public Health degree.

6. Do you have a mentor? Why is this helpful? Advice on finding and working with a mentor?
   Yes. Mentorship is extremely important for residents, fellows, and junior faculty. Find a more senior individual at your institution with similar interests who has the time, willingness, and resources to serve in the mentorship role. Meet frequently and be prepared. I meet with my primary mentor one-on-one 3-4 times per month and a larger mentorship committee quarterly.

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cont. Update from the Resident and Young Hospitalist Subcommittee

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7. If you could tell residents one thing to do during their training to prepare for a hospital medicine career, it would be: Find a good mentor.

8. What are your opinions on completing a Pediatric Hospitalist fellowship? Is it necessary? Is it helpful? Others may find that this isn’t necessary for their chosen career path, but completing a fellowship was essential for my research career. Fellowship allowed me to obtain an advanced degree, "protected" my time to develop research skills, and build a research portfolio, and exposed me to a number of career development opportunities.

Pediatric Hospitalist Q&A - Community Hospital
Dr. Lindsay Fox, MD

1. Where do you work and how long have you been there for? What type of hospital is this?
MetroWest Medical Center; 2 years. Community Hospital affiliated with Tufts Medical Center

2. A career as Pediatric Hospitalist encompasses a wide spectrum of possibilities (i.e., NICU coverage, ED shifts, teaching, administrative meetings). Can you please describe the different roles that you perform during a typical year?
I cover the pediatric unit and normal newborn nursery at our hospital. I cross-cover the SCN (what is SCN?) overnight and weekends. I do consults in the ED. I attend administrative meetings including division meetings both at MWMC and Tufts, education meetings at MWMC, and GME/CME meetings at MWMC. I attend on the general pediatric floor at Tufts two weeks of the year including handling triage and transport phone calls from our affiliate hospitals 24/7 during that week.

3. To display the variation of pediatric hospital medicine career duties, could you briefly list a few activities you have done today?
We rounded as a team with the pediatric resident, transitional interns, and medical students. I performed an LP on a rule out sepsis admit from overnight. I spoke with one of our surgeons at Tufts about the care plan of an abdominal pain admit we had overnight. We then had student presentations for our daily conference. I received a phone call from the ED and helped facilitate transfer of a patient to Tufts for telemetry. I also received a phone call from a pediatric office and helped them track down the correct office for the paperwork that had mistakenly been sent to them. I called the pediatricians of all of the admits overnight. So far today, I haven’t had much time for administrative work, but this afternoon I intend to sign off on some dictations, finalize the teaching schedule I put together yesterday, and start filling out the student and intern evals that are due next week. If time, I will continue working on my presentation for Hospitalist CME that I put together last week, and I have several other research projects that I hope to get some work done on in the near future. I am also filling out this questionnaire.

4. Why/How did you decide to become a Pediatric Hospitalist?
We had an extensive pediatric hospitalist program where I trained. They did a variety of different things: Floor attending, ER shifts, Transport, Sedation, Newborn Nursery, satellite hospital work. I liked the idea of shift work, being able to leave my work at work, not have to flag phone calls from home all night, and getting paid for the time I put in which is not well-compensated in private practice. I enjoy taking care of sick kids and didn’t enjoy the “feared complaint” visits of primary care. I never found myself gravitating toward any particular subspecialty.

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cont. Update from the Resident and Young Hospitalist Subcommittee

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5. Did you have any additional training after residency before you became a Pediatric Hospitalist?
   Nope

6. Do you have a mentor? Why is this helpful? Advice on finding and working with a mentor?
   No specific named mentor, although I’ve been going to Priya Garg for input on how to get involved/improve on my skills as an educator. I am collaborating with one of the ED docs, Matt Trokel, on an educational grant which will be useful in that he is much more experienced in research that myself.

7. If you could tell residents one thing to do during their training to prepare for a hospital medicine career, it would be:
   Find out what different hospitals use their Hospitalists for and find a good fit. Decide how important it is to you to be involved in education. Find a program that will support your endeavors to further your career (emotionally, financially, and protected time).

8. What are you opinions on completing a Pediatric Hospitalist fellowship? Is it necessary? Is it helpful?
   Unsure. It would probably be helpful from the administrative perspective, especially if you had no chance at a QI project and have never been exposed to research. I felt most uncomfortable with billing at the start. The medicine part you know.

Members can find Plenty of Ways to get Involved in AAP Leadership

Carmelita Britton, MD, FAAP
Chairperson, Committee Forum Management Committee

Barbara Frankowski, MD, FAAP
Chairperson, Council Management Committee

Paul V. Williams, MD, FAAP
Chairperson, Section Forum Management Committee

The Academy thrives because of the dedication and leadership of its members, and it encourages pediatricians, especially our young physicians, to get involved in opportunities offered at the chapter and national levels. The time commitment can vary, and an AAP member can usually find an opportunity that fits their interest and commitment availability in chapters, councils, or sections. You do not have to be an expert to get involved in any of these groups, just be willing and interested in a specialty or topic.

Chapters are independently incorporated and are governed by an elected executive body, typically comprised of a president, vice president, secretary and treasurer. Chapters further the aims of the Academy while focusing on the needs and interests of their members. To address local priorities, chapters convene committees and encourage member participation.

At the national level, leadership and networking opportunities abound in councils, sections and committees. There are more than 50 councils and sections, which are comprised of members who are trained in a pediatric subspecialty or pediatric surgical specialty, or who are interested in a multidisciplinary area.

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Members can find Plenty of Ways to get Involved in AAP Leadership

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Council and section members play a vital role in educational programming, policy statement development and implementation, and advocacy. More than half of the AAP membership belongs to one or more of these groups.

Councils and sections are led by executive committees, which are elected by their respective membership and include a chair and typically five to 10 members. Each year, the Academy solicits input from chapters regarding nominations for open positions. Nominees must be AAP members in good standing and a member of the council or section in which they wish to be considered. This year, there were more than 100 vacancies on council and section executive committees.

Members of councils and sections can volunteer or be called upon to help the Executive Committee with educational activities at the NCE, writing policy statements, or assisting with advocacy efforts. These involvements can often become part of your curriculum vitae, and help with academic promotion. Even if you are not looking for promotion, involvement in these activities can increase your job satisfaction as you make meaningful contributions beyond your practice.

The first step is to attend a Chapter meeting, or look at the list of Sections and Councils and see if anything stimulates your interest. Joining a Chapter, Council, or Section does not obligate you to any activity to begin with, but offers an opportunity to see what the group is doing, and give you the opportunity to jump in if you want.

National committees serve as the experts who work to achieve AAP goals and objectives, and develop policy statements, clinical and technical reports, and manuals, such as the Red Book, Pediatric Nutrition Handbook and other resources.

The call for nominations for committee members is sent to all district and chapter officers, chapter executive directors, AAP leadership, and staff in November. Fellows in good standing are eligible for nomination and can be nominated by another Fellow or themselves. The committee chair and members are appointed by the AAP Board of Directors. If you have interest, experience, and expertise that you think would be of value to specific committees, be sure your chapter or district leaders are aware of this. They can help guide you through the process of becoming a nominee when the call for nominations is received.

Resources
Information about chapters, committees, councils, and sections is available on aap.org, on the right, under “Get Involved.”

Information about 2012-13 committee nominations and council and section elections can be found on the leadership website, lead@aap, at: http://www2.aap.org/moc/leader/ccs.cfm#Elections. Select “committees, councils, & sections,” then “appointments and elections.” For information about leadership opportunities on committees and councils, contact Cyndy Rouse at 800-433-9016, ext. 7938, or crouse@aap.org.

For information about section leadership opportunities, contact Carolyn Mensching at 800-433-9016, ext. 4079, or cmensching@aap.org.
Hands on Advocacy

“Your Message Moves Our Mission”

If you missed the 2011 AAP National Conference & Exhibition (AAP Experience) you can still take part in a unique photo project that began there.

Robert Fogarty, journalism major turned photographer, began the Dear World project in New Orleans with one simple premise — take a portrait to show a person’s face with their message.

Intrigued by this concept, we invited Robert to the 2011 conference to photograph our pediatricians and their messages to raise awareness for your work and the AAP mission, “Dedicated to the Health of All Children.” www.AAPexperience.org/DearWorld

We ask that you take a moment to reflect on your work and take part in this photo project. It’s a great way to express your views and requires no cost and very little time and effort.

It’s no coincidence the AAP Mission so closely aligns with the 2012 Pediatrics for the 21st Century pre-conference event and special programming track on child health equity/disparities. This topic is central to the Academy’s core values, vision and mission. We hope you and your colleagues advocate with a photo and message, and that you will join us at the 2012 AAP Experience in New Orleans, October 20-23. Mark your calendars (or hands) now to attend.

How To Make Your Dear World Photo

Step 1, Plan
Think before you write. What is most meaningful about your work in pediatrics? What are you doing, or need, to advance the physical, mental, and social well-being for all children? Be creative!

Step 2, Do
Write your message on your face, hands, arms, legs or feet (you may need assistance from a friend or co-worker). Choose a dry-erase marker certified AP Nontoxic conforms to ASTM D-4263. Marker can be removed from skin with an alcohol pad, baby wipe or soap and water.

Step 3, Act
Take your picture, check that your message is clear, then post your image on our Facebook wall at www.Facebook.com/AAPexperience or email it to NCE@aap.org.
Call for Abstracts

Submission deadline is April 13, 2012 for the AAP National Conference & Exhibition (NCE) in New Orleans, Louisiana.

Abstracts will be accepted for the following programs: Breastfeeding; Cardiology and Cardiac Surgery; Clinical Information Technology; Critical Care; Emergency Medicine; Foster Care, Adoption, and Kinship Care; Hospital Medicine; Injury, Violence & Poison Prevention; International Child Health; Medical Students, Residents, and Fellowship Trainees; Medicine-Pediatrics; Orthopaedics; Otolaryngology - Head and Neck Surgery; Pediatrics for the 21st Century (Peds-21) - Combating Health Care Disparities in Your Office and Community; Perinatal Pediatrics; School Health; Sports Medicine & Fitness; Surgery; Transport Medicine; and Urology.

For online submission, visit http://aap.confex.com/aap/2012/cfp.cgi. For more information, call 800-433-9016, ext. 4079, or e-mail abstracts@aap.org.

Pediatric Care Online™ Adds New Apps for iPad, Windows Phone

Pediatric Care Online™ is one integrated resource for expert help with your primary care information needs. Now new apps especially for the iPad and Windows Phone join those already available for iPhone/iPod Touch, Android, and PDAs. Access continually updated content and tools from the American Academy of Pediatrics, optimized online or via selected modules for download to your mobile device – all included as part of a Pediatric Care Online subscription.

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

For more information, visit www.pediatriccareonline.org or www.facebook.com/aappco.

Practical Pediatrics CME Courses are Practical for You

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

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

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

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

But don’t just take my word for it. See what your colleagues had to say about our most recent PPCs.

“The course was a concise update of some of the most recent changes in standards of care…a must for a busy practitioner. The scheduling allowed free time to refuel both professionally and personally.”
Damea Bourne Benton, MD; Hattiesburg, MS.

“The instructors were all excellent and entertaining. I always leave with pearls and improvements to my practices. I am always ‘better’ when I leave.”
Lucille E. Kanjer Larson, MD; Clinton, MA.

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

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

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

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

**Orlando, Florida**
March 23-25, 2012

**San Francisco, California**
April 20-22, 2012

The American Academy of Pediatrics (AAP) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

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

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The AAP designates each of these live activities for a maximum of 17.25 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Hilton Head Island, South Carolina**
May 24-26, 2012

**New York, New York**
May 25-27, 2012

**Las Vegas, Nevada**
August 31-September 2, 2012

**Marco Island, Florida**
November 9-11, 2012

**Chicago, Illinois**
December 7-9, 2012

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

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**PREP®: EM – An Intensive Review and Update of Pediatric Emergency Medicine**

*Denver, Colorado*
August 4-8, 2012

**Sheraton Downtown Denver Hotel**
Earn a Maximum of 33.25 *AMA PRA Category 1 Credits™*

*Sponsored by the American Academy of Pediatrics (AAP) and the AAP Section on Emergency Medicine.*

Whether you are preparing for the Subboard exam in pediatric emergency medicine or looking for a comprehensive update focused on pediatric medical and surgical emergencies, PREP®:EM is right for you.

**For the EM subspecialist**, this course will provide an intensive review of topics in pediatric emergency medicine that are identified by major subheadings on the American Board of Pediatrics Subspecialty Certifying Examination Content Outline developed by the Subboard of Pediatric Emergency Medicine.

**For general pediatricians, hospitalists, and other health care providers attending PREP:EM**, you will learn state-of-the-art pediatric emergency medicine, hear what is new from nationally recognized experts in the field of pediatric emergency medicine, explore alternative management strategies, and discuss interesting and controversial issues you encounter in daily practice.

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**cont. PREP®: EM – An Intensive Review and Update of Pediatric Emergency Medicine**

*Cont. from page 28*

This year’s schedule will feature case-based sessions and hot topics including:

- Pediatric and Neonatal Resuscitation
- Shock
- Sedation and Analgesia
- All elements of Pediatric Trauma
- Pediatric Infectious Diseases Emergencies
- Pediatric Toxicological Emergencies
- Visual diagnoses

Plan to join us this August in Denver for PREP®:EM and register by July 3, 2012 for Early Bird Rates! Register online at [www.pedialink.org](http://www.pedialink.org) or call 866/THE-AAP1 (866/843-2271).

Richard A. Saladino, MD, FAAP
Chairperson, PREP®:EM Planning Group

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The AAP designates this live activity for a maximum of 33.25 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.