Inside this issue:

“Life is not merely being alive, but being well.”

Marcus Valerius Martialis

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SOYP News

Volume 11, Issue 2

Summer 2011
Chair’s Welcome

Kelsey Logan, MD, FAAP
Chair, SOYP

As you can see, the SOYP members have been busy! The summer newsletter is packed with news and opinions from our membership. You’ll see that we have also been busy collaborating with other AAP sections and councils. We have had great success recently in partnering with them for newsletter exchanges, NCE planning, and finding areas where SOYP membership benefits can be enhanced.

You should know about two events that are ongoing or quickly upcoming. First, you all should have gotten an email about the fund drive the SOYP is having for American disaster relief, through Friends of Children. Many members and our patients have been affected by flooding and tornados in the Midwest and the South. We are challenging ourselves to raise $5000, but I know we can easily beat that! Please consider donating to this worthy effort. Make sure to note this is for disaster relief through SOYP when you donate. We are showing that even though we are young, we can really make a difference.

Secondly, we will have a conference call to pose questions to the AAP candidates for president soon. A date is being finalized in August for the call, and we want to hear from you on questions you would like answered. This is our second year of doing this, with help from the National Nominating Committee, and it is a great chance for us to get to know the candidates (and for them to understand what we need). We are partnering with the section for senior members this year on the call, and we anticipate a lively discussion.

Thanks for making the SOYP a wonderful resource for us all.

Editor’s Note

Aimee P. Vafaie, MD, FAAP
SOYP Newsletter Co-editor

Welcome to the Summer 2011 Ultra-Edition of the AAP SOYP Newsletter!

After a few months, I forget how compelling and interesting these newsletters can be. This may be my favorite yet! We have heart-warming insights on the joys of general pediatrics from our regularly featured contribution from the AAP Senior Section. We have inspiring stories about service to the underserved at home and abroad through articles on the Indian Health Service, Immigrant Health, and the 2010 disasters in Haiti. We have incredibly useful advice on practice management from SOAPM. The AAP and its sections, as always, have a lot of information for us about educational programs for practitioners and their patients, as well as upcoming conference and CME opportunities.

There is something in here for everyone. Take a moment to peruse the Table of Contents, and click to your favorite title. We hope you enjoy reading and learning from our colleagues and sections as much as I did.
Every spring, the American Academy of Pediatrics (AAP) holds the Annual Leadership Forum (ALF) where resolutions from any AAP member are discussed, voted on, and passed on to the Board of the AAP. All ten of your SOYP District Representatives join all of the chapter presidents and vice presidents, section, council and committee chairs, and other AAP leaders at the ALF. This year the SOYP submitted four resolutions, all of which passed and one of which made it to the “Top 10,” meaning that it goes directly to the AAP Board for consideration. The various relevant AAP Sections, councils and Committees follow up on the resolutions and SOYP will continue to support the authors in pushing their agendas forward.

These are the resolutions which the Section on Young Physicians brought to the ALF:

#9 (Cvijanovich) RESOLVED, that the Academy work with state and national education leaders to advocate for the development of age-appropriate school hours.

_The intent of this resolution is to focus on ideas such as a later school start time for adolescents._

#42 (Vo) RESOLVED, that the Academy develop educational materials for pediatricians and families regarding the value of organic foods in children.

_The intent of this resolution is to fill a gap for pediatricians as they teach families about nutrition. The Committee on Environmental Health has already contacted Dr. Vo to say that such materials are already being written._

#60 (Vo) RESOLVED, that the Academy’s National Nominating Committee consider changing the election calendar so that the candidates for President elect and other national elections are announced at the beginning of each summer before the district meetings and have the voting period commence during the National Conference and Exhibition.

_The intent of this resolution is to make the election process more meaningful to members and therefore increase the voter turnout for AAP elections. This resolution made it to the top 10. The AAP is working on the logistics of changing the election calendar, which will likely take at least 2 more years._

#65 (Choi) RESOLVED, that the Academy work within its present structure (the Council of Community Pediatrics) to establish an Immigrant Health Special Interest Group.

_The COCP is currently publishing a statement on Immigrant Health and will house a special interest group on the topic; the author of the resolution hopes one day to create a Section on Immigrant Health. (See the article in this newsletter to learn more!)_

The top 10 resolutions can be found on the AAP website at: [http://www.aap.org/moc/chapters/res2011.htm](http://www.aap.org/moc/chapters/res2011.htm)

All of the ALF resolutions came from AAP members who saw a need in some area in the practice of pediatrics, in advocacy for children, or in the operations of the AAP itself. Anyone can write a resolution. If you have an idea, let us know! Your District Representatives can help you write your resolution and get sponsorship both from the SOYP and your District. If you have any questions, please contact me at christinavomd@gmail.com.
Thank you to those of you who voted in the recent election for District IX Representative! Starting in October of this year, Tracy Zaslow, MD, FAAP will be your new SOYP District IX Representative. Tracy hails from Los Angeles and has already led her chapter in efforts such as a “Walk to School” program. She has seen how she can inspire young pediatricians to become community leaders and I hope that you will be inspired to get involved working with her through the next 3 years.

Meanwhile, I have become the District Representative to the Committee on Membership. We are working hard to bring the chapters and national AAP together to keep our organization strong. If you have ideas about how the AAP can better serve its members or if you need tools to help your friends or colleagues join the AAP or become more active, please let me know.

State Legislative Update

Thanks to all of you that participated in the April Legislative Day in Sacramento! It was the best attended Legislative Day yet. Two physician legislators went head to head answering questions from the AAP and California Medical Associates (CMA) attendees. We were surprised by the arrival of both Governor Brown and Lt. Governor Newsome. The various residency programs, especially Stanford University, University of California San Francisco (UCSF), UC Davis, and Children’s Hospital Los Angeles (CHLA) helped to prepare materials to give to legislators about bills of interest to the care of children. We have already heard about one success: Senator Dutton withdrew his bill to completely eliminate the First 5 program. Updates on other bills can be found on the AAP-CA website at www.aap-ca.org. For those of you who missed the program, be sure to look for it next spring!

Budget shortfalls continue to threaten the state’s children. Education has taken a huge hit. First 5 has been raided but, as mentioned above, no longer faces threat of elimination. Our state may be moving toward rolling all of the Healthy Families patients (SCHIP funded) into Medi-Cal. Luckily, many pediatricians have completed a survey regarding Healthy Families and Medi-Cal participation and legislators have listened! If there is a roll over it will likely occur in stages.

Finally, AAP-CA has signed on to an amicus brief by the American Diabetes Association stating that trained non-nurses be allowed to administer insulin in schools. AAP-CA does prefer school nurses to give insulin, but in current times when budget shortfalls make it impossible for school districts to maintain the number of nurses required to administer medications safely, other options such as personnel trained by nurses or other health professionals must be available. This stance is consistent with National AAP policy.

Questions or comments? Contact me at christinavomd@gmail.com.
District IV Update

Elizabeth H. Mack, MD, MS
District IV SOYP Representative

Membership: Recently we have worked with the national AAP Membership office to allow members to pay their dues in installments, as dues may be particularly hard to pay in a lump sum for those early in practice.

We are reconnecting with former national & chapter members whose memberships have lapsed in an attempt to regain them as members. We have established a Facebook site “SC Chapter of the American Academy of Pediatrics”--- come visit us and “like” our page! Or check out our online portal Young Peds Network at www.aap.org/ypn, where you can enter our YP Connection social networking site. We’ll update it with information relevant to your patients and practices.

We are working to be sure pediatricians AND pediatric subspecialists see the value of the AAP. Of course the AAP provides CME opportunities, the Red Book, and tools for practicing pediatricians, but perhaps its greatest value is its voice for children at the state and national level. Our state and federal affairs offices are full of highly qualified impressive people whose passion, like ours, is to advocate for kids.

Giving: At the AAP’s Annual Leadership Forum in March 2011, the Section on Young Physicians executive committee was recognized because 100% donated to the Friends of Children Fund. There’s no greater cause than to help children domestically or internationally, especially in this time of seemingly endless disasters affecting children worldwide. The AAP SOYP has most recently mounted a response for the victims of the tornados and flooding in the Midwest and South. Give in honor or in memory of someone...a loved one, a mentor, or a patient. Go to www.aap.org/donate/fcfdonate.htm

Advocacy: I had the opportunity to attend the AAP Legislative Conference in Washington, DC. This fabulous meeting provided the opportunity to learn how to advocate on a local, state, and national level. We had the opportunity to go straight to “the Hill” and meet with staffers in Senators Graham and Demint’s offices and Representative Clyburn’s office to discuss our issues relevant to pediatricians and children in our state. Our messages were short and sweet...keep Medicaid strong, preserve the Affordable Health Care Act (ACA), preserve Children's Hospital GME funding, but most of all “do no harm to kids.”

Expertise: We are establishing a database of YPs experts who would be willing to serve on special task force, speak for a local/state/regional/national conference, or serve as a liaison to another organization. Our national and chapter leaders are often looking for YPs to serve or speak and they would like more YP involvement. So if you’re interested or if you know someone who is, please contact me at emack@aap.net.

What’s next?
District II/District IV Meeting
June 23-26, 2011
Nashville, Tennessee

SCAAP Annual Meeting
July 21-24, 2011
Grove Park Inn Asheville, NC

AAP National Conference & Exhibition
October 15-18, 2011
Boston, MA

Want more info about the SOYP?
http://www.aap.org/sections/ypn/yp/
http://www.facebook.com/AAPSOYP
www.aap.org/sections/ypn/yp/aap_yp/youngphysiciansguide2008_FINAL.pdf


**Cont. District IV Update**

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**AAP lingo**

**SCAAP:** South Carolina Chapter of the American Academy of Pediatrics

**SOYP:** Section On Young Physicians

**SOMSRFT:** Section On Medical Students, Residents, Fellowship Trainees

**District:** Group of chapters (ex: SC, NC, VA, KY, TN make up District IV)

**Chapters:** Local AAP affiliate, usually a state, with the exception of California and New York which, due to size, have 4 and 3 chapters respectively (the chapters in each of these states come together to make a district (California—District IX and New York—District II))

**Section:** Group of AAP members who share a pediatric subspecialty, surgical specialty, special area of interest, or stage of life. Generally any AAP member can join a section for a nominal fee on the AAP Members Only Channel, and section leaders are elected by section members. To view a list of sections, go to: [www.aap.org/sections/shome.htm](http://www.aap.org/sections/shome.htm).

**Committee:** Group of AAP members who are appointed to work on a particular area of interest. To view a list of committees, go to [www.aap.org/visit/aapcomm.htm](http://www.aap.org/visit/aapcomm.htm).

**Council:** Councils generate policy, create educational programming and resources, develop and promote advocacy initiatives, support translation of policy and education into practice, and integrate and evaluate these efforts to maximize effect. For a list of councils, go to [www.aap.org/sections/shome.htm](http://www.aap.org/sections/shome.htm).

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~ WHAT’S ON YOUR MIND ~

**Work Life Balance**

*Christina Vo, MD, FAAP*

*SOYP Immediate Past Chair*

*District IX SOYP Representative*

Throughout the years I have been involved with the Section on Young Physicians (SOYP), I have heard over and over again that young pediatricians have a better sense of work-life balance than their senior colleagues. I have to dispel that myth because everything I have based my work-life balance on, I learned from my most senior partners: “family first, practice second, AAP and anything else third.”

So simple, yet this ranking of activities and, therefore, my own time management took quite a bit of practice on my part. Throughout medical school and residency, we are taught not to think about ourselves first. Patient care is of the utmost importance: every waking hour is spent making sure orders are written and carried out, labs are followed up, and in your free time, research is done to make sure that you are treating your patient in the optimum way. During my pediatrics rotation in medical school, I would get in my car by 4:30am in order to see all my patients, write my notes and talk to my senior resident BEFORE rounds started at 8:00am. I sat by the patient’s bedside to learn what the specialists had to say and talked to the parents to learn more about their experience in the hospital. I stayed late to learn what it was like to “be on call.” My husband says that year of inpatient rotations in medical school was the worst because even though he lived with me, he often didn’t see me. When I was home, I was exhausted.

During residency, 26 of us in a class took care of the hospital’s patients while trying to meet the various requirements to complete pediatrics residency. Our schedule was dictated by our chief residents. We tried our best to make trades if someone in the program had something important to attend such as a wedding. And the chiefs went crazy when six of us were pregnant in our third year (they thanked me for being due AFTER July 15). But who else in the world calls a Saturday and Sunday off a “golden weekend”? We lived for those golden weekends when we could sleep all day for one day then actually have an almost normal day off afterwards. The bonding this schedule created

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Cont. Work Life Balance

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made each of us acutely aware that missing one day of residency could have consequences for the rest of the program.

A few people in my residency had children. I do not know how they did it. To dedicate so much time and energy to the residency program must have meant a huge sacrifice for their families. I was married, but we didn't even think about having a family until the end of residency was in sight. And thank goodness my husband's mom lived nearby and he could have dinner with her once or twice each week! I am trying to think of what we ate when we ate together during those years, but I can only remember thinking that I deserved a serving of tater tots from the cafeteria after a long night on call.

And then one day, I finished residency. And I had a child. And I got a job. A great job, if I may say so, in a private practice with seven other pediatricians (we are a total of nine now). I threw myself into the practice, learning about the styles and personalities of the various doctors, getting to know the staff, and figuring out logistics about how the office runs. I laid awake at night worrying that I had forgotten to do something for my patients or that I had missed some major diagnosis in someone I had seen that week. When something came up that meant a lot to me at the time (I cannot remember what it was now!), I was so nervous about going to my partners to ask for the time off. It would be a big deal to take the day off, see if someone could cover, rearrange staffing, and have all of my patients re-scheduled. But my partners said, “of course, take the time you need.” That was the first time that I heard the phrase “family first, practice second, AAP and whatever else third.”

Now, I have to say that I was surprised. My observation of most of my partners at the time was that they were bonified work-aholics. Our practice schedule is rigorous; our bottom line is critical to daily decisions; and at the time we were going to the hospital to see patients both before and after work hours. My partners seemed to fit the stereotype of the “more seasoned” pediatrician who didn't know how to balance work and home life.

Since that first year in practice, I have learned more about my partners and I have learned to follow their guidelines in terms of priorities. My partners are all amazing physicians and they each have very different personalities and different interests. Dr. Oken is on the Board of almost every relevant physician management organization I know of, he goes pheasant hunting every year, and he loves spending time with his grandchildren. Dr. Abbott knows everyone at the AAP but also has time to watch every game, see the best shows in town, and travel the world with his family. Dr. Jones went to every one of her son's high school baseball games and now runs a Rett Syndrome Clinic at Children’s Hospital Oakland. Dr. Charles-Mo can out-compete Martha Stewart any day with her home grown roses and vegetables, her fabulous baking and her ability to entertain huge parties at her beautiful wine country home, including her son's wedding. And that’s just the docs over 50. I don’t think that the rest of us (five of us are 40 or under) could come up with such an array of outside of work activities.

I am working on it. Many of you know that I have done a lot of work with the AAP both locally and nationally. Now I am also more involved with my children’s schools, running the community service program at the elementary school and heading the Lunar New Year celebration at the preschool. I am a dedicated soccer mom. My kids expect to see me outside their classroom door after school or at the pre-school field trip. And I get to play with my kids every day. I am not good at organizing playdates, but the kids, my husband, and I always want to spend the time we have together.

The most amazing thing about doing all the things I do is teaching my children about the work in which I take pride. I checked my son’s ear at home and pulled out a huge piece of ear wax. My son was so excited: “Mommy, you ARE a real doctor!” he exclaimed.” Yes,” I got to tell him, “I get to take care of all the parts of kids’ bodies if they are hurt or sick.” After I attended the state legislative day, I told the kids about what I was doing there. Now they ask, “Mommy, are you going to make sure they don’t take any money from the kids again?” When I hear these things from my children, I am satisfied that my work and my life are balanced. And I thank my partners for teaching me how to make that possible.

*This article is being published in both the Section on Senior Members (SOSM) and Section on Young Physicians (SOYP) newsletters this summer.
Teen Suicide: How We Can Help
Joni Bhutra, MD, FAAP
Santa Clarita, California

During the upcoming holiday season, while we are all listening for the material items our children may want, I hope we also listen for the emotional support they may need. For our youth, life is complicated by academic, social, and family pressure. This generation also suffers from peer pressure, bullying, and peer rejection—not just in the lunchroom anymore, but 24 hours a day, through text messages, chat rooms, and social network websites.

No sign that our youth need our support and guidance speaks more to us than the fact that suicide is the third leading cause of death in the 10-24 year old age group. This means that suicide takes approximately 4500 youth lives each year. In Los Angeles alone, it is estimated that 300-400 children between these ages take their lives each year.

Deaths from youth suicide are only part of the problem. More young people survive suicide attempts than actually die. Each year, approximately 149,000 youth receive medical care for self-inflicted injuries at emergency departments across the United States. A nationwide survey of youth in grades 9-12 in public and private schools found that 15% of students reported seriously considering suicide, 11% reported creating a plan, and 7% reported trying to take their own life in the 12 months preceding the survey.

Suicide affects all youth, but some groups are at higher risk than others. Boys are more likely than girls to die from suicide. Of the reported suicides among our youth, 83% of the deaths were males and 17% were females. Cultural variations in suicide rates also exist, with Native American/Alaskan Native and Hispanic youth having the highest rates of suicide-related fatalities.

A special population to consider given the recent string of teen suicides is the gay and lesbian population. According to the Centers for Disease Control (CDC), youth suicide attempts in homosexual individuals are often associated with a history of childhood emotional disturbances. Most of these disturbances are associated with pressures both inside and outside the home—whether it is verbal abuse, physical abuse, or neglect—after gender atypical behavior. As mentors of our youth, we should provide the factual and emotional guidance to help all children become more comfortable in their own skin, and help alleviate emotional, societal and family problems often associated with childhood gender nonconformity.

Some factors that predispose youth to attempting suicide include a previous attempt, family history of suicide or mental illness, and any type of drug abuse. Moreover, we need to especially pay attention when a child’s personality changes dramatically, his schoolwork suffers dramatically, or he starts to use more dramatic language, “That’s the last straw,” “I can’t take it anymore,” or “Nobody cares about me.” Threatening to kill oneself precedes four out of five suicidal deaths.

If you suspect that a patient might be thinking about suicide, do not remain silent. Suicide is preventable, but we all must act quickly. If you are concerned about a teenager, discuss the available options and therapies including treatment for depression. According to one study, 75% of the people who commit suicide are having a major depressive episode.

Advise parents that if they suspect that a suicide attempt is imminent, they should seek professional help immediately and never leave their teen alone. They should talk to the teen about it and not be afraid to say the word “suicide.” Getting the word out in the open may help the patient believe that someone has heard his or her cry for help. Ask him or her to talk about her feelings. Listen carefully. Advise parents to not dismiss the teen’s problems or get angry. According to the CDC, 90% of suicidal teenagers felt their families did not understand them. This population also reported that when they tried to tell their parents about their feelings of unhappiness or failure, their point of view was denied or ignored.

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Cont. Teen Suicide: How We Can Help

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Take a child’s fears and threats seriously. Advise parents to remove objects that can be used as weapons from the home, including guns, pills, kitchen utensils and ropes. Most importantly, remind them to reassure their teen that they love him. Remind patients that no matter how awful problems seem, they can be worked out --- and you are willing to help.

If you need more resources, please visit the following: The US Department of Health and Human Services operates the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), www.suicidepreventionlifeline.org/, which can provide immediate attention and referrals to over 150 crisis centers across the country. In addition, The Trevor Project is an excellent organization that offers a suicide prevention hotline (Lifeline) at 1-866-4-U-TREVOR (1-866-488-7386) for gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youth. The Trevor Project also provides online support to young people through the organization’s web site, as well as lifesaving guidance and vital resources for educators and parents at www.thetrevorproject.org/lifelinechat.

Immigrant Health Special Interest Group:
a NEW Resource!
Ricky Y. Choi, MD, MPH
Pediatrics Department Head
Asian Health Services Community Health Center
Oakland, California

As an urban community health center pediatrician that cares for a primarily immigrant population, I searched for a home within the AAP that included pediatricians with similar interest and concerns. In my experience, immigrant children face unique challenges. They are more likely to be uninsured, live in poverty, have a parent who has limited English proficiency, and face significant barriers to accessing health care. The AAP produced a 1997 policy report on immigrant and refugee children which was updated in 2005 and 2010. Some Districts have engaged this issue at regional meetings.

I believe that more focused activity is needed that extends to the national level. Pediatricians who see immigrant children need further guidance on how to meet the complex and diverse needs of these communities. With 20% of children today living in an immigrant family and non-Hispanic white children representing less than half of all children by 2030, the challenges of taking care of immigrant children will impact all pediatricians. Immigration policy continues to hold national attention where the welfare of children are at the center of the debate or significantly impacted. Because 4 million children in the United States have undocumented parents, pediatricians are unavoidably drawn into this debate. Following passage of the 2010 immigration legislation in Arizona, there were reports of children forgoing needed specialist care out of fear that family members would be deported.

There are few voices speaking out about the impact of such policies on child health. Documented or otherwise, the best interest of the child is paramount for pediatricians. In the interest of expanding the AAP’s capacity around immigrant child health issues, colleagues and I submitted a resolution at the AAP Annual Leadership Forum (ALF) in December to create a Section on Immigrant Health. The outcome was the creation of an Immigrant Health Special Interest Group within the Council on Community Pediatrics (COCP). The goal of the Interest Group will be to generate discussion around these issues, supporting research, disseminate best practices, develop policy, and inform the Academy on the ways pediatricians can provide the best care for these vulnerable children.

Please contact us if you are interested in participating: Jean Davis, 800/433-9016 ext 4080, cocp@aap.org
Many young physicians go through residency with lots of questions lingering on their mind. “Do I go on to fellowship?” “Do I open my own practice?” “Do I join a practice?” “What am I going to do about all that debt?”

I finished my pediatric residency and signed up for a 4-year commitment to the Indian Health Services (IHS). I had grown up in the IHS system, but as a patient, not a physician. I really didn't know what to expect as a physician in the IHS, but I did know that I wanted to make an impact. Wow! The shock of my life was not how much different the IHS system was compared to what I was used to, it was how much better it was. Clinic is clinic, and in-patient is in-patient, but the intangibles were staggering. I found a team approach to medicine. I found pharmacists working with doctors, who at the same time were working with administration to improve the lives of those around them! Working for IHS allowed me the opportunity to practice pediatrics the way I wanted: patient oriented.

Many new graduates are not familiar with what the Indian Health Services has to offer. Many ask the question, “Why would I consider IHS?” Let me ask you, “Why not?”

The Indian Health Service consists of over 670 IHS and tribal health care facilities scattered throughout 36 states. Their locations vary from rural to urban, from Cherokee, North Carolina to Anchorage, Alaska. Other than the wonderful possibility of seeing some of the most beautiful terrain in the US, you also get the opportunity to care for some of the most beautiful people. The cultural diversity in the Indian Health Service is one of its most unique attributes. From the various dances and ceremonies to the warm hospitality, the people for whom the IHS cares are truly fascinating and compassionate individuals.

Whatever stigma you may associate with the IHS, I advise you to reconsider it. Most of our colleagues know someone that served in the IHS. The stories that I have heard from physicians that had worked in or continue to serve the Native communities are fascinating and inspiring to say the least. Many retired pediatricians actually return to the IHS to do locum tenems in underserved clinics and hospitals because of their past experiences.

As for payback, a large number of sites offer loan repayment for medical school debt or J1 waivers. A competitive salary AND loan repayment?! I was sold.

My time with the Indian Health Services made me a better physician, a better individual, and gave me memories that I will cherish always. I wish that everyone could experience the pure joy of being a pediatrician that I felt during my time with the IHS. For more information regarding the Indian Health Service, visit their website at http://www.ihs.gov/.
Children and Disasters: We Each Can Make a Difference

Oneka Bynoe, DO, MPH
Pediatric Resident, PGY-3
Chief Pediatric Resident 2011-2012
Palms West Hospital, FL

The 2010 earthquake in Haiti was the disaster heard around the world. Within just a few days of the tragedy, the world mobilized and mounted one of the largest global humanitarian relief efforts ever seen. A very diverse group of volunteers responded and each one of them brought their own unique skills, personnel and resources. Among the responders, there were residents and young physicians who dedicated their time for the people of Haiti. For many, this was their first major disaster and mass casualty event. It proved to be both physically and mentally challenging, and called upon unknown strengths and resources of the individuals. It was an overwhelming, life changing and humbling experience that gave an opportunity to truly make a difference.

Over the last century, and especially within the last 10 years, “disasters” (both natural and man-made) have become a common household term. On the state, local, national, and international levels, disaster preparedness has become a priority issue for many professional and governmental organizations. Of note, pediatric concerns during disasters and emergency preparedness have gained considerable recognition as priority issues. In the final report of the National Commission on Children and Disasters, submitted in 2010, the unique needs of children during disasters was highlighted and explored. They also identified a number of areas for improvement in pediatric emergency preparedness. One of these areas was focused on the need for federally qualified pediatricians and pediatric sub-specialists to staff disaster response teams in case of emergency. The willingness on the part of these pediatric practitioners is important. However, experience and training in federal disaster response techniques is also crucial to ensure safety and efficiency during relief efforts. Since the aftermath of the rescue efforts following the Haiti earthquake, the American Academy of Pediatrics, in collaboration with the National Disaster Medical System and the National Association for Children’s Hospitals and Related Institutions, has explored several avenues to address how to rapidly “federalize” physicians. Ongoing efforts continue to be made in this area.

Young pediatric physicians, sub-specialty fellows, and residents represent a vital workforce that can be prepared now in efforts to supplement future pediatric disaster response teams. Opportunities to become involved abound, and it all starts at home. Good ways to start include getting involved in one’s local hospital emergency preparedness team, practice, and community. Local and state public health departments are often looking for pediatric specialist to provide expert input during their emergency planning efforts. In addition, residency programs can provide didactic series introducing residents to basic disaster response concepts. As we tackle the floods in the South and move forward into the hurricane season let us all take up the gauntlet of responsibility and prepare ourselves, our patients, and our communities to care for the most vulnerable amongst us. We each can truly make a difference!

For resources and many more ideas for getting involved visit the AAP’s Children and Disasters website, see: http://www.aap.org/disasters/index.cfm.

Dr. Bynoe and a patient in Haiti after the earthquakes.
Proton Pump Inhibitors Should be Restricted for Management of Symptomatic GERD in Patients Less Than 1 Year of Age

Andrew E. Mulberg, MD, FAAP, CPI
Hari Cheryl Sachs, MD, FAAP
Division of Gastroenterology and Inborn Errors Products
Pediatric and Maternal Health Staff
Food and Drug Administration

*The recommendations in this review are those of the authors and do not represent the views of the US Food and Drug Administration.

Acid reducers, including proton pump inhibitors (PPIs), are used frequently by the general pediatrician for the management of the infant with symptoms suggesting the diagnosis of gastroesophageal reflux disease (GERD) such as crying, irritability, arching and regurgitation. According to the Medco 2010 Drug Trend Report, http://www.drugtrend.com/art/drug_trend/pdf/DT_Report_2010.pdf the use of proton pump inhibitors increased by 147 percent from 2001 to 2009 in children (1). The prevalence of use in the pediatric patients less than 1 year and the failure of four Phase 3 clinical trials to demonstrate efficacy of proton-pump inhibitors (PPIs) in this age group was the topic of the FDA Gastrointestinal Drugs Advisory Committee (GIDAC) on Nov 5, 2010 (2). The Committee discussed results from clinical trials of esomeprazole, lansoprazole, pantoprazole and omeprazole to treat GERD in patients between 1 month to 12 months of age, performed in response to a Pediatric Written Request under the Best Pharmaceuticals for Children Act (Nexium, esomeprazole by AstraZeneca LP; Prevacid, lansoprazole by Takeda Pharmaceuticals North America, Inc; Protonix, pantoprazole by Pfizer, Inc.) or as part of a Pediatric Research Equity Act (PREA) requirement (Prilosec, omeprazole by AstraZeneca LP). The design and results of these trials are summarized in the table below. The pathophysiology of GERD, its diagnosis and management, and issues related to the design of clinical trials in this age group were considered.

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cont. Proton Pump Inhibitors Should be Restricted for Management of Symptomatic GERD in Patients Less Than 1 Year of Age

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The lack of efficacy of PPI’s in these trials in improving GERD symptoms presumed to be acid related in infants supports a previously published expert opinion, which does not recommend the use of PPI’s to treat GERD in infants without justification of clinical need based on confirmation of acid related disease. According to 2009 guidelines (3) from NASPGHAN/ESPGHAN, the US and EU-based consortium of pediatric gastroenterologists there is no evidence to support an empiric trial of acid suppression as a diagnostic test in infants and young children where symptoms suggestive of GERD are less specific.

The management of infants with GERD is complicated by challenges in diagnosis. Routine use of pH measurements of acid exposure do not appear to be sufficient for confirmation of a GERD diagnosis (4). Novel techniques to assess the correlation of signs and symptoms presumed to be related to GERD with acid exposure have also provided inconsistent results. Vandenplas and colleagues have recently used multiple intraluminal esophageal impedance recording with pH-monitoring (MII-pH) to detect all episodes of gastroesophageal reflux (GER) (5). These newer data further strengthen the lack of association of acid reflux to commonly reported signs and symptoms of infant GERD.

The Gastrointestinal Drug Advisory Committee (GIDAC) concluded that the pathophysiology of symptomatic GERD in infants differs from adults. In contrast, erosive esophagitis is known to be acid-mediated, and therefore extrapolation to adult disease can be accepted. In light of the ability to extrapolate in erosive esophagitis, the Committee supported reliance on pharmacokinetic, pharmacodynamic and safety studies in studies of PPIs for treatment of erosive esophagitis in infants. These recommendations did not apply to premature infants and neonates.

<table>
<thead>
<tr>
<th>Study Feature</th>
<th>Esomeprazole (NEXIUM®)</th>
<th>Lansoprazole (PREVACID®)</th>
<th>Pantoprazole (PROTONIX®)</th>
<th>Omeprazole (PRILOSEC®)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsor</td>
<td>AstraZeneca</td>
<td>Takeda</td>
<td>Takeda</td>
<td>AstraZeneca</td>
</tr>
<tr>
<td>Number of Patients/Group</td>
<td>40</td>
<td>80</td>
<td>50</td>
<td>35</td>
</tr>
<tr>
<td>Study Design*</td>
<td>R,DB,PC,W</td>
<td>R,DB,PC</td>
<td>R,DB,PC,W</td>
<td>R,SB (3 active dose groups)</td>
</tr>
<tr>
<td>Duration of Assessment</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Primary Endpoint</td>
<td>Time to withdrawal for GERD worsening</td>
<td>Difference in Response Rates</td>
<td>Difference in GERD worsening Rates</td>
<td>Change in daily vomiting frequency</td>
</tr>
<tr>
<td>Primary Efficacy Result</td>
<td>No significant difference</td>
<td>No significant difference</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Statistical method</td>
<td>Hazard Ratio=0.69 (p=0.275)</td>
<td>d=0.0 % (p=1.000)</td>
<td>d=1.0 % (p=1.000)</td>
<td>ANCOVA: All pairwise p&gt;0.50</td>
</tr>
</tbody>
</table>

R=randomized; DB=double-blind; SB=single-blind; PC=placebo-control; W=randomized PPI withdrawal; WD=withdrawal for GERD worsening

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cont. Proton Pump Inhibitors Should be Restricted for Management of Symptomatic GERD in Patients Less Than 1 Year of Age

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The Committee also discussed a need for further studies of PPIs in children with cystic fibrosis, underlying neurological disease, and congenital esophageal lesions without erosive esophageal disease, and possibly in peptic ulcer disease, airway disease, and *Helicobacter pylori*. With respect to study design, the Committee supported use of randomized, placebo-controlled designs in which all patients are also treated with concomitant conservative GERD measures, but disagreed with PPI withdrawal designs to assess efficacy in children less than 12 months of age.

Although PPI’s have been used for more than a decade to manage presumed acid related signs and symptoms in infants, there was a strong consensus from the Advisory Committee that these clinical trial data call into question this practice. Accordingly, in clinical practice, the use of PPI’s in infants less than 1 year of age should be limited to management of acid related erosive esophagitis. Continued treatment of infants with PPI’s for symptoms of GERD is not recommended based on these new data and publications. Further education of the general pediatric, family medicine and Pediatric Gastroenterology community is strongly recommended to modify the current practice.

References

2. [http://www.fda.gov/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/GastrointestinalDrugsAdvisoryCommittee/ucm195280.htm](http://www.fda.gov/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/GastrointestinalDrugsAdvisoryCommittee/ucm195280.htm).
Careers for Pediatricians in Industry: A Largely Unknown Alternative

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For many physicians-in-training, the concept of a career not involving direct patient care is rarely discussed. Sure, there are the stories of medical students and residents who go on to develop wonderful careers in areas outside of clinical medicine, such as research or law, but these are often the exception rather than the rule. During our training, most folks knew that the pizza and pens came from the promotional efforts of pharmaceutical companies, but few, if any, were aware of the work being done by bright, hard-working and dedicated physicians in industry.

Similar to the multiple career paths available to practicing physicians, there are many diverse and gratifying options for pediatricians outside of the traditional practice setting. To keep this article focused, we will discuss only careers in the pharmaceutical or biotechnology industry, but pediatricians should know there are many other options such as in health insurance and regulatory agencies (e.g., FDA). Perhaps the easiest way to grasp the spectrum of career choices in industry is to understand the drug development process. Typically, discovery chemists and biologists (basic science researchers) begin the process by selecting a receptor target, chemical, large molecule or antigens (e.g., vaccines) that have the potential to impact a disease state and are often advised during this process by physicians on the clinical aspects of the compound and program.

After significant preclinical testing, a promising candidate compound may enter the clinical trial stages of testing in humans. A pediatrician ushering this product through these various stages would be working in fields such as clinical development or patient safety. These physicians would use their clinical knowledge in addition to a host of other skills to design and implement clinical studies to test a drug’s safety and efficacy. If the FDA or other global regulatory agency approves the product in question, a pediatrician working in Medical Affairs or Scientific Affairs now takes over as the medical expert on that product. Some pediatricians working in this area might be based at the company headquarters and oversee postmarketing safety studies, interact with key physicians working in the therapeutic area or educate the community physicians on the medical aspects of the product. Other pediatricians, often called medical science liaisons, might be field-based and act as the medical “ambassador” for the product to physicians, researchers and insurance companies in a designated geographic area. While there are certainly other areas within industry for physicians, clinical development, safety and medical affairs are some of the more common roles. Pediatricians in industry can work with drugs or biologics for adult use and are the experts for their use in pediatric patients.

The timing is excellent for pediatricians in industry as every drug developed in the clinical space must be considered for use in children.

Regardless of the position, there are numerous advantages to working within industry compared to working in a clinical setting. Intellectually, an industry career is incredibly stimulating and offers opportunities to acquire new skills. Your work might allow you to become more proficient in public speaking or enhance your knowledge of biostatistics and epidemiology. You may have the opportunity to specialize in certain therapeutic areas or hone select skills like clinical trial
cont. Careers for Pediatricians in Industry: A Largely Unknown Alternative

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design and medical writing. You will likely travel to national or international scientific meetings and have the opportunity to interact with leaders in the field. In addition, working in industry provides you a career path in which your growth in the company or therapeutic area is only limited by your interest, effort, and the skills and knowledge you acquire. Rather than treating individual patients, many of us working in industry, feel that our work is improving the health and well-being of millions of children around the world through the discovery, development and translation of new medicines, devices and vaccines into practice.

While salaries in both clinical practice and industry are variable and beyond the scope of this article, there are a variety of human resource perks that may not be available in the practice setting (without raising the blood pressure of your partners). For example, many companies offer sick days (for your own recovery from illness, sick children, doctor’s visits, etc.), flexible work schedules, telecommuting options, tuition reimbursement plans, continuing education plans, and onsite gyms and daycares. In short, many companies are excellent employers and may treat you better than you treat yourself in the practice setting.

Despite the numerous positive aspects of a career in industry, there are some limitations. First, and probably foremost for many, is the lack of patient contact. Depending on your personality and interests, this issue may or may not be a negative of working in industry. Many industry pediatricians find creative and impactful ways to remain clinically active if so desired. Working in a large (or for that matter even a small) company can also result in a decent-sized serving of corporate politics and reporting structure. However, this experience may not be all that unfamiliar to those in academia or a group practice. Pediatricians in industry often find themselves “constantly connected” and working long hours. While the emergencies and urgencies are certainly different, the time and effort committed to the job are probably similar to our clinical counterparts with perhaps a bit more flexibility. Fortunately, we both have had positive experiences in regards to each of these limitations.

Ultimately, a career in industry can be an incredibly rewarding alternative to clinical practice. The options and growth opportunities are quite diverse for the pediatrician interested in bringing new medicines, devices and vaccines to patients. Unfortunately, these important career alternatives are largely unknown to physicians in and just out of training. We hope that the new Provisional Section on Advances in Therapeutics and Technology (P-SATT) will help to increase awareness of these options as well as improve education and collaboration among physicians to bring medical advances to children.

About The Provisional Section on Advances in Therapeutics and Technology (P-SATT)

P-SATT was launched in July 2010 with a mission to advance pediatric health and well-being through collaboration, communication and education on the discovery and development of therapeutics and technology and their successful translation into practice. P-SATT’s diverse membership includes pediatricians working in industry, the Food and Drug Administration, clinical practice and other organizations.

If you would like to know more about our section or careers in industry, please feel free to contact either of us via the email addresses listed earlier in this article. AAP members may join P-SATT by clicking this link, http://www.aap.org/moc/memberservices/sectionform.cfm, logging in as an AAP member, checking the box for “Advances in Therapeutics and Technology,” and completing the remainder of the form.
Children’s Cabinets and Other Related State Governance Entities

AAP Division of State Government Affairs

Children’s cabinets and other related state governance entities perform an array of functions that seek to improve the health and well-being of children. These entities act as policy advisors to governors, state legislatures, and other key state decision makers; develop and implement improvement plans for state services; set child health and well-being goals and monitor outcomes; advocate for access to state services; and fulfill many other roles concerned with improving the well-being of children. These governance entities can focus on a specific issue, such as early childhood, but more often focus on a broad number of issues affecting children.

As children’s cabinets and other related state governance entities are well established in numerous states, many state AAP chapters are directly involved with their respective state governance entities. The first, best step for pediatricians who want to impact child health and pediatric practice issues is to be active members of their state AAP chapters and engage in chapter-level advocacy efforts.

Two examples of chapter involvement include M. Alex Geertsma, MD, FAAP, who is the chairperson of the Connecticut Commission on Children and Youth and Chad Rodgers, MD, FAAP, president of the Arkansas AAP Chapter and a member of the state’s Early Childhood Commission.

During the 2011 state legislative sessions, a number of bills have been introduced concerning children’s cabinets and other related state governance entities. In California, legislation was introduced to create a state children’s cabinet while the governor’s latest budget proposal seeks to eliminate the state’s early learning advisory committee. Lawmakers in New Mexico introduced a measure that would have repealed the state’s children’s cabinet. The New Mexico AAP Chapter opposed the measure in their state and it was defeated. Tennessee passed legislation extending the state’s Commission on Children and Youth’s sunset date from June 30, 2011 to June 30, 2015. In addition, both the Georgia AAP Chapter and Missouri AAP Chapter are currently advocating for the creation of children’s cabinets via legislation in their states.

New Mexico and Oregon both introduced legislation to create their federally mandated state early childhood advisory councils, responsible for coordinating statewide early childhood services. The legislation in New Mexico was signed into law by the governor in April while the legislation in Oregon is still being debated.

For more information on children’s cabinets and other related state governance entities, see the AAP Division of State Government Affairs resource on the subject at www.aap.org/moc/loadsecure.cfm/stgovaffairs/StateChildrensCabinetsandGovernanceEntities.pdf (Log in required)

Advocacy Support from the AAP Committee on State Government Affairs (COSGA) and the AAP Division of State Government Affairs

To address this issue, along with others, the AAP Committee on State Government Affairs (COSGA) and the AAP Division of State Government Affairs provide consultation and strategic guidance to AAP chapters, members, and other AAP entities working with chapters engaging in state advocacy efforts on issues impacting pediatricians and children.

COSGA and the Division of State Government Affairs work closely with AAP committees, councils, sections, task forces, and the Board of Directors to analyze state public policy issues and provide strategies for addressing them to better inform and guide state chapters in their advocacy work.

One Voice
By working with and through your state AAP chapter, members of the Section on Young Physicians can...
Cont. Children’s Cabinets and Other Related State Governance Entities

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take full advantage of the resources and information available from the AAP, the state chapter, and its coalition partners.

In addition, active chapter participation ensures that all pediatricians in your state will be using consistent information and messages about pediatric advocacy issues. By speaking with one voice, pediatricians not only bolster their strength in numbers, but maximize their credibility with those they seek to influence. Your knowledge, perspective, and expertise will greatly enhance the effectiveness and reach of your state chapter.

We Need You!
To learn more about the AAP chapter in your state and to obtain chapter contact information, please visit www.aap.org/member/chapters/chapserv.htm, or contact the AAP Division of Chapter and District Relations at 800.433.9016, extension 7649.

For More Information
Please contact the Division of State Government Affairs at stgov@aap.org or 847.434.7799 for the latest information on pediatric advocacy in the states, to receive technical assistance on state level advocacy, and for strategic guidance on coordination of state advocacy efforts with AAP chapters.

Issue Brief: Does Fellowship Pay?
Division of Workforce and Medical Education Policy

In the February 2011 issue of Pediatrics, Drs. Jonathan Rochlin and Harold Simon published the results of their study which pediatric subspecialties generate positive financial returns when compared to those generated by a practicing general pediatrician (Rochlin JM, Simon HK. Pediatrics. 2011; 127:254-260). Of eleven subspecialties reviewed, only three (cardiology, critical care, and neonatology) were equated with positive financial returns. The remaining eight subspecialties (emergency medicine, gastroenterology, pulmonary, hematology/oncology, rheumatology, nephrology, endocrinology, and infectious disease) were associated with negative financial returns.

In order to put these sobering findings into perspective—especially in light of the devastating shortages that exist in many pediatric subspecialties and surgical specialties, and the complete elimination of funding for children’s hospital graduate medical education (CHGME) in President Obama’s currently proposed Fiscal Year 2012 budget—staff in the Division of Workforce and Medical Education Policy worked with AAP President O. Marion Burton, MD, FAAP, on a commentary which highlights the importance of advocating for more money for pediatric fellowship training. The commentary also urges full funding of the pediatric subspecialty loan-repayment program authorized (but not appropriated) under the Affordable Care Act, maintains the Academy’s call for payment parity with adult medicine, and insists that Medicaid reimbursements be at least equal with Medicare. Dr. Burton further acknowledges that there are many reasons why individuals choose to pursue subspecialty training, and applauds those pediatricians, pediatric subspecialists, and pediatric surgical specialists who choose their careers based on great personal interest and a genuine desire to improve the health of the nation’s youngest patients.

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Cont. Issue Brief: Does Fellowship Pay?

Pediatric workforce issues will only become more important as the remaining pieces of the Affordable Care Act (ACA) are implemented in the upcoming months and years, and the pediatric workforce community is concerned that many of the ACA’s primary care initiatives are adult-medicine focused. We need your help to ensure that the public does not forget about the specific health needs of children and the importance of providing pediatricians to care for them.

Consider using your voice to:

- Write a letter to the editor of your local newspaper, insisting that the federal government fully fund CHGME in its FY 2012 budget.
- Call your Representatives and Senators, and explain to them why it is important to appropriate funding for the approved pediatric subspecialty loan-repayment program.
  Participate in an AAP legislative advocacy day on the Hill, or e-mail kids1st@aap.org to become a Key Contact and receive timely e-mails with legislative updates and requests for action.

For more information, contact Carrie Radabaugh, MPP, Senior Health Policy Analyst at Division of Workforce and Medical Education Policy at cradabaugh@aap.org.

Pediatric Hospitalist Mentorship Opportunity

Elena Aragona, MD
Tufts PGY-3

This year the Pediatric Section on Hospital Medicine launched a Mentorship program in an effort to provide young physicians with valuable advice. Goals of the program are to increase awareness of the different types of pediatric hospitalist positions, to develop a network of practicing veterans who will act as mentors to young careerists, and to prepare residents for a future in hospitalist medicine. We also hope to be a resource for ideas and conferences.

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

Additional information can be found at our SOHM Mentorship website: http://www.aap.org/sections/hospcare/residents_subcomm/residents-mentorship.htm or you can email earagona13@gmail.com for more information.
From SOAPM:
Seth Toback, MD, FAAP and Betsy Peterson, MD, FAAP
SOAPM Membership co-chairs

I am sure the SOYP newsletter readers are quite familiar with SOAPM from our many contributions to your newsletter in the past. SOAPM is currently the 7th largest section with just over 1,000 members. Yet you may not know that we are in the middle of our first ever Free One Year Membership Drive and Competition which is specifically geared to recruiting young pediatricians.

The free membership is simple; any AAP fellow who is not a current SOAPM member may join the section for free. This offer began March 1, 2011 and will last for one year. The contest part of this membership drive involves current SOAPM members and you the SOYP. The first 30 young physicians to join SOAPM will receive a fabulous, custom SOAPM t-shirt, complete with AAP logo and SOAPM tagline "The curbside consult on practice management"! The top current SOAPM member "recruiters" will receive a shirt a well.

So what are you waiting for? Now is the time to try all the benefits of SOAPM for free!! https://www.formrouter.net/forms01@AAPED/SOAPM.html

From Practice Management Online:
Buddy Shenkin, MD, FAAP

Managing Staff

Once employees have been hired, you must manage them. You do not want loose cannons, but you also do not want unimaginative drones. You do not want to micromanage your staff, dotting their i’s and crossing their t’s, but you also do not want them going forward with a blank slate. So how do you simultaneously trust and guide?

First of all, determine if you should be doing the job of practice administration. The debilitating conceit of practicing physicians is thinking that administration is only pushing paper and that practicing medicine directly with patients is the only respectable pursuit of a physician. If this is your belief, and you don’t find running a practice or practicing administration to be challenging and rewarding, you should not be the one doing it. If you find yourself not tending to your administrative job, consider hiring a practice administrator. Read “Factors to Consider When Hiring an Administrator: A Practice Management FAQ” for more information.

To run a practice, you need to have regularly scheduled meetings with key staff. Be sure to take them seriously. Do not be late for them—that is disrespectful; and do not hurry off to do your “real job” of taking care of patients. When conducting the meeting, follow an agenda, and include follow-up of issues from previous meetings. Each topic should have an action item with progress documented. Try to distinguish what is urgent from what is important. Urgent tasks tend to drive out important ones. However, it is crucial to remain aware of the important tasks; otherwise they will languish and you will not make real progress.

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How Do You Keep Track Without Micromanaging?

Although much contact between levels of management will inevitably be oral, important things need to be written down and saved. Some practices have many different practice locations, each one with an office manager. Consider requesting that the office manager complete a weekly report due on the same day each week. Use a standard template for the report with standard items to complete. Color code each week’s comments so that it is easy to see new editions. Leadership can then respond to these reports with comments within 24 hours. The comments may or may not be substantive, but the reports always need to be acknowledged. The templates also need to be simple enough so that they are not oppressive. Besides helping the upper levels of administration keep track of local events, these reports can serve as a to-do list and help the office manager think about goals and priorities. Click here for a sample.

A second type of report is called a management action plan. This report can be used by a business manager, clinical office manager, IT manager, and others. It is similar to the office manager report but more variable and detailed. This is used as a guide for meetings to track progress and keep objectives in mind. Click here for a sample.

Setting Office Policies

The importance of having clear policies in place for the practice cannot be emphasized enough. Just as with patients, documentation is critical. For example, if the practice does not have a written policy and procedure for addressing tardiness, supervisors can become increasingly frustrated with no guidance or support to address an employee who consistently arrives late for work.

Practices should have policies that address a variety of different areas. Policies should address not only the functional issue but also the consequences and procedures in the event the policy is not followed. Each policy should identify the appropriate staff person to address questions or concerns related to a policy. Likewise, there should also be a policy about the process for creating policies and procedures. It should delineate who has the authority to write, approve, and terminate policies. A standard format for policies can also be helpful, if appropriate.

Some common policies and procedures found in the pediatric practice setting are:

- General employee handbook that address personnel issues and office operations (e.g., time off, schedules)
- Privacy manuals (e.g., “HIPAA: A How-To Guide for Your Medical Practice” “Preparing Your Practice for the “Red Flag Rules”)

Staff should be alerted immediately if policies are changed or introduced. To keep staff familiar with existing policy, consider reviewing a policy at each staff meeting or regularly posting one policy in a common area (e.g., lunchroom, locker area) for staff to review. Consider requiring all staff to have received and reviewed the employee handbook to ensure that they are aware of the policies.
Come Join SOAPM at the NCE!

You depend on your section to keep you abreast of relevant developments in clinical care. Don't neglect to care for your PRACTICE itself. Depend on the Section on Administration and Practice Management (SOAPM) to keep you current on practice management issues and trends, from billing and collection ideas to insurance company issues.

Come join us for our section session at the NCE on PEDIATRIC PRACTICES IN EVOLUTION on Saturday, October 12 from 8 am - 2 pm. Topics to be covered include the patient-centered Medical Home, the concierge model for pediatric practice, alternative payment models and the effect of health care reform on pediatrics.

On Saturday evening, come meet with other SOAPM members at our section cocktail party, at 5:30 pm. We are always willing and anxious to share what we have learned with new members, and learn from them as well.

And, for a limited time you can join SOAPM with NO INCREASE in your AAP dues! Go to https://www.formrouter.net/forms01@AAPED/SOAPM.html

For additional information, please email Section Manager, Trisha Calabrese at tcalabrese@aap.org.
Practicing Medicine is a Good Thing To Do

Michael J O’Halloran, MD, FAAP

In the current discussion about problems with our health care system, the chatter among us physicians often is focused on the negative. This is a brief note about some of the positive aspects of practicing medicine which we sometimes forget.

I speak as a physician whose medical career spanned nearly 35 years and who has been retired for almost 10 years. I practiced 30 of those years as a pediatrician in a large multispecialty group in northern Wisconsin. The welfare of children, the discipline of pediatrics, the well-being of my colleagues, and medicine in general continue to be an integral part of my life.

So what’s good about practicing medicine in this ever more complex world of paperwork and diminished incomes? I suppose there are lots of ways to answer this but here are some ideas.

One day, about 20 years ago, while sitting in the hospital coffee room, I was once again witnessing, and sometimes participating in, the ongoing conversation bemoaning the changes in the practice of medicine. We were traveling a much used path. You know the drill; paperwork obligations, problems associated with electronic medical records, call schedule, reimbursement, too many government regulations, too few government regulations, work load impacting family time, influence of administrators, … etc. Then, in a moment of silence, a respected friend and colleague quietly said, “Being a doctor is a good thing to do with ones life.” Such a simple comment but it was interesting how that changed the conversation, at least for the moment. For me it expressed something that has been a part of me since one summer day almost 60 years ago when my mother casually asked me, her almost 11-year-old eldest child, whether I thought I would like to be a doctor.

After 35 years practicing medicine and 30 years as a pediatrician, I’ve belatedly come to realize the importance of organized advocacy, and how advocacy is an essential feature of our lifelong dedication to the welfare of children. The American Academy of Pediatrics is an example of this. We know that the number of members represented by an organization is a principal determinant of the clout that it has with policy makers. The AAP currently has about 60,000 members so that anyone proposing policies involving children needs to consult with, or at least deal with, the AAP. Participation in that advocacy clout is sufficient reason for us all to belong to the AAP. It is another amazing opportunity, open, in some ways, only to those with an MD diploma.

Being a doctor is a good thing to do.

The history of healing is long and peppered with bright spots and dark spots. Of course there were occasional charlatans but overall it is an enduring story of compassion, heroic actions, and perspicacity. For many of us, the connection we feel with that tradition adds to what might be thought of as the romance of being a healer.

Being a doctor is a good thing to do.

Another positive aspect is how we become knowledgeable consumers of science. Over the years most of us expend prodigious effort keeping up, trying not to let medical advances crush us under their weight. For me that’s been an odd sort of pleasure. Many years into my retirement, I very much enjoy reading JAMA and Pediatrics. And the Pediatric Yearbook is my preferred bathroom reading. We learn that science is a contingent and sometimes a messy process. There is much that’s imperfect about the studies upon which we base our medical activities, but most of us develop a sense for how best to use all this information.

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Cont. Practicing Medicine is a Good Thing To Do

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We grab a handle and go with it until new information corrects us or adds to our effectiveness, and then we grab a new handle and go with that. All in all, practicing medicine is a fascinating place from which to observe the march of the scientific enterprise.

Being a doctor is a good thing to do. Fun too.

The problems and changes of the healthcare system are weighty indeed. Nevertheless, the intrusions of a complex world into our practices will never, I suspect, take from physicians the most profound and consequential aspect of practicing medicine--the reward that comes from walking with our patients and their families through a significant life problem. To become a part of people's lives in this way is an awesome and extraordinary privilege.

Being a doctor is a good thing to do.
For us and for our patients.
We should enjoy it.

~ AAP Sections ~

Team Healthy: Pediatric Resident Action to Fight Childhood Obesity

Kate Roberts, MD
Former Resident, Children's Hospital in Orange County, California
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Childhood obesity is a rising epidemic pediatricians face every day. Studies show 30% of the pediatric population has a BMI of 30 or greater, and the rate is rising. Co-morbidities are significant and include diabetes, asthma, cardiovascular disease as well as low self-esteem and depression.

Sixteen years ago, the American Academy of Pediatrics (AAP) launched Bright Futures, a prevention-oriented guide to well-child care that emphasizes nutrition education for patients and their families. Now sixteen years later, the AAP has teamed up with the White House and other national organizations pledging to reverse the spiraling epidemic of pediatric obesity within a generation. First Lady Michelle Obama launched her Let's Move! initiative in February 2010 and the AAP has been a partner from the very beginning of the movement, encouraging pediatricians to calculate BMI at every well-child visit for children over two years, and making available downloadable “prescriptions” for healthy, active living that pediatricians can give to families to promote a healthy lifestyle. Now in its second year of partnership with the initiative, the AAP rolled out another component at the 2010 National Conference & Exhibition called “Let's Move in the Clinic.”

And the AAP’s focus on preventing childhood obesity doesn’t stop there. In October 2010 the AAP Section of Medical Students, Residents, and Fellowship Trainees (SOMSRFT) launched our 2010-2011 advocacy campaign focusing on child obesity. Our project, Team Healthy, is now being implemented by pediatric residents across the country.
Cont. Team Healthy: Pediatric Resident Action to Fight Childhood Obesity

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Team Healthy is being implemented in two phases:

**Phase 1: Community Policy Advocacy**

The first phase provides the foundation for a community needs assessment and resources to make a difference in your community within a limited time frame.

- Step 1: Explore your community. Identify strengths and needs. Explore what is already being done about obesity prevention (it might surprise you!). Learn about existing and proposed policy regarding childhood obesity.
- Step 2: Partner with existing community efforts. Work to strengthen the movements within your community.
- Step 3: Move your policy agenda forward. Become a key contact for schools, community groups, policymakers, and legislators.

**Phase 2: Clinic-based Quality Improvement Projects**

For the second phase, residents have teamed up with the Let’s Move! initiative to bring the tools of child health advocacy into clinics. This predesigned clinic intervention makes it easy for your program to meet the QI requirements of the Pediatric Residency Review Committee.

- Step 1: Each resident pledges participation in the Let’s Move! initiative. This takes less than 2 minutes. You are now officially committed to fighting childhood obesity!
- Step 2: Implement a quality check in your clinic, make changes, then check again:
  - Examine 10 patient charts for a few key indicators. Was BMI checked? Was nutrition discussed?
  - Use the downloadable form to see what you have missed. Upload your data to see how your clinic compares to others.
  - Identify one change you would like to make. Use the Tips for Improvement sheet for simple solutions and advice on implementing change in your clinic.
  - After those changes are made, check 10 charts again to see what a difference you have made!

Team Healthy is structured for those with little free time to get involved and make a difference. Whether you are a resident or out in practice, you have the tools, the qualifications, and the experience to be an effective child advocate.

Check the Team Healthy website at [www.aap.org/sections/ypn/r/advocacy/obesity.html](http://www.aap.org/sections/ypn/r/advocacy/obesity.html) to find resources that will help you to make a difference in your community and clinic.

Together we will make a difference! Go Team Healthy!
Recording, Transcript on Culturally Effective Care Now Available

The Healthy Tomorrows Partnership for Children Program hosted a webinar, “Culturally Effective Pediatric Care in a Community-based Health Program” focused on the AAP's new online resource, the Culturally Effective Care Toolkit. This toolkit demonstrates the importance of incorporating cultural competency into healthcare delivery systems to promote optimal health outcomes. The webinar highlights a Healthy Tomorrows grantee's experiences creating culturally responsive health education materials and training health care professionals on how to care for patients and families with diverse health literacy levels.


To access the Culturally Effective Care Toolkit, visit the Practice Management Online Web site: http://practice.aap.org/content.aspx?aid=2990.

For additional resources on this topic, browse the Healthy Equity page: http://www.aap.org/commpeds/resources/health_equity.html

For questions please contact: healthyt@aap.org.

Practice Services Improvement Program (PSIP) and the Medical Home

In May 2010 the AAP Board of Directors approved the use of venture capital to establish the PSIP Practice Service Improvement Project. The PSIP provides with the intent of providing an array of innovative services both to pediatric medical homes and to national and regional private health plans to aid in practice transformation as well as the successful implementation of the Patient and Family Centered Medical Home (PCMH) model.

To date seven (7) potential service offerings designed to frame the PSIP approach have been proposed:

- **Webinar Series:** Focused on best practices in practice management and medical home implementation.
- **Digital Navigator:** Offers on line access to the implementation process for your practice transformation with a modular format to enable practices to select the focus and scope of their improvement efforts. You also receive a step-by-step guide for how to implement each component of a medical home and offer recommendations for project organization and the roles each team member will have within your very own practice. Lastly, it will provide links to supporting tools, document templates, articles, and educational materials for you, your staff, and your patient population.
**Workshops:** Provide an opportunity to participate in an intensive, collaborative, learning experience designed to achieve real results.

**Virtual Facilitation:** Delivered by expert facilitator who guides the practice in its transformation via phone and secure electronic means.

**Onsite Practice Consulting:** An expert in practice transformation will do an on-site practice assessment at your convenience.

**Multi-Practice PCMH Implementation Management:** Coordinate practice transformation across multisite practices.

**Practice Services Web Portal** and Online Community

PSIP has recently obtained feedback from member pediatricians on the possible service offerings and in response has now moved forward with the launch of the first webinar on June 21, 2011, titled *Access and Continuity in the Medical Home Setting: Enhancing Continuity of Care in Your Practice Through 21st-Century Communication.* You may access this archived event by clicking on the link below:

http://event.on24.com/r.htm?e=308568&s=1&k=774A3A2ABF9430FE44F542BF388EC78F.

By the end of this webinar, participants will understand the key components for enhanced access in the medical home setting and will be able to:

- Explain the value of providing each patient with a personal primary care physician as well as enhanced access to care during and after office hours.
- Discuss opportunities for access to care via shared visits, secure e-mail, or an online patient portal.
- Describe the value of providing families; electronic access to medical records, e-prescribing, referral requests, point-of-care reminder systems, and appointment scheduling in a timely manner.
- Implement open access in a paper chart practice.
- State the importance of providing culturally and linguistically appropriate services and patient materials that meet the language and literacy needs of patients.
- Describe the relationship between telephone management and non-face-to-face visits and use of 21st-century communication in primary care.
- Outline facilitators and barriers to integrating 21st-century communication in the primary care medical home.

Please contact Sherry Fischer at sfischer@aap.org or (847) 434-7106 with any questions.
Learn about new resources and funding opportunities by subscribing to the FREE Medical Homes@Work monthly e-Newsletter (www.medicalhomeinfo.org/about/newsletter/) from the National Center for Medical Home Implementation (NCMHI). The NCMHI is a cooperative agreement between the Maternal and Child Health Bureau (MCHB) and the American Academy of Pediatrics (AAP). The NCMHI provides medical home resources, technical assistance, and support to physicians, families, and other medical and non-medical providers who care for children. The e-Newsletter focuses on medical home implementation tools and resources, training materials, and information about national initiatives, including updates from medical home partners. To subscribe, fill out the Contact Us form at www.medicalhomeinfo.org/contact/.

Find us on Facebook! Visit www.facebook.com/medicalhome
Are You a Member of the Council on Children with Disabilities?

The AAP Council on Children with Disabilities (COCWD) is composed of nearly 500 AAP Fellows who care for or have an interest in children and youth with special health care needs (CYSHCN). Members of the COCWD are dedicated to the optimal care and development of children with disabilities and to the support of their families within a medical home.

The COCWD’s mission is to improve care of CYSHCN through policy, education, visibility of disability issues, advocacy, and collaboration with national, community, and family partners. The COCWD also has a very active Autism Subcommittee (ASC) that is dedicated to helping the Academy ensure that accurate information about autism is communicated to pediatricians, parents, and the public.

The COCWD connects with its members through a “members-only” Listserv®, a quarterly e-Newsletter, a comprehensive Web site with resources that complement COCWD policies, and numerous educational offerings presented each year at the AAP’s National Conference and Exhibition.

The COCWD offers members many exciting opportunities to participate in a variety of activities including: providing expert opinion and review on AAP publications, providing feedback on current policy, submitting ideas for educational topics, and serving as faculty on COCWD-sponsored education sessions.

Current COCWD in the list of policies, publications, educational offerings, & initiatives focus on:

- Autism
- Care Coordination
- Care of Children and Youth with Cerebral Palsy & Spina Bifida
- Developmental Surveillance and Screening
- Early Intervention Services
- Education Services for Children and Youth with Special Needs
- Home Care of Children with Special Needs
- Learning Disabilities
- Medical Home Implementation in Your Practice
- Sexuality of Children and Adolescents with Developmental Disabilities
- Sports and Physical Activities for Children and Youth with Special Needs
- Transitioning from a Pediatric to an Adult Medical Home

If you would like to join the COCWD:

1. Go to www.aap.org/moc and login with your AAP ID and password.
2. Click on “Member Community”.
3. Click on ”Join a Section or Council“ under Section, Council & Committee Information.
4. Choose the Council on Children with Disabilities, answer a few questions, and click ”Submit“.

For more information about the COCWD, visit http://medicalhomeinfo.org/about/cocwd/
New Clinical Report: Supporting Health Care Transition from Adolescence to Adulthood in the Medical Home

Stephanie Mucha Skipper, MPH
Manager, Children with Special Needs Initiatives
Staff Lead, Autism and Transition Initiatives

"Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home," jointly authored by the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians, appears in the July issue of Pediatrics.

The report provides practical guidance on how to plan and execute better health care transitions for all patients and follows a detailed algorithm from age 12 through the transfer of care to an adult medical home. The report addresses transition for all youth but also provides a pathway for youth with chronic conditions.

The clinical report can be accessed here: http://www.medicalhomeinfo.org/how/care_delivery/transitions.aspx. Questions about the report can be emailed to transitions@aap.org.

The new National Health Care Transition Center works with pediatric and adult primary care practices to develop resources that align with the report’s guidance: www.gottransition.org.

From the AAP Section on Breastfeeding

Richard J Schanler, MD, FAAP, FABM
Chairperson

The Section on Breastfeeding has been busy with a myriad of activities. We await final approval of our revised and updated Policy Statement, “Breastfeeding and the Use of Human Milk.” You also should be aware that there has been a wealth of national support for breastfeeding, starting with Mrs. Obama’s inclusion of breastfeeding as a first step in obesity prevention.

The Surgeon General, Dr. Regina Benjamin, released a Surgeon General's Call to Action in January. In her “Roadmap to Improve Support for Breastfeeding Mothers,” she emphasized several areas: 1) Mothers and their Families - education on importance of breastfeeding, and provide needed ongoing support; 2) Communities - entire community to support breastfeeding, provide peer counseling support, promotion of breastfeeding through community organizations and media, and the removal of commercial barriers; 3) Health Care - adopt evidence-based practices (Baby-Friendly Hospital Initiative), provide health professional education, ensure access to lactation services, and increase availability of banked donor milk; 4) Employment - paid maternity leave and worksite accommodations; 5) Research and Surveillance - need for research, address disparities and measure the economic impact of BF; and 6) Public Health Infrastructure - enhanced national leadership.

Because we believe that best breastfeeding practices begin in the postpartum units in hospitals, we applaud The Joint Commission for including the rate of exclusive breastfeeding in postpartum units as one of their Perinatal Core Measures.

In our support of breastfeeding we have been outspoken on a number of issues. We challenged the unusual recommendation made by the Committee on Nutrition for iron supplementation of exclusively breastfeeding infants before 6 months of age. There is a paucity of data in this area and universal supplementation is unproven.
Cont. From the AAP Section on Breastfeeding

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(See Pediatrics 2011 Apr; 127(4):e1097). Currently, we are responding to a critique on the benefit of measuring exclusive breastfeeding in postpartum units.

Lastly, we attempt to maintain our knowledge of evidence-based practices relative to breastfeeding and human milk. We review published literature each year at the NCE. Excerpts from the last NCE are included:

- During their first 24 hrs after birth term breastfeeding infants in Brazil ingest 15 g of milk.
- There is a significant role for antiretroviral therapy in breastfeeding. Studies in Malawi and Botswana described protocols that reduced HIV-1 transmission during breastfeeding.
- There was a 77% reduction in necrotizing enterocolitis if extremely premature infants received, as supplements to their mother’s own milk, an exclusively human milk diet comprised of pasteurized donor human milk and human milk fortifier prepared from donor human milk, compared with a diet containing bovine milk products as human milk fortifiers or formula.
- Implementation of the Section on Breastfeeding residency curriculum (www.aap.org/breastfeeding/curriculum) was associated with a significant increase in exclusive breastfeeding that continued through 6 months at intervention sites.
- There were no long-term sequelae (neurodevelopmental outcome or hearing loss) reported in premature infants fed their mother’s milk containing CMV.
- There is a correlation between bilirubin levels and epidermal growth factor concentrations in infants with breastmilk jaundice.

The Section on Breastfeeding has unique membership which supports national education and practice initiatives on breastfeeding but also serve to monitor activities within the AAP to protect, promote, and support breastfeeding. We have a strong committed membership and we would welcome Young Physicians input and membership!

Have a great summer!

**New** Pediatric Tobacco Control Resource Guide

The U.S. Food and Drug Administration has recognized that the connection between pediatric diseases and tobacco use is so strong that household tobacco use itself should be considered a pediatric disease. Tobacco use is a pediatric disease that you will inevitably encounter during your career.

Children are at risk of serious adverse health effects from the smoke of others, as well as at risk of addiction and harm from their own smoking. Most smokers know they are addicted and want to quit. Now it is easier to find guidance on how to assist the patients and families that you encounter.

The American Academy of Pediatrics Julius B. Richmond Center has a new resource guide to assist you in addressing tobacco use and secondhand smoke exposure with children and families that you may utilize in your clinical encounters. This Guide includes resources for clinicians, guidance on working with youth and families, cessation materials, and strategies to help keep our communities smoke-free.

Copies of the Guide are available on the Richmond Center website, or by contacting the Richmond Center directly.
AAP National Conference and Exhibition (NCE) Session on Preparing for Disasters

Save the Date! The AAP Disaster Preparedness Advisory Council will present an educational session during the AAP NCE on Monday, October 17, 2011 from 2:00-3:30 pm. “Preparing for the Worst: How to Practice and Survive After a Community-Wide Disaster,” an interactive group forum, will be presented by Scott Needle, MD, FAAP. Registration materials and housing information will be available June 1, 2011.

AAP Adolescent Health Web Site and 2011 NCE Activities

Adolescence, according to the Bright Futures Guidelines includes children from 11-21 years of age, and is a time of extensive growth, new experiences, as well as exploring and learning about life that may involve risky behaviors. The AAP has developed a wealth of resources that help pediatric professionals care for their adolescent patients. The AAP Adolescent Health Web site www.aap.org/sections/adolescenthealth/default.cfm contains many professional resources on adolescent health. The Adolescent Health Web site is your source for practical handouts and tools, access to educational opportunities, current adolescent health publications and AAP policy statements, information on state and community projects, and much more.

New to the site is important information for those planning on attending the 2011 National Conference and Exhibition (NCE) in Boston, MA, from October 15-18, 2011. For the upcoming 2011 NCE, the Adolescent Health Web site has a compiled list of all the sessions that have an adolescent focus to help you with planning which sessions you may want to attend related to adolescent health. You can access the listing by both date of the conference, as well as by sub-topics (i.e. mental health, dermatology, substance abuse, etc.). There are over 40 sessions at the upcoming NCE that include specific adolescent health content. To visit the Adolescent Health Web site’s NCE page directly, go to www.aap.org/adolescenthealth/nce.cfm.

If you would like to meet others who are actively working on adolescent health projects, chapter adolescent committees and other who are interested in adolescent health, consider attending the Section on Adolescent Health (SOAH) program, scheduled for Sunday, October 16, 2011, which is open to any AAP members. This year the SOAH program will focus on evaluating and managing sleep-related disorders. The business meeting of the Section immediately follows the educational program.

For specific questions about the SOAH or other adolescent health activities, contact Karen Smith, Manager, Committees and Sections, at ksmith@aap.org or Charlotte Zia, Program Manager, at czia@aap.org.
AAP’s Pediatric Care Online is a continually enhanced point-of-care resource, with regular updates to textbook chapters, quick reference topics, drug information, and more. Brand new content is added all the time, with the recent addition of AAP policy statements and hundreds of more forms, tools and patient handouts from key AAP resources. In May, Pediatric Care Online introduced a new, streamlined login process, making it easier and faster than ever to use.

Request a free 3-month trial from your Mead Johnson representative or call 888/363-2362; to subscribe today, visit www.aap.org/bookstore and order item # PCO, or call 888/228-1281. For more information, visit www.pediatriccareonline.org.

Pediatric Care Online also offers FREE monthly webinars on current topics in pediatrics! Sign up for PCO eAlerts today at http://www.pediatriccareonline.org/pco/ub/emailalerts to receive webinar information and access instructions.

Patient Education Online is a print on demand library that puts more than 300 pediatric health care handouts right at your fingertips, so you are always ready with the most current information as needed. To learn more, please visit www.patiented.aap.org or e-mail aapproducts@aap.org. Order item # ONPE at www.aap.org/bookstore or call 888/228-1281.

AAP Pediatric Coding Newsletter is a monthly print and online advisory service to help you maximize payment, save time, and implement best business practices to support quality patient care. For more information, please visit www.coding.aap.org or e-mail aapproducts@aap.org. Order item # SUB1005 at www.aap.org/bookstore or call 888/228-1281.
4th Edition of the Pre-Participation Physical History and Examination Forms and Monograph

Michele Labotz, MD, FAAP
AAP Council on Sports Medicine and Fitness
Sports Medicine Physician

With summer pre-participation physical visits arriving en masse to pediatrician offices, the AAP Council on Sports Medicine and Fitness (COSMF) appreciates the opportunity to share a helpful resource with the Section on Young Physicians. The COSMF supports optimal and safe physical activity in the pediatric population and invites young physicians to join our council. For more information, please visit our website at http://www.aap.org/sections/sportsmedicine/ or contact Anjie Emanuel at aemanuel@aap.org.

At its spring meeting, the COSMF Executive Committee reviewed utilization and implementation of the 4th edition of the Preparticipation Physical Evaluation (PPE) history and examination forms. This newest edition of the PPE format was released in 2010 and represents a consensus effort between the AAP, American Academy of Family Physicians, American Medical Society for Sports Medicine, American College of Sports Medicine, American Orthopaedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.

The 4th edition PPE is the current standard of care for evaluation of young athletes preparing for athletic or other physically strenuous activity. This updated form represents a significant evolution from previous versions in multiple areas. Several of these changes include:

- Continued fine-tuning of the personal and family history in detecting potential causes of sudden cardiac death.
- “Ticklers” on the physical exam form regarding appropriate cardiac evaluation.
- Recognition that for many patients the PPE is their only contact with the health system.
- Provision of opportunities to raise dietary concerns, risk-taking behaviors, and other sensitive issues.
- Inclusion of a supplemental history form for special needs athletes, as well as release of a Spanish version, enhances applicability for a broad number of young athletes.

Publicity surrounding the release of the 4th edition PPE included a plenary session at the AAP NCE, presentations at other national medical society meetings, and a news conference at the National Press Club in Washington DC. However, in spite of these efforts by the AAP and the other author societies, alternative or older versions of the PPE are still in common use. The executive committee has decided to make a concerted effort to promote use of the 4th edition, which should result in better standardization and enhanced quality of the PPE process. Current endeavors include:

- Collaboration within the AAP with members of the Council on Clinical Information Technology and the Child Health Informatics Center to potentially work with vendors on development and implementation of an electronic PPE template.

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cont. 4th Edition of the Pre-Participation Physical History and Examination Forms and Monograph

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- Outreach to national councils/sections and state chapters to encourage pediatricians to utilize the PPE form whenever an evaluation is performed to assess sports or physical activity participation, including sports camps.
- Outreach to other medical and sports-related organizations to promote recognition and adoption of the PPE 4th editions forms as the preferred format for preparticipation exams.
- Education of parents about the importance of the PPE, the need for their accurate input on completion of the history forms, and the desirability of having the PPE performed in the medical home.

For more information about the 4th edition of the PPE, please visit: http://www.aap.org/sections/sportsmedicine/PPEAbout.cfm

Sound Advice on Autism

Parents of a child who has recently been diagnosed with an autism spectrum disorder experience a variety of feelings and have many questions. To provide parents with guidance and support, the American Academy of Pediatrics (AAP), led by the Council on Children with Disabilities (COCWD) Autism Subcommittee, has created Sound Advice on Autism a series of audio interviews with developmental and behavioral pediatricians, a pediatric neurologist, a general pediatrician, autism researchers, and parents of children with autism. Pediatricians are encouraged to share this resource with parents.

At the Sound Advice on Autism site, parents can listen as experts answer questions about autism spectrum disorders including:

- What causes autism? How common is it?
- What are the early signs of autism?
- How can families learn about early intervention services in their area?
- What are the most effective therapies for autism?
- How could a child’s autism diagnosis affect a family?
- What guidance would you offer parents who want to explore complementary and alternative therapies?
- Can particular diets or vitamins help children with autism?
- Is autism related to gastrointestinal disorders?
- Why do some children “lose” their autism diagnosis?

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Cont. Sound Advice on Autism

"We want parents to use these audio interviews as a resource as they learn about their child's diagnosis and plot a course of therapies and services," said Judith Palfrey, MD, FAAP, past president of the AAP. "We know parents have many questions, and pediatricians want them to have access to the scientifically based information they need to make decisions about their child's care."

Additional AAP autism resources for health care professionals and parents can be found at medicalhomeinfo.org.

Get Involved with the AAP at the State and National Level—Check Out these Opportunities

The AAP Early Hearing Detection and Intervention (EHDI) Chapter Champion Program and Medical Home Chapter Champions Program on Asthma (MHCCPA) are looking for volunteers!

In 2001 the American Academy of Pediatrics implemented a program, Improving the Effectiveness of Newborn Hearing Screening, Diagnosis and Intervention through the Medical Home. This focused on increasing the involvement of primary care pediatricians and other child health care providers by linking follow-up services more closely to the newborn's medical home.

Later—in 2008—the Academy identified a need for the development of a high impact, national initiative focused on improved quality care of pediatric patients with asthma, including the facilitated implementation of the National Heart, Lung, and Blood Institute (NHLBI) 2007 asthma guidelines within the context of a medical home. To meet this need, the Academy established the Comprehensive Asthma Program (CAP), initiated with the support of the Merck Childhood Asthma Network, Inc. (MCAN). Both of these programs utilize a network of chapter champions for implementation at the state and local level.

In order to meet the goals of these programs, the Academy has worked to identify one pediatrician in each chapter to “champion the cause.” These champions serve as a conduit for disseminating best policies and practices to pediatric health care providers nationwide through the leadership and networks of AAP chapters; serve as advocates for change at the local, state, and national levels; become involved in providing technical assistance as well as tools and resources to pediatricians and other pediatric health care providers; and assist in aligning national and chapter/state, local, and/or community priorities. Champions play a vital role in coordinating efforts between pediatricians, health care professionals, state health departments, hospitals, and others in an effort to implement these programs and/or best policies and practices and to ensure that issues related to newborn hearing, medical home and asthma, respectively, are prioritized.  

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Cont. Get Involved with the AAP at the State and National Level—Check Out these Opportunities

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As a young physician, you may be looking to get involved with your chapter and are uniquely poised to further the efforts of the AAP in an exciting way. Here is your opportunity to do just that. Currently the EHDI program has vacancies in the following chapters: California Chapter 3, District of Columbia, Mississippi, New Hampshire, Oregon, Puerto Rico, and South Dakota. The MHCCPA is looking for champions in the following chapters: California Chapter 3, Delaware, Maine, Nevada, Oklahoma and West Virginia. The role of the chapter champion is completely voluntary and does not involve a substantial time commitment.

If you are interested in either of these voluntary roles or know of a pediatrician that might be right for either of these opportunities, contact Faiza Khan, fkhan@aap.org (EHDI) or Suzi Montasir, smontasir@aap.org (MHCCPA). To learn more about both programs, visit:

EHDI: www.medicalhomeinfo.org/how/clinical_care/hearing_screening/ehdi.aspx
MHCCPA: www.medicalhomeinfo.org/national/mhccpa.aspx

Results of the SOYP Survey on the Pediatric Review and Educational Program (PREP)

Taylor Sawyer, DO, Med

Members of the section on young physicians were recently surveyed and results were shared at the 2011 PREP Advisory Group meeting. An e-survey was sent to the 1,545 members. One hundred and twenty six (8%) members responded to the survey.

When asked for specific suggestions on how to improve the PREP products, respondents provided many ideas including: improving online accessibility, improving the search functionality of PREP Self Assessment and Pediatrics in Review, a greater focus on articles relevant to everyday practice and decreasing the length of the articles.

Many survey respondents were interested in the possibility of new electronic media modalities to access PREP, specifically a smart phone app. Plans to address these suggested changes are actively being investigated.

SOYP respondents preferred online access to PREP products. Currently both the Pediatrics in Review journal and PREP Self-Assessment can be purchased at a reduced rate with online access only.

The Academy thanks those who took the time to provide valuable feedback. Congratulations to Alan Grimes, MD, FAAP who was randomly selected to win a 2010 PREP Reference on CD-ROM as a thanks for his participation!
PREP®: ID - A Comprehensive Review and Update of Pediatric Infectious Diseases

Westin Chicago River North
Chicago, Illinois
July 25-30, 2011
Earn a Maximum of 39.0 AMA PRA Category 1 Credits™

Sponsored by the American Academy of Pediatrics (AAP), the AAP Section on Infectious Diseases, and the Pediatric Infectious Diseases Society (PIDS)

Whether you’re preparing for the Subboard exam in pediatric infectious diseases or just looking for an infectious diseases update geared toward the office-based pediatrician, PREP®:ID is right for you. For the ID subspecialist, this course provides a comprehensive review and update of pediatric infectious diseases, based on the Subspecialty Certifying Examination Content Outline developed by the Subboard of Pediatric Infectious Diseases. For general pediatricians and other health care providers, the course is designed to enable participants to apply infectious disease updates and case presentations readily in their own practice settings.

While most ID subspecialists will participate in the full course (July 25-30), most general pediatricians and others will attend the Infectious Diseases in Clinical Practice track, offering both a mornings-only (July 26-30) and a weekends-only (July 28-30) option. Participants in this track will attend general session presentations with nationally renowned faculty, a full morning of lectures and panel discussion on vaccines, and six, case-based sessions on hot topics in ID. This year’s hot topics include:

- Antibiotics in Office Practice: Choosing the Right Drug for the Right Bug
- The Child With Recurrent Infections
- Travel Medicine
- Germs in the Environment: Home, Office, Daycare, and School
- Point of Care Diagnosis: ID Testing in the Outpatient Setting

Whatever your educational and scheduling needs, PREP®:ID has an option for you. And when the sessions are through, Chicago’s world-class offerings will keep you busy with an almost infinite array of sites, recreation, entertainment, shopping, and dining choices to help you make the most of your free time.

Register online at www.pedialink.org/cmefinder or call 866/THE-AAP1 (866/843-2271).

The American Academy of Pediatrics (AAP) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The AAP designates this live activity for a maximum of 39.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
PREP®:CAP – An Intensive Review and Update of Child Abuse Pediatrics

July 20 – 24, 2011
The Westin Denver Downtown
Denver, Colorado
Earn a Maximum of 30.25 AMA PRA Category 1 Credits™
Rich A. Kaplan, MD, FAAP - Planning Group Chairperson

When all the forms of child maltreatment are combined, they account for more morbidity and mortality than all of the childhood cancers. Whether you plan on entering primary or subspecialty care, as a pediatrician you will inevitably encounter a variety of forms of child maltreatment. Your ability to recognize and appropriately respond to child abuse will have a profound effect on the well being of your patient and his or her family.

We have brought together a wonderful faculty and will be presenting this material in a beautiful setting in Denver, Colorado. This course represents not only an excellent learning opportunity, but also an exciting and pleasurable networking opportunity with a variety of pediatric specialists and subspecialists from around the country.

PREP®:CAP will be presented in two tracks. A four-and-one-half day intensive review is designed for those preparing for the Subspecialty Certifying Examination in Child Abuse Pediatrics or Maintenance of Certification™ (MOC) and for those who want the most vigorous educational experience. A second track intended for general pediatricians and other healthcare providers, two and one-half days in length, focuses primarily on abusive head trauma, child sexual abuse, and the courtroom experience.

The second track begins at 8:30am on Friday, July 22, 2011 and continues through the scheduled conclusion of the course at 11:45am on Sunday, July 24, 2011. For those individuals interested in participating in the track designed for general pediatricians and other healthcare providers, a special registration fee of $595.00 has been established. Individuals who wish to attend the 2011 PREP®:CAP for the Friday, July 22 through Sunday, July 24 educational sessions may register for the fee of $595.00 by calling 866/THE-AAP1 (866/843-2271) or online at www.pedialink.org/cmefinder.

I urge you to consider this as a critical step in the enhancement of your pediatric practice.

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Future of Pediatrics Conference - Embracing Change: Improving the Health of ALL Children

Chicago, Illinois
July 29-31, 2011

Earn a Maximum of 17.5 AMA PRA Category 1 Credits™

Mark S. Reuben, MD, FAAP – Planning Group Co-Chair
Colleen A. Kraft, MD, FAAP – Planning Group Co-Chair

The Future of Pediatrics Conference is an outstanding opportunity for young physicians to learn the latest research findings in a variety of clinical and practice management topics, as well as advances in community pediatrics and the medical home. A variety of educational formats will be utilized, including abstract presentations and posters, interactive roundtable discussions, and opportunities to network with national experts in pediatrics. Many sessions specifically address the needs of young physicians and include content that was likely not covered in residency, including:

- Accountable Care Organizations (ACOs) and Other Integrated Care Practice Platforms
- The Medical Home – It’s Not Just About Coding Anymore
- Managing Patient Expectations
- Kick it up a Notch: Strategies and Tools to Measurably Improve Your Well Child Care
- Implementing Bright Futures Preventive Services Guidelines
- National Resources Supporting Local Pediatrics Advocacy Efforts
- Addressing the “Oh, By the Way” Issue: Behavior Management in the Office Setting
- Management of Childhood Obesity
- Genetics in Pediatric Care – The Future is Now
- Change Management: A Day-to-Day Activity
- Building Bridges: Effective Strategies for Transitioning Youth with Special Needs into Adult Care

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cont. Future of Pediatrics Conference - Embracing Change: Improving the Health of ALL Children

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Here’s what past attendees have to say about the Future of Pediatrics Conference:

“Great practice-focused conference. Practical, cutting-edge pediatrics like only the AAP can do!”
Rob Dudley, MD, FAAP • New Britain, Connecticut

“This meeting is a wonderful collection of practical and cutting edge material with very good speakers to highlight the material. Worth the trip!”
Catherine A. Goodfellow, MD, FAAP • Rochester, New York

“I learned things I can use to improve my practice and to work at a state level to improve care for children across the state.”
Jane Turner, MD, FAAP • East Lansing, Michigan

“A good mixture of clinical, medical home, and practice management issues!”
Robert Mendelson, MD, FAAP • Portland, Oregon

“One of the best conferences I’ve attended in terms of learning the things I need to know to move my practice forward: practice management, QI, integrating services with the community.”
Gonzalo Paz-Soldan, MD, FAAP • Arlington, Virginia

“A great chance to step back and look at the big picture of pediatric care while thinking about how to implement improvements in our practices to provide the best care to our patients.”
Seth D. Kaplan, MD, FAAP • Plano, Texas

Register online at www.pedialink.org/cmefinder or call 866/THE-AAP1 (866/843-2271). Make sure to register by June 29, 2011 for Early Bird Rates! We look forward to seeing you this summer in Chicago.

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Plan to arrive early and participate in the Mental Health Preconference - Embracing Mental Health Care: Lessons Learned for Success, and earn a maximum of 5.5 AMA PRA Category 1 Credits™.

Thursday, July 28
10:00am - 5:15pm

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Cont. Future of Pediatrics Conference - Embracing Change: Improving the Health of ALL Children

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The Preconference is an opportunity designed to empower pediatricians with innovative best practice models for addressing mental health concerns and practical tools for clinical care. Advance registration is required, and seating is limited. For more information, visit www.aap.org/mentalhealth.

The Preconference is supported by the Child, Adolescent and Family Branch (CAFB), Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA). The content of this preconference does not necessarily reflect the views, opinions or policies of CAFB, CMHS, SAMHSA or the Department of Health and Human Services.

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The AAP designates this live activity for a maximum of 5.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
2011/2012 CATCH Planning Funds Program Call for Proposals

Applicants notified December 2011—projects begin January 2011
Applications available May 2, 2011—submissions due July 20, 2012

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

This grant cycle includes a special call for projects that focus on American Indian/Alaska Native children and projects to improve access to immunizations for children who are most likely to experience barriers.

The grants are awarded in amounts from $5,000 to $12,000 on a competitive basis for planning activities such as needs assessments and community asset mapping, feasibility studies, community coalition/collaboration meetings, focus groups, and development of grant proposals project implementation after the planning phase is complete. Project activities should include developing broad-based collaborative community partnerships. Priority is given to projects that will be serving communities with the greatest health disparities.

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

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

One pediatrician can make a difference!

Text4Baby State Enrollment Contest

Text4Baby is a free service designed to promote maternal and child health by providing pregnant women and new moms with weekly text messages on pregnancy and baby care, timed to the due date or baby’s date of birth. From May until October 2011, states around the nation will be looking for innovative ways to encourage moms to engage with the text4baby program, as part of a recently launched national competition to get moms to sign up and join the movement. The top 3 states to enroll the most users in text4baby between now and the end of October 2011 will be announced at the American Public Health Association Annual Meeting in Washington, DC in November.

Here’s what you can do to help your state win!
Learn about text4baby by watching this short clip of a news special that featured the program.
• Put up text4baby posters in your waiting areas and exam rooms.
• Place text4baby tear-off pads next to your check-in/check-out desks and encourage moms to take a sheet.
• Promote text4baby via Facebook or Twitter.
• Add a text4baby banner or button to your practice’s Web site and encourage your AAP chapter to add one to their Website too.

E-mail Renee Jarrett, AAP staff, at rjarrett@aap.org to let us know how you have/plan to promote text4baby in your practice or community! For more information and text4baby materials, visit: www.text4baby.org/index.php/get-involved-pg/10-news/80
Completed Management Plan - PMO

Weekly Office Manager Report - PMO

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<thead>
<tr>
<th>PROGRESS OF CONTINUING GOALS</th>
<th>GOAL</th>
<th>STATUS OR MEASURE OF PROGRESS</th>
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<tbody>
<tr>
<td>1. Statistics (report on the statistical report that you receive)</td>
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<td>2. TVI (discuss how and why it has improved or not)</td>
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<td>3. Mystery Caller scores (discuss why it has improved, or not,</td>
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<td>and if improved, what you did to help improve the score. If not</td>
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<td>improved, what are your plans to improve the scores)</td>
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<td>4. Patient Satisfaction survey scores (discuss why it has</td>
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<td>improved, or not, and if improved, what you did to help improve</td>
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<td>the scores. If not improved, what are your plans to improve the</td>
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<td>scores)</td>
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<td>5. Include “Culture of Caring” in all training and office</td>
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<td>Meetings (what successful tools are you using to ensure that</td>
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<td>this program is known and used throughout your office)</td>
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<td>6. Maximize your office (what are you doing to market your office</td>
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<td>or what help do you need to market your office)</td>
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<td>7. New patient statistics (how many new patients did you see in</td>
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<td>your office and how did the new patient score about Bayside)</td>
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<td>8. Monthly meetings with staff and clinicians (report on which</td>
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<td>clinician provided the training for the month, what the topic</td>
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<td>was and how successful or unsuccessful it was, and why)</td>
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<td>9. Health e-scripts (how many e-scripts were done this week)</td>
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<td>10. Staff</td>
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<td>11. No show</td>
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