SOYP News

Volume 12, Issue 2
Summer 2012

Section on Young Physicians

"No one has yet fully realized the wealth of sympathy, kindness and generosity hidden in the soul of a child. The effort of every true education should be to unlock that treasure. “

Mignon McLaughlin

Inside this issue:

** Click on the bookmark to your left to view an easy to read and clickable table of contents.

Chair’s Welcome............................................... 2
Editor’s Note...................................................... 3

What’s On Your Mind

- Lost in Translation: Transition of Care in Hospitalist Medicine........................................... 4
- Reflection as a Pediatrics Intern: Three Main Points of My Year........................................... 5
- Book Review ...................................................... 6
- Summer Water Safety........................................... 8
- “Stop That Crying and Be an Athlete” .............. 11
- Making a Difference for Kids.............................. 13

SOAPM Corner

- How Your Medical Practice Can Hedge Against Loss of Visits............................................. 14

COCM Corner

- Media, Technology & Children: How to Guide Learning...................................................... 15

From the AAP

- From the Committee on Medical Liability and Risk Management: Common Misconceptions About Medical Liability.......................... 19
- Embracing Mental Health Care: Lessons Learned for Success.............................................. 21
- Can a Resident Continuity Clinic Become a “Cadillac” Practice?.......................................... 22
- Learn More About Medical Home Implementation with New Videos......................................... 24
- Friday Afternoon Special: A CAP Can Help................................................................. 24
- Connected Kids Promotion................................................................. 25
- New AAP Research Study Monitors Pediatrician Life and Career Experiences............................. 26
- Dedicate a Brick................................................................. 28

Your SOYP Representatives................................. 30

From the Section for Senior Members

- A Report from Bill Kueffner, Ninety-One Years Younger .................................................. 16
Chair’s Welcome
Rachel Dawkins, MD, FAAP
Chair, AAP Section on Young Physicians

Laissez les bon temps rouler! Let the good times roll!

In October 2012, I will have the good fortune to welcome the American Academy of Pediatrics (AAP) and hopefully many of you to New Orleans. I moved to New Orleans (NOLA) for residency in 2004 (do not do the math---I feel old enough with the new interns starting!). I love living in NOLA and more than that, I love sharing my love for the city with visitors.

You will find some of the kindest and most welcoming people in the world here. It is the norm to say hello or have a great (or blessed) day to the strangers you pass on the street.

Maybe it is all the fantastic food in New Orleans that makes people so happy and friendly. Maybe it is the amazing live music you can hear in just about any bar across the city. I would like to think we just have a special joie de vivre.

If you are coming to New Orleans for the National Conference and Exhibition (NCE), take the time to explore different parts of the city. Contrary to popular belief, New Orleans is more than the drunken debauchery of Bourbon Street. Most of us leave that to the tourists! You can find many family friendly things to do within walking distance of the convention center including the Audubon Aquarium of the Americas, the Children’s Museum, the National World War II Museum, and the Audubon Butterfly Garden and Insectarium.

I suppose you should find time to attend some of the incredible programming at the NCE. The Section on Young Physicians (SOYP) has partnered with the Section on Administration and Practice Management to present a day-long session entitled the Physician Leadership Academy: “How to Run with the Big Dogs.” The session includes information on developing the skills to run a practice, how to integrate quality and improvement projects into your daily work, and how to market your practice.

You are also invited to our annual Young Physicians’ Reception Sunday night for some food, networking, and fabulous door prizes! The reception is always a lot of fun and a great way to end the day.

As if your schedule was not full enough, I would like to challenge you to participate in the Friends of Children Fund 5K Fun Run and Walk. This run raises money for the Friends of Children Fund, a fund that gives support to a number of Academy initiatives including grants for residents and young physicians and support for pediatricians in areas affected by disasters such as hurricanes, tsunamis, and tornados. The suggested donation is $25 per family and I would love for the Young Physicians to have a major presence at the run. Don't worry--- New Orleans is flat and the weather in October is great for running/walking. It is also a great opportunity to burn off the calories from some of the decadent food you will be eating all weekend!

I hope to see all of you in New Orleans at the NCE!
After months of anticipation, the drama surrounding the future of the Patient Protection and Affordable Care Act (PPACA) has shifted from the judicial branch to the outcome of the upcoming elections. While the law lives on for now, given its unpopularity in public opinion polls, its future is by no means guaranteed.

The American Academy of Pediatrics (AAP) has been very clear in its support for the PPACA, and has taken pains to spell out the anticipated benefits the act has to offer to our patients. In advocating for the well-being of our children, the Academy has provided guidelines for screening of treatable conditions, prevention of childhood diseases with vaccination programs, and supporting the creation of the Children's Health Insurance Program. Since the inception of the PPACA, many children have received care in spite of having preexisting conditions or have received preventive services at no cost to their families. In addition, college-aged students and college graduates alike have been able to pursue their dreams, unencumbered by the stress and worry associated with going it alone without health insurance. These are just a few changes that the health care reform brought to our patients in the past two years.

Dr. Robert Block, AAP president, in a letter sent to the AAP members prior to the Supreme Court ruling, stated that we, AAP members, simply are performing Basic Life Support advocating to the care of our children. He said that, regardless of the decision of the court, the AAP will continue advocating for a health care system that provides children with the “ABCs.” In Dr Block's own words: “Access to health care services, age-appropriate Benefits in a medical home and health care Coverage for all children in the United States.”

This is the mission of our Academy and the vision of our current government, and we should not see it as politics because the people who really are going to be affected are the ones who cannot vote, the ones who we should advocate and fight for: our children. As Doc Hudson (aka, the Fabulous Hudson Hornet) said to Lightning McQueen when he was teaching him how to turn on a dirt track: “I'll put it simple: if you're going hard enough left, you'll find yourself turning right.” After all the votes have been cast in November, regardless of what turn we take politically as a country, we will eventually finish in the same place as pediatricians: working tirelessly for our kiddos.

With this in mind, I welcome you to our SOYP Summer 2012 Newsletter. As always, we have received a variety of contributions, so I am confident that you will find an article of interest inside. Please stay cool, relax, and enjoy! And keep your articles coming!
"That's an amazing invention, but who would ever want to use one of them?" It was obvious that President Rutherford B. Hayes had reservations about the future implications of Alexander Graham Bell’s telephone. In 1877, an answer to Hayes’ inquiry may have been realized when twenty-one local doctors in Hartford, Connecticut were connected to the Capital Avenue Drugstore via the first rudimentary telephone exchange on record. By 1923, the utilization of the telephone was so entwined in the medical field that a Philadelphia doctor's manual stated that it had become as necessary to the physician as the stethoscope. Communication at that time must have seemed so lucid.

Advancements in communication have undoubtedly revolutionized every aspect of medicine. Thanks to the Federal Communications Commission’s (FCC) National Broadband plan, a major stroke center can provide real time management to an outlying ER through telemedicine. The parents of a two-year old girl can rest soundly at night knowing that their daughter's Medtronic® insulin pump will provide a radiofrequency transmitted alarm when she is hypoglycemic. The Food and Drug Administration’s Medical Device Data Systems (MDDS) rule is fighting an everlasting battle against companies rushing to develop “mobile medical apps” for the sole purpose of data storage, management, analysis, and transmission.

However as a hospitalist, I cannot help but notice the fundamental basics of patient care that is being lost in translation through this buildup of arms in communication. It could be frustrating for any physician to halt family-centered rounds because outside hospital transfer records have not been obtained. At the same time, it must be infuriating for the generalist who received a Grade 5 mess of a hospital discharge without any direction. You can attribute this to fax machines, the schedule of today's pediatrician or the countless failed quality improvement projects that have tried to tackle the conundrum that is transition of care. The blame is a blanket that covers all facets of medicine on either side of a hospital or clinic wall.

The AAP Hospitalist Guidelines call for ‘timely and complete communication’ between the inpatient and outpatient realms. Multiple adult studies have clearly depicted an overall deficiency when it comes to transition of care. Pantilat et al demonstrated that only 8-33% of primary care physicians receive discharge summaries at time of follow-up. Phone notification at time of discharge is seen in 31% of cases, with only 8% being documented. Only 56% of primary care physicians think patient handoff is adequate.

Our inadequacies directly affect medical care and patient satisfaction. Moore et al showed that 49% of discharged patients in adult hospitals experience at least one medical error in medication continuity, diagnostic workup, or test follow-up. Hruby et al found that only 61% of patients knew that the hospitalist and primary care doctor were in contact. How can I sit inside of my hospital knowing that 42% of patients prefer a serious diagnosis discovered in the hospital to be conveyed from the primary care physician rather than the hospitalist?

Cont. page 5
cont. Lost in Translation:
Transition of Care in Hospitalist Medicine

Cont. from page 4

It is Kosair Children’s Just For Kids Hospitalist policy for an attending physician to document transition of care via tele-
phone for its nearly 5900 annual admissions based on the primary care’s preference. This can range from a call at dis-
charge to a daily phone call update. Is this a perfect system? No by any means. An hour’s worth of phone calls on a
Saturday evening to rehearse the same bronchiolitic’s disposition over and over again is less than ideal. As defeat sits
in, I close my eyes and picture those twenty-one physicians in Hartford, Connecticut in 1877. Their elation must have
been so palpable. Communication must have been so lucid.

Transition of Care Resources:

1. Pantilat SZ, Lindenauer PK, Katz PP, Wachter RM. Primary care physician attitudes regarding communication with hos-
3. Moore C, Wisnivesky J, Williams S, McGinn T. Medical errors related to discontinuity of care from an inpatient to an
http://pediatrics.aappublications.org/content/112/6/1314.full.pdf
5. AAP Report: Hospital-to-Home Transitions for Children with Chronic Medical Conditions
http://pediatrics.aappublications.org/content/early/2012/04/25/peds.2012-0606.abstract

Reflection as a Pediatrics Intern:
Three Main Points of My Year

Monique Cunningham-Lindsay DO, PGY-2
Morehouse Community Pediatrics Residency

As I sit here and think back, I am blown away with all that I have seen, heard, experienced, and been through in just
my first year as a pediatrics intern. Whether while on the floor, or through my day to day experiences, I know for a fact
that nothing could have prepared me for what has transpired. To start, I gave birth to my first child during my first
week of residency. What a difficult time I had balancing being a new mom and the rigors of the intern year. Neverthe-
less, I can truly say my daughter’s entrance into the world and my new job were the beginning of the experiences that
started molding me into the person and the pediatrician that I am becoming now. As I see parents and patients, I feel
more prepared with a new found understanding of what it means to be a mom, in particular, a working mom. I would
not have been able to meet these challenges without the help of my caring husband. He managed to work part time as
an adjunct professor in order to care for our daughter. With all this learning and experience, and as I progress through
the final months of internship, there are three main important points that top my list which, I would like to reflect on.

First, take the time to listen. Thus far, I have seen that taking the time to listen can prevent so many medical errors
and incidents from occurring within the hospital. It is easy to get into a mode of half listening because we have so
many things on our plate. In addition, because of stress, a hectic and busy schedule or insecurity, we may fail to ask

Cont. page 6
Reflection as a Pediatrics Intern: Three Main Points of My Year

more questions for clarification. The act of shortening the time we spend with our attendings, patients, parents, nurses, and those around us can cost us a lot in the long run. Moreover, it often takes away from our ability to provide the best care possible to our patients and families. So let us be mindful of the time we take each day to truly listen to those around us.

Second, *keep your fire to learn burning*. We live and practice in a technologically advancing environment with new breakthroughs in medicine, and new insights in the care and treatment of our patients, therefore, we must seek to understand things we do not know and build upon what we already know. Our experience, complemented with evidence-based medicine, will help us make the right decisions in the treatment and care of our patients. In addition, we can find comfort in knowing that we are knowledgeable and ready to answer questions, providing reasoning behind our medical decisions. So let us keep our learning fire burning. We can never know too much, and our patients' satisfaction and well-being will demonstrate that it has not been in vain.

Third, *place yourself in your patient's shoes*. As physicians, we can sometimes forget what it is like for a child to face hospitalization in an often frightening and overwhelming environment. From lines and drains, to injections and masks, to pain and strange faces, to routine vitals, being hospitalized as a child is not an easy experience. It takes a champion pediatrician to know how to appease the fears, of not only children, but their families as well. Because of this, it is so important for us to keep our patients comfort in mind when deciding on treatment plans and to be cognizant of the words and approach we use while at the bedside. It is one thing to provide treatment and another one to be an advocate and healer for our patients.

In all that we have personally learned over this year as interns, senior residents, graduates, and hospitalists, let us continue to use what we have been given, so that our patients and families may surely reap the benefits. Let us take pride in how far we have gotten and where we are going. Let us teach others as we move forward and remember those that have helped and continue to help us along the way. This year has been a whirlwind for many of us. I am definitely no longer the same and I am grateful because of it.

---

**Book Review**

Randi Teplow-Phipps, MD, FAAP

*Title: The Boy in the Moon: A Father's Journey to Understand His Extraordinary Son*

*Author: Ian Brown*

Ian Brown is a journalist whose son, Walker, is born with a rare genetic condition called Cardio-Facial-Cutaneous (CFC) syndrome. From a non-medical perspective, we are invited into Brown's life to catch a glimpse of the continual dedication required to take care of a disabled child. Walker’s condition impairs him both mentally and physically including the difficult aspect of self-mutilating behavior. Brown often questions what Walker actually understands, but something as simple as a smile is enough to reinforce their interaction. He describes the unique bond he feels with his son as they communicate in their special way without words. The stresses of multiple doctor appointments and the endless sleepless nights required the family to completely alter their lives in order to care for Walker. This becomes even more complex as he discusses the guilt they feel in order to give appropriate attention to their older daughter.
**cont. Book Review**

**Title:** The Boy in the Moon: A Father's Journey to Understand His Extraordinary Son

The stress of caring for Walker's needs clearly takes over every aspect of Brown's life. Brown is able to frankly discuss how he learned to cope and handle his son's disability. Brown reached out to other parents with children affected with CFC in order to deal with some of the difficulties in his own life. Through this journey, he is able to remind himself that it is actually a two way street and that he continues to grow as a person with each new challenge Walker presents.

The reader experiences the mental anguish when Brown's family decided that Walker would benefit from living in a chronic care facility. This decision incorporates feelings of inadequacy, failure, and a desire for a "normal" kid, but also includes the ultimate goal of helping their son. The emotional struggle was paired with the political and financial trouble of petitioning the government to help provide the needed services and support for his child. Brown attains higher insight when he realizes that Walker is an independent being who deserves to have new experiences and additional people who can influence his life. Some of the caregivers at the facility are described as angels who understand his son beyond any way the family would ever be capable of doing. Brown's journalistic instinct eventually landed him in France to explore the idea of semi-independent living for those with disabilities. He thoughtfully discusses how the norms of this unique society are adapted and how the people with varied disabilities are joined together to create a community. Brown's personal struggle with Walker's illness and the candid discussion of his emotional experiences help the reader gain insight into the strains of caring for a disabled child. The rewarding feeling of caring for his son and his infinite love, in the end, rises above all else. This book highlighted some of the difficulties and hardships not often discussed in clinics and at doctor visits. It makes the reader think twice about living in our world and the obstacles that some families endure every day of their lives.

**Title:** The Immortal Life of Henrietta Lacks

**Author:** Rebecca Skloot

Henrietta Lacks, born in 1920, was a southern, African American, farm woman who worked the fields and lived a relatively simple life. She was born into a large southern family, but was sent to live with her grandfather in Virginia when her mother died during the birth of her 10th child. She married her first cousin, David "Day" Lacks, and they proceeded to have five children together. With no money in their pocket and with the hopes of a better life, they moved to Baltimore in order to work in a steel-mill town. Henrietta, after feeling a "knot" in her stomach, was soon diagnosed with cervical cancer just a few months after her fifth son was born. At Johns Hopkins Hospital, she was given trials of radium tube insertion, radiation treatment, and antibiotic therapy, but nothing seemed to help. She passed away at the young age of 31 years and is buried in an unmarked grave.

Despite her relatively ordinary life, Henrietta Lacks, unknowingly, has become one of the most influential individuals in the history of modern science. She is better known to the scientific and medical world by her cells, HeLa, an immortal cell line taken from her body without her consent or knowledge during one of her medical treatments. Dr. George Otto Gey, who was conducting research using Henrietta's cells, noticed that they would continue to grow and stay alive beyond all other cell lines. They could be divided endlessly, which would prove to be a huge benefit to science. HeLa cells have since been essential in the following ways: to develop the first Polio vaccine by Jonas Salk, to test sensitivities to cosmetics, to discover how Parvovirus infects humans, to help clarify the role of the Papillomavirus and apoptosis, to create anti-cancer medications, to detect cancer markers, and to identify chemical dying in medical diagnostics. These are just among the few ways Henrietta, or more specifically, her HeLa cells, have helped to advance science.
**Book Review**

**Title:** The Immortal Life of Henrietta Lacks

Cont. from page 7

This book was captivating and easy to read. Skloot brings the reader into the mundane life of Henrietta Lacks and parallels it with the great scientific discoveries. The family is followed as they discover the truth about the cells, complicated by racial discord and issues of class and education. They were angry and confused about how her cells had been taken without her knowledge and have been used for scientific study. This raises the issues of ethics and consent within the medical research world. Since 2010, this book has been on the New York Times best seller list for more than 30 weeks and has won multiple awards. This scientific book is accessible to both medical and non-medical readers and is a definite must read for everyone!

For comments, feedback, or suggestions of future books to review, please feel free to email me at rnt9005@nyp.org.

Happy Reading!

---

**Summer Water Safety**

*Shani-Kay Chambers, MD, FAAP*

*Gessler Clinic*

Summer has arrived once again. It is time for barbecues, vacations, and fun in the sun. One of the more popular ways to enjoy the season is by relaxing in and around pools, lakes, or the ocean. Many hazards lurk within these waters, especially for children. Before making travel plans and packing swimsuits for your child, be aware of the hazards and become familiar with the safety tips below.

**Swimming Safety**

Swimming is a way of life in Florida; in fact, our very own Polk County has 381 lakes. It is critical that our children learn to swim to stay safe in the water. Swimming readiness depends on several factors, including developmental abilities, emotional development, and the baseline health of your child.\(^1\) Children must have the appropriate neuromuscular coordination needed to perform maneuvers for swimming. If your child can walk well, climb, follow instructions, and is between the ages of one and four, he or she is most likely ready for swimming lessons. Since all swimming lessons are not the same, parents must search for the best class for their child. When enrolling your child in swim lessons, ensure that the class follows YMCA guidelines. Swim instructors must be certified in lifeguarding or aquatic safety, possess a national swim instructor certificate, and have first aid or CPR training.\(^2\) It is encouraged to enroll in a class that features parent participation.

**Staying Safe Around Pools**

Pools themselves lure children and can pose as a hazard. Take the following precautions to ensure your pool is safe. A pool fence is an invaluable safety tool. When purchasing a pool fence, remember the rule of fours: buy a 4-sided fence at least 4 feet high and with openings 4 inches or less under the fence and between the vertical slats.\(^3\) Pool gates must have an automatic latch mechanism at least 54 inches high and should open out from the pool. Pool covers, pool alarms, and chain link fences around the pool are not sufficient and can lead to a false sense of security. Potential hazards also exist within the pool, such as broken or missing pool drains and covers. In 1991, a three-year old girl was unable to remove herself from an uncapped pool suction drain. As a result, she suffered severe intestinal injuries which required extensive surgery.\(^4\) This unfortunately is one of many incidents in which children have suffered critical injuries due to hazardous pool conditions.

Cont. page 9
Staying Safe in Natural Water Environments
Lakes, rivers, and the ocean can also pose health hazards. Be aware of creatures, large and small, that can lurk within these natural bodies of water. Microorganisms, such as E. coli, cryptosporidium, and Giardia, if ingested, can result in abdominal pain, fever, and diarrhea. Other bacteria can cause outer ear infections. Animal bites or stings from alligators, snakes, or jellyfish will necessitate a visit to a physician. Consider the strength of the water before swimming. If caught in a rip current while in the ocean, swim parallel to the shore until you have escaped the current, and then swim towards the shore. Finally, look before you leap. Diving head first into water of unknown depth can result in severe head injuries, even death.

Out on the Open Water
The open water also exposes us to the use of recreational water vehicles. Boats, jet-skis, and water skis can all pose a danger. Life jackets are recommended at all times while using a water vehicle. Avoid intoxication with drugs and alcohol, which can severely impair one's judgment. Avoid speeding while using these vehicles.

Know How to Respond to an Emergency
Knowing how to respond in case of an emergency is critical in preventing injuries or death. Never leave your child unattended around water and stay within an arm's reach at all times. Learn to administer both adult and pediatric CPR. Keep rescue equipment and emergency numbers on hand.

Our community offers many resources to protect our children. Your local YMCA may offer parent-child swim lessons, group lessons, and private lessons. Now that you have the tools to make this summer a safe one, go out and enjoy Florida's beautiful season.

Community Resources
Lake Wales Family YMCA
http://www.lakewalesymca.org/
1001 Burns Ave
Lake Wales, FL 33853
Phone: 863-676-9441

Winter Haven Family YMCA
6955 Cypress Gardens Blvd.
Winter Haven, FL 33884
Phone: 863-292-0922

Lakeland Family YMCA
3620 Cleveland Heights Blvd
Lakeland, FL 33803
Phone: 863-644-3528

Polk County Chapter
American Red Cross
147 Ave A NW
Winter Haven, FL 33881
Phone: 863-294-5941

Cont. page 10
cont. Summer Water Safety

Cont. from page 9

Leslie's (Pool Supply Store)
7050 Cypress Gardens Blvd
Winter Haven, FL 33884
863.326.9380

Leslie's (Pool Supply Store)
4770 S Florida Ave
Lakeland, FL 33813
863.647.2343

Leslie's (Pool Supply Store)
111 Ambersweet Way
Davenport, FL 33897
863.420.9120

REFERENCES


“Stop That Crying and Be an Athlete”
Raising Our Kids to Be Super Athletes Out of the Womb and the Effects on Their Bodies and Minds

Bianca Edison, MD
Chief Resident UCLA Medical Center/Peds

I recently covered a high school football game as a team doctor and one of the players remained down on the field after a play. When I went to go assess him, I noticed one of his fingers pointing in a completely different angle as his others. He had an open compound fracture of his middle finger, bones and tendons exposed. As I helped him off the field, I knew that he was in excruciating pain, but his first question to me was, “when can I go back in, Doc?” When I told him that I was sending him to the orthopedic hospital, he pleaded with me to bandage him up and let him finish his championship game because coming out of the game was “weak.”

I stood there in shock as I listened to this 15 year-old place more value on how the players would perceive him instead of on his own finger. I quickly realized, however, that this player represented the collective socialization of our youth, the same standards that were reinforced when I grew up. His concerns echoed what my siblings and I were taught: “athletes do not cry…had to be tough…must perform without fear...show no pain…”

As a pediatrician, I remain deeply concerned because these standards stand in the way of children's physical and mental health. When a young teenager believes in her heart that she should not call attention to her nagging knee pain for fear of being perceived as “weak,” she not only risks the future functionality of that knee, but she also stands to be victim to more serious injuries later by remaining silent.

“But my trainer told me I would be fine, that all I would need would be a prescription for physical therapy from you.” When I told my patient that she could not return to soccer this season out of concern for an ACL tear (which was later confirmed), she transformed from a confident, head strong, 17 year old young woman to a sobbing child in a matter of seconds.

Neither of these athletes' stories are isolated occurrences. Many have told me that they “fight through pain, ignore the subtle warning signs, sacrifice their bodies for the love of the sport.” Have we set a standard of play for our young athletes that poses a serious risk to their longevity and future?

Thirty million US children participate in organized athletic programs and with that increase in participation there have been increases in acute injuries and chronic overuse problems. Over 33 percent of school-age children will sustain an injury severe enough to be treated by a doctor or nurse. Almost four million injuries per year amongst our youth translate to a yearly price-tag estimated as high as $1.8 billion. As I say to my young patients, I can fix most injuries, such as broken bones or sprained ankles. I cannot fix a broken brain, an injury that unfortunately has come into the spotlight lately.

Approximately 300,000 sports-related concussions occur each year, yet this reported number pales in comparison to the actual estimations of 3.8 million concussions arising from recreation and sports activities. Concussions represent roughly nine percent of all high-school athletic injuries. Female youth athletes are reported to have higher rates of concussions than boys in similar sports. The long term effects of what was previously written off as a “ringer,” something to tough through for a young athlete, are staggering. Three months after a concussion, children eight to sixteen years old have been found to have persistent deficits in processing complex visual stimuli. Post-autopsy, an eighteen-year-old who experienced multiple concussions was found to have brain injury findings previously only reported in professional football players and professional boxers. The need for answers behind these surprising findings has not only resonated with health professionals, but also with some athletes themselves.

Cont. page 12
“Stop That Crying and Be an Athlete”
Raising Our Kids to Be Super Athletes Out of the Womb and the Effects on Their Bodies and Minds

In February 2011, a premiere football athlete, Dave Duerson, tragically took his life by a shot to the chest. His reasoning for ending his life remains a mystery, but he did leave one wish before parting: He wanted his brain donated to research to help figure out why contact sports cost lives.

Until we, as health professionals and as the community at large, start teaching young athletes that communicating pain is smart and does not reflect their ability as an athlete, we will continue to see a rise in preventable injuries, such as overuse problems, heat stroke, and second-impact syndrome from unreported concussions. Educating parents, coaches, trainers, and young athletes themselves about recognizing early injury warning signs is crucial in the rally to prevent unnecessary injuries in children.

Working the sidelines for pediatric sporting events, I am continually reminded of the importance of having a strong academic and evidence-based foundation to children’s involvement in athletics, a foundation that can grow along with and inform the changing dynamics of recreational and competitive sports amongst children. I have witnessed occasions when some trainers or coaches were still unaware of the latest recommendations of concussion injuries and return to play, which speaks to the need for effective dissemination of the latest policies, regulation of those policies, and the widespread use of patient education materials.

We also need to delve further into this issue and tackle it from a psychological and social perspective as well. How far is too far? Should the professionalization of children’s sports, via private individual coaches, ranking systems, and year-round seasons, be encouraged? By supporting our children to participate in sports for the sake of healthy competition and skill building instead of demanding them to be elite, professional athletes at 10 years old, we can help them become more responsible for and honest about their own bodies. Furthermore, by encouraging both our sons and daughters to express their feelings, we will not stymie their emotional growth and development. As physicians, we need to continually have conversations with parents about their notions of raising their children along the lines of realistic expectations.

The next time you see a seven year-old in clinic or in the store, decked out in his pee-wee football uniform, let him be just that, a seven year-old and not the next Tom Brady.
Making a Difference for Kids

Christina Bourland, MD
Pediatric Hospitalist
Assistant Professor of Pediatrics
Children's Medical Center of Dallas

The news for children in our country is not good these days. Nationally and at the state-level, funding for social programs is being cut, yet more children than ever need these services. We continue to work tirelessly in our clinical settings, counseling families daily about nutrition and safety, seeking to prevent obesity and accidental injury. Will our efforts make a difference if our patients do not get enough to eat this month, or fail to graduate from high school? While the duty of a physician is to provide medical care for an individual, we as pediatricians have a responsibility for the overall health of a nation of children.

I recently had the good fortune to attend the 2012 American Academy of Pediatrics (AAP) Advocacy Summit. I anticipated that I would be impressed by the breadth of experience represented by the AAP leadership, and I was not disappointed. I learned the meaning of dedication through personal accounts of persistent advocacy at the state and federal level, advocacy that at times required years of perseverance before policies respecting child health were enacted. What I was surprised to learn first-hand are the many ways that young physicians can educate themselves and their peers, and engage in meaningful action designed to influence our policy-makers to enact decisions that honor our children.

Each state has a unique political climate with associated child health challenges, and we can work within the systems in our specific states to promote change. State AAP chapters tailor activities to promote child health in ways that support their particular members and child populations. The state AAP chapter is a wonderful resource of information for physicians, and can help you organize your community and understand your state's position in the evolving world of health care reform.

In turn, our state chapters need us to stand for children in our communities and our capitals. Each one of us has a cadre of patient experiences that illustrate the importance of social programs that serve children, as well as child health issues that we feel strongly about. We need to actively engage in our AAP chapters, and identify like-minded pediatricians that we can partner with to increase awareness and guide policy change.

Our involvement must go beyond this individual commitment to work to promote a shift within the culture of medicine that celebrates social responsibility and community health. As pediatricians, we understand that the problems of childhood obesity and poverty are not isolated to the individual; they are problems that affect the health of the entire nation, and will only grow in magnitude as today’s children become adults. We as a health care profession cannot stand by and continue to watch these problems cripple our communities and consume our nation’s budget.

We are living at a critical time for child health. Write a letter, join your state chapter, visit your state capitol, and organize your peers. Millions of children are depending on you.
How Your Medical Practice Can Hedge Against Loss of Visits

Brandon Betancourt, MBA
Pediatric Practice Managers Alliance Leadership Team

One of the numbers that I check regularly month after month is the number of patients seen in our practice. One of the advantages of tracking these numbers is that they are a good forecasting tool. Studying the numbers and anticipating things like the flu season gave me a real good idea of how many patients to expect in the coming months. For example, the numbers tell me when traditionally our practice does not see that many patients. Then, instead of freaking out why our office is seeing fewer patients in July, I remain calm knowing that historically July is generally slow. Over the years, I became in-tuned with our practice's seasonality trends. If we were less busy, I would not worry because I knew things would eventually pick up. In fact, I knew to the month when things would start moving. And over time, I fell complacent with these fluctuations. Consequently, I started relying on the better months for patient traffic to compensate for weaker months.

During the winter of 2009-2010 (soon after the H1N1 debacle), I got one of the rudest awakenings when the expected upward trend did not occur. We were sitting dead in the water and the patient drop put a heavy burden on our cash flow. That experience led me to be more proactive with our patient flow as well as not rely so heavily on seasonal trends, but rather rely on a different strategy all together.

So what was our new approach? Recalls. Patient recalling is probably one of the most underutilized initiatives pediatricians do and our practice was in that bunch. The truth is, recalls are one of the most effective ways to hedge against loss of visits as well as a strong predictor of potential income. In 2010, we started focusing on bringing kids back that were due for their well-visits, asthma check-ups, children over a certain BMI, and patients behind in their immunizations. I still used my “patient seen” numbers, but this time, I used them differently. Our data has always shown that our patient visits downward trend starts in April and continues to go down until late July. July has always been our least busy month.

As an alternative to waiting out the season (waiting for the winter months to kick in), we started recalling patients starting in May. For the months of June and July of 2010, we were able to bring in 138 more patients than in 2009. That extra 138 patients will go a long way to offset any downturn we may face in the coming months should they occur again. One hundred thirty-eight extra patients might not be significant to your practice. I know of one large practice that in 2008 did 4400 overdue well visits. At $112 a visit (excluding vaccines), they were able to bring in an additional $493,000. How is that for perspective?

Here is the bottom line. The recalls have helped my practice reduce the risk of adverse seasonal trends, but that is not the only benefit. By taking the recall approach, the practice is taking a proactive approach in the health of our community. Thanks to our efforts, more kids came to see the doctor. As the saying goes, prevention is the best form of medicine. Oh, and we made a little bit of money too.
Media, Technology & Children:
How to Guide Learning

Ricky Y. Choi, MD, MPH, FAAP
Member of the Council on Communications and Media

The technology revolution is transforming my life. I have reconnected with long lost friends on Facebook. I consistently find excellent places to dine within a short walking distance when I travel to a new place (or get lost). I can find obscure information in seconds or blast my latest blog post to millions of people with just a click. As a parent and a pediatrician, I wonder about the ways that these technologies can benefit children and the use parameters we should have to minimize harm.

In my house, my children engage in imaginary play with dolls, make elaborate crafts with colored paper, and read books. They also use my iPad. Through this amazing piece of interactive technology, my children have practiced the correct stroke order for Korean characters, learned where milk comes from via YouTube videos, and came to the conclusion that no satellites orbiting the earth are the color pink. My parents live 2700 miles away, so most of my children’s interactions with their grandparents are over Skype video chats. So much so, in fact, calling them “grandma Skype” and “grandfather Skype” is no longer funny, it is a reality. While a second best to actually being together, the weekly video calls have supported a relationship that hand written letters and phone calls never could.

The American Academy of Pediatrics (AAP) has policy positions on screen time and social media, as they relate to health, highlighting the link between excess television viewing and obesity, poor sleep, and decreased activity. In today’s world, discussions about media use are no longer talking about passive media consumption. We must now include interactive technologies such as touchscreens and body sensors. Watching TV on the couch is not the same as playing tennis with a Wii remote. And beyond setting boundaries, how should children actually use technology, and how should we as parents and health care professionals guide its use for learning?

The National Association for the Education of Young Children and the Fred Rogers Center for Early Learning and Children’s Media at Saint Vincent College have released a position statement that it is worth reviewing. They take the position that “when used wisely, technology and media can support learning and relationships.” While this position statement was directed towards educators, I find their recommendations to be easily applicable to parents - who are, after all, a child’s first teachers. They offer a thorough evidence based discussion on the range of ways that these new technologies can enhance learning. It is more than consent to “pass back” the iPad to your child in the back seat. Their guidelines are specific and inline with the AAP’s policy statements:

• No screen time for children under 2 years of age
• Technology should be developmentally appropriate
• Technology should be used to support specific educational goals
• It should be used with specific intentionality not for the sake of using the technology itself
• Parents/Teachers should seek to link on and off screen activities
• Technology should augment, not impede, or be a substitute for social activity, play, and learning

I was also pleased to find their report included a discussion on the role of technology for children with autism and developmental delay. In fact they seek the “Intentional leveraging [of] the potential of technology and media for the benefit of every child.”

Cont. page 16
cont. Media, Technology & Children: How to Guide Learning

Cont. from page 15

This report even makes an important equity argument. Lower income families own fewer media devices and so can get left behind. Drawing an interesting parallel between “technology handling” and the importance of teaching “book handling” skills, the report argues the value of exposure of these technologies in a structured classroom environment to low income children so they learn how to both use these technologies and benefit from them. Furthermore, they suggest that together with good teaching, this could “accelerate learning and narrow the achievement gap.”

Technology has, and will continue to have, a growing role in our lives. Parents, pediatricians, and educators are clamoring for guidance on how to maximize the benefits of technology while minimizing the harm for children. This position statement is an important contribution to this discussion.

~ FROM THE SECTION FOR SENIOR MEMBERS ~

A Report from Bill Kueffner, Ninety-One Years Younger

William R. Kueffner, MD FAAP
Emeritus Fellow

On March 14, 1920, in St. Paul, Minnesota, Helen and Bill Kueffner became the proud parents of a baby boy, William Robert Kueffner. The family lived in St. Paul, where the senior William worked as an attorney and spent summers at a family cottage in Marine on St. Croix. Bill attended Creighton High School where he was a good student and a strong member of the swim team. He also was a Boy Scout and earned the honor of Eagle Scout. He went on to Carleton College (Class of 1941) on a full scholarship. Over the summer, he worked at Glacier National Park Hotel. During his time off, Bill would go hiking in the park’s mountains, often with the hotel photographer who was diabetic. Not yet trained in medicine, Bill remembered how the photographer would eat raisins when he “needed a boost.” At one point he had considered studying engineering, but after two years at Carleton, he transferred to the University of Minnesota where he went into a pre-med program. With schedules compressed because of the war, Bill graduated from their medical school in 1943. The entire medical school was enrolled in the ASTP - Army Student Training Program. The Army would pay for their education, but they would become medical officers.

After graduating, Bill started his internship at City Hospital in Washington, D.C., until he was sent to Camp Upton Army Hospital on Long Island for Army medical training. There he met an occupational therapist named Elizabeth. They married at St. Patrick’s Rectory in New York City. Shortly thereafter, Bill was sent to Italy as a Battalion Surgeon, rising to the rank of Captain in the 10th Mountain Division. He replaced a doctor who had walked the wrong way into enemy lines and had been captured. Bill looked after the soldiers in the 2nd Battalion in the Apennine Mountains of Central Italy. The wounded brought in by the medics were treated or sent back to a M.A.S.H. He celebrated VE day at a
A Report from Bill Kueffner, Ninety-One Years Younger

From page 16

battalion aide station he had set up on beautiful Lake Garda, across the water from the villa where Mussolini and his mistress were captured. After that, the 10th Mountain Division was rumored to be the lead attack in the invasion of Japan until the surrender after Hiroshima changed those orders.

Back in the States, Bill and Elizabeth's first son, Bruce, was born in October, 1945. The young family moved to Brighton in Boston where Bill gained pediatric training at Boston Children's Hospital and Harvard Medical School. It was a wonderful opportunity to meet renowned doctors, pioneers in pediatrics, such as Dr. Gross, Dr. Green, Dr. James Gambol, Dr. Lewis Diamond, Dr. Sydney Farber, and Dr. Charles Janeway.

Why did Bill decide to go into pediatrics? "I liked children and I had been encouraged by Dr. Lewis Sweet during my internship in Washington," he said. In June 1946, Bill and Elizabeth moved to New York City and Bill studied at Cornell Medical School at New York Hospital. They lived in a fifth floor walk-up on East 75th Street.

They later moved to Fairfield, Connecticut, closer to Elizabeth's parents, where Bill started his practice in 1949. That same year their second son, John, was born. As a young pediatrician, Bill volunteered his services as team doctor for the Roger Ludlowe High School football squad. He was amazed how, despite their injuries, the players always wanted to get back on the field. Over the years, the practice grew and moved from a second floor office over Clampett's Drug Store to a house in downtown Fairfield.

In 1951, Bill's wife Elizabeth was diagnosed with breast cancer at the age of 32. She died the following year. With two young sons and a fledgling practice, Bill was a busy man. He met Nancy during a ski weekend with friends and they were married in 1953. In the years to follow, the family grew from four to eight: sons Paul, Eric, Carl, and Chris were born. A doctor from the old school, or at least one from an earlier time, Bill made house calls all over town carrying his familiar doctor's bag, which is now part of the collection at the Fairfield Historical Society Museum. As a result, he still knows Fairfield's streets as well as any firefighter. Patients also came to the house on Old Academy Road to be checked or examined - that is, if they had not been cured over the phone while he sat at the table during family meals. One family, short on funds, offered Bill a weekly supply of eggs in return for his pediatric services. Unfortunately, the hens stopped laying. So the family presented Bill with a donkey instead. Christened Sybil, the donkey was warily accepted, but enjoyed by a sleigh full of Kueffner boys on the next available snow day.

In 1957, Bill and his partner, Frank Scholan, moved their office to a 200-year-old building that served as a Tide Mill, and later a restaurant, overlooking the harbor in Southport, Connecticut. With intriguing waterfowl outside the windows, the waiting room was equipped with fascinating push-button, ping-pong distractions for children including old typewriters, telephones, cash registers, and airplane controls that Bill obtained from the Salvation Army. When the building came up for sale in 1974, Bill took a deep breath and bought it from the Wakeman Boys Club. With retirement in mind, he and Nancy had their sons build a compact, but airy apartment on the third floor, where Bill lives today.

Bill has long been active in both Fairfield and in the local medical community. He served on Fairfield's Board of Health for a number of years. He has been a member of the staff at Bridgeport, St. Vincent's, and Norwalk Hospitals. He headed the pediatric department at Bridgeport Hospital for several years. He also worked at Yale Medical School and was the Connecticut State Chairman of the American Academy of Pediatrics. Finally, in 1985, Bill retired, but he did not slow down. Fulfilling a long-held goal, he volunteered at the Albert Schweitzer Hospital in Haiti, fully contributing his career-long experience and expertise. He and Nancy made several subsequent trips to Haiti where they both

Cont. page 18
volunteered their services. Between visits, he helped raise funds and he located sources of medicine and supplies for the hospital. He continues to be very active in supporting the hospital today.

Bill never lost his enthusiasm to be involved with people and projects. From his dedicated efforts in Haiti to attracting purple martins to the Tide Mill Martin House, from helping research and shepherd the design and construction of handicap ramps at the Pequot Yacht Club and at the Fairfield Beach Club, to tending to his plants in his greenhouse. While managing to stay quite active in the community, Bill spent the last several years caring for Nancy, who developed Alzheimer's and died in 2007.

These days, it is hard for Bill to go anywhere without someone saying "Hi, Dr. Kueffner, I was one of your patients." Often there are generations of patients including children and their parents. Arthritis and glaucoma do not slow him down. To him, these are inconveniences, not impediments, and not enough to prevent him from being the first on the dance floor at the Pequot Yacht Club, where he has sailed for more than 50 years.

What is Bill's advice to young pediatricians? Bill said, "One should choose pediatrics because one wants to help children and their parents. Making money is not the goal. If that's what you're after, go into finance! The reward in our profession comes from the satisfaction after an accurate diagnosis and successful cure and a smiling patient." And what is most important? "We should take the time to listen," says Bill.
From the Committee on Medical Liability and Risk Management:

Common Misconceptions About Medical Liability

Jeffrey L. Brown, MD, FAAP
Member of the AAP National Committee on Medical Liability and Risk Management

Medical errors and medical malpractice are the same: Not all medical errors represent malpractice. Medical malpractice is a legal term that suggests that treatment rendered by a physician or other medical professional does not conform to a “standard of care” that would be given by others with similar training and under similar circumstances. It also requires that the patient has been harmed as a result of that care. The standard of care may be subject to interpretation and expert witnesses chosen by the plaintiff and defense teams will testify as to what should have been done.

If I am very careful, I will never make a medical error: Physicians who are new to the profession should remember that (1) many physicians will be sued at least once during his or her career; (2) the best defense against being sued is to provide good medical care; and (3) it is unrealistic to assume that anyone could complete their entire medical career without ever making a medical error. A more practical goal is to try to make as few mistakes as possible, to catch and correct them as quickly as possible, and to be committed to learning from them when they occur.

A medical error must be committed before a patient can bring a malpractice suit: Not all malpractice actions occur because someone did something that was medically “wrong.” Sometimes, they occur because it appears that they did something wrong. For example, a patient might be diagnosed with an incurable illness, but the jury has been convinced that earlier diagnostic testing would somehow have altered its outcome. A patient might develop a medical symptom shortly after an incident that was not actually caused by the treatment. It might be difficult to convince a jury that there was no association between them. Occasionally, parents might bring a lawsuit because they believe that their damaged child will require life-long care and they have an obligation to provide for him – even if it means suing the doctor. Parents might be under social pressure to bring a suit. Parents may have been told that no one is harmed by suing. “If I can collect some money, the insurance company will pay for it anyway.”

If I document everything that happens, I am less likely to get sued: Not necessarily. Some strategies used by younger physicians to avoid lawsuits are ineffective and counterproductive. Both over- and under-documentation carries risk. Everything that is medically pertinent to the patient’s care should always be documented. Some compulsive physicians might believe that “If I am super careful and write very complete notes, no one can fault me.” Over-documentation may include information that might be misinterpreted or otherwise damaging, and this process consumes time that must be borrowed from other patients and lead to errors when caring for them. Similarly, choosing under-documentation with a “less is more” strategy poses the risk that a physician might be viewed as providing inadequate care.

If I see an error in the chart, I should correct it: Yes, but only if the alteration or deletion carries an explanation that a correction is being made, and the original entry remains visible. If it appears that an entry was changed so that “unwanted” information would not be visible, the physician’s credibility is tarnished, and the case may become legally indefensible regardless of its merits.

It is more important to do what is medically correct than to spend time explaining it to the patient: Both are equally important except when there is a life-threatening emergency. Improving your communication skills with patients is essential for providing good care and preventing law suits. If a patient is angry at the time of a visit, you are less likely to obtain accurate history which may result in a poor outcome. Similarly, if you have not established trust between your

Cont. page 20
From the Committee on Medical Liability and Risk Management: Common Misconceptions About Medical Liability

Cont. from page 19

self and the patient, they are less likely to follow your advice and more likely to blame you when something goes wrong. For example, when a physician instructs a parent to call if the child’s condition worsens, and there are symptoms of meningitis the next day, one physician might say “Why didn’t you call me sooner? Couldn’t you see how sick he was?” Another might say “It is very difficult to tell when young children are becoming sicker, and they can get worse very quickly. You must be very worried. Let me do everything medically necessary, and then we can talk about it.” The first physician is more likely to be sued because he believed he put her on notice that it was not his fault, but inadvertently made her feel guilty and became her adversary. The second physician remained her advocate.

Patient grievances are handled best by the administrators: There are many times when administrators should be involved, but the physician is on the front line for managing complaints. When patients are upset about their care, their grievances must be addressed by the physician in a manner that is sensitive and effective. Patients want you to be empathetic and they want someone (preferably you) to take responsibility. You can agree with the patient’s perception without necessarily agreeing with their facts. “If that happened to me, I would be as upset as you are. Let me talk with the people involved, find out exactly what happened, and I will call you back later today.”

Attention to all areas of medical care are important: Yes, but some are more likely to be trouble-spots for potential liability than others. Everyone in the care team is responsible to ensure (1) patient confidentiality; (2) reduced risk for wrong-patient mix-ups; (3) proper follow-up of test results; (4) good communication when patients are handed off from one doctor to the next; (5) good record keeping; (6) proper response to patient grievances; and (7) good quality control and supervision.
Embracing Mental Health Care: Lessons Learned for Success

Future of Pediatrics Conference July 2011

Now available! Check out the recordings and summary report from the Future of Pediatrics Mental Health Preconference.

The Future of Pediatrics Mental Health Preconference was used as a vehicle for: 1) raising the awareness about the mental health needs of children and youth; 2) educating attendees on innovative best practice models for addressing mental health concerns; and 3) improving the skills of clinicians by providing practical tools for clinical care. The goal of the preconference was to empower pediatricians to address the health and well-being of children and youth with mental health concerns.

“Extremely engaged pediatricians, mental health specialists, government officials, researchers, and advocates met to embrace the challenge of caring for children and youth with mental health issues in the context of a rapidly changing health care system. The agenda was crafted to allow discussion of current efforts within government, primary care practices, and community-based agencies and from the perspective of patients and their families, with an eye toward breaking down walls and encouraging collaboration between sectors. There are small miracles happening all around the country that are changing the life-course trajectories of children, one family at a time. There are models that we can bring to scale, if we are able to muster the will. If one had to take a single message home from the day, it would be that, in order to meet the needs of patients and families, all who care for children with mental health concerns will need to continue to collaborate at home with the same vigor and enthusiasm that they brought to the conference to ensure that our constantly changing understanding of brain, development, and behavior is reflected in the systems of care that we create within our communities.”

~ David Keller, MD, FAAP
Can a resident continuity clinic be an efficient clinic, achieve high patient satisfaction, and even become a “Cadillac” practice such as a National Committee on Quality Assurance Certified Medical Home? Most of our experiences working in clinics during residency training would dictate a definitive “no” to each aspect of this question. My experience has been that given the opportunity and support, residents can transform their clinic into an excellent, outpatient practice that continuously improves.

In 2007, our residency program tested and implemented a mandatory quality improvement training program for residents. As part of this process, each resident completed a brief quality improvement (QI) project using the Model for Improvement and its powerful tool, Plan-Do-Study-Act cycles. The timing of our resident-based program corresponded with a healthcare system QI initiative to improve access and efficiency for outpatient visits system-wide. We had several faculty members with expertise in improvement science and additional faculty who were very interested in learning from them. All of these factors converged and have allowed us to transform our continuity clinic over the subsequent years.

I was one of those eager (but somewhat QI-challenged) faculty who were eager to learn more about QI. Prior to returning to my current academic institution, I worked in a small community health center. While there, I struggled with setting appointment templates to maximize patient flow, developing a system so that a patient could be seen on the day they needed an appointment, and working on a visit prompter and call-back tickler system for preventive care. I did not realize then that I was working on core outpatient QI activities, and I certainly did not have a theoretical background with which to approach these complex problems. Luckily, our development of a resident training program in QI has helped me learn QI methods and also stimulated me to pursue self-directed learning. Are those not the buzzwords of residency education and our own ongoing expectations around life-long learning and Maintenance of Certification?

Since that initial stimulus, I have grown to love reading and thinking about how to improve healthcare systems. Additionally, these interests have helped expand my reading lists from purely clinical journals to books about Lean, Six Sigma, Model for Improvement, as well as change management and leadership. In addition to helping shape my own personal interests, this new fund of knowledge with direct impact on healthcare has provided me with a whole new area of medicine to teach to students and residents. I had always been interested in “evidence-based medicine” and I think a QI approach to care systems fits as a good partner to an evidence-based clinical approach. Thinking about quality, systems, and improvement has really impacted the way I look at everything within, and even outside of, medicine. For instance, the coffee supplies in our house now sit together with coffee beans, sugar, coffee mugs, coffee pot, a spoon, and coffee maker in the same corner of the kitchen. This helps minimize motion, transport, and lots of other types of waste that Lean methods target, and get me that morning cupful as quickly as possible.

So how do we do this in clinic? Our improvement team meets twice a month and includes people from all roles in the clinic and, more importantly, includes a family that uses our services. By continually looking for areas to make more efficient visits and frequent tests of change, we have been able to make dramatic improvements in the average total visit time over the past 4 years, from about 1 hour and 20 minutes to about an hour, despite the implementation of an electronic health record during this time. As I often say to the group, if we can cut 3 minutes off of each of the 40 patients we see in a day, that means someone could see patients for an extra for 120 minutes or multiple more visits and it would not increase our overall work time. More importantly, we have worked hard on improving continuity of care with our residents. We have taken the approach that this is a ‘continuity clinic’ and continuity is the absolute...
**cont. Can a Resident Continuity Clinic Become a “Cadillac” Practice?**

Cont. from page 22

The most important thing we can provide for residents and families. In our experience, better continuity improves resident satisfaction with clinic and improves our ability to teach about diseases over time. There is no doubt that continuity is difficult to achieve in resident clinics, especially since one-third of our physicians leave (graduate) every year. As seen in the graphic, the continuity rate decreases at the beginning of each academic year due to residency graduation each spring. With numerous resident-led changes, we have been able to shift the continuity achievement up each year, month over month. During this time, we have also gone from one of the lower rated outpatient sites in resident evaluations to the highest rated site.

Recently, in our ongoing pursuit of high quality care, we decided to pursue Patient-Centered Medical Home (PCMH) certification. I am pleased to say that thanks to our resident-led teams, we have achieved Level 3 PCMH status with NCQA.

I am very optimistic about the ability of committed residents and multi-disciplinary improvement teams to transform continuity clinics into efficient and effective providers of care for the millions of kids who use them annually. I personally have grown immensely, thanks to my ongoing experience with QI. I really appreciate all of the work that residents, schedulers, nurses, and our support staff have done to help move our clinic forward. I am optimistic this new career interest will help me continue growing our QI program, and more importantly, improve the care experienced by patients and families.

![Continuity Percentage Graph](image)

Originally published in the spring 2012 issue of the SCOQIM newsletter, AAP Quality Connections.
Learn more about Medical Home Implementation with New Videos

Have you heard about medical home, but not sure what it really means? Are providers and staff in your office talking about becoming a medical home for your patients and their families? Many practices and integrated systems of care across the country are implementing the medical home approach to improve health outcomes and reduce costs of care. The National Center for Medical Home Implementation (NCMHI) has developed a short video explaining the medical home concept of care, particularly from the pediatric perspective, and how the NCMHI is uniquely positioned to help ensure that every child and youth has a medical home.

The NCMHI has also produced interviews with medical home experts to capture their thoughts on medical home and successful ways to implement it in practice. Framed around the six building blocks of the Building Your Medical Home toolkit, the interviews provide an in depth view of the essential components that make up the medical home approach. All of the NCMHI videos are available on the new NCMHI YouTube channel. These videos are available for free and can be used in a variety of ways, including as educational tools at conference/meeting presentations or when working with residents, medical students, and family advocates. You could also link to any of the videos from your organization or practice web sites, Facebook pages, or in electronic newsletters or embed them directly on your web site. Contact the NCMHI if you would like more information or additional tools.

Friday Afternoon Special: A CAP Can Help

Rebecca Moles, MD, FAAP
Child Abuse Pediatrician
Division Chief, Child Protection Program
Assistant Professor of Pediatrics, UMASS Medical School
Worcester, MA

One fine summer day, you are seeing patients in your pediatric office. It is about 3 pm, and you walk into the room to start your 2:15 pm patient. Lizzie is a 19 month-old girl with a chief complaint of “ear infection.” You have seen the family once before for a normal 18 month-old well-child visit. As it is a hot day, Lizzie is wearing shorts and a halter top. As you move to examine her ears, you notice a bruise on her back. As you examine further, you see that the bruise is long and curved, and there are a few areas of scabbing. When the mother notices you looking at the bruise, she says “I think she fell on the slide, but it is really her ears that I am worried about.” You ask to remove the child’s shirt and see a similar bruise on the child’s lower back. She has no bruises on her knees or shins.

While you are still thinking about the girl with the bruising, you start the next patient, Ericka, who is a 3 ½ year-old girl present with her grandmother. Grandmother cares for the child while her mother is working and her father is in jail. Grandmother is concerned that mother’s new boyfriend is sexually abusing Ericka and would like you to check her “down there.”

All pediatricians, especially those new in practice, have certain chief complaints or body systems they are less comfortable with and patients that they dread coming into the office due to a lack of experience with the diagnosis or treatment. Suspicions of child abuse can cause even the best-trained and cool-headed providers to panic, send children unnecessarily to the emergency department, or fail to report to child protective services.

Cont. page 25
**cont. Friday Afternoon Special: A CAP Can Help**

Cont. from page 24

Child Abuse Pediatrics (CAP) is a relatively new subspecialty of pediatrics, with the first subspecialty board examination in 2009. There are now 264 board-certified CAPs in the country. Depending on where you practice, you may have CAPs in your community, at a local child advocacy center, or affiliated with your academic medical center. CAPs are not the only clinicians who have expertise and training in child abuse and neglect; pediatric and adolescent sexual assault nurse examiners (SANE) and other physicians with experience in child abuse cases are also a wonderful resource to many communities nationwide. These clinicians are available to you to answer questions about patients like Lizzie and Ericka, perform a medical examination of the child, and communicate concerns to law enforcement and child protective service agencies. Very often these cases are NOT best treated in local emergency departments.

The Section on Child Abuse and Neglect (SOCAN) of the AAP is a tremendous resource of information and access to AAP members with expertise and experience with child abuse and neglect cases. You can join the section and the listserv to post questions for assistance from practitioners across the country. The website offers information about child abuse and neglect, statistics, and available trainings, as well as a list of child abuse programs across the United States and Canada. Visit the website at [http://www2.aap.org/sections/childabuseneglect/](http://www2.aap.org/sections/childabuseneglect/).

Many of you are likely wondering what to do with the cases presented above. Lizzie, the child with suspicious pattern or “loop mark” bruising, needs a detailed history from the parent, as well as a thorough physical paying particular attention to ears, mouth, frenula, and all skin surfaces, including the genitals. She needs additional testing such as a skeletal survey for occult fractures and blood work screening for abdominal injury with AST, ALT, amylase, lipase, and urinalysis. Child Protective Services should be notified, and the child should not return home until safety is assessed. For Ericka, you need more information from the grandmother about the nature of her concerns, a full examination including genitals, perhaps sexually transmitted infection screening, and forensic evidence collection (rape kit) depending on how recent sexual contact may have been. All of this is second nature to a CAP, but not in the standard workday of a primary care pediatritian. SOCAN is here to help.

**Connected Kids for Continuity Clinics:**

**Changing Practice, Changing Lives**

[Connected Kids: Safe, Strong, Secure](www.aap.org/connectedkids) is part of the American Academy of Pediatrics (AAP) violence prevention program resource set. It offers pediatricians and the entire medical home team a comprehensive, asset-based approach to integrating violence prevention efforts in the medical home setting, helping parents and families raise resilient children. Connected Kids provides information on suggested topics for pediatric health care providers to discuss at each health supervision visit from birth to age 21, supported by materials available in print and electronic format to give parents and teens to reinforce advice.

The AAP knows that residents play a critical role in the successful implementation of the Connected Kids program. We are also aware that many young physicians feel they do not receive adequate training on counseling for various violence prevention issues. To ensure that residents are equipped to effectively counsel on violence prevention, Friends of Children Funds were designated to provide up to 300 continuity clinics access to the Connected Kids materials free of charge. Available online, the Connected Kids materials will include:

- Clinical guidance
- Patient education handouts that can be printed or posted electronically
- Implementation Guide for training programs
**cont. Connected Kids for Continuity Clinics: Changing Practice, Changing Lives**

*Cont. from page 25*

In addition, opportunities to dialogue with other continuity clinics that are implementing the program will be available through mainstream social media venues and regularly hosted by violence prevention experts.

Continuity clinics will also have the opportunity to participate in a study that will gather information on the effectiveness and ease of implementation of these materials in a medical home setting. Data from the project will be used to continue improving our efforts to support pediatrician-led medical home teams in their efforts to counsel children, youth, and families on violence prevention.

Program directors or continuity clinic directors who would like to participate should contact AAP staff Heather Fitzpatrick at hfitzpatrick@aap.org or 800/433-9016, ext. 7642.

---

**New AAP Research Study Monitors Pediatrician Life and Career Experiences**

*Ashley Brunelle, MD, FAAP*

*PLACES Project Advisory Committee*

The AAP recently launched a longitudinal study of early career pediatricians – **The Pediatrician Life and Career Experience Study (PLACES)**. PLACES is a major research initiative to understand the changes, successes, and satisfaction that pediatricians experience in their personal and professional lives.

Over 1,800 participants were recruited in the winter and spring of 2012 via a scientific selection process. **Thanks to all of you who signed up to participate!** The AAP recognizes that the challenges that we face today are different than those of previous generations and knows that the opinions of young physicians are needed to shape the future of pediatrics.

There are two important cohorts of pediatricians who have signed up for PLACES: 1) recent residency graduates, and 2) early career physicians. The majority of participants are women, have a spouse or partner, have children, and are working full-time (see Table).

Participants will be asked to give annual updates on core issues related to career choice and satisfaction, work-life balance, work environment, daily stressors, life changes, and emerging issues in pediatrics. The first annual survey is being fielded in late spring-early summer, 2012.

Participants will be the first to see results and will be able to compare their experiences and career paths with those of their peers. We will also include results in this newsletter - if you are interested in the percentage of participants practicing subspeciality versus general care or inpatient versus outpatient care, stay tuned. Preliminary results will be included in the next issue of this newsletter!

*Cont. page 27*
**cont. New AAP Research Study Monitors Pediatrician Life and Career Experiences**

*Cont. from page 26*

For more information, please visit our [PLACES website](#) or send an email to [places@aap.org](mailto:places@aap.org).

---

**A Snapshot of PLACES Participants**

<table>
<thead>
<tr>
<th></th>
<th>Recent Residency Graduates Cohort N=925</th>
<th>Early Career Physicians Cohort N=931</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women, %</strong></td>
<td>75</td>
<td>70</td>
</tr>
<tr>
<td><strong>Married/Partnered, %</strong></td>
<td>78</td>
<td>89</td>
</tr>
<tr>
<td><strong>Children, %</strong></td>
<td>52</td>
<td>84</td>
</tr>
<tr>
<td><strong>Number of children, mean</strong></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Work Status, %</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>85</td>
<td>70</td>
</tr>
<tr>
<td>Part-time or reduced hours</td>
<td>13</td>
<td>28</td>
</tr>
<tr>
<td>Not currently working</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
American Academy of Pediatrics
Dedicate a Brick

Please complete the following information for each brick ordered. Copy form and attach extra pages if necessary. A limited number of spaces are available. Or place your order online: http://aap.thatsmybrick.com

### 4” x 8” Sized Bricks

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Item</th>
<th>Gift of</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Walkway Brick</td>
<td>$200.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wall Brick</td>
<td>$800.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Replica Brick</td>
<td>$50.00</td>
<td></td>
</tr>
</tbody>
</table>

Please print the wording in the boxes below EXACTLY as you wish to have it on your brick. All text will be centered on the brick. Maximum of 18 characters allowed per line. **Punctuation and spaces count as characters.**

### 8” x 8” Sized Bricks

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Item</th>
<th>Gift of</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Walkway Brick</td>
<td>$400.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wall Brick</td>
<td>$1,000.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Replica Brick</td>
<td>$50.00</td>
<td></td>
</tr>
</tbody>
</table>

Please print the wording in the boxes below EXACTLY as you wish to have it on your brick. All text will be centered on the brick. Maximum of 18 characters allowed per line. **Punctuation and spaces count as characters.**

*No email addresses/websites/phone numbers allowed. Bricks are not for advertising or marketing purposes. All wording will be approved by the AAP before the brick is ordered.*
cont. Dedicate a Brick

Cont. from page 28

PAYMENT METHOD

Please attach this form and enclose your personal check, money order, or credit card information. Make checks payable to: Friends of Children Fund Bricks

☐ Check ☐ Money Order ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

Credit Card Account Number

Expiration Date _____ / _____ (Month/Year)

Signature of Authorized Buyer

PURCHASED BY

AAP ID# (if applicable)

Name

Address

City

State Zip

Daytime Phone (_____) _____ - _______

Evening Phone (_____) _____ - _______

Fax Number (_____) _____ - _______

E-mail

REPLICA BRICK SHIPMENT ADDRESS (SORRY, NO P.O. BOXES)

Name

Address

City

State Zip

Daytime Phone (_____) _____ - _______

Evening Phone (_____) _____ - _______

E-mail

MAIL THIS FORM WITH PAYMENT TO

American Academy of Pediatrics
Development Lockbox
38367 Eagle Way
Chicago, IL 60678-1383

Have questions? Call the AAP Dept. of Development at 888/700-5378.

Purchase of bricks, excluding replica bricks, are tax deductible as allowable by law.
Section on Young Physicians

Rachel Dawkins, MD, FAAP
Chairperson and
Executive Committee Member – District VII
rcheldawkins@gmail.com

Ashley Brunelle, MD, FAAP
Executive Committee Member – District I
dr.ashley.brunelle@gmail.com

Rhonda Graves, MD, FAAP
Executive Committee Member – District II
Rhonda.Graves@nyumc.org

Elizabeth H. Mack, MD, FAAP
Executive Committee Member – District IV
ElizabethH.Mack@PalmettoHealth.org

Kelsey Logan, MD, FAAP
Executive Committee Member – District V
klogan@aap.net

Patricia D. Quigley, MD, FAAP
Executive Committee Member – District VI
patricia-quigley@uiowa.edu

Elizabeth Meade, MD, FAAP
Executive Committee Member - District VIII
elizabeth.meade@swedish.org

Tracy S Zaslow, MD, FAAP
Executive Committee Member - District IX
tzaslow@gmail.com

Cristina Pelaez, MD, FAAP
Executive Committee Member – District X
cristypelaez@hotmail.com

Julie Raymond
AAP, Manager Young Physician Initiatives
jrayment@aap.org

Barb Miller
AAP, Young Physicians Program Assistant
bmiller@aap.org

Visit us on the YoungPeds Network
www2.aap.org/sections/ypn OR
the YPConnection http://ypn.aap.org.

Newsletter Editors:

Elsa Vazquez-Melendez MD, FAAP
eluciav@uic.edu

Tyler Smith, MD, MPH, FAAP
tylersmith8@aol.com

Interested in writing an article?
Email one of our newsletter

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Opinions expressed are those of the authors and not necessarily those of the American Academy of Pediatrics. The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Copyright © 2012 American Academy of Pediatrics Section on Young Physicians