



VIRGINIA PEDIATRICS

AMERICAN ACADEMY OF PEDIATRICS ◊ VIRGINIA CHAPTER ◊ SPRING 2011

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2011 LEGISLATIVE WRAP UP

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Chapter Lobbyist

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VA Chapter, AAP Legislative Chair

This was a both a busy and successful year in the legislature for the VA Chapter, AAP. We had quite a few legislative and budgetary successes, including the critically important elimination of the



proposed 4 percent Medicaid reimbursement cuts in the final 2011 budget.

The Chapter played a crucial role in the killing of two dangerous bills - HB 1419 designed to eliminate the HPV

vaccination mandate for girls and HB 2434 allowing for the full licensure of naturopaths in the Commonwealth. The naturopath bill didn't even get a hearing because of the concerns that were voiced by the physician community and the HPV bill was killed resoundingly in the Senate Education and Health committee.

In addition, we provided expert testimony on numerous bills, helping to shepherd them toward passage. The autism bills, requiring insurance coverage, were a great example. Both Dr. Kenneth Norwood and Dr. Colleen Kraft attended committee hearings and provided excellent medical testimony about the necessary access to early treatment for autism. Without the Chapter's help, these bills would

have had a tougher time in the legislature. Currently, they are awaiting the Governor's signature amid talk of possible amendments and a potential veto.

The same can be said for Senator Northam and Delegate O'Bannon's bills requiring 150 minutes of physical education in grades K-8 so we can begin to address the issue of childhood obesity. The Chapter lobbied all session on the bills and we had pediatricians come to testify in committee, such as Dr. Sam Bartle, VA Chapter, AAP Legislative Chair. As the session progressed, the opposition toward the bills became stronger from the teachers, principals and school boards. We are continuing to work with our partners, the American Heart Association, the VA Cancer Society and the YWCA's to let the Governor know what an important step this is toward improving the health of children in the Commonwealth.



We will likely need your help contacting the Governor to avoid harmful amendments or an outright veto.

(Continued on page 2)



Other bills that VA-AAP worked on this session include:

- HB 1836 (O'Bannon) Infant blood sample provided to parents: PASSED
- HB 1459 (Albo)/ SB 771 (Saslaw) Med Mal Cap: PASSED
- HB 2373 (Peace)/SB 1469 (Saslaw) Peer review; privileged communication: PASSED
- SB 960 (Northam) Children's hospital; new definition: PASSED
- SB967 (Northam) Medically accurate family life education: FAILED
- SB 978 (Whipple) Increasing eligibility for FAMIS: FAILED
- HJ625 (Bell) Anti-bullying policies in public schools; DOE to study: PASSED
- HJ 632 (Oder) Shaken Baby Syndrome, JCHC to study: PASSED
- HJ 623 (Greason) Pediatric Cancer Awareness Month, September: PASSED

We could not have been as successful without the active involvement of our members and our legislative committee who provided needed counsel and guidance throughout the legislative process.

It is with your support that the Chapter continues to be recognized as a leader in children's health and safety at the VA General Assembly.

About us ...

Virginia Pediatrics is Provided as a Service to Members of the Virginia Chapter and the Virginia Pediatric Society to Promote the Profession of Pediatrics and to Further Benefit the Children We Serve. It is a quarterly publication of the VA Chapter, American Academy of Pediatrics and the Virginia Pediatric Society.

We welcome your opinions and ideas.

Please send comments on articles, ideas for new articles, letters to the editor, suggestions for making Virginia Pediatrics more useful and address changes to:

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Virginia Chapter

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An evolution of the pediatric workforce is underway that demands innovation, flexibility, work-life balance, and diversity in academic and practice options. But the structure of the pediatric workforce as it adapts and evolves may not be aligned with the changing nature and needs of the health care-delivery system. Workforce shortages present a significant

challenge. Will these provider gaps lead to the development of innovative workforce models that leverage technology, long-distance medicine, and the use of allied health professionals to fill critical care gaps? Or, will there be a persistent mal-distribution and shortage of pediatric providers that lead to worsening health outcomes for children? The dynamics of the pediatric workforce and other megatrends are discussed in "Pediatrics in the Year 2020 and Beyond: Preparing for Plausible Futures" (Pediatrics 2010;126:971-981).

The financial returns in most primary care fields, including pediatrics, are lower than those in law, business, dentistry, or even procedure-based medical or surgical specialties.

Compounding this problem is the fact that many graduate medical school with significant debt. Indeed, > 87% of 2008 medical school graduates had some educational debt and among those who did, the mean debt burden approached \$160,000. These issues make the financial implications of choosing a career in pediatrics significant. An increasing number of graduating pediatric residents are opting to enter fellowship and although the choice is clearly based on many factors (prestige, intellectual stimulation, interest in specific diseases or organ systems, the desire to work with certain patient populations, lifestyle issues, and research and academic aspirations), economic considerations are certainly important.

But not so fast. I read with interest a recent paper (Pediatrics 2011;127:254-260) in which the authors calculated a measure called the Lifetime Relative NPV (net present value), defined as the present value of the net income generated from a career in 1 of 11 different pediatric subspecialties relative to that generated from a career in general pediatrics over the working lifetime.

Now, as you expect, there are a lot of

assumptions, but the results I believe are worth noting. (see figure page 4).

An investment in a pediatric fellowship generated variable returns, depending on which subspecialty was chosen. Pursuing a fellowship in cardiology, critical care, or neonatology yielded greater financial returns than pursuing no fellowship at all or practicing as a general pediatrician. However, pursuing a fellowship in the other 8 pediatric subspecialties was a negative financial decision when compared with pursuing no fellowship at all or practicing as a general pediatrician. Really? This bodes poorly for the relative financial attractiveness of these fields. Could the differences in expected financial returns have an effect on the distribution of physicians? When variations in return between fields are substantial, fewer graduating residents may opt to pursue the careers with significantly lower returns. Tell me it ain't so! Let's see where we are now.

The supply of pediatric subspecialists is inadequate to meet the health needs of children.

For most subspecialties, there are on average between 100,000 and 200,000 children per provider across hospital referral regions. **Most pediatric subspecialists practice in academic settings, leaving many rural areas and regions at some distance from academic centers without any subspecialists.** It should be no surprise that approximately 1 in 3 children must travel 40 miles or more to receive care from a pediatrician certified in adolescent medicine, developmental behavioral pediatrics, neurodevelopment disabilities, pulmonology, emergency medicine, nephrology, and rheumatology. (see Figure on page 4)

Even in regions with subspecialists, families often face long wait times to obtain an appointment.

In a 2009 national survey of children's hospitals, the average wait time to see a pediatric neurologist was 9 weeks. An appointment with a developmental- behavioral pediatrician requires a wait of 13 weeks.

... (continued) WORKFORCE SHORTFALL

(Continued from page 3)

68% of primary care pediatricians practicing in rural communities and 49 percent of non-rural pediatricians reported dissatisfaction with waiting times for subspecialists.

Many pediatric subspecialties report very low numbers of physicians currently being trained. The ABP reports that in 2006 there were only 21 first year fellows training in adolescent medicine, 29 in developmental behavioral pediatrics and 32 in pediatric rheumatology. The crisis is further compounded by the aging and anticipated retirement of our existing pediatric subspecialty workforce. With the exception of those specializing in emergency medicine- a relatively new subspecialty- the mean age of pediatric subspecialists exceeds 50 years. Job vacancies lasting more than one year have been documented for pediatric neurology, endocrinology, pulmonology, gastroenterology, and developmental-behavioral pediatrics. (see Figure below)

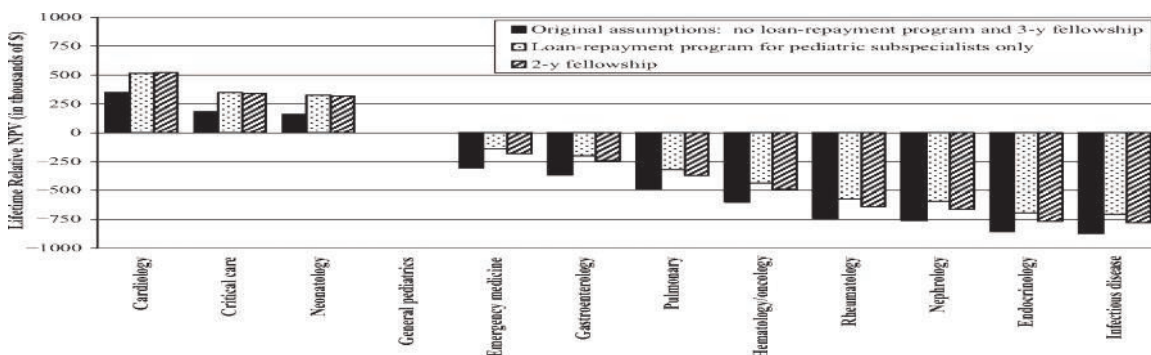
As the workforce continues to shrink, demand for pediatric subspecialty care has reached unprecedented levels. The pediatric population has experienced dramatic increases in the incidence and prevalence of conditions such as ADHD, autism, asthma, depression, diabetes, obesity along with increased demand for surgical correction of cleft lip and palate, congenital heart disease and orthopedic anomalies. The proportion of visits to pediatric subspecialists increased significantly from 1980 to 2000, from 1.6 percent to 4.5 percent.

And for those of us in academic medical centers, I mention this “just because.” Unintended consequences of the new (July 1) standards for duty hours for residents include insufficient clinical exposure and experience to prepare residents for greater patient care responsibility and inadequate time for residents to observe the course of a disease’s or illness’ development. Insufficient clinical exposure in training may lead to overutilization of the few subspecialists to support the primary care provider in caring for more mundane issues. Conversely, insufficient clinical exposure might lead to the need to lengthen the duration of residency, which would have severe financial, as well as workforce supply, repercussions.

Enter the cavalry: The US Government. The affordable Care Act recognized the critical nature of timely access to pediatric subspecialist and pediatric surgical specialist care in Sec.5203, “Health Care Workforce Loan Repayment Programs.” Sec. 5203 will incentivize training and practice in subspecialties in underserved areas across the US by establishing and implementing a loan repayment program of up to \$35,000 for each year of service for a maximum of three years. The program is authorized at \$30 million for each of FY 2010 through 2014 for loan repayments for pediatric medical and surgical specialists and \$20 million for each of FY 2010 through 2013 for loan repayments for child and adolescent mental and behavioral health professions. By fully funding this authorization, more graduating pediatricians and mental and behavioral health professionals will choose to train and practice in these specialties and more children will be able to access the care they need. (see Figure below)

I’m not so sure.

FIGURE Lifetime Relative NPV



PEDIATRICS IN THE 3RD MILLENIUM

Robert L. Chevalier, MD, FAAP

David Harrison Professor of Pediatrics
University of Virginia School of Medicine

After 14 years as Chair of the Department of Pediatrics at the University of Virginia, I stepped down last September to return to my laboratory full-time. My successor, Dr. James Nataro, has asked me to share my thoughts with you regarding changes I have observed in Virginia pediatrics over the past decade.

I recently came across an article in the *Journal of Pediatrics* entitled, "The pediatrician and his changing world". As you might guess from the title, this paper was published over 50 years ago, when the majority of pediatricians were male (the author is Dr. Carl Fischer of Philadelphia, former Chair of Pediatrics at Hahnemann Medical College, who presented the talk to the Pediatric Society of North-eastern Pennsylvania in 1957).

There is no question that the switch from male to female majority in our specialty has accelerated in the past 10 years, and the career plans of our residents has changed accordingly, with more choosing hospitalist or part-time positions. These changes in pediatric practice require a greater sensitivity on the part of academic pediatric departments and of group practices, both of which must increase flexibility in assignment of duties and schedules. Done thoughtfully, such reorganization of the workforce can enhance the quality of care, which is under increasing scrutiny.

In his paper, Dr. Fischer comments on a transition from a focus on pediatric disease in the early 20th century to a focus on the psychosocial aspects of pediatrics in the mid 20th century, reflected by the popularity of Benjamin Spock's *Baby and Child Care* (which has now sold well over 50 million copies—placing it among the top 10 bestsellers of all time, along with the Bible and works of Shakespeare)! Fischer coins a term that I believe perfectly fits our current times: "pediatric ecology"—in recognition of the impact of the family and community on the health of the child, and the responsibility of the pediatrician to become expert in these vital determinants of child health. The specific challenges facing the pediatrician for which she/he had not been adequately prepared in the 1950s included accidents, adoption, school health, handicaps,

and juvenile delinquency. I believe we may take much pride in our current approach to a number of these issues, with our expanded poison center network, bicycle helmet programs, adoption clinics, school-based pediatric obesity programs, and establishing a "medical home" for children with chronic illness or disabilities. The problem of "juvenile delinquency" is more difficult, but our recent Pediatric Grand Rounds speaker, Dr. Patrick Tolan, Director of the new Youth-Nex program (based in the Curry School of Education at UVA), has brought his expertise from Chicago to Virginia to address the study and management of adolescent violence using a multidisciplinary approach.



Another area that has seen much progress over the past decade is the development of transition programs from pediatric to adult care for children with chronic disease or handicaps. At UVA these include formal programs in pediatric cardiology, cystic fibrosis, oncology, and nephrology. We recently hosted one of our colleagues from the National Children's Hospital of Costa Rica, Dr. Orlando Urroz, pediatric

surgeon, and now Vice-Chair of his institution. This year we celebrate the 29th year of our exchange program between the UVA Children's Hospital and the National Children's Hospital of Costa Rica. Dr. Urroz is developing a nationwide program to transition all of the Costa Rican children requiring complex care to specialists in adult medicine. Since the population size of Costa Rica is about that of Virginia, we should be able to learn much from them regarding the implementation of such a plan.

As a member of the Executive Board over the past 14 years, I have been highly impressed by the dedication and commitment of the Virginia Chapter of the AAP. The officers and staff of the Chapter work tirelessly with the members at large in addressing the immediate and long-term needs of Virginia's children. Unlike many states, where the academic health centers are aggregated,

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ours are spread over the entire Commonwealth (as are our patients). The Chapter has done a superb job in bringing together the academic subspecialists and community primary care providers, which positions us well for the future challenges of managing to decreasing resources in both the public and private sectors. Our interdependency is very clear: community pediatricians must take on more ambulatory patients with complex chronic conditions, leaving more inpatient medicine to the academic health centers, all of which requires enhanced coordination and communication. The academic health centers must also continue to train pediatricians of the future who will have the flexibility to enter these disciplines as well as public health and epidemiology.

In 1997, shortly after I became Chair of Pediatrics, I asked Virginia Senator Emily Couric to present our first grand rounds of the season: the title of her talk was, "Our government and our children: the responsibilities and limitations of public policy". Senator Couric discussed public education, juvenile justice, day care, Child Protective Services, and health care — all of which continue to remain major issues for the Virginia pediatric community. The main topic at the time was the Balanced Budget Act and rolling out the state's SCHIP program. Now we face even greater challenges as the federal budget is hammered out, with enormous implications for Medicaid and state budgets. The role of the Chapter in serving as the "nerve center" for coordinated planning of health care for Virginia's children has never been more important. Although Senator Couric died tragically of pancreatic cancer, a new cancer center building at UVa bearing her name has recently been

inaugurated: her legacy to the people of Virginia will never be forgotten.

The pediatric chairs of the academic health centers are working together to address the shortage in pediatric subspecialists, challenges of decreasing resident duty hours, and constrained research funding. Workforce reductions in subspecialties such as pediatric neurology and diabetes have led to restricted access for children requiring timely referrals from their primary care physicians. All of us will be directly affected by the raging health care debate and its impact on Medicaid.

*These are challenging times for pediatrics,
but we have all of the expertise and the will
to work together
to ensure better health for Virginia's
Infants, children, and their families.*



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POLYCYSTIC OVARY DISEASE

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Childhood obesity is an increasingly prevalent problem: approximately 17% of U.S. girls ages 6-19y have a body mass index percentile-for-age ≥ 95 (according to standard curves). Among other complications, obesity is a strong risk factor for polycystic ovary syndrome (PCOS) in adulthood. PCOS is the most prevalent female endocrine disorder, affecting 6-8% of reproductive-age women; is the leading cause of female infertility; and is associated with metabolic abnormalities such as type 2 and gestational diabetes mellitus, dyslipidemia, and hypertension. Our studies at the University of Virginia show that 70% of obese peripubertal girls (from pre-thelarche to post-menarche) have elevated androgen levels. Androgen excess in adolescence is a forerunner to adult PCOS, yet the sources of androgen overproduction in pubertal girls remain unclear. Other girls at risk for PCOS include those previously born small-for-gestational-age, those with premature adrenarche, or those whose mothers have PCOS.

Diagnostic criteria for PCOS remain controversial; however, a useful definition is: (1) menstrual irregularities (at least 2 years after menarche) and (2) clinical or biochemical evidence of androgen excess (significant acne/hirsutism or elevated total/free testosterone levels).

Ovarian ultrasounds in pediatric patients are troublesome to perform (transvaginal approach is best) and half of adolescent girls show increased follicle number as a normal variant of ovarian maturation. Therefore, ovarian ultrasound is not useful for diagnosis of PCOS in adolescents.

Metformin and combined oral contraceptive pills (OCPs) have been the primary treatment options for older adolescent girls with PCOS in the U.S. Insulin is thought to activate the rate-limiting enzyme of androgen synthesis in the ovary and adrenal gland. Metformin—an insulin sensitizer—lowers total testosterone levels, improves menstrual irregularities and anovulation, and raises HDL cholesterol levels. This occurs even before improvement in insulin sensitivity or body weight. Some studies suggest that metformin can reduce body mass index. OCPs are frequently used to suppress ovarian androgen production in adolescent PCOS, but may have untoward metabolic side effects (e.g. hypertension, dyslipidemia). They cannot be used



in pre-menarcheal girls for androgen excess, as estrogen administration long-term would stimulate early breast development and accelerate growth plate fusion, resulting in short stature. Spironolactone—an androgen-receptor blocker—is used with some regularity by endocrinologists for adult and late-adolescent PCOS accompanied by significant hirsutism. It is typically used in combination with OCPs, as its anti-androgenic activities could have teratogenic effects on a male fetus.

Abnormal gonadotropin secretion may be one mechanism by which androgen excess during puberty contributes to the development of PCOS. Girls with androgen excess, like women with PCOS, have abnormalities in the response of luteinizing hormone to feedback by progesterone. This defect may result from androgen excess itself, as it is reversed in adult PCOS by blocking the androgen receptor. Gonadotropin signals mature in a distinct pattern during puberty—a pattern that may be critical for normal progression through puberty and the establishment of regular ovulation. By interfering with set-points for feedback by the ovaries to the hypothalamus, androgen excess might modify patterns of gonadotropin secretion across puberty, potentially predisposing girls to PCOS.

Research at the University of Virginia is geared toward exploring potential reasons for androgen excess in overweight adolescent girls and mechanisms by which PCOS develops during puberty. Specifically, we are investigating the sources of androgens in puberty, the correlation of insulin resistance with androgen excess, and potential therapies to ameliorate gonadotropin secretion abnormalities in girls with androgen excess. Normal and overweight girls ages 7-18y are being recruited to participate. Our research may lead to interventions to treat androgen excess when it first develops, even if this occurs during early puberty—potentially preventing the development of full-blown PCOS.

CELIAC DISEASE

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Celiac disease (CD) was first described in children by Dr. Samuel Gee in 1887. Early descriptions of the disease highlighted failure to thrive, edema, diarrhea and abdominal distension during the second 6 months of life as the clinical hallmarks. CD was subsequently linked to wheat sensitivity by Dr. Willem Dicke during the Dutch Famine of World War II. Dicke noted that while other children starved, children with CD thrived, only to relapse when wheat became available.

The **diagnosis** of CD is made by a small bowel biopsy performed while the patient is consuming gluten. The classic features of lymphocyte infiltration, villous blunting and crypt hyperplasia have been graded to form the Marsh classification. Although various antibody tests have been available for decades, they were not sufficiently sensitive and specific until the anti tissue transglutaminase antibody and anti endomysial antibody tests became available. Both of these tests have sensitivity and specificity exceeding 90%. Their frequent use to screen populations has linked CD to other conditions, including juvenile onset diabetes, autoimmune thyroiditis, primary biliary cirrhosis, osteoporosis, iron deficiency anemia unresponsive to iron supplementation, microscopic colitis, Turner Syndrome, Down syndrome, and Williams syndrome. **Unfortunately, the sensitivity of antibody testing in infants under 1 year of age is low, and small bowel biopsy must be performed in infants with suggestive histories.** Children with positive serologies and/or extremely suggestive histories should be referred to a pediatric gastroenterologist for small bowel biopsy to confirm the diagnosis.

The **genetics** of CD are well described. Approximately 95% of patients with CD have an isoform of DQ2 (90% of celiacs) or DQ8 (10% of celiacs). But since 30% of the population is positive for DQ2, its presence does not uniformly predict disease. The prevalence of CD in the general population in the United States is approximately 1 of 130 individuals.

Widespread **screening** for CD has produced an increase in health care costs nationwide. Judicious test selection can minimize that cost. An IgA transglutaminase or endomysial antibody alone is adequate for screening (\$50 per test). There is no advantage to a celiac “panel” which pairs these antibody tests with less specific (often false positive) older tests such as anti-reticulon or anti-gliadin antibodies. In the absence of significant diarrhea it is unlikely that

an IgA level (\$50 per test) will be helpful, as most patients with both CD and IgA deficiency will have severe diarrhea. A genetic analysis of DQ2 and DQ8 status costs approximately \$700 and is neither sensitive nor specific in making the diagnosis; however, if both DQ2 and DQ8 are absent, the disease is unlikely (although not impossible).

CD has become a very popular diagnosis. It is not unusual for people to decide that they are gluten sensitive without medical testing, or in the face of negative medical testing. To some extent wheat source carbohydrates are less digestible than rice source carbohydrates and therefore generate more gas and discomfort for some individuals, especially those with irritable bowel syndrome. It is also possible to have IgE mediated wheat allergy that can mimic CD. Therefore, the discomfort that people feel with wheat may be real in the absence of objective tests supporting CD. Despite the fact that the cost of gluten-free foods can be 5 times conventional foods, many people eat a gluten free diet without medical documentation of celiac disease or wheat allergy.

Some individuals who are screened for CD may exhibit only partial diagnostic criteria. Occasionally, we will see very high antibody titers in symptomatic or asymptomatic individuals who have normal biopsies (the gold standard). In this situation we let the patient and parents decide whether to institute gluten restriction. If they decide against dietary treatment, we suggest that they be monitored with bone density, blood counts and hepatic enzymes.

The risk of malignancy in CD is only slightly higher than the general population. Some surveys suggest that gluten restriction decreases this risk. In one study, during the first year after the diagnosis of CD, the absolute excess rate for all malignancy was 51/10,000 patient years; after the first year the excess risk was 6/10,000 patient years. The rising incidence of CD raises many questions that will require careful clinical studies.



SLEEP FOR THE GENERAL PEDIATRIC PATIENT

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TV's and computers are in the bedroom. School days are extended with after-care. And home life is chaotic. Among the distractions of today's society, it is hard for children to get an adequate amount of sleep, and pediatricians hear a lot of complaints about sleep problems. So when is a referral to a pediatric sleep specialist useful in the management of a child with sleep complaints?

Some kids have specific sleep-related medical problems that may be best managed with the aid of a specialist. One obvious and common problem is sleep-disordered breathing. If the tonsils are enlarged and the child is snoring, a pediatrician may wonder if a referral should be to a pediatric sleep specialist or directly to an otolaryngologist. Good question!

Only a sleep specialist can perform the sleep study needed to optimally guide management. The AAP Clinical Practice Guideline for Childhood OSAS published in 2002 states that a formal sleep study is the gold standard to establish the diagnosis and determine the severity of sleep-disordered breathing.

The differential diagnosis in a snoring child includes primary snoring, obstructive sleep apnea syndrome (OSAS), and central sleep apnea. If an adenotonsillectomy is indicated, knowing the severity helps to guide perioperative management of the patient. Patients with severe OSAS, for example, are at risk for post-operative complications through at least the first sleep period after the procedure. Deaths



have occurred when a patient is sent home prematurely after the procedure.

Snoring with apnea may not always be caused by OSAS. Central sleep apnea syndrome may present exactly like OSAS until a sleep study proves otherwise. The CSAS may suggest treatment of an Arnold Chiari malformation rather than adenotonsillectomy.

In cases where environmental influences may impair sleep, a sleep study can show how well the patient will sleep in a foreign environment with no external distractors. The specialist will be able to counsel parents and child to improve "sleep hygiene."

A child with apnea or who snores, exhibits excessive daytime sleepiness, concentration problems, and/or hyperactivity may not have big tonsils, or may have already had them removed. This child may need continuous positive airway pressure therapy (CPAP).

Despite the fact that we all do it, sleep is astonishingly misunderstood and frequently problematic. Timely referral to a pediatric sleep specialist can help with definitive diagnosis of disorders such as sleep-disordered breathing (OSAS vs. CSAS vs. primary snoring), and may help to tease out behavioral from treatable medical conditions.

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The quality of medical care delivered in the U.S. is under intense scrutiny, and response by the medical community must occupy the highest priority. The Quality and Performance Improvement (QPI) program at the University of Virginia Children’s Hospital, led by Dr. Tracey Hoke, stands at the forefront of our efforts, rigorously identifying and disseminating best medical practices.

In the inpatient arena, we have focused on bloodstream infections and handwashing. It has been shown consistently that catheter-related BSIs can be reduced by implementing both an insertion and maintenance “bundle” to guide clinical practice. First, as a part of the National Association of Children’s Hospitals and Related Institutions’ PICU CA-BSI collaborative, and now as a part of standard practice across the UVA Children’s Hospital, we implemented checklists and bundles that support a uniform approach to central line placement and care. This 2-year effort has resulted in a decrease in the CA-BSI rate by almost half in the PICU, and a near-eradication of CA-BSI in the NICU. In coordination with this effort, a house-wide hand hygiene campaign was undertaken that increased awareness and handwashing by all providers and staff across all inpatient care delivery venues.



In the Newborn Nursery we have instituted a Newborn Oximetry Screening Program designed to study the impact of routine oximetry on our ability to diagnosis occult congenital heart disease. We are also interested in the impact of such a program on family and provider satisfaction and on resource utilization. To date, nearly 1000 screens have been recorded and no additional specialty consultations or studies have been observed. Provider satisfaction is quite high. Family satisfaction will be assessed in an upcoming annual survey. We are currently partnering with other interested hospitals to collect data in a uniform way, with a plan to report on our regional experience in an upcoming publication.

In the outpatient arena, one area of focus is the comprehensive care of children with asthma. Our Primary Care Center Pediatricians have joined the Medical Society of Virginia Foundation’s Improving Asthma Care and Treatment (IMPACT) program, an effort to meet and exceed guidelines for identification and treatment of patients with asthma. In addition, our Pediatric Residents have described a need for the collection and evaluation of clinical outcomes in this population. In a collaborative effort to strengthen our assessment of IMPACT, our pulmonologists have made available the spirometry lab, and have trained our pediatricians both to conduct testing and read spirometry results. In addition, patient education materials developed for IMPACT have been revised to come more in line with discharge materials developed for the inpatient Asthma Core project. The Children’s

Asthma Core project was developed by the Joint Commission to assess both care delivery and adequacy of handoff of care to the medical home.

By now every pediatrician is aware of new requirements from the American Board of Pediatrics for Maintenance of Certification or evidence of activity to assess one’s

“Performance in Practice.” These requirements can be fulfilled either by completing web-based Quality Improvement activities or by participating in an ongoing ABP-approved collaborative Quality Improvement project. Some of the projects described above fulfill these MOC requirements.

Others opportunities to fulfill these new requirements can be found on line at www.abp.org.

EARLY BRAIN AND CHILD DEVELOPMENT

Francis E. Rushton, MD, FAAP

District IV Chairperson, AAP

With some difficulty, the Academy has been wrestling with one of its newest strategic planning planks: that of sorting out what we in pediatrics should be doing to ensure optimal early brain and child



development (EBCD). EBCD is difficult to get our hands around. We already do lots in our daily routines as we talk to families about their parenting needs and support them in their daily activities. Bright Futures has a strong emphasis on EBCD, one that we can build on. Yet, there is still a sense that far too many children in the United States miss important opportunities for early brain development and the resulting impact on poor school performance and loss of human potential is too great for us to ignore.



As the Academy searches for a coherent message and focus, we rely heavily on others such as Dr. Jack Shonkoff and his work (www.developingchild.harvard.edu). We know that most learning occurs very early, that learning builds on the lessons of the past, that there is tremendous plasticity in the infant brain and there are developmental windows that open and close. And we know the developing brain responds to stress, some stress is good, but too much is toxic and can cause lasting damage.

For pediatricians, we need to know what point-of-care practice enhancements are effective in promoting EBCD. How can we build on the recent work of the AAP Task Force on Mental Health and the recommendations in our about-to-be-published AAP policy statement on toxic stress and child development? The community links that help us maximize EBCD are important too. How can we maximize support for brain development through “Help Me Grow” programs, or by links to home visitation parent

support efforts, early childhood councils and family and parent education programs? Our Task Force on Early Brain and Child Development has many questions, and hopefully it will provide us further answers in the months and years to come. If you have specific suggestions, Dr. Colleen Kraft from District IV sits on the Task Force and Dr. David Willis in Oregon chairs it. They both would appreciate your input.

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Resource Brief on Culturally Competent Services

The Maternal and Child Health (MCH) Library at Georgetown University has updated its Culturally Competent Services Resource Brief, a guide to Web sites and related professional resources. The Brief contains links to federal agency and other organizational Web sites, along with descriptions of selected resources. Also featured are selected resources developed by the MCH Library including an annotated bibliography on culturally competent services, links to minority health organizations and non-English-language materials and resources, and a knowledge path on racial and ethnic disparities in health. The brief is available at <http://www.mchlibrary.info/guides/culturalcompetence.html>.

In memoriam: Dr. Walter Edward Bundy, Jr.

Dr. Walter Edward Bundy Jr., 91, a devoted husband, father, physician and friend, passed away on February 25, 2011. He was one of five children born to Dr. Walter E. Bundy and his wife, Margaret Louise Graham Bundy, of Newhall, W.Va. He is survived by the love of his life, his wife of 66 years, Jane Callison Bundy; four children, Dr. Walter E. Bundy III and wife, RoseMarie, of Richmond, Jo Carter Bundy Hall and husband, Wayne, of Nottoway County, Va., Mark C. Bundy and wife, Jody, of Cape Charles, Va. and David S. Bundy of Ocracoke, N.C. He is also survived by 13 grandchildren and step-grandchildren; 10 great-grandchildren; friends and caregivers, Sharon and Brittany Hawkins; and many loving and loyal friends and thousands of devoted patients cared for by Dr. Bundy through the years. A graduate of Emory University in Atlanta, Ga., Dr. Bundy received his medical degree from the Medical College of Virginia in Richmond. He continued his lifelong love and association with MCV as Professor of Pediatrics. Dr. Bundy founded Pediatric Associates of Richmond in 1952, a practice that continues to thrive today. In addition to his private practice, Bundy was known for his community outreach efforts - he was a familiar face at various pediatric clinics across the state specializing in the treatment of rheumatic fever and polio. In 1998, Dr. Bundy's lifelong devotion of teaching and conducting clinical research was honored through the establishment of the Walter E. Bundy Jr. Professorship in Community Pediatrics



by the Medical College of Virginia. He was a member of the American Medical Association, the American Academy of Pediatrics, the Medical Society of Virginia, the Virginia Pediatric Society, the Richmond Pediatric Society and the Country Club of Virginia. Dr. Bundy also served as a deacon at Grace Covenant Presbyterian Church. Dr. Bundy was not an ordinary man. He grew up in the coalfields of West Virginia during the Great Depression. His father was the physician for the New River and Consolidated Coal Company in Minden, W.Va., where he was purported to have treated both the Hatfields and the McCoy's in their notorious feud. Dr. Bundy's father was also a graduate of the Medical College of Virginia, as well his son, (Walter E. Bundy III) and grandson, (Graham Matthew Bundy).

Dr. Bundy wanted to be a physician from his early childhood and wished to leave some small lasting contribution to humanity.



PEDIATRIC DAY AT THE GENERAL ASSEMBLY

Diane Pappas, MD, JD has been organizing a Pediatric Day at the General Assembly on the 4th Thursday of January for the past four years for the Chapter. This year, we had about 50 participants, including pediatricians in practice, pediatricians in academics, pediatric residents, medical students, law students, lawyers, and social workers. This year, we had 13 pediatric residents from across the state participate, including 8 from VCU!! We have been fortunate to have the full support of the Virginia Chapter, American Academy of Pediatrics, the MSV, the pediatric residency programs in Virginia, and the



MCV Resident program brought the most residents

Pediatric Chairs in Virginia. By organizing this every year well in advance and getting the word out through all of our supporters, we have been quite fortunate in getting a good turn-out. We start planning about a year in advance and really start pushing hard to get the word out in the fall. By September and on into November/December, we work with everyone to get the word out about the day any way we can - email alerts, individual emails, emails to the pediatric residency

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programs, electronic newsletters, etc. This year, the VA Chapter, AAP also provided funding for hotel accommodations for each residency program to have a room the night before in order to make participation easier for our busy residents. We further encourage the residents with a bagel breakfast for the program that brings the most residents to our day and a drawing for a dinner for two for one resident participant. Pediatric Day at the General Assembly started as a result of the residency requirement for advocacy training and we sought to put together a legislative training with hands-on advocacy experience for our pediatric residents. And, as is so often the case, things seem to work best when you bring seasoned advocates and new advocates together to learn and work together.

The benefits of a pediatric day are many and include:

1. Working together for a common cause
2. Training students, residents, and others in legislative advocacy
3. Bringing policy makers and child advocates together face-to-face; this year, our participants heard from state policy leaders including Dr. Karen Remley (VA Commissioner of Health) and Dr. Bill Hazel (Secretary for Health and Human Resources) and from pediatric leaders, including Dr. Bill Moskowitz (VA Chapter, AAP President), Dr. Samuel Bartle (VA Chapter, AAP Legislative Committee Chair), and Aimee Perron Siebert (VA Chapter, AAP Lobbyist). This really lets them see and understand and question policies and how they are made at the state level.
4. Provides a collaborative environment for the many disciplines that advocate for child health (including attorneys, social workers, students, etc.)

Secretary Bill Hazel
at debriefing



Secretary Bill Hazel shares his thoughts at Debriefing

Senator Northam
takes time to answer
questions



The issues that are most important to us are those affecting child health - this year, some of the main issues included covering the 4% Medicaid cuts in order to maintain access to care, requiring PE in grades K-8, and autism coverage.

ACOs-PEDIATRICIANS NEED TO BE AT THE FOREFRONT

William C. Rees, MD, MBA, FAAP

Vice President, Virginia Chapter AAP

Pediatric care management is dysfunctional, quality suffers from poor cost control and inadequate payment by private insurance and Medicaid. Time-wasting bureaucracy, such as pre-authorizations are infuriating and unnecessary. Payment systems don't make sense. Health systems are fragmented, and were kept that way by law. ObamaCare wants to cut costs, but will increase enrollment in Medicaid by 15%. Where is this all going? Is there a solution?

If you've been keeping up with your journals, and reading articles not purely academic, you've noticed more health policy, politics and economics than ever before. The New England Journal routinely now carries such articles with every issue. AAP "Pediatrics" has begun to recognize the importance of discussing Medicaid faults, physician education and quality versus cost issues. It's essential as pediatricians that we understand business. Management skills, health politics, comparative effectiveness training, biostatistics, pharmaceutical economics, accounting, budgeting and medical legal matters, among others, will be required core knowledge for pediatricians in the future.



A medical care design, the ACO (Accountable Care Organization), is an experimental economic model. There are different designs, certainly more will arise based on cost containment for adults, but there will be Medicaid and independent pediatric systems based upon both cost control and strongly favoring preventive care. There will be models that are hospital centered, some independent practice oriented, and hybrids. We'll see which is the most appropriate and successful.

ACOs are legal entities that will combine regional medical and paramedical practitioners under one legal umbrella. Past restrictions under Stark Laws would not allow such arrangements because of the consideration of favoritism and collusion and consequent price fixing. Retrospectively, they did more harm than good, as it did not allow for medical systems to combine resources to approach a disease state in its entirety and allow for a cooperative approach to quality and cost control. As the law works its way through Safe Harbor systems, ACOs will proliferate. Nationwide Children's Hospital System (Ohio State) in Columbus now has formed a pure pediatric ACO of 285,000 patients. We will see pediatric ACOs across Virginia; one is now in early stages at Carilion in Southwest Virginia. Let me give a simple example of its modus operandi.

A child has an asthma attack. The parents wait until things deteriorate because they lack the proper knowledge to judge severity. They arrive at an ER several days too late for outpatient control, and are admitted to a hospitalist service. The acute attack is controlled and the child is discharged to their primary care pediatrician who may not yet know the child was discharged until after the fact. The parents are relieved their kid is better, and do not do the follow-up visit to their primary care physician. Three days later the child is readmitted in the same fashion. Possibly this time, they do get the message and follow-up with their primary care doctor. By this time, the child is completely normal and leaves the office with an albuterol inhaler and some basic instruction from the physician because it appears that the acute process is over. Several months later, after 3 refills of albuterol from different sources, the child again visits the ER wheezing. The ER is becoming the primary care physician. This is a very common story. ER costs are high and readmissions happen unnecessarily. The parents are still not educated.

The insurance companies are repeatedly writing checks to the primary care physician, hospital ER, the hospitalists, and the pharmacy. If in fact, there had been an asthma counselor and coordinator after the first attack, things may have been much less expensive.

This is not theoretical.

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ACOs-PEDIATRICIANS NEED TO BE AT THE FOREFRONT

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Coordinated asthma care programs have been very successful. Children's Hospital Cincinnati is a glowing example of how to integrate care.

With an ACO approach, the finances are straightforward, at least for the insurance company. The insurance plan writes one check for a fixed amount for the care of this patient. It is to the ACO who then is responsible to split the payment to pay the primary care doctor, hospital, hospitalists, ER physicians, and pharmacy. It is not pay for service care. It is capitation on a broader scale. Obviously, if this asthmatic child had received proper care initially, payment from insurance would have been more favorable per time involved in care and therefore more productive.

Insurance plans, including Medicaid, can much better set their costs and reduce their risk. If an ACO is poorly run, it won't matter to them. The plans know their asthmatic population; they therefore can set their capitated costs. The financial onus is on the ACO.

The power lies on the Board of the ACO. They will be the decision makers. They will allot payments to the stakeholders.

The AAP has officially recognized the importance and required structure of ACOs. In a prepared statement available on its website:

"The ACO should be guided by a Board of Directors that is elected by the ACO physicians. Any physician entity (medical group, IPA) that contracts with the ACO should be physician (and not hospital) controlled and governed by an elected Board of Directors."

There are now, more than ever, physicians learning management and in management positions, but still not enough. We can have the unique skills of understanding the financial process and also understanding the medicine. Fifteen years ago, few physicians were astute in business practices. It was simple in a small private practice -- see a patient, send a bill, collect directly from insurance and patient, pay your office bills, and take home the money. But now we deal with complexities. We are being pushed into PPOs, and HMOs, learning about Medical Homes, and NCQA standards, and IT solutions (that's computers, folks). Medical school and residency and fellowship training are not enough as they are now structured.

Here is the opportunity.

Get business training. You will become an asset in the future. You understand the medicine, learn the money part. Your value in an ACO is exponential.

Most ACOs are in infancy and hospital run and oriented. Hospitals certainly have the infrastructure capability to be operational but they do not have the most knowledgeable personnel. Do they understand outpatient medicine, the crux of cost savings? Should they have control? There are physicians in Congress who believe doctors should have the power. Let the MDs with business expertise and training be the leaders.

In whatever format exists. I propose ACO Boards should be physician majority and run, not simply advisory. This can be an integrated system with hospitals, and all paramedicals. It's not that physicians will form a bloc vote. There will be diverse medical opinion from generalists, sub-specialists, hospital based and private practice, but the combined experience of patient care with a business foundation is the only successful approach.

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ACOS PEDIATRICIANS NEED TO BE AT THE FOREFRONT

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If you think I'm wrong, do you think managed care run by business types so far has been successful? If you were around in the 80's you will remember the overwhelming failure of hospital systems that bought out primary care practices but lacked the expertise to be successful. The cog in the wheel required for success is going to be the primary care pediatrician who coordinates universal care.

Your AAP chapter encourages you to learn more business. Attend our annual CME conference on the Art and Business of Pediatrics. Virginia has a Claude Moore Scholarship Program through MSV for physicians to improve your business expertise. Think about executive or full MBAs, MPHs, or MHAs offered throughout the state university system.

The valued future pediatrician needs to become a leader in health management. With changing scope of practice regulations and inadequate primary care resources, the demand for pediatrician leaders will be critical.

If anyone is interested, I have prepared an "ACO Package" of relevant articles I will pass on electronically. Contact me at wcrees@aap.net.

VA-AAP OBESITY TASK FORCE UPDATE

Robert S. Shayne, MD, FAAP

Margaret N. Jeffries-Honeycutt, MD, FAAP

Co-Chairs Obesity Task Force



The obesity task force has been active in the last 6 months. We have placed our emphasis both on education of physicians and advocacy. Our goal is to make physicians as astute and as comfortable with managing obesity as we are with asthma or ADHD. We have followed the lead of other chapters around the country by creating a tool kit and a website. Both should be out by the summertime. We also have plans for training seminars in conjunction with other pediatric meetings around the state. The first of these was at the Inova meeting last November. A seminar in motivational interviewing is planned during the summer Pediatrics at the Beach conference in July. Our curriculum is evolving and we are receiving expert opinions from our academic colleagues at VCU, UVA, and King's Daughters.

Our pediatric White Coat Day provided our members the opportunity to lobby for mandatory physical education in grades K through 8. Many more issues are expected to be on the table in the next few years on issues ranging from creating walking paths to school to choices made regarding the school menus. Certainly we would love to see walking, running or biking programs from the Northern Neck to Wise County. We are looking for pediatricians all over the state to take the lead in promoting these programs and in lobbying efforts. Our academic centers are looking for partners and opportunities to do research to make sure our efforts are not wasted.

We are looking for pediatricians and other providers to help us provide a network of professionals across the state to help with event planning and to facilitate with bringing our educational seminars to different parts of the state.

If you are interested in helping, contact Bob Shayne at kidzdoc78@gmail.com.

www.virginiapediatrics.org

Do you want to learn more about providing a medical home for children in your practice who have asthma? Look no further! Your AAP chapter is involved in a new program, the Medical Home Chapter Champions Program on Asthma and now has a member champion who is here to help.

AAP chapter champion programs have been very effective as a conduit for disseminating best policies and practices to pediatric health care providers nationwide through the leadership and volunteer networks of chapters. Champion programs also serve as a mechanism by which pediatricians can advocate for change at the local, state and national levels. Read on to learn more about this exciting new chapter champion project.

Background

In 2007, the AAP partnered with the American Academy of Family Physicians (AAFP), American College of Physicians (ACP) and the American Osteopathic Association (AOA) to publish the Joint Principles of the Patient-Centered Medical Home. This consensus statement describes seven principles of a medical home, which include personal physician, physician-directed medical practice, whole-person orientation, coordinated care, quality and safety, enhanced access and appropriate payment. Childhood asthma is a serious and chronic condition that affects one in seven U.S. children and their families. Receiving care within the context of a medical home has the potential to improve care for children and youth with asthma. The medical home model has demonstrated a positive relationship between the medical home and desired outcomes, including better health status, timeliness of care, family-centeredness and improved family functioning.

A Medical Home Framework for Asthma Care

The seven joint principles of the patient-centered medical home provide a framework for implementing the 2007 National Asthma Education and Prevention Program (NAEPP) national asthma guidelines.

1. A personal physician provides continuity of care in a partnership, eg, scheduling routine follow-up care and monitoring use of beta2-agonist medications.

2. A physician-directed medical practice coordinates family-centered, high-quality, accessible and affordable services for children with asthma.
3. The practice has a whole person orientation providing comprehensive, compassionate, culturally-effective care in a family-centered partnership. This holistic approach includes control of environmental triggers such as allergens and irritants—especially tobacco smoke, and treats or prevents co-morbid conditions that affect asthma. It also promotes physical fitness for children with asthma.



4. Care is coordinated and integrated across the community-based system and facilitated by information technology including asthma registries. Care coordination includes referrals to specialty care, if needed, and eventual transitions to adult care. A medical home with electronic health records improves performance and outcomes measurement and accountability.
5. Quality and safety are hallmarks of patient-centered and evidence-based asthma care. NAEPP provides guidelines on establishing the asthma diagnosis, providing asthma education on patient self-management, prescribing medications, especially inhaled corticosteroids for persistent asthma, using a stepwise treatment approach for patients of different ages, and developing a written asthma management plan to help families. The AAP Chapter Alliance for Quality Improvement (CAQI), and now the Medical Home

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Chapter Champions Program on Asthma, offer state and local resources for practices. The AAP Education in Quality Improvement for Pediatric Practice (EQIPP) online courses—for both medical home and for asthma—provide Continuing Medical Education (CME) credits and Maintenance of Certification (MOC) Part 4 support.

6. Enhanced access to care includes pediatrician availability to assess, classify and monitor asthma severity and control. It also reduces disparities in processes and outcomes in asthma care.
7. Appropriate payment recognizes the added value provided to patients with asthma who receive care in a medical home as defined above.

Clinical Examples – Asthma Care in a Medical Home

The aforementioned medical home principles can be further illustrated by the following clinical examples of asthma management:



1. Personal physician: During urgent care hours, 7-year old, Jackson comes in to see your on-call partner with a chief complaint of cough. Since he is listed in your registry of Children with Special Health Care Needs (CSHCN), your scheduling staff and care providers are aware that he is a known asthmatic and had a gastric duplication repaired at birth, therefore, he needs and is given a longer appointment. He has just spent the weekend in his paternal grandmother’s home; mom sent his “puffers” but they were not used during his visit. Your colleague accesses his problem list and current asthma plan from his medical record, stabilizes him and arranges for him to return to see you the next day for follow-up, sending an email to you and your care coordinator.
2. Physician-directed medical practice team: Having recently completed his kindergarten check-up, you know that Jackson’s parents are not together and his dad is only peripherally and episodically involved in his care. His mother, maternal grandmother and uncle are his usual care providers. You and your care coordinator have worked with a Medicaid case manager to assist in the home by providing education about medicines and compliance.

3. Whole-person orientation: Prior to receiving care in your medical home system, Jackson was hospitalized twice for asthma exacerbations, once with a complicating pneumonia. You discovered that he sleeps on the floor on a very old mattress and the family claims that they do have “lots of” cockroaches in the home. You and your care coordinator have arranged for dust-mite covers for his bedding and have contacted his school’s social worker to assure his medications are given at school, when necessary. You also updated his asthma plan at his recent check-up.
4. Care is coordinated and integrated: After Jackson’s second hospitalization, he had quantitative IGE allergy testing with you and saw the pulmonologist to consider what role GER might play in his exacerbations. Your review of his pulmonology consult in his medical record confirms your recollection that studies for reflux were negative, but his allergy testing showed marked reactivity to cockroaches and dust mites. You place a reminder on his chart to arrange asthma education for Jackson’s father when he is stable; you plan to do spirometry to assess control at that visit.
5. Quality and safety: Using NHLBI guidelines, you and your partner move Jackson’s medications up to the “yellow zone” in his asthma plan and arrange for him to return for his flu shot and follow-up in the two weeks. You remind his uncle of the importance of using his controller medicines daily. His uncle says “he does much better with his nebulizer when he’s sick”, but they have lost their tubing. You replace his tubing and mask and adapt his asthma plan for nebulizer use until his return visit. An electronic reminder for his flu shot is replaced in his chart, along with a reminder that his father needs an asthma education session and an asthma care plan for his home.
6. Enhanced access: Jackson arrives with his uncle at 1 pm on Sunday to be seen during urgent care hours. A consent by proxy is on the chart which permits his uncle to seek care for him. A “same-day” appointment is available and scheduled for follow-up by you the next day. An ED visit is unnecessary.

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7. **Payment:** Your partner charges an “after-hours” code (code 99051) for Sunday care and captures charges for oximetry (94760) and nebulization (94640), and nebulizer tubing (A7003). Your visit the following day is moderately complex (99214), sorting out the exacerbation and assuring that Jackson is clinically improved. Your nurse reviews inhaler use with his local family (code 94664) and makes an appointment in 2 weeks for spirometry to assess control (94060) and for this father’s asthma education visit.

Summary

The medical home model of care should be the foundation of care for all children, especially children with chronic conditions like asthma, the single most common childhood chronic condition and the second most prevalent childhood condition. For a child with asthma, care received within the context of medical home that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective can be the difference between control and the emergency room.



AAP Medical Home and Asthma Project

In 2009, the AAP established the Medical Home Chapter Champions Program on Asthma (MHCCPA) with support from the Merck Childhood Asthma Network, Inc. (MCAN). To connect with the Virginia Chapter Medical Home Champion and for more resources on asthma, please contact Helen Ragazzi, MD via email at hragazzi@comcast.net.

For more information go to the Medical Home Chapter Champions Program on Asthma (MHCCPA) web page <http://medicalhomeinfo.org/national/mhccpa.aspx>.

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Impact of Oral Health on School Attendance and Performance

A study published online February 17th for the March edition of the *American Journal of Public Health* looks at the impact of poor oral health on children’s school attendance and performance. The study authors examined school days missed for routine dental care in comparison with days missed for dental pain or infection. Data from the 2008 North Carolina Health Assessment and Monitoring Program was used to study more than 2,100 school children and assess school absences and performance, oral health status, parental education, health insurance coverage, race and gender. Children with poor oral health status were nearly three times more likely than those with good oral health to miss school as a result of dental pain. Absences caused by pain were also associated with poorer school performance, but absences for routine care were not.



The study authors conclude that improving children’s oral health status may be a way to enhance their education experience.

To review the study online, go to <http://ajph.aphapublications.org/cgi/content/abstract/AJPH.2010.200915v1>.

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Introduction

Early childhood dental caries (tooth decay) is a transmissible, bacterial infection of the oral cavity. The subject has received increased attention from medical and dental professionals over the past 10 years primarily due to the increase in disease prevalence in children aged 2 to 5 years. (1) The collaboration between professions reflects a shift in providing preventive oral health services for young children outside of the dental setting. Early oral health risk assessment and disease identification, topical fluoride varnish application, anticipatory guidance, and timely dental referrals have proven effective in reducing dental treatment needs. (2) The purpose of this article is to provide information about the disease process and discuss simple, effective preventive strategies that can be easily incorporated into a medical setting.

Early Childhood Caries

Dental decay is considered the most common chronic disease of



Picture 1: Early Childhood Caries

childhood. When the disease is found in children less than 6 years of age it is termed early childhood caries (ECC). When experienced in children younger than 3 years of age, it is considered the severest form of the disease. (3) Described as a highly complex disease with

multiple associated risk factors and protective factors, ECC is the direct result of interaction between the oral flora and dietary carbohydrates. (4) Risk indicators for ECC are based on both population and individual status. Children from low income or minority families or who have special health care needs are typically at the highest risk for ECC. Despite existing disease disparities, all children have some individual risk of acquiring the disease because of the potentially high risk environment of the oral cavity. Therefore, individual risk assessments are extremely important for tailoring oral health messages to the parents and preventing ECC.

Risk factors include:

- the presence of cariogenic bacteria in the mouth of parent and child
- frequent exposure of parent and child to dietary fermentable carbohydrates
- inadequate fluoride exposure
- reduced salivary flow

Protective factors include:

- good daily oral hygiene to control bacteria
- reducing dietary sugar intake
- appropriate systemic and topical fluoride exposure
- adequate salivary flow

Left untreated, ECC can result in severe pain, failure to thrive, delayed speech development, and life-threatening systemic infection. Failure to prevent ECC also increases the risk of disease in the permanent dentition. Therefore, preventing disease early in a child's life can have a lifelong impact on his or her oral health.

The Role of the Physician

Because the pediatrician typically sees a child 8 to 12 times for well-child visits before age 3, an invaluable opportunity exists for the active role of medical providers in oral health prevention strategies. Primary prevention measures are most effective if applied as soon as the teeth erupt into the mouth, which is normally around 6 to 8 months of age. Best practice strategies include identifying risk, applying fluoride varnish semi-annually, educating parents, and making timely dental referrals. The American Association of Pediatric Dentistry, American Dental Association, and American Academy of Pediatrics have officially endorsed the recommendation of the first dental visit by the first birthday, although, many parents and providers are not aware of this recommendation. (5,6,7)

Bright Smile for Babies Program

Virginia's Bright Smiles for Babies (BSB) Program provides the necessary training for implementing early oral health prevention services for high risk patients. Trainings are free-of-charge and offered on-site in local offices.

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Physicians are reimbursed by Medicaid (fee-for-service and all managed care) for the application of fluoride varnish for children 6 months to 3 years of age.

The BSB training includes all components of the oral health intervention:



Picture 2: Risk assessment and screening of young child

Risk assessment and screening

The caries risk assessment includes a clinical observation of the oral cavity as well as a verbal assessment of the presence of behavioral risk factors and/or lack of protective behaviors.

Fluoride varnish

Fluoride varnish is the first effective topical fluoride that is safe to use on children under aged 3. Effectiveness in disease reduction in the primary dentition ranges from 30% to 63%. (8) A recent study illustrated the effectiveness of fluoride varnish in reducing the incidence of ECC when combined with parent counseling. (9) Additionally, fluoride varnish applications performed in medical offices for Medicaid-covered children are associated with fewer caries-related treatments in dental offices. (10) The high concentration and sticky nature of the varnish allows for a quick and easy application, reducing the risk of ingestion. One of the main advantages of the product is its ease of use in non-dental settings. Application time is less than one minute, depending on the age of the child. Registered nurses and licensed practical nurses may apply the varnish to children under aged 3 with a physician’s standing order. The supplies are minimal and cost approximately \$1.00 per application. Medicaid reimbursement in Virginia is \$20.79 per application.

Anticipatory Guidance

Providing parents with timely and targeted oral health information is essential. The desired behavior changes typically include improved daily oral hygiene measures, reduced amounts and frequency of intake of fermentable carbohydrates, avoidance of feeding practices that result in

bacterial transmission, and cessation of sleeping with a bottle containing anything except water.

Referral

Tooth decay should be treated no differently than any other chronic health condition requiring the attention of a specialist. It is important that physicians and their staff are comfortable in referring to dental offices for needed treatment and the age-one dental visit.

Summary

The 2000 Surgeon General’s Report on Oral Health termed tooth decay in children as a ‘silent epidemic’. (11) By broadening the domain of medical professionals to include ECC prevention strategies, physicians and nurses can improve the health and well-being of our most vulnerable children.

For information about Bright Smiles for Babies, or to schedule a training, contact:
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 Dental Health Program,
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EASTERN VIRGINIA MEDICAL SCHOOL DEVELOPS A PEDIATRIC PUBLIC HEALTH CERTIFICATE PROGRAM FOR ALL PEDIATRIC RESIDENTS

Kate Ferguson, EdD

Director, EVMS Pediatrics Division of Community Health and Research

CW Gowen Jr MD, FAAP

Associate Professor of Pediatrics

As pediatricians, we have long been advocates for the health and safety of our patients. A five year grant from the federal Bureau of Health Professions/ Health Resources and Services Administration (HRSA) will support the development of a new 12 credit-hour Pediatric Public Health Certificate for all the pediatric residents at ECMS/CHKD. It is important for residents in training to gain an understanding of the social and cultural context of their patients' health, know how to link families with community resources, and be able to advocate for children's health at multiple levels. To this end, the public health and population-based approaches would be crucial components in training new pediatricians in the current and future health care environment.

In 2009 three new faculty members were recruited by the Department of Pediatrics. Dr. Natasha Sriraman, MD, MPH, joined the general academic pediatrics practice at Children's Hospital of The King's Daughters (CHKD). A physician and long-time public health practitioner, Dr. Sriraman had completed a fellowship in urban community health working with Asian and Pacific Island immigrants, and most recently had served on a working group for the Pediatric Public Health Residency Curriculum Initiative, a HRSA-funded nationwide effort facilitated by the UCLA Center for Healthier Children, Families and Communities. In 2010 our residency was selected as one of six national pilot sites to develop and implement this basic curriculum.

Also in 2009 Dr. Bryan Fine, MD, MPH, joined EVMS to lead CHKD's new hospitalist program. Dr. Fine's interest in the impact of public health policy and finance on children's health led him to establish the Virginia Child Health Policy Center based at CHKD with a mission to educate pediatricians, community leaders, and the public on the link between policy and clinical decision making. Medical educator and writer Dr. Kate Ferguson, EdD, the new Director of the EVMS Pediatrics Division of Community Health and Research, worked with Drs. CW Gowen, Sriraman, and Fine to develop a proposal to build on the basic public health curriculum to develop a certificate program with courses that residents could later apply to an MPH degree. Pediatrician Dr. David Matson, Director of the joint EVMS-Old Dominion University MPH Program, worked closely with the group to plan for a series of courses that would meet the Association of Schools of Public Health-established Public Health Competencies and Pediatric Public Health Goals developed by the UCLA-led group. AAP materials

from the Community Pediatrics Training Initiative were also incorporated into the plan.

Community-based experiences, resident projects, and reflection through journaling will be key components of the residents' public health learning. Two regional child health coalitions, the Hampton Roads-based Consortium for Infant and Child Health and the rural Eastern Shore Healthy Communities Coalition, led by EVMS Pediatrics Instructors Amy Paulson and Patti Kiger, will provide numerous community connections where residents will learn first-hand about such challenges as the growing child obesity epidemic, family difficulties in finding a medical home for their children, and the role of the home environment in allergic asthma and other chronic illnesses. Both coalitions emphasize advocacy training in addressing child health problems through policy, systems, and environmental change. Speakers such as Virginia's Health Director Dr. Karen Remley and Representative Dr. Ralph Northam, both pediatricians with close EVMS ties, will reinforce how pediatricians can influence policy.

Residents will focus on such topics as the Social and Behavioral Context for Health, Providing Culturally Competent Pediatric Care, Working with Communities, Narrative Medicine, and Developing a Public Health project. Three courses will be offered per year on a rotating basis, so that by the end of their training residents will have taken 9 credit-hour courses with additional credit received from conducting community-based projects. Part of the learning for both residents and faculty will be that Public Health is not Poverty Health, but encompasses everyone. Nor it is just relevant to Primary Care. Pediatric subspecialties will provide an important component of the initiative as well. We will be rolling-out of the first lectures this spring with a substantially revised residency curriculum beginning in 2012.

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Pediatric Genetics Web Site from CDC

A new Web site from the Centers for Disease Control and Prevention (CDC) features information on Pediatric Genetics. The site is research-based and includes easy-to-read information on genetic disorders, family health history, genetic counseling and newborn screening. Also highlighted is a compilation of key data and scientific publications plus an individualized page for health professionals. The site was created by the Pediatric Genetics Team in the Division of Birth Defects and Developmental Disabilities in the National Center on Birth Defects and Developmental Disabilities at the CDC. Access the site at <http://www.cdc.gov/ncbddd/pediatricgenetics/>.

Dates to Remember!

MCLEMORE BIRDSONG PEDIATRIC CONFERENCE

March 25 - 27, 2011

The Pavilion, Boar's Head Inn—Charlottesville, Virginia
This is a combined CME conference with the Virginia Chapter, American Academy of Pediatrics.

Chapter members receive \$100.00 off of the conference registration fee!

Simply indicate that you are a Virginia Chapter member on your course registration form.

Earn 13.75 hours in AMA PRA Category 1 CME credits.

The Chapter will hold a free Luncheon on Saturday, March 26 at 1:00 p.m. in the Hearth Room. Please make plans for you and your family to join us for lunch!

For more information contact Nancy Jarvis, Conference Coordinator, via email naj7s@virginia.edu. Check www.cmevillage.com for online registration.

CARING FOR NEWBORNS IN A BUSY PRACTICE

April 29, 2011

UVA Jordan Hall Conference Center—Charlottesville, VA

Pediatricians, Family Physicians and other health care providers on the multidisciplinary team, in the hospital and office setting, face numerous challenges caring for newborns and their families. Included among these challenges are: changing recommendations, unfamiliarity with available resources, cultural differences, and lack of time and adequate reimbursement. Course faculty will present practical advice on how to overcome these barriers.

Check www.cmevillage.com for online registration.

11TH VACCINE UPDATE CONFERENCE

May 6, 2011 8 AM - 4 PM

Hilton Richmond Hotel & Spa at Short Pump

This day-long conference will focus on the latest vaccine recommendations, techniques, and strategies to reach diverse populations with advice from state and national experts. This program is intended for physicians, nurses, pharmacists, immunization advocates & other allied health professionals.

If you are a VA-AAP member you may register on the VA-AAP website www.virginiapediatrics.org before April 1 at a discounted rate of \$45.00, after April 1 \$65.00. Registration closes April 22.

No walk-in registrations will be accepted.

PEDIATRICS AT THE BEACH

July 22 – 24, 2011

Wyndham Virginia Beach Oceanfront Hotel Virginia Beach, Virginia

This is a combined CME conference with the Virginia Chapter, American Academy of Pediatrics.

Chapter members receive \$100.00 off of the conference registration fee!

Simply indicate that you are a Virginia Chapter member on your course registration form.

Earn 13.0 hours in AMA PRA Category 1 credits.

The Chapter will hold a free Luncheon on Saturday, July 23 at 1:10 p.m.

Please make plans for you and your family to join us for lunch!

For more information contact VCU Office of Continuing Medical Education, via email cmeinfo@vcu.edu.

Check www.cmeregistration.som.vcu.edu for online registration.

MOHSEN ZIAI PEDIATRIC CONFERENCE

November 4 & 5, 2011

Ritz-Carlton Tysons Corner—1700 Tysons Boulevard, McLean, VA

Inova's Mohsen Ziai Pediatric Conference is a full two-day comprehensive symposium that offers top-quality education and the opportunity to talk directly with our expert faculty.

This symposium provides current and practical information in addition to cutting edge advances and hot topic discussions covering the latest in pediatrics. Furthermore, physicians and other health care providers will have the opportunity to consider current standards or care, as well as recommendations for optimizing patient care. The overarching goal for this conference is to update the practicing pediatrician and pediatric health care professional in topics that will improve patient care.

For more information contact Catherine Tumelty via email Catherine.Tumelty@inova.org.

Visit

www.virginiapediatrics.org
for more information about
our upcoming events!



Centers for Disease
Control and Prevention
National Center for Injury
Prevention and Control

Free Web-Based
Violence Prevention
Course

Each year, more than 53,000 people around the US lose their lives to violence. In addition to the tremendous physical and emotional toll, violence has substantial medical and lost productivity costs. In 2000, these totaled more than \$70 billion in the United States. The figure grows when we add criminal justice system costs, social services, and other expenses. As Dr. Rodney Hammond, Director of CDC's Division of Violence Prevention, says, "Violence isn't something that just happens that you can't do anything about. It can be prevented."

One way CDC is helping the nation prevent violence is a free Web-based course that's available 24 hours a day, seven days a week. It's called Principles of Prevention. The course—which offers continuing education credits—teaches key concepts of primary prevention, the public health approach, and the social-ecological model. Participants complete interactive exercises to learn to help prevent five types of violence: (1) Child abuse and neglect, (2) Intimate partner violence, (3) Sexual violence, (4) Suicide, and (5) Youth violence. The course is designed for those working to stop violence from ever happening. It helps professionals move from the problem to the solution. *This course teaches the fundamentals of effective violence prevention methods and incorporates the growing body of research on what works.*

THE PRINCIPLES OF PREVENTION COURSE INCLUDES:

- (1) Interviews with leading experts in the field,
- (2) Dynamic graphics, (3) Interactive exercises, and
- (4) Compelling storytelling that makes the case for violence prevention.

The course is available at www.vetoviolence.org/pop. For additional information on Principles of Prevention, contact Jennifer Middlebrooks (jod5@cdc.gov).

Value of being a Chapter Member!

The benefits of being a member of the Virginia Chapter, AAP are many, such as updates from the VA-AAP about legislation and health policy changes plus you receive discounts on registration at all 4 major state CME events as well as up to half off the one-day, single-topic conferences on Breastfeeding, School Health, Pediatric Practice Management, and Vaccine Conference *just to name a few.*

With your involvement and the involvement of your peers, we can be a more powerful voice for issues that impact children and pediatric subspecialists. Chapter membership offers numerous opportunities for involvement, leadership development, strengthening the everyday practice of pediatrics and providing a voice at the local level that is unsurpassed. Our Chapters can provide a forum to network with other pediatricians, sponsor CME activities and can be an integral part in shaping the development and implementation of child health policy at the state level. We need the support of all Virginia Pediatricians to continue our work!

Please encourage your colleagues to
become active members in the Virginia Chapter.