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President's Column

By Zoey Goore, MD, MPH, FAAP

Better communication. Whether we look at the main source of medical error at most hospitals, disengaged employees citing lack of transparency at work, strained family relationships, or feedback from our membership, all roads seem to point to better communication. In this vein I'd like to share with our membership that over the past few years we (California Chapter 1 AAP) has made some much needed investments into technology and communication channels in an effort to move our chapter into the modern era.

We've made purposeful investments using reserves in an effort to move forward and to better serve and communicate with our membership. Membership continues to be on the decline as people's finances are stretched, their work load increases, board dues increase, and time becomes more limited. Also services that were previously found only within member benefits are offered for free by employers and third parties. We are tightening our fiscal belt in an effort to sustain our chapter as we try to focus on what matters to members and to children in Northern California. We are encouraging more virtual meetings as a way to save money and be more inclusive to folks who want to participate and don't want to drive to San Francisco for a weeknight

meeting. We are cutting expenses and moving toward a virtual office by early next year. The board is looking very closely at how to engage members, be fiscally responsible, and further the mission of Northern California AAP (and national AAP) for the pediatricians and children of California. We welcome all feedback and input.

In the past year in addition to looking over our finances we have been involved in a considerable amount of advocacy on the state and local levels. We have worked in the Bay Area on resources referrals with an organization called **One Degree**. We have worked with several counties on soda tax initiatives. We worked very closely with Senator **Richard Pan** and others on the vaccination bill (SB277). This year our advocacy committee has reviewed approximately 500 bills and has taken positions on many of these with 10 high priority bills and taken formal positions on over 50. This year our state organization has worked with leaders on CCS, gun safety, and health care for undocumented children. Just this week I testified for a bill that we sponsored that would urge the dental board to look at the how anesthesia is delivered in oral surgeons' offices. Currently they are managing both the anesthesia and the surgical procedure.

Our Early Childhood Development committee, our Foster Care committee and our School Health committee continue to be very active as well. Our CME committee historically has been the busiest, putting on fabulous CME events. This year we've had two already: one in Oakland at UC Berkeley with Dr. **Paul Offit** and one in Sacramento at UC Davis with Dr. **Daphne Say**. We look forward to another fabulous CME event on December 3, 2016.

I hope my attempt to have greater specific communication about where we are and what we've been doing has helped. I'm always available by phone or email if you want to reach out. We'd love your participation at whatever level. We also want you to know where your money is going. I for one will continue to pay my dues if for no other reason than the incredible advocacy that we do on behalf of Pediatricians and children in the state of California. I guarantee no other group has pediatrician's interests at heart like we do.

Vice President's Column

By John Takayama, MD, MPH, FAAP

Member Survey: What are Chapter 1 members interested in? We conducted a chapter member survey this spring to find out what activities members wanted the chapter to focus on. Although the response rate was only 8% (184/2200), the responses represented a variety of practice types (private practice, staff model HMO, university-based practice and community health clinic) and the results seemed relevant. The following is a summary with some thoughts on potential chapter activities.

Child Health

1. Provide leadership and advocacy to improve patient (family) access to developmental and mental health services.

2. Educate members about screening, assessment and treatment related to mental health problems. 11-21% of children have a behavioral or emotional disorder at any given time and up to 39% will have a diagnosis during childhood. Given the shortage of mental and behavioral health providers, both nationally and in California, pediatricians have been asked to offer not only screening but also initial care for children with mental/behavioral health issues. AAP National has initiated a number of projects to help pediatricians available at: AAP Mental Health Initiatives

At the recent Chapter 1 Developmental and Behavioral Pediatrics (DBP) committee meeting, many committee members voiced enthusiasm about helping to bridge the information and resource gap between DBP and general or primary care pediatrics.

At a recent workshop on "Strategies to Address Behavioral and Mental Health Concerns in Primary Care" at the Pediatric Academic Societies (PAS) Annual Meeting in Baltimore (April 2016) the PSC (Pediatric Symptoms Checklist) was recommended as a useful screening tool. It is short, free and available in multiple languages. The checklist is available at: Pediatric Sympton Checklist

This parent-completed questionnaire can be used to categorize problems as attention, externalizing (i.e., conduct disorder) or internalizing (i.e., depression). The workshop also suggested a common factors approach with the acronym HEL2P3. During the initial time period when parents raise behavioral or mental health concerns, pediatricians can respond effectively by providing hope, by being empathetic, using language that is understandable, and by partnering with the family to develop a plan.

Member Health

1. Develop programs and provide resources to improve pediatrician wellness.

Both at a resident retreat last fall and at the AAP Annual Leadership Forum in March 2016, I was moved by the testimonials, which reflected the degrees to which pediatricians and residents were affected by daily stress. At the Pediatric Academic Societies (PAS) Meeting, I participated in the "Battling Burnout: Strategies for Promoting Wellness" workshop. I learned about self-care assessment, mindfulness practice and planning for wellness. An easy to adopt first step is to think about three good things that happened during the day, just before going to sleep. We have expertise in our chapter and sharing these, including resources, may be the next step for member health.

Chapter Health

1. Improve communication between chapter leadership and members using email.

2. Develop and offer in-person systems (i.e., conferences, meetings) so

members can network with each other

There are many ways for our chapter to be active and one important aspect is to develop a set of priorities every year. This way, we can focus our efforts and also monitor what we achieve. We hope this provides opportunities for members to be involved and adds value to membership. If you are interested in more information and/or becoming involved in any of the above activities, please send email to info@aapca1.org.

CME Update

By Mika Hiramatsu, MD, FAAP, CME Committee Co-Chair

Infectious diseases, orthopedics, dermatology . . . the CME committee is busy putting together an exciting program for you on December 3 at UCSF Mission Bay. Two of the featured speakers will be Dr. **Meg Fisher**, infectious disease expert and beloved local dermatologist, Dr. **Renee Howard**. We received a lot of positive feedback for our location last year, so we are keeping it at UCSF.

Because the AAP National Conference and Exhibition will also be in San Francisco this year, our members worked hard to create an original meeting for you. Therefore, our day will be full of case studies and unknowns - a "What's the Diagnosis?" format. In addition, we will have a fun end-of-the day quiz show for attendees to test the knowledge that they have gained.

Twenty-two pediatricians attended a special education event on gastroesophageal reflux put together by Dr. **Jim Marcin** at UC Davis in May. The goal was to educate and also recruit to the chapter, and several attendees were not chapter members. The speaker, Dr. **Daphne Say**, was positively received. The committee is trying to create more CME opportunities outside the Bay Area to be more inclusive of our large chapter.
Many of you answered the brief CME questionnaire I sent out last month. Based on the response, we are planning a half-day Saturday dermatology meeting for Spring 2017. We are always interested in dynamic, inspiring speakers - please send along any suggestions to me.

SAVE THE DATE

California Chapter 1, AAP ~
Winter CME Conference

PEDIATRIC PUZZLES

December 3, 2016

Mission Bay Conference Center, UCSF
San Francisco, California

Passion and Purpose in Medicine

By Kerstin Rosen, MD, MA

Passion is key to success according to **David Lucatch**, founder and CEO of Yappn Corp. "The people I have seen achieve the greatest success in their professional and personal lives are passionate people that lead, support, and mentor others with that 'zeal and zest' for the work and people." Wellness and mindfulness programs help physicians cope with stress, connect with their patients and improve their general quality of life (Dr. **Shauna Shapiro**, Santa Clara University).

As a growing number of medical providers are becoming burnt out it is crucial to develop ongoing wellness programs that are readily available and sustainable for busy physicians.

At Kaiser Santa Clara two dynamic physicians (Drs. **Joanna Stark** and **Wakako Nomura**) set out to introduce their colleagues to a coaching opportunity to simply be good to themselves. This duo designed a one-half day Passion and Purpose conference on a Saturday morning and had more than 40 engaged participants. To date they have facilitated several of these

sessions and had more than 150 colleagues attend.

Surrounded by the safe and familiar environment of colleagues, the course was designed as an introductory session to ignite thought about what fuels us as physicians. This wellness program was unique in that it was catered towards clinicians. In the session, physicians spent time trying different therapeutic modalities; coloring, journaling, visualizations and meditation. For the closing, physicians shared positive feedback of each other in groups of five. This activity was one of the most well-received as it was a unique opportunity to see oneself through a colleague's perception.
For some physicians the process was easy but for others it took some time of reflection to accomplish.

The outcome and what providers took away varied. Some lacked time to spend with friends and others missed volunteer opportunities. Some wanted to exercise more and others wished to develop their spiritual practice. Smaller groups that lead to more intimate sharing of thoughts worked better than the larger groups and having participants who were truly interested in self-exploration resulted in a richer satisfaction of the program. A one-time intervention around physician wellness is a good start, but to sustain this kind of work physicians need ongoing support according to Drs. **Stark** and **Nomura.**

IMQ Child Abuse Course

By Dorothy Wilborn, MD
Contributor, IMQ's Child Abuse Prevention, Recognition and Reporting Course

Moment of Suspicion - As pediatricians, we know that suspecting child abuse is one of the most uncomfortable moments encountered in our practice. As mandated reporters, we also know that the moment of suspicion is the beginning of several processes involved in advocating for the child's health, well-being and safe disposition. The pediatrician's ability to recognize injuries and findings suspicious for abuse and/or neglect, utilize appropriate medical decision making and state mandated reporting processes can help save a child's life.

Scope of the problem - Child abuse occurs at every socioeconomic level, across ethnic and cultural lines, religions and at all levels of education. About 1 in 8 US children experience maltreatment so persistent or severe that it results in a state confirmed substantiated maltreatment report. This represents about 12% of the 0 - 18 years of age population. Since this data represents only the

confirmed cases, we know this is only the tip of the iceberg.

Consider the following scenarios -

Scenario #1: It's another busy clinic day. The toddler you're seeing at 3:30 pm for a rash, doesn't have a rash after all. He has patterned bruising - in his face, his arms and his back. You remember from your Child Abuse CME that these parallel, well defined linear bruises with petechiae are consistent with slap marks. You notice he's crying and irritable in the caregiver's arms. When he refuses to stand, you see that his ankle is swollen and tender.

Scenario #2: Your last patient of the day is a 13-year-old who has questions about birth control options. Your patient speaks to you confidentially and discloses that she is sexually active with a 17.5-year-old friend of the family. Their parents are completely unaware.

Scenario #3: A family you know believes in and practices corporal punishment for discipline. The parents and grandparents feel so strongly about corporal punishment that they refer to it as their generational family policy. Your school aged patient has been coming to see you for check-ups since birth and has always had a normal clinical exam. He is growing well and getting all A's and B's in school.

Scenario #4: The story just doesn't fit for the 10-month old brought into urgent care with a burn. The caregiver admits to drinking coffee every morning and reports the 6-year-old sibling spilled coffee on the patient's hand. As you examine the 2nd degree circumferential burn on the patient's hand, the 6-year-old sits quietly in the exam room. You also notice that the 6-year-old has moderate bruising on the helix of both ears.
Sound familiar? How would you address each scenario?

Knowledge is Key - The Institute for Medical Quality (IMQ) offers a Free On-Line Child Abuse Prevention, Recognition and Reporting Course, developed by a local Steering Committee of Child Abuse Specialists and Pediatricians in collaboration with the Child Abuse Prevention Center in Sacramento. This interactive and case-based training takes about 1 hour. The course provides a thorough, concise review of child physical, sexual, emotional abuse and neglect, along with the California state mandated reporting requirements, instructions on how to report, as well as a printable toolkit for future reference.

CME is provided for completing IMQ's Child Abuse Course, Post-Test and Course Evaluation at no cost through September 30, 2016. Additional grant funding to support CME for the training beyond September 2016 is dependent on the number of completions, so please be sure to complete the Post-Test and Evaluation to receive your CME certificate. Take advantage of this CME opportunity and share with a colleague!

Never Give Up On The Human Spirit

By Carson Welty, MD, Member-at-Large, Santa Clara County

It is a common occurrence upon reviewing my charts in the morning that I find a baby double- booked onto my morning schedule. Upon chart review I discover that the mother was methamphetamine positive during her pregnancy. With this information comes a flood of stereotypes, anxiety and significant concern about the wellbeing of the newborn.

About 15 months ago I had just such a patient walk into my clinic for routine newborn follow-up. When I introduced myself to mom there were obvious signs of methamphetamine abuse. I saw a young woman worn down by addiction, abuse, poverty, and starvation. She described to me how she had another child that was currently under the custody of her mother. She reported to me that she was sober for the last 6 months. When she found out she was pregnant she was living underneath a bridge, strung out on methamphetamines, homeless, and hopeless. She however knew that she did not want to lose another child and knew that this was her opportunity to find meaning in her life.

When her beautiful baby girl was born she was in love immediately. She knew that she was given a second chance on life. She was placed in a transitional housing unit which provided support to recovering mothers and a place to live for her and her baby. In that initial visit we had a very frank discussion about addiction and the importance of sobriety on the wellbeing of her newborn. Mom returned to every single appointment during the newborn period. She relentlessly worked on breast feeding. At each visit I noted a change in the mother. Every visit she gained more color, light, and life into her face. She became excited about life and about all life's possibilities. At the 2 month visit she broke the news that she was hired for her first job. The excitement on her face and the energy in the room was palpable. She not only maintained this job while beautifully raising her daughter, but was later hired on by the transitional unit house. She is now maintaining two jobs and living independently. She has since started reunification with her older son and is rebuilding her relationship with her mother. At every well child check I remind mom how proud I am of her success. I usually do not make it through a visit without tears welling in my eyes.

Amphetamines are such a dangerous and lifeless drug. Stimulants take a hold of humans so viciously and so rapidly. They destroy lives and families. I have had many other patients that have gone the opposite direction, returning to the streets with babies being placed into foster care. I am lucky to live and work in a county that has resources and successful transitional programs like the one my patient entered. I credit my patient's success to her personal strength and resiliency but also think that her social worker, transitional housing unit, and even medical home helped in her recovery. Stories like this remind me that we can never give up on the human spirit.

We need to continue to support humans in recovery no matter what their disease may be and no matter what the cost. This mother's strength motivates me daily to provide compassionate, empathetic, and humble care to every

patient that I see.

Accessing Autism Treatment

By Renee C. Wachtel, MD
Chair, Committee on Development and Behavior

As you may know, Autism Spectrum Disorders (ASD) are now a commonly diagnosed condition with the Centers for Disease Control (CDC) reporting recently (March 2016) that **1 in 68** US children are diagnosed with ASD. In addition, autism diagnostic and treatment services are now mandated for coverage through health insurance for most private insurance and all children with Medi-Cal. This is in addition to the services that are available through the Regional Center system (at all ages) and the school system for children over age 3 years.

There are two autism spectrum disorder (ASD) tools available for pediatricians for **free**. They are worth checking out for use in your practice. The MCHAT-RF is a screening tool for children ages 16 to 30 months and is available for free download at **www.mchatscreen.com**. The MCHAT-R/F is a two stage screener, with the first stage being reduced to 20 yes and no questions, and a score of 3 or above needing the second stage follow up. The new version detects ASD at a higher rate than the old version, and fewer children have false positive first stage screens requiring follow up. Positive screens were found to be indicative of Autism Spectrum Disorders in 47% of the children, and 94.6% of the children with positive screens were found to have developmental delays upon follow up testing (Pediatrics December 2013). This new screen improves early detection of ASD and therefore should result in earlier referrals for diagnostic evaluations and early intervention.

For families who have a newly diagnosed child with ASD, Autism Speaks has put together a free "100 Day Kit" that can be downloaded at their website **www.autismspeaks.org**. It covers topics such as ASD diagnosis, causes and symptoms, family tips, early intervention and educational rights, and ASD therapies and treatments. It also provides useful forms and ideas for developing a treatment team for the child with ASD. By providing the information to families about the "100 Day Kit", you will be helping families to learn about issues that they will confront after their child has received an ASD diagnosis, and answer many of the questions that they may have. The Autism Speaks website is also a place where pediatricians can obtain information about recent scientific research related to ASD.

The Autism Health Insurance Project (**www.autismhealthinsurance.org**) is available to families who are having trouble accessing autism treatment services through Medi-Cal or other health insurance. Their website has valuable information including form letters and a good description of the process. Our committee would be very interested in hearing about any difficulties that your families are having accessing autism services.

Valuing Mid-Career Physicians

By Zoey Goore, MD, MPH, FAAP

My brother, age 42, just bought a Toyota Landcruiser. He says he's having a midlife crisis. He's got two kids ages 8 and 10, the cruiser has no seat belts in the jump seats in the back. (He assures me he'll put in proper seats and proper seat belts). Like many of us, he's recognizing his own mortality, thinking about what he wants out of life, and trying to balance - whatever that means (ask me another time about the Venn diagram of work-life balance).

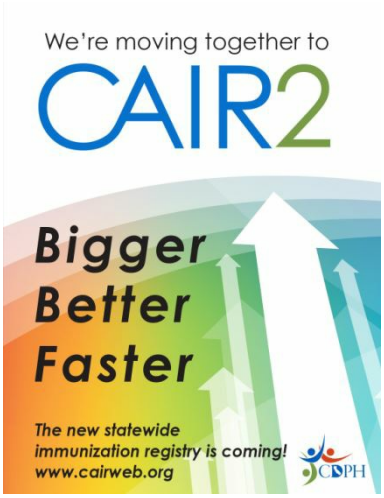
When thinking about my brother and his pursuit I also look around at many of my colleagues who, like me, are mid-career. We've already been at this a decade or two but have almost two decades to go. Our kids are starting to move on to college, careers, etc, and we're starting to wax theoretical about where we've been and where we are going. Many of us have leaned out at work so we could lean in at home. We've cut our leadership teeth negotiating with toddlers - or more recently with frontal lobe-absent teens. Having a difficult conversation with a colleague often seems easier after having your teen scream "I hate you, you are so mean!" at the end of a conversation about why she can't be on her phone all night long. We've developed filters for what's really important. We've learned to be efficient, think critically about finances, used our organizational skills on committees, board, councils of our children's activities, all while managing our practices. Some of our colleagues may have chosen to lean in at work, climbing up the leadership ladder at work or working full time in clinic.

Now at this crossroads those of us who were leaning in at home may find ourselves with thoughts of leaning elsewhere. It can be intimidating to try our hands at something new in the work or volunteer arena. We've been comfortable at home and our children's schools and activities. Remember that the skills you've employed running your household are very useful at work as well - especially your ability to filter out the baloney.

There is work to be done to improve health care both at all our practices and in our communities. With at least a decade worth of experience and 20+ years left in your career I'd like to reach out to my mid-career colleagues and welcome you with open arms if you are now finding time to engage with your interests and the interests of your patients (or you just want to escape the nerf wars at home - which is happening in the background as I write this). This is all in addition to the health benefits of altruism. I know I can learn from you and our communities can benefit from your wisdom and you can still buy yourself a crisis car if you need one.

CAIR is moving to CAIR2: It's bigger, better, faster!

Jane Pezua, MPH, VIP Program Coordinator, Immunization Branch, CDPH



An increasingly complex immunization schedule can be confusing for providers, schools, colleges, and individuals. Compounding this problem is the fact that immunization records are often scattered, making it difficult to assess whether a person is truly up to date.

An immunization registry is a secure, confidential, web-based database that stores the immunization records of children and adults. Registries help medical practices keep patients of all ages up to date on vaccinations by avoiding under-immunization or over-immunization. Immunization registries are an important component in achieving and maintaining high immunization coverage rates, allowing providers, health departments, schools, and health plans to target those in need of immunizations.

The **California Immunization Registry (CAIR)** is currently comprised of nine regional or county registries, several which have been in existence since the early 90's. Seven of the nine CAIR regions use the same software and are managed by the California Department of Public Health.

Starting in the fall of 2016 through the summer of 2017, the CAIR system will be moving to an enhanced system, called CAIR2, which promises to be bigger, better, and faster.

CAIR2 is bigger. By the summer of 2017, CAIR2 will consolidate immunization records from all regional immunization registries across the state. This means that providers will be able to access more complete immunization histories, even if your patient visited multiple providers in different clinics and regions. This will enable you to make better informed decisions on what immunizations your patients need and save you from waiting and deferring or repeating doses.

CAIR2 is better. Starting in the summer of 2017, EHRs can be set up for bidirectional data exchange. This will allow patient immunization records to be sent from CAIR2 to your EHR for viewing and updating within your EHR along with recommendations on what doses are due.

CAIR2 is faster. Patient lookups and reports will run faster. You no longer have to wait to provide updated yellow cards to patients, since data sent to CAIR2 will appear within seconds.

In addition, provider offices may spend less time pulling patient charts since schools and child-care centers will find records easier to look up in CAIR2. Health plans will be able to run their own reports of their members' immunizations from CAIR2.

CAIR2 will still provide the same functions you value from the previous system, including routine vaccine scheduling, which shows what doses are due for your patients using the latest guidance from the Centers for Disease Control and Prevention (CDC), reports to help you manage vaccine inventory and tracking of doses administered, and reminder or recall notices, so your office can identify and contact patients who are in need of immunizations.
CAIR San Diego, CAIR San Joaquin, and CAIR Imperial users will continue using the same software so will not need to be trained. To learn more about CAIR2, when your region will move, and other details such as any training requirements, visit CAIRweb.org.

HPV Survey

By Sunnah Kim, Director, AAP Division of Pediatric Practice

The AAP received a request to disseminate an HPV survey on behalf of a 4th year ENT resident at Nemours Al DuPont Hospital in Delaware, Dr **Lindsay Goodstein**. Dr. **Goodstein** shares our goal of improving HPV vaccination rates among teens. Her survey assesses pediatricians' current practices, as well as their knowledge of the relationships between HPV and head and neck cancer.

The survey has been distributed in Delaware, and preliminary results show that a surprising number of clinicians reported that they were not aware that HPV infection can lead to oropharyngeal cancer. They are hoping to obtain additional data from other states to further study this topic.

This is a short survey that should take no longer than 5 minutes and can be accessed at:
Link to Nemours Research Survey. We appreciate your assistance in completing the survey and sharing this information with your colleagues.

Visit our Website