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DEDICATED TO THE HEALTH OF ALL CHILDREN™

California Chapter 2

President's Report

The Quality of Ambulatory Care for Children

By Wilburt Mason, MD, MPH, FAAP

Pediatricians pride themselves on the care and devotion they provide to their patients. Indeed from our first day in internship we were thought to provide the highest quality of care possible in the most caring and nurturing way in all aspects of healthcare. In fact, data shows that pediatric providers use antibiotics most judicially, are more available to their patients, and offer more preventive services such as immunizations than other primary care providers. However, a new study published in New England Journal of Medicine in October identifies deficits in the quality of care provided to children that are similar to those previously reported in adult patients. The study from the Department of Pediatrics University of Washington and Children's Hospital Regional Medical Center in Seattle, RAND in Santa Monica, and UCLA, addressed five questions:

1. How good is the quality of care for children overall?
2. Does quality vary according to the type of care (i.e., acute, chronic or preventive care)?
3. Does quality vary across the continuum of care functions (i.e., screening, diagnosis, treatment, and follow up)?
4. Does quality vary according to the mode of care (i.e. history, physical examination, laboratory testing, medication, immunization, etc.)?
5. Does quality vary according to the type of clinical area (e.g. URI, acne, fever, immunizations, etc)?

The study spanned the years 1998 to 2000, was methodologically sound and evaluated a representative sample of over 1500 pediatric patients from across the country. Medical histories of these patients were reviewed for the two years prior to the evaluation and they were examined for a carefully selected group of clinical indicators for which evidence based standards of care had been established.

The results of the study were, to say the least, disturbing. On average, children in the study received 46.5% of the indicated care they should have received in the various categories; they received 67.6 % of the indicated care for acute medical problems, 53.4% of the indicated care for chronic medical problems and, 40.7% of the indicated preventive care. Two tables from this article demonstrate that the adherence to quality indicators according to mode of care and according to clinical area of care. (See attached) Examples of deficits in care quality identified by the study included the following:

- Only 44% of children with asthma who were noted to be using ß-2 agonists at least three times per day could be documented to have been prescribed an anti-inflammatory medication. Similar studies in the literature focusing just on asthma care have shown similar findings.
- In terms of immunizations, only 49.8% of children who had reached two years of age were fully immunized according to their records. Similar immunization rates have been identified by Health Plan Employer Data and Information Set (HEDIS) monitoring.
- Finally, for children 3 to 36 months of age in this study who presented with fever of an unknown origin, only 16.2% had urine cultures performed.

Clearly gaps in the quality of pediatric health care in the U.S exist.

What are the elements that define quality in health care? The Institute for Healthcare Improvement describes 6 characteristics of a "quality" healthcare system as one that is Safe, Effective, Patient Centered, Timely, Efficient, and Equitable.

The American Academy of Pediatrics has been interested in improving quality of care for children in pediatric ambulatory practices for several years. In 2001 it established the Steering Committee on Quality Improvement Management (SCOQIM). The SCOQIM offers a more integrated voice for quality and enables the Academy to best support its members in providing the highest quality clinical care for children. The group is comprised of pediatricians with expertise in practice, technology, and evidence-based medicine as well as liaisons from the Agency for Healthcare Research and Quality and the National Association for Children's Hospitals and Related Institutions. Dr. Glenn Takata represents Chapter 2 on this Committee.

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Is There Life After Pediatric Residency?

FRIDAY, FEBRUARY 1, 2008,
10 AM – 4 PM

KAISER PERMANENTE
WEST LOS ANGELES
6041 CADILLAC AVENUE
(basement classrooms)
LOS ANGELES

The American Academy of Pediatrics, California Chapter 2 sponsors a program called "Is There Life After Pediatric Residency" on a yearly basis. The program will be on February 1, 2008, at the Kaiser Permanente West L. A. Facility from 10:00 am – 4:00 pm. This program is for PL2's and PL3's who wish to attend these informative sessions for career planning.

There is no charge for the meeting or luncheon, but we must know in advance who will attend. For more information, contact Kathleen Shematek at kshematek@aap.net or call 213/250-4876.

Chapter 2 CME Accreditation Update

By Robert Adler, MD, FAAP, Chair, Chapter 2 CME Committee

All Continuing Medical Education (CME) providers in California have had to meet increasingly stringent requirements for accreditation. AAP California Chapter 2 had an in-depth site visit by a CME reviewer in July 2007 and on September 24, 2007; the California Medical Association's Committee on Continuing Medical Education awarded the Chapter a two-year reaccredidation to provide programs assigned AMA PRA Category 1™. The surveyor made some suggestions for improvement, which have been implemented, and the Chapter will continue to be committed to presenting the highest quality, up to date topics and outstanding speakers at our various Chapter-sponsored meetings.

President's Report

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Another initiative of the AAP aimed at improving quality in the office setting is the Quality Improvement Innovation Network (QuIIN). QuIIN is a network of pediatricians and their staff teams) that use quality improvement methods to test tools, interventions, and strategies to improve health care and outcomes for children and their families. The network will serve as a practical working lab for pediatricians to test how improvements can be implemented in practice. This network will offer AAP members the opportunity to be part of a learning community that shares strategies about improving care. As a result, QuIIN will provide resources for clinicians to do the right thing at the right time.

More recently the AAP has formed collaboration with the American Board of Pediatrics, Child Health Corporation of America, and the National Association of Children's Hospitals and Related Institutions (NACHRI) called the Alliance for Pediatric Quality.

Goals of the Alliance are to:

1. Promote the use of meaningful pediatric measures.
- Accelerate the identification and use of measures that will best drive change in the quality of health care for children
- Define measures that will emerge as measures for both improvement and public reporting for pediatrics

2. Ensure health information technology works for children.
- Ensure adoption of pediatric data standards by vendors and the government that work across care settings

Dr. Alan Lieberthal represents Chapter 2 on the Alliance for Pediatric Quality.

The AAP also provides numerous tools to assist physicians in improving quality in their practices. Among these are numerous guidelines that assist the practitioner in selecting the best approach in management of pediatric patients. The most recent was "Infection Prevention and Control in Pediatric Ambulatory Settings" that appeared in the September issue of Pediatrics. EQIPP, a web-base improvement module, can be found on the AAP web site and offers a performance improvement approach to the management of ADHD. The Practice Management link on the Members Center web site also has numerous opportunities for ideas in quality improvement in your practice.

How does one get started in quality improvement? One of the first steps is beginning to measure processes and outcomes in your practice. What IS the up-to-date immunization rate in your patients? Do you measure a BMI in children at risk for obesity? How well do you document developmental milestones? Measurement of indicators like these might identify gaps in care for you to address.

California Chapter 2 of the AAP is eager to assist practitioners in identification of quality gaps and strategies to improve the care you provide. We urge you to contact Al Lieberthal, Glenn Takata or myself if you are interested in joining us in PI projects.

Table 4. **Adherence to Quality Indicators, According to Mode.**

Mode	No. of Indicators	No. of Eligible Children	Total No. of Times Indicator Eligibility Was Met	Weighted Adherence Rate (95% CI)
				percent
Encounter	27	1062	1914	44.8 (41.5–48.1)
Medication	34	880	1560	81.0 (78.7–83.3)
Immunization	13	333	1257	52.6 (45.8–59.4)
Physical examination	46	1519	6118	38.7 (35.6–41.7)
Laboratory testing or radiography	52	403	1022	36.3 (29.8–42.7)

Table 5. **Adherence to Quality Indicators, According to Clinical Area.***

Indication	No. of Indicators	No. of Eligible Children	Total No. of Times Indicator Eligibility Was Met	Weighted Adherence Rate (95% CI)
				percent
Upper respiratory tract infection	5	654	914	92.0 (89.9–94.1)
Allergic rhinitis	2	156	159	85.3 (79.6–90.9)
Acne	8	72	85	56.8 (45.4–68.2)
Fever	15	148	328	51.4 (43.2–59.6)
Childhood immunizations	15	769	2498	49.8 (45.6–54.0)
Urinary tract infection	6	84	144	47.8 (36.7–59.0)
Vaginitis and sexually transmitted diseases	15	59	169	44.4 (33.5–55.3)
Asthma	17	165	676	45.5 (42.3–48.7)
Well-child care	33	1022	4406	38.3 (34.2–42.5)
Acute diarrhea	12	76	419	37.8 (33.3–42.3)
Adolescent preventive services	8	532	1852	34.5 (31.0–37.9)

* Data are not reported for the management of prenatal care, otitis media with effusion, depression, or attention deficit–hyperactivity disorder, because fewer than 50 children were eligible for care processes related to these clinical areas.

NOTICES

EMAIL ADDRESSES

Your email address is important. By registering your email address with AAP, you will be able to receive up to the minute information on legislation, meetings, and other information for you and your practice. If you have not already done so, go to www.aap.org/ member center and record and/or update your email address. Also, be sure your contact information is current, such as address, phone, fax, etc.

SAVE THE DATE!

Advances in Pediatrics, 19th Annual Las Vegas Postgraduate Pediatric Meeting, April 3–6, 2008, the Flamingo Hotel. Program and registration information will be available in the next 6 weeks.

QUALITY IMPROVEMENT INFORMATION ON-LINE

AAP's Practice Management Online includes a Quality Improvement section with easy access to theoretical and practical content including tools that can be incorporated into practice. Go to http://practice.aap.org.

Use of Health IT to Reduce Gaps in Care:
A Medi-Cal Managed Care Pilot

L.A. Care Health Plan is a local public agency and health plan serving residents of Los Angeles County through a variety of programs including Medi-Cal, Healthy Families, and Healthy Kids. With nearly 800,000 enrolled members, L.A. Care is one of the largest health plans in California and is the nation's largest public entity health plan. L.A. Care is constantly developing new programs through innovative coalitions and partnerships designed to support public health, the safety net, and health insurance coverage for vulnerable populations.

In 2001, the Institute of Medicine published its landmark report "Crossing the Quality Chasm" in which it noted that "between the health care that we now have and the health care that we could have lays not just a gap, but a chasm."[i] A few years later in 2003, Elizabeth McGlynn, et.al. published a key study reporting that the typical patient receives the right care about 55% of the time.[ii] Many have written before and since, that the primary source of these gaps in care is the lack of appropriate systems to help us do better.

Increasingly, evidence suggests that use of clinical information technology (IT) systems is associated with improved quality of care for patients. Clinical IT systems can electronically track service utilization, identify gaps in patient care, and prompt physicians to assure that appropriate and timely care (clinical reminders) are provided during patient visits. The use of a computerized registry provides one option for improving patient information management and an opportunity to improve both preventive care and compliance with evidence-based guidelines for patients with chronic conditions.

The Pilot Project

L.A. Care Health Plan developed a demonstration pilot to support health information technology (HIT) adoption among physicians with a high volume of members. Launched in June 2007, L.A. Care provided access to a computerized disease registry to a selected network of primary care physicians. The goal is to improve the utilization of preventive health services and the management of patients with chronic diseases by utilizing a computerized disease registry to capture, manage, and provide information on specific conditions.

L.A. Care contracted with Intelligent Healthcare to provide the registry program. This selection was based on several criteria including availability of a web-based system, cost, scalability, reporting capability, and the ability to pre-populate the registry with electronic clinical and administrative data (i.e., lab results, pharmacy data, inpatient and outpatient encounters, and claims). Intelligent Healthcare's registry has been used successfully over the last several years by commercial IPAs and their contracted physicians to optimize commercial P4P earnings.

Perhaps the greatest appeal of the selected registry product is the fact that it is web-based and pre-populated using data from other pre-existing electronic data sources. Physicians do not need to invest in any additional hardware or software and do not need to manually enter any data in order to take advantage of the clinical information and functionality of the registry. Within a few keystrokes, physicians or their staff can identify patients in need of services such as well care visits, cervical cancer, breast cancer, or retinopathy screening. Further, the registry can help to target outreach to patients by readily identifying those with HbA1c or LDL levels not meeting goals, generating outreach letters, and producing a number of reports to assist in managing individual patients and the physician's complete panel of patients.

L.A. Care chose to partner with a physician organization with a high volume of L.A. Care members and a representative sample of private and safety net physicians. MedPOINT Management, a management services organization (MSO) that manages multiple medical groups and IPAs was selected based on their interest in participating in the pilot, the high number of L.A. Care members assigned to them and the variety of models their medical groups and IPAs operate under. Approximately 95,000 L.A. Care members are assigned to approximately 550 MedPOINT physicians affiliated with medical groups and IPAs managed by MedPOINT.

Slow but Steady Uptake

After just a few months into the project, approximately 200 of the 550 physicians eligible for the pilot had been issued login names and passwords. Logins are distributed to physicians by request only so that a basic level of interest has already been established and technical assistance can be provided to users in smaller increments. Project staff conducts telephone outreach to inform practices with a high volume of members about the pilot and generate interest. All pilot participants are invited to a large scale, live demonstration at the end of October 2007,

where they can learn how to use the registry and pick up their passwords.

Translating Research into Practice

Physicians are interested in solutions to the everyday challenges they face in their practices however; their experience with research indicates that it is often difficult to translate into practice. Given the disconnect (or chasm) that lies between evidence-based research and the ability of physicians to implement the research into practice, L.A Care is launching a Primary Care Based Research Network (PCBRN) to bring practicing physicians together with researchers to identify best practices to improve quality of care and outcomes for patients. The PCBRN aims to bridge the gap by bringing practicing physicians together with researchers to focus on outcomes relevant to clinical practice.[iii] These networks have been developed based on the need for better ways to translate research into practice and for physicians to play a more active role in directing research efforts rather than in the traditional researcher-driven model. L.A. Care will be working with researchers from USC and LA County Department of Health Services to test a PCBRN as a vehicle to engage physicians in quality improvement, translate research-based practices into primary care practices, and evaluate the effectiveness of various interventions.

In addition, a more traditional evaluation will consist of monitoring the utilization of the registry and evaluating whether there is an association between physician utilization and improvements in clinical measures (HEDIS and HEDIS-like measures) and incentive earnings.

The pilot was launched June 2007 and is scheduled to run through September 2008. The evaluation will be conducted Fall 2008.

For more information about this pilot, contact Richard Seidman, MD, MPH, Medical Director, L.A. Care Health Plan at (213) 694-1250 x4366 or rseidman@lacare.org or Phinney Ahn, MPH, QI Project Manager at (213) 694-1250 x4379 or pahn@lacare.org.

[i] *Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC. National Academy Press. 2001.*

[ii] *McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The Quality of Health Care Delivered to Adults in the United States. N Engl J Med 2003. 348: 2635-2645.*

[iii] *Mold JW, Peterson KA. Primary Care Practice-Based Research Networks: Working at the Interface Between Research and Quality Improvement. Ann Fam Med 2005. 3(Supp 1):S12-S20.*

Successful Coding For Dollars Seminar

By Laura Mabie, MD, FAAP, Member, Pediatric Practice Committee

The Pediatric Practice Committee put on another informative Coding for Dollars seminar in July 2007. Sixty-six physicians and office staff attended the half-day seminar and went away with many good suggestions related to office billing and coding. Dr. Allan Schwartz began the morning with the basics of E and M coding and then moved on to the complicated topics of coding for behavioral and developmental evaluations. Wendy Karsten, the CEO of the Huntington Medical Foundation then spoke on billing and collecting, stressing the importance of good demographic data checked at the time of service. She also spoke on reviewing insurance contracts on a regular basis. Yvonne Mart Fox, a practice management consultant, then spoke on the role of the physician as the CEO of his/her office. She concentrated on communication between physician and staff. A lively question and answer session ended the morning.

Pediatric Practice Committee is looking forward to presenting another Coding for Dollars seminar in May 2008.

New Area Representative in Riverside County

Dr. Christopher Dael has been a pediatrician in Southern California since 1997. His work has taken him from Childrens Hospital Los Angeles where he worked as a critical care transport physician to the Inland Empire where he has spent the last 9 years. Dr. Dael spent two years at Loma Linda University Children's Hospital as an Assistant Professor of pediatrics. While there he split his time between the pediatric residency teaching office and his own practice at the Faculty Medical Offices. From there Dr. Dael took a position at Riverside County Regional Medical Center as an attending physician in pediatrics. He has spent the last 5 years as the Medical Director for Children's Medical Services for the County of Riverside.

Dr. Dael has a personal interest in improving access to care for children with special health care needs especially as they transition to adulthood. He is also active locally and sits on the Program Services Committee for the March of Dimes in the Inland Empire.

Dr. Dael is married to Ressia Lee, a local pediatrician and they have two wonderful children, Raphael and Evangeline. The family spends most of their free time trying to find the prettiest spots in California.

The Iraq war and the Health of Children

By Curren Warf, MD, MSEd, FAAP

As we lead our day-to-day lives it is uncomfortable to think about what is happening on the other side of the world to the children who are directly affected by the war in Iraq, launched in our name by President Bush and paid for with hundreds of billions of our tax dollars. Though we are naturally concerned about the physical and psychological health of our own children, the American adolescents and young adults who have been sent to fight and participate in a seemingly endless occupation, we must also be concerned about the direct and indirect consequences of the U.S. invasion and occupation.

What about the children of Iraq?

Prior to the U.S. invasion of 2003, there had been post-Gulf war economic sanctions implemented against Iraq, which, according to the United Nations, led to the death of 500,000 children. In 1996, Secretary of State Madeline Albright when asked about the number of children's deaths during a television interview famously replied that: "I think this is a very hard choice, but the price - we think the price is worth it." One in eight children in Iraq died during that period from malnutrition, disease, and lack of medicine.

With the invasion of 2003 and subsequent occupation and war, conditions for children have only gotten worse.

The mortality rate in Iraq for children under five is now the highest in the world. According to a 2007 The State of the World's Mothers Report by Save the Children, Iraq's child mortality rate has increased by a staggering 150 percent since 1990. Some 122,000 Iraqi children died in 2005 before reaching their fifth birthday. More than half of these deaths were among newborn babies in the first month of life. The most serious issue is diarrhea from water contamination and lack of sewage facilities. Over 50% of the country's water supply is currently contaminated because the infrastructure and water purification systems were destroyed during the war. According to an Oxfam Report, the number of Iraqis without access to an adequate water supply has risen from 50 per cent in 2003 to 70 per cent today, while 80 per cent lack effective sanitation. Recently, there have even been outbreaks of cholera with 11 confirmed deaths, over 1,000 confirmed cases and 15,000 suspected cases diagnosed because of clinical signs. Fortunately, to date the epidemic seems to be limited to several cities in the northern area of the country, but in view of the grave deterioration of water supplies and sewage management there is a very high risk of the emergence of cholera in other areas of the country.

According to an Oxfam report on Iraq released July 30, 2007, child malnutrition rates in Iraq have risen from 19 percent before the invasion in 2003, to 28 percent. The report states, "More than 11 percent of newborn babies were born underweight in 2006, compared with 4 percent in 2003." According to UNICEF, 20% of children show signs of stunted growth, indicating severe nutritional deficiencies.

About 4.2 million Iraqi's are now refugees, this includes over 500,000 children. Some two million Iraqi's have fled the country and live as refugees mainly in Syria and Jordan. Another two million have been internally displaced partially in response to an escalation of sectarian violence. These internal refugees have no means of support and constitute the most rapidly growing refugee cri-

sis in the world. According to the UN High Commission on Refugees, about 270,000 are considered "recently displaced," with 80,000 people displaced between the end of 2006 and March, 2007- about 70% of whom are women and children. The large population movements have unbalanced social services and left many communities struggling to cope with the influx of new people. Most of the refugee children are out of school and growing up without education. The displacement of children fundamentally undermines their sense of safety in the world, not only for the displaced children, but also for children of the host communities. Many of these children have been exposed to unimaginable levels of violence. Many have lost the main wage earner of the family, contributing to ongoing poverty, instability, and an uncertain future. There is a high risk of separation of children from families, of survival on the streets without adult supervision, leading to a high risk of exploitation, abuse and substance abuse. Increasing numbers of children resort to begging, selling chewing gum and other attempts to eke out survival.

The war and violence have led to a "brain drain" in which at least 40% of physicians and other professionals have already left the country. This has had a particularly negative affect on emergency medical services, in particular prenatal care and care of pregnancy related emergencies. According to UNICEF, one million children, about one out of five, do not receive even routine preventive childhood immunizations. About 1 million children are now susceptible to measles; UNICEF and the World Health Organization are initiating a "Reach Every District" campaign to target areas of Baghdad and other cities with low immunization rates.

According to UNICEF, stresses on children witnessing violence or living in fear of violence are increasing their risk of psychosocial problems, with abuse and exploitation ever-growing risks. Street children and substance abuse are increasingly visible phenomena in Iraq's central cities.

Children are orphaned by violence almost daily, and the number of female-headed households is rising as more families lose their primary wage earner in the conflict.

An "orphanage" was discovered last June where 24 children aged 3 to 15 were found in a dark room naked, tied to their beds and severely malnourished; some had mental retardation. As quoted in the United Nations report, the case has infuriated parents of the children. "If we were living in a normal country, I would have sued these criminals," said the father of two of the boys. "But we are living in complete chaos," he added. The father refused to be identified. He left his children in the orphanage after becoming a displaced person nearly two years ago. "What can we do? They became a heavy burden on us. We decided to send them there and we still can't take them back because of our harsh living conditions," said the father.

A social services administrator acknowledged that some caretakers had been negligent, but said the orphanage had been doing its best to provide care for the children under difficult circumstances. He said the caretakers had to take off the orphans' clothes to cool them down as the place had no electricity and thus no cooling systems. "The handicapped children were abandoned by their families and we are trying to save them from death, but the whole of Iraq is undergoing difficult circumstances," he said.

The World Health Organization estimates that 30% of Iraqi children are suffering from psychological problems. The San Francisco Chronicle reported in March 2007 on a survey conducted by the Iraqi Society of Psychiatrists and the World Health Organization of 10,000 primary school students in the Shaab section of north Baghdad that found 70 percent of students were suffering from trauma-related symptoms. Those numbers appeared so high that the survey was redone, only to come up with similar results.

For some Iraqi doctors, the increase in the number of children traumatized by violence is apparent at the workplace and at home. "I look into the eyes of children whose parents have been killed or are imprisoned every day," said Dr. Nadal al-Shamri, a pediatrician at the Medical City health complex in Baghdad. "The psychological trauma is so deeply ingrained in some children that they may never lead a normal life." Al-Shamri said his 7-year-old son suffered an apparent nervous breakdown last year and stopped eating after the slaying of a close friend's father. "It's difficult for me to eat after watching him cry," al-Shamri said.

There are training and service shortages. No psychotherapy or crisis centers exist, and Ibn Rushd is the only psychiatric hospital in the capital of 6 million people.

The tragedy of the situation of the children of Iraq is multidimensional and affected by many factors including: widespread malnutrition, lack of potable water, lack of immunizations, mass displacement of families with disruptions of social supports, mass emigration of physicians and other professionals, death of wage earners and widespread unemployment with extreme poverty, children forced into labor for survival, orphaned or abandoned to the streets, pervasive lack of safety, sectarian violence, witnessing of war and death, and growth of homelessness among youth.

America's Pediatrician Benjamin Spock, famously picketed the White House against the U.S. involvement in Vietnam, and had dinner with the Kennedy's the same night. His profound and lasting influence among parents during the 1940's and 50's led some to blame Dr. Spock for the dynamic youth culture of the sixties and the willingness of a generation of young people to challenge the political establishment, especially American involvement in Vietnam. When confronted and asked what he thought about these kids and the effects of his "permissive" parenting, he replied that "first, I never promoted 'permissive' parenting and second, I'm very proud of them."

The AAP promises to be "Dedicated to the Health of All Children." If this is to be more than a hollow phrase, pediatricians must bring their voice to bear, as recognized advocates for the welfare of children, to end the American occupation and war in Iraq. Ending the war and occupation is the overriding priority to end the disaster that has devastated the lives of the children of Iraq. The horrific price that the children of Iraq have paid for the invasion and occupation of Iraq has been effectively concealed from the American people. The great Greek dramatist Aechylus famously wrote "In war, truth is the first casualty." Never has this been truer than in the Iraq war. But the exposure of the horrific effects of the war on the children of Iraq cuts through deceit, revealing a truth of the barbarity of war known by the rest of the world but never disclosed in the American media. If Doctor Spock were alive today, he would demand an end to this war, it is his legacy and, as pediatricians, it is our inheritance.

What's a SCOQIM? What's a CAQI?

By Glenn S. Takata, MD, MS, FAAP, SCOQIM Member

Have you every wondered about SCOQIM and CAQI? In a rare moment devoid of insurance documentation, I searched the Merriam-Webster online dictionary for SCOQIM, and some interesting words popped up such as "syconium" "the multiple fleshy fruit of a fig in which the ovaries are borne within an enlarged succulent concave or hollow receptacle." I don't think I will eat any more figs. Less reassuring was "scholium" "a marginal annotation or comment (as on the text of a classic by an early grammarian)." CAQI yielded the expected "khaki" and "cocky". As pediatricians, we all know what "caca" means, but did you know that "kaka" is "an olive-brown New Zealand Parrot (Nestor meridionalis) with gray and red markings"? Of course, none of this is actually relevant; but, if you have never wondered about SCOQIM and CAQI, you should.

The Steering Committee on Quality Improvement and Management, more commonly known as SCOQIM, is the AAP's voice for quality and supports AAP members in providing the highest quality of care for children. Elizabeth "Sooze" Hodgson, MD, FAAP, Child Advocate for the State of New Jersey, who actually sees patients, chairs the Steering Committee which is made up of AAP members and liaisons from the American Board of Pediatrics (ABP), the National Association for Children's Hospitals and Related Institutions (NACHRI), and the Agency for Healthcare Research and Quality.

SCOQIM has primary responsibility for the AAP Clinical Practice Guidelines and AAP Endorsed Guidelines that provide evidence-based recommendations on important pediatric problems. (See http://aappolicy.aappublications.org/.) Our very own CA Chapter 2 Immediate Past-President Allen S. Lieberthal, MD, FAAP, chaired the guideline development for Diagnosis and Management of Acute Otitis Media. Dr. Lieberthal and Wilbert Mason, MD, FAAP, CA Chapter 2 President, were committee members who contributed to AAP guidelines on Otitis Media with Effusion and Diagnosis and Management of Bronchiolitis, respectively.

SCOQIM plays an active role in representing pediatricians in quality measurement initiatives. The AAP itself does not develop measures. The AAP will soon publish Principles for Quality Measurement authored by SCOQIM and the COPAM (including member Edward S. Curry, MD, FAAP, CA Chapter 2) that places the focus on measurement for improvement. SCOQIM members (including this author) represent the AAP on the Alliance for Pediatric Quality's (APQ) Improve First Task Force. The APQ is a coalition of the AAP, ABP, NACHRI, and Child Health Corporation of America that advocates that pediatricians and other child healthcare providers should define quality for pediatric health care. SCOQIM members also serve to represent pediatric interests on important national quality measurement initiatives, including the AQA, AMA Physician Consortium for Performance Improvement, National Committee for Quality Assurance (NCQA), and National Quality Forum (NQF). SCOQIM understands the importance of valid quality measurement in the incipient pay for performance (P4P) arena that we will all inevitably face to a greater degree in our practices.

Patient safety is another priority area for SCOQIM. Marlene Miller, MD, FAAP, a nationally recognized patient safety expert, spearheads SCOQIM's patient safety initiative. The AAP's Safer Health Care for Kids initiative has launched a patient safety website which includes resources, expert question and answer opportunities, safety tips, and a parents' corner at www.aap.org/saferhealthcare. Web-based seminars on patient safety are also offered through the website which include no-cost CME credits for participants and have covered ambulatory as well as inpatient topics. The AAP is involved in the Institute for Healthcare Improvement's 5 Million Lives Campaign as part of the Pediatric Affinity Group addressing important patient safety issues including adverse drug events, MRSA, and nosocomial infections in pediatrics. How can anyone argue with not harming Kids?

eQIPP yourself using the AAP's Education in Quality Improvement for Pediatric Practice, a web-based CME activity that helps pediatric practices identify gaps and improve performance using proven quality methods. Topics have included asthma and ADHD and more are coming. SCOQIM also endorses QuIIN (Quality Improvement Innovation Network) a network of practicing AAP pediatricians who test practical tools, measures, and strategies for use in everyday practice. QuIIN practices are on the cutting edge of innovation. If you are interested in getting involved in eQIPP or QuIIN go to the following websites: www.eqipp.org and www.aap.org/moc/quiin.

Sorry, I have not forgotten about CAQI, but I will try to keep it brief. CAQI is the AAP's Chapter Alliance for Quality Improvement. It is an alliance of chapter leaders working together to build chapter capacity and infrastructure to advance quality improvement among member practices. Its efforts are based in part on the AAP's Partnerships for Quality (PFQ) project led by Carole M. Lannon, MD, MPH, FAAP, that improved statewide ADHD care in Connecticut, Indiana, Mississippi, New Mexico, and Virginia.

At the June 2007 CA Chapter 2 Board Meeting CAQI's Resource Guide for Building Local Capacity for Improvement was presented and discussed by your leadership. The CA Chapter 2 leadership also recently responded to CAQI's Needs Assessment Survey.

Vanessa Brown, MPH, Project Manager for CAQI, provided preliminary highlights from that survey. Leaders from 51% of chapters reported quality improvement efforts. Many chapters report needing help to build infrastructure to support quality

improvement among their member practices. Chapters involved in quality improvement are primarily working on developmental screening and services, obesity, and the medical home as partnerships with a local state, or national entity or in multipractice improvement collaboratives. Chapter leaders were interested in getting help with data collection, analysis, and presentation, identifying resources and funding for quality improvement activities, and on quality improvement best practices and mentoring.

On a chapter level, CA Chapter 2 is working on efforts to prevent and treat obesity and to promote literacy efforts such as Reach Out and Read. CA Chapter 2 leadership is seeking your input on what our members need to get quality improvement started in your practice as well as on a Chapter level. Finally, I want to mention that SCOQIM sponsors the AAP Quality of Care Award to recognize pediatricians who have demonstrated the effective use of quality improvement methods to improve the quality of care for children in their practices. Past winners have improved asthma care and implemented open access scheduling. Please contact Bill Mason, Allen Lieberthal, or myself with any ideas you may have on Chapter-level quality activities or if you would like to nominate a Chapter member for the AAP Quality of Care Award.

Remember SCOQIM is not about figs and CAQI is not about gray and red marked parrots from New Zealand. For more about SCOQIM go to www.aap.org/visit/SCOQIM.htm; and, to learn more about CAQI, call Vanessa Brown in the AAP Department of Community, Chapter and State Affairs, at 800-433-9016, ext. 7797, or e-mail vbrown@aap.org.

Town Hall Meetings in the High Desert

By Damadora Rajasekhar, MD

Members of of AAP California Chapter 2 in the High Desert hosted State Senator George Runner and State Assembly member Sharon Runner at an evening meeting in Victorville on October 30, 2007. Also present at the meeting were Marc Lerner, M.D., (Chair, AAP District IX SGA Committee), AAP District IX Executive Director Kris Calvin, and members representing Regional Perinatal Program from Loma Linda. The Runners offered the attending pediatricians a unique opportunity to establish a dialogue about the State Republican priorities in health care reform that have been put forward as a proposal for the state. This proposal is built around a series of principals, foremost of which are: 1) maximizing choice; 2) reducing cost; and 3) increasing access. Links to the relevant bills to support these proposals can be viewed at http://republican.assembly.ca.gov/topics/hc1/sensible-health-care-solutions.aspx

Sharon Runner spoke of her long commitment to the Healthy Homes Program in her district and her priorities for enhancing the public safety for families.

George Runner is the Vice Chair for Appropriations of the California Senate and has been a leader on health care matters for the State Republican Caucus. He spoke of his priorities for future changes in health care including transparency of health outcomes and transparency of health care costs to inform the decisions of California citizens. He spoke of his desire to see changes in the State system to include incentives for change, not mandates or a tax on physicians. He spoke of the potential problems of attracting and maintaining physicians in our state in the face of a physician tax. He also favors reasonable reimbursement for doctors and incentives for poorly compensated critical physician contributions, via a charitable tax credit. Senator Runner spoke of the challenges of promoting not just insurance cards, but true access to quality medical care, but states that the Republicans are willing to explore models including retail clinics and expanded practice opportunities for nurse practitioners and other non-physician providers to allow convenient and competitive health care options to expensive emergency room care for minor illnesses.

From left to right are Dr. Pazdral, Dr. Rajasekhar, Dr. Brams, Assemblywoman Sharon Runner, Dr. Lerner, and Senator George Runner.

Marc Lerner, M.D., AAP State Government Affairs Chair, spoke of the challenge to the pediatricians in California and to their practices in the face of such competition and the problems of sustaining medical homes in the face of pressures, which create splintered health care.

D.Rajasekhar, M.D., Area Representative, addressed the burden of the current vaccine system on practitioners who must serve as the bank for the distribution system for vaccines and possible solutions seen by pediatric advocates and the AAP CA CH2. He also mentioned that there was an abundant testimony given, at the California Medical Association House Of Delegates meeting addressing this issue with a positive outcome.

Overall, this meeting represented a unique opportunity for Chapter 2 pediatricians to both listen and be heard by some of our State's most influential legislators.

Anti-HPV Vaccine in California

By Curren Warf, MD, MSEd, FAAP

The anti-HPV vaccine is now available for all girls and young women aged 9 to 26; ideally immunization should be started at age 9.

The CMA Foundation-HPV Committee, on which the AAP is represented, has conducted a statewide survey of physicians including pediatricians, Family Practitioners, Ob-Gyn's, Internists, and General practitioners to evaluate current utilization of the vaccine.

Pediatricians are the most likely physicians, followed by FP's, to be utilizing the vaccine in patients. The current HPV vaccine protects against the two most common strains of HPV, 16 and 18, associated with cervical cancer; it also protects against two strains associated with visible sexually transmitted condyloma accuminata, a common and frequently expensive condition of adolescents and young adults.

Responding pediatricians providing the anti-HPV vaccine identified cost as the major barrier. The federal Vaccines for Children Program and Los Angeles County provide the vaccine for eligible children and sixty percent of pediatric practices are estimated to be using these resources for this vaccine. It is important that Pediatricians and other physicians fully utilize these programs to assure greatest access to vaccines (see http://www.cdc.gov/vaccines/programs/vfc/default.htm).

Cost and time barriers include high up-front vaccine costs, complicated or split billing procedures, low health insurance reimbursement relative to cost, low health insurance vaccine administration reimbursement, lack of time to educate parents and patients during the office visit, immunization tracking, and compliance with ACIP recommended scheduling. Other identified barriers include concern of parents about the safety of the vaccines. 24% of physicians report that parents have expressed concern about safety and side effects, but only 2% report parent concerns about promoting sexual activity.

For women age 18-26 appropriate for the vaccines that are no longer eligible for the VFC program and who do not have health insurance, vaccines may be obtained by Pharmaceutical Patient Assistance Programs available through the manufacturer with documentation.

Start HPV Anti-Cancer Vaccine at Age 9 Years.

The vaccine is recommended for all girls aged 9 years to 26, though it is funded through the VFC program through age 18. According to pediatricians who responded to the survey, 20% initiated the vaccine at age 9-10, 53% age 11-12. As with other vaccines, the anti HPV vaccine is a preventive, not a treatment, so that earlier administration has the greatest chance of efficacy. Serological studies show sustained levels of protective antibodies when vaccines are initiated from age 9-11. Further research is needed to demonstrate if antibody levels are sustained when given at younger ages.

As with Hepatitis B vaccine, HPV vaccine prevents a viral infection implicated in human cancer that is generally contracted through sexual activity. To be effective the vaccine should be provided before sexual activity has begun-currently data support starting the vaccine at age 9; when there is supportive data the vaccine may be initiated at an earlier age.

HPV Vaccine Not Yet Recommended for Boys

At this time, recommendations do not include vaccination of boys –though they are obviously implicated in the spread of HPV. Research is currently underway and recommendations may change to include boys in the future.

Start Pap Tests Three Years after Sexual Debut

Since the vaccine does not prevent all oncogenic strains of HPV, though it does prevent the two most common strains, vaccinated women need to continue receiving their routine surveillance Pap tests. Pap recommendations for adolescents have been revised over the last few years, so that ACOG now recommends deferring the first Pap test until three years after sexual debut. Girls who are found to have abnormal findings such as ASGUS or LGSIL, with or with out high risk HPV types, can be monitored with Pap tests every six months until age 21, after which they should be referred for colposcopy if the abnormality persists. Pap recommendations for reflex HPV testing and referral recommendations for colposcopy continue to evolve and further changes may occur.

HPV is a very common virus, including the strains with oncogenic potential. Early abnormal Pap tests found in adolescents and young women are usually associated with the initial infection with the virus, not with cervical cancer. Most of these abnormal Pap tests revert to normal with time. The large majority of women who contract HPV, including the high-risk types, do not develop cervical cancer. Those that do have had persistent infection. The best prevention, in addition to early immunization, is the continued monitoring for abnormal Pap smears, beginning three years after sexual debut and continuing according to ACOG recommendations.

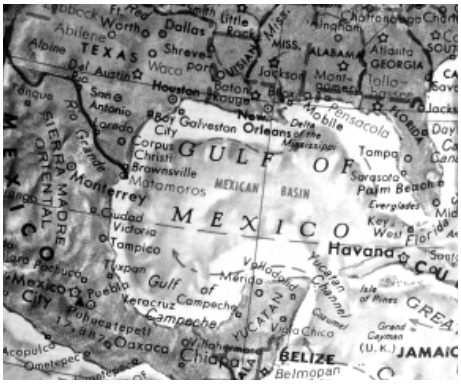
The provision of the vaccine is a preventive measure. It is not necessary, nor is it usually appropriate, for the administration of this vaccine to be linked to a discussion of sexuality or the utilization of Pap smears, any more than the administration of Hepatitis B vaccine, or other vaccines, require a detailed description of the means of transmission. Clearly, sexual safety, contraception and prevention of infection are important health education topics for all young people, but the provision of vaccinations is usually not the best time for these discussions, clinically or developmentally.

Resources

There are a variety of resources available to physicians regarding HPV, cervical cancer screening and the anti-HPV vaccine. An excellent place to start is the CMA-HPV website (http://www.calmedfoundation.org/projects/HPV/index.aspx).

A Pediatrician in Mississippi

By Meera Beharry, MD, Adolescent Medicine Fellow, Childrens Hospital Los Angeles



The plan was to spend a year working with those who needed the most help.

I had visions of working in a tropical country with a handful of medicines and a shoddy generator powering a hospital full of malnourished and battle scarred children. Perhaps I would be in Africa using my high school French to help me learn a beautiful singsong patois. Perhaps I would be in Darfur, or Chad. I didn't know where I would end up, but I was looking forward to it. Looking forward to an adventure.

On the drive up to Batesville, Mississippi I couldn't help but reflect on the chain of events that had led to me taking a locum tenens job there. I also couldn't help but wonder what it would be like.

As a New Yorker, I had heard many stereotypes about many places, especially the Deep South. Would it all be true? Surely, it couldn't. After all, New Yorkers are renowned megalomaniacs. I figured the comments I'd heard were a result of our narcissism.

Having completed my residency at SUNY Downstate in Brooklyn, NY, a chief year at Lenox Hill Hospital on the Upper East Side of Manhattan and spending two weeks on a medical mission in Haiti, I figured I was prepared for whatever I would find.
I was wrong.

The first week was fairly unremarkable. That is until a spider the size of my hand walked through an exam room while I was seeing a patient.

But I took in stride. In New York, we had had roaches and mice. In Haiti, we had very large waterbus that liked to shower with us in addition to the roaches and mice and unidentified insects that I felt crawling on me one night. This was just Mississippi's brand of critter. I could deal.

After a couple of weeks of working as the pediatrician for the city's medical center, the staff and I felt more comfortable with each other and I got to know a little bit more about the area, the people, their way of life.

I learned that the functional literacy rate of the surrounding areas was approximately 50%. I learned that a little more than 22% of the county's population lived below the poverty level. I learned that there was no Planned Parenthood in the state. Nor was there any type of abortion provider north of Jackson, which was two hours away by car. I learned that there was no taxi, no bus.

Once I found this out, I understood why a new, teen mother who had given birth at 36 weeks gestation couldn't bring the baby in for frequent follow-up as I had asked. She had no way of getting to clinic when one of the eight other adults in the household took the family car to work or to run errands.

The baby died of sudden infant death syndrome a few days before I left town.

Infant Mortality Higher than Vietnam, El Salvador or Iran

Marianne Wharton, the nurse practitioner I worked with, informed me that this was not uncommon and the infant mortality rates of the area were the highest in the nation. She shared with me a series of articles from the Memphis Commercial Appeal that cited the infant mortality rate as 31/1000 in certain Memphis neighborhoods.

According to the 2005 series by Aimee Edmondson, "Memphis has the highest infant mortality rate among the nation's 60 largest cities…. Several Memphis ZIP codes have infant death rates higher than scores of Third World countries. North Memphis' 38108, which includes the tattered communities of Douglass and Hollywood, is deadlier for babies than Vietnam, El Salvador and Iran."

Memphis was the nearest large city to Batesville and we would transfer our sick patients there. If they had such a high infant mortality rate, what was it like in Batesville? What was it further west, in "the Delta"?

It is 7/1,000, which is about the national average in Panola County, where I was working, and is in the high teens to low 20's for the majority of the Delta, the poorest region in the poorest state in the country. Not as bad as Memphis, but still not good for the Delta.

Maybe I just didn't know about this because I never looked at the data for areas outside of New York. I remembered hearing of a recent article about the health status of children in the rural South that was published in Pediatrics. I pulled the article and found that I was not alone.

As Dr. Jeffrey Goldhagen and his colleagues noted, the health status of children in the South is not only a neglected issue, but "Living in this region is a powerful predictor of poor child health outcomes."

During my stay in Northern Mississippi, I saw some of this myself.
Some children showed up to clinic dirty and with worse teeth than I had ever seen in my life. Even in Haiti, the children came to clinic as clean as they could possibly get. I found myself surprised by the apathy that some families exhibited. It seemed as if they felt, "things are bad, things were always bad and they'll always be bad."

Hope is the Best Contraceptive

I have always believed that hope is the best contraceptive. As a future Adolescent Medicine fellow I began to wonder about the teen pregnancy rates in the area.

As I reviewed the deliveries that I had attended, I found that the vast majority of moms were or had been teen mothers. I was told that the primary medical resource for the prevention of teen pregnancy was the county health system. As Batesville had a population of a little more than 7,000 people during the 2000 US census, confidentiality

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SCHIP bill vetoed by President Bush

By Susan Wu, MD, Assistant Professor of Clinical Pediatrics, USC/CHLA and Emily Webber, MD, Chief Resident, Childrens Hospital Los Angeles

The State Children's Health Insurance Program (SCHIP) was established in 1997 as part of the Balanced Budget Act, to increase access to health coverage for low-income children. The bill authorized $40 billion over 10 years, to allow states to expand or create programs to provide comprehensive insurance for children who do not qualify for Medicaid, yet whose families are unable to afford private coverage. This is accomplished via federal matching grants for each state, which range from 65% to 85%. Similar to Medicaid, this matching rate varies depending on a formula based on the state's per capita income, although for most states the SCHIP rate is more favorable. For example, California receives $1 from the federal government for each $1 the state contributes to the Medicaid program. For SCHIP, California receives $2 for every $1 the state contributes.

Most states use SCHIP funds to expand eligibility for Medicaid, or to extend coverage to children with family income levels up to 200% of the federal poverty level (FPL), or $41,000 for a family of four. Another 5 states include children up to 250% FPL. California covers children up to 250% of the poverty level, through the Healthy Families program. Seventeen states cover children greater than 250% FPL. States can also apply for Section 1115 waivers to expand coverage to other groups, such as adults. Currently 11 states have Section 1115 waivers to cover parents of eligible children, and 4 states have programs, which cover childless adults.

Since its inception, SCHIP has decreased the number of uninsured children from 23% to 14%. Currently there are more than 6 million children covered under SCHIP programs, including approximately 860,000 children in California. More than 90% of these children are below 200% FPL. In addition, there are 600,000 adults covered through Section 1115 waivers. Most states waive any cost sharing for lower income families, with modest cost sharing via limited premiums and co-pays for higher income levels. In California, premiums range from $0 to $15 per month per child, with a family maximum contribution of $45 per month. Of the 9 million children

who remain uninsured, almost two-third are eligible for either Medicaid or SCHIP, but are not enrolled.

Increased health insurance coverage translates to increased access to health care and better health status. Children with health insurance are more likely to have a usual source of care, and are more likely to receive recommended routine health screenings. They are less likely to report unmet health care needs such as prescription drugs, specialty services, and hospital care. Children with Medicaid and SCHIP report better health status, as well as improved health outcomes such as fewer hospitalizations for asthma and better school performance.

This year, both houses of Congress introduced their own versions of SCHIP reauthorization bills. The House bill, H.R. 3162, included $47 billion in additional funding (total $72 billion) over the next five years to increase coverage to an additional 5 million children. The funding would come from increasing tobacco taxes by $0.45 per pack, and from reducing overpayments to Medicare Advantage plans. The bill would also allow options for expansion to children of any income, as well as children up to age 21, pregnant women, and legal immigrants. The Senate bill, S. 1893, included $35 billion in additional funding over the next five years, and is estimated to cover an additional 4 million children. The funding would come from a $0.61 per pack increase in tobacco taxes. Under the senate version, there would be more restrictions to enrollment, including phasing out all adult coverage and verification of social security number for enrollment. In addition, the SCHIP matching rate would only be applicable up to 300% FPL; expansions beyond this would draw in the less favorable Medicaid rate. States would also be allowed to offer premium subsidies for families to purchase employer-based insurance. Neither plan extends coverage to undocumented immigrants.

House and Senate leaders eventually agreed on a compromise bill, H.R. 976, which is nearly identical to the Senate version. The Senate approved the measure with a veto-proof majority (67-29), and the House vote was 265-159. Two Democratic congressmen voted no, and 45 Republicans voted yes. The bill passed and was sent to President Bush. In the interim, SCHIP authorization expired on September 30, so Congress passed a continuing resolution to temporarily fund the SCHIP through November 17, 2007. The President vetoed the bill on October 3, citing concerns that covering children at higher income levels would cause families to drop private coverage in favor of public coverage ("crowd out"). In addition, President Bush opposed the increase in tobacco tax, calling it an unfair burden on the working class. He also warned that incremental increases in programs like SCHIP would lead to government-run universal health care. He proposed limiting coverage to children < 250% FPL, and increasing funding by only $5 billion over the next 5 years. However, the Congressional Budget Office estimates than an additional $14 billion over the next 5 years must be authorized to maintain current programs, or else states will need to start dropping coverage. On October 18, the House failed to overturn the veto 273-156-- still 13 votes short of the necessary two-thirds.

Congress remains determined to pass an SCHIP reauthorization bill, and reintroduced H.R. 3963 on October 24. H.R. 3963 remains largely the same as H.R. 976, except with more requirements for documenting citizenship, clarification on the 300% income cap, and acceleration of the timeline for dropping childless adults from the program. The revised bill was passed by the house on October 25, 265-142, but did not attract any new support from House Republicans. President Bush has again indicated his plan to veto this bill as well if further modifications are not made. Until an SCHIP reauthorization bill is passed, health coverage for more than 6 million children remains in jeopardy.

CHLA Employees and Residents Stand together to support SCHIP

*6 million: number of children covered through State Children's Health Insurance.
*500: number of ribbons handed out to CHLA employees and families.

*400: number of letters sent to President Bush by CHLA employees, patients and residents asking him not to veto the bill.
*15: minutes spent in the Healing Garden contacting California House representatives to convince them to supply the Children's health insurance program reauthorization act.
*1: goal shared by nationwide movement to continue SCHIP federal support.

On Tuesday, October 2nd, CHLA participated in a nationwide grassroots effort to urge passage of H.R. 976, the SCHIP reauthorization bill. CHLA was among 38 children's hospitals, which participated in the "Stand Up for SCHIP" campaign, which was coordinated by Dr. Lisa Chamberlain at Stanford University Medical School. At CHLA, pediatric residents and Community Affairs personnel staffed two information tables throughout the day, handing out information about SCHIP and other programs for the uninsured. They distributed baby blue ribbons, which people wore to show support for SCHIP. CHLA employees, families and patients were also invited to sign postcards and letters that were mailed to President Bush, urging him to sign the bill. Residents also attended a noon conference on SCHIP, where AAP Chapter 2 president Dr. Wilbert Mason spoke about the impact of SCHIP on the population the program serves. Gail Margolis, CHLA Vice President of Governmental Affairs, and Dr. Roberta Williams, Chair of the Department of Pediatrics at USC, also spoke at the event.

At 12:30pm, CHLA residents met in the Healing Garden to join pediatric residents and faculty across the country to stand for 15 minutes as part of the "Stand up for SCHIP" campaign. Residents, fellows, and faculty spend their lunch hour calling their representatives' offices, urging them to vote "yes" when the bill returns to the house for a veto override. Kathleen Ostrom, M.D., said, "It was great to be able to advocate for our patients in such a real way. This legislation will affect their lives, and making sure it passes is an important part of being a pediatrician." Dr. Roberta Williams, Chair of the Department of Pediatrics, gave an enthusiastic thumbs-up to the proceedings while talking on her cellular phone to a California representative's office.

Although the president did veto the bill, and the House failed to overturn the veto, the "Stand up for SCHIP" event demonstrated the ability of pediatricians to mobilize nationwide and advocate for their patients, the "non-voting" constituents.

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The Kaiser Commission on Medicaid and the Uninsured. SCHIP reauthorization: Key questions in the debate. A description of new administrative guidance and the house and senate proposals. August 2007. www.kff.org/kcmu

Cuttler L, Kenney GM. State children's health insurance program and pediatrics. Background, policy challenges, and role in child health care delivery. Arch Pediatr Adolesc Med. 2007;161(5):60-633.

Bill summary and status. Library of Congress website http://thomas.loc.gov/home/bills_res.html

Mississippi

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when using the county system was more a theory than a reality. I saw the stigmata of methamphetamine use on some of the mothers and I was told that the adolescent unit of the Substance Abuse Center had a long wait list. These were problems that the media had led me to believe were concentrated in urban areas. It was not what I expected to find in the country.

Mississippians the Friendliest People

In addition to all this, there were many positive aspects to my "Deep South" experience. I discovered that Mississippians are among the friendliest people I've ever met. They were all a lot more tolerant and open than my New Yorker stereotypes had led me to believe. I was able to have a very civilized discussion about my rationale for being pro-choice with the largely pro-life staff and not have it change my relationship with them.

When I made a comment about one of my bright toddler patients becoming our first female president, I was pleasantly surprised to hear her grandmother hoping that Hillary Clinton would beat her to it. So much for my notion of the South as solidly red!

I met many strong women who were caring for their families with a meager income, and limited resources, but a smile on their face. I saw a sense of connectedness to family and community that was very refreshing. I also had the pleasure of working with a group of people who took tremendous pride in their work and did it exceedingly well.

In summary, I not only found my adventure, but I gained knowledge about an area of need that doesn't require me to have a passport and that I would be happy to return to.

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http://www.commercialappeal.com/mca/local/article/0,2845,MCA_25340_4757196,00.html

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Infant mortality rates from the Mississippi Department of Health at http://www.msdh.state.ms.us/msdhsite/_static/resources/1991.pdf

Palm Springs Clinical Pediatrics Conference Schedule

PROGRAM

Thursday Evening, February 14

5:00pm-7:00pm **Registration and Welcoming Reception**

Friday Morning, February 15

7:00am **Registration**
Continental Breakfast and Visit the Exhibits

7:55am **Welcome and Introduction**
Presiding Officer: Robert Adler, MD

8:05am **Life-Threatening Complications of ENT Infections – Considerations in an Era of Growing Antimicrobial Resistance** – Dr. Ross

8:40am **Headaches and Migraines** - Dr. Sankar

9:15am **Practical Pediatric Asthma** – Dr. Lieberthal

9:50am **Refreshment Break/Visit the Exhibits and Chat with the Professors**
Presiding Officer: Wilbert H. Mason, MD

10:20am **What's New and Hot in Pediatric GI: GER and GERD** – Dr. Cannon

10:55am **Menstrual Disorders – When to Worry, When to Not** – Dr. Tanaka

11:35am **Meet The Professors**
Chair: Robert Adler, MD
Panel: Robert A. Cannon, MD
Allan Lieberthal, MD
Lawrence A. Ross, MD
Raman Sankar, MD, PhD
Diane Tanaka, MD

12:15pm – 1:30pm **WORKSHOP SEMINARS**
Attendees may choose one of the following seminars.
Please note: these will be repeated on Saturday to allow you a second choice. Light refreshments will be available.

No. 1 **Dealing with "Functional" Abdominal Symptoms**
Robert A. Cannon, MD

No. 2 **Asthma-How to Use the Tools of the Trade**
Allan Lieberthal, MD

No. 3 **Instructive Case Presentations of Pediatric Infections**
Lawrence A. Ross, MD

No. 4 **Pediatric Epilepsy Update**
Raman Sankar, MD, PhD

No. 5 **Contraceptive Choices for Young Women with Chronic Illnesses**
Diane Tanaka, MD

Saturday Morning, February 16, 2008

7:00am-8:00am **Continental Breakfast & Visit the Exhibits**
Presiding Officer: Allan Lieberthal, MD

8:00am **The ABC's of STI's** – Dr. Tanaka

8:35am **What's New and Hot in Pediatric GI: Probiotics from a Gastroenterologists' Viewpoint** – Dr. Cannon

9:10am **Common Fungal Infections in Pediatric Practice** – Dr. Ross

9:45am **Refreshment Break/Visit the Exhibits**
Presiding Officer: Wilbert H. Mason, MD

10:20am **Obstructive Sleep Apnea: The Essentials** – Dr. Ward

10:55am **Cerebral Palsy – Management and Approaches to Prevention** – Dr. Sankar

11:35am **Meet the Professors**
Chair: Wilbert H. Mason, MD
Panel: Robert A. Cannon, MD
Allan Lieberthal, MD
Lawrence A. Ross, MD
Raman Sankar, MD, PhD
Diane Tanaka, MD
Sally L. Davidson Ward, MD

12:15pm - 2:45pm **WORKSHOP SEMINARS**
Please see Friday listing for selection.

Sunday, February 17, 2008

7:00am-7:55am **Continental Breakfast/Visit the Exhibits**

7:55am **Announcements**
Presiding Officer: Wilbert H. Mason, MD
Please note: A five-minute question period will follow each lecture.

8:00am **What's New and Hot in Pediatric GI: Liver Disease in Obese Children** – Dr. Cannon

8:40am **Bronchiolitis: The AAP Guidelines** – Dr. Lieberthal

9:20am **Evaluation of the Floppy Infant** – Dr. Sankar

10:00am **Refreshment Break/Visit the Exhibits**
Presiding Officer: Robert Adler, MD

10:30am **From K-Holes to Tweaking – An Update on Substances of Abuse** – Dr. Tanaka

11:10am **Reading, (W)Riting and Revaccination: Immunizations for Teenagers** – Dr. Ross

11:50am **Course Summary and Questions**

12:00pm **Adjournment**

Clinical Pediatrics Conference Registration Form
February 14-17, 2008
Hilton Palm Springs Resort, Palm Springs, CA

Contact Information:

Name: _____
First (please print) Middle Initial Last

Address: _____

City: _____ State _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

Attendee Profile:

MD __ DO __ RN __ NP __ PA-C __ Other _____

Payment Information:

Tuition Fee:	Before Feb. 14	At the Door
Physician Member (AAP Chapter 2 ONLY)	$575.00	$600.00
Physician Non-Member	$625.00	$650.00
Pediatric Residents	$300.00	$325.00
Allied Health Professionals	$300.00	$325.00
Physician Emeritus & Retired	$300.00	$325.00

Friday workshop seminar: 1st choice _____ 2nd choice _____
Saturday workshop seminar: 1st choice _____ 2nd choice _____

3 Ways to Register:

1. By Check: Please make check payable to: AAP CA2
Mail registration form and check to:
AAP CA2, Box 527
4067 Hardwick Street, Lakewood, CA 90712

2. By Credit Card: Please fax registration with credit card information to: 970-314-9984 OR mail completed registration form with credit card information to the above address.

3. Online: Please visit our website at: www.aapca2.org and click on "Future Events" for the registration form.

___ I have enclosed a check (payable to the AAP CA2) for $_____US
___ Please charge my credit card __ MasterCard ___ Visa for $_____ US

Account # _____ Exp. Date _____

Signature _____

Name as it appears on Credit Card _____

Security Code (last 3 digits on back of credit card)_____

Billing Address if different from above: _____

Zip Code on Credit Card billing address: _____
(Please note: we can not process without your zip code)

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by Debbie Mackay

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