



Minnesota www.mnaap.org Pediatrician

THE NEWSLETTER FOR THE MINNESOTA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

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MN-AAP Named Outstanding Large Chapter of the Year by AAP!

The Minnesota Chapter of the American Academy of Pediatrics (MN-AAP) was recently selected as the

Outstanding Large Chapter of the Year by the AAP! The announcement was made before a large national forum of pediatric leaders at the AAP's Annual Leadership Forum, held March 12-14, 2010 in Chicago, IL.



Accepting the award (left to right) are Katherine Cairns, executive director, Anne Edwards, MD, president, Marilyn Peitso, MD, president elect, Pam Shaw, MD, District Vice-Chair, Mike Severson, MD, District Chair

The Outstanding Large Chapter of the Year Award is based on a written report that the Chapter submits each year to the AAP on its achievements and an oral report made by the Chapter president to a national committee.

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President's Message Anne Edwards, MD



One of the distinct privileges I have had as president of MN-AAP is to present the accomplishments of our Chapter over the last year to the selection committee for Outstanding Chapter at the national Annual Leadership Forum.

Many of these are highlighted in our "accomplishments" section on the website (www.mnaap.org/accomplishments.htm). However, I thought I would take the opportunity to summarize some of my comments from the presentation to the best of my recollection.

MN-AAP is first and foremost a "community of pediatricians," which of course supports the health and well being of children in the state of Minnesota. And our engaged members with the very able support of engaged staff serve as the energy and passion behind all efforts of our Chapter. Communications play a key role: a quarterly newsletter, bi-monthly all member emails, continuous ongoing website development, webinars to support CME and our annual membership survey all support creating community.

Indeed, over 1,300 individuals participated in MN-AAP events, from medical home learning

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**MN-AAP
Annual Meeting
June 4, 6-9 p.m.
Hilton at
Mpls/St. Paul Airport**

Details on page 5.

Register online at
www.mnaap.org

Minnesota

Pediatrician

The official publication of the Minnesota Chapter of the American Academy of Pediatrics

Minnesota Chapter-
American Academy of Pediatrics

1043 Grand Ave. #544
St. Paul, MN 55105

Phone: 651-402-2056

Fax: 651-699-7798

www.mnaap.org

Executive Director:
Katherine Cairns

Director of Communications:
Melissa DeBilzan

STATEMENT OF PURPOSE

Minnesota Pediatrician is dedicated to providing balanced, accurate and newsworthy information to Minnesota pediatricians about current issues in pediatrics and the actions of the Minnesota Chapter of the American Academy of Pediatrics.

Articles and notices cover organizational, economic, political, legislative, social, and other medical activities as they relate to the specialty of pediatrics. The content is written to challenge, motivate, and assist pediatricians in communicating with parents, colleagues, regulatory agencies, and the public.

ACCEPTABILITY OF ADVERTISING

All products and/or services to be considered for advertising must be related to pediatrics.

The Minnesota Chapter does not accept advertising or sponsorship dollars from pharmaceutical companies. The Chapter reserves the right to reject or cancel any advertising.

(Continued from page 1)

collaboratives, the Somali Autism Forum, developmental screening programs, and immunization forums to highlight a few activities.

MN-AAP creates coalitions to improve children's health, many times taking a leadership role with larger stakeholders committed to children. Our primary care coalition with MN Academy of Family Physicians and MN Academy of Physicians serves as an example. These coalitions always involve families and frequently the MN Department of Health, MN Department of Human Services, MN Department of Education and private foundations. Such coalitions have supported our policy efforts, including successful passage of booster seat legislation and maintenance of our current newborn screening program as an "opt out" program. They will continue to inform our efforts surrounding oral health, obesity and mental health issues for children.

Issues of cultural effectiveness were addressed through shared learning forums involving families, educators, clinicians, therapists and interpreters at events such as the Somali Autism Forum.

A coalition serves as the base of our MN Child Health Improvement Partnership to support quality improvement efforts in the state. As one of our partners was quoted, "Such partnerships have led to a culture

change, one where commitment to children and quality within the state is evident."

MN-AAP creates change to drive ongoing efforts of health care reform, especially those that support children. Our primary care coalition as noted has supported efforts to promote family-centered health care homes. In the past year, MN-AAP hosted four learning sessions on health care homes, educating more than 500 participants. In addition, we supported implementation of health care home in 22 primary care clinics serving 12,000 children.

MN-AAP representatives participated in state workgroups related to quality measures and potential payment restructuring on key pediatric issues, including health care home, preventative care, and asthma. We continue with our partners to look for opportunities to drive ongoing change.

All of these successful efforts are the results of many dedicated individuals who always put children first. I am optimistic for the future ... this is only the beginning.

Anne Edwards, MD
President
MN-AAP

Join the Community of Pediatricians on www.mnaap.org

Connect with member pediatricians from across the state!

The screenshot shows the website for the Minnesota Chapter of the American Academy of Pediatrics. At the top, it says "American Academy of Pediatrics" with the tagline "DEDICATED TO THE HEALTH OF ALL CHILDREN™". Below that is a search bar for the "Minnesota Chapter". A navigation menu on the left lists: ABOUT US, COMMITTEES, TASK FORCES, ADVOCACY, PROJECTS, ONLINE RESOURCES, LIBRARY / ARCHIVES, EMPLOYMENT OPPORTUNITIES, FIND A PEDIATRICIAN, MINNESOTA CME, COMMUNITY OF PEDIATRICIANS, GET INVOLVED, FOR PARENTS. The main content area features a large photo of a sleeping baby. To the right of the photo is a "Happenings" section with dates: May 20: Committee on Rural Health Educational Meeting; May 22: H1N1 Physician Feedback Forum; June 4: MN-AAP Annual Meeting; September 4: Peds Day at the Park (Twins Game at 3 p.m.). Below the photo is a "What's New" section with the headline "MN-AAP Selected as Outstanding Large Chapter of the Year!". At the bottom right, there is a "Pediatrician of the Week" section with a photo of a child.

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What has Your Chapter Done Lately? Top 20 Accomplishments 2009-2010

1. Hosted four learning sessions on health care homes, educating 500 + participants.
2. Supported implementation of health care home in 22 primary care clinics serving 12,000 children.
3. Supported an autism health care home pilot program with 7 clinics.
4. Delivered increased reimbursement for primary care coordination. Provided an additional \$250-\$450 per six months per patient to more than 25 pediatric and family physician clinics statewide.
5. Developed task forces on child safety, newborn screening, childhood obesity, and immunizations. Held more than 60 individual meetings with legislators on these issues.
6. Participated in MDH workgroups related to quality measures and potential payment restructuring on key pediatric issues, including preventative care and asthma.
7. Helped to pass booster seat legislation, modifying seat belt requirements and requiring children under age 8 to ride in a booster seat.
8. Hosted a CME forum with MDH and MDE on autism in the Somali community, involving over 170 attendees representing health, education and parents statewide. Hosted focus groups with more than 40 Somali parents to discuss ways to educate the community about the importance of vaccines.
9. Identified healthcare issues and barriers surrounding new immigrants in target communities: St. Paul (Somali community), Rochester (Mayo grant for outreach to Somali community) and Brooklyn Center (West Africans).
10. Developed a presentation for providers about maintenance of certification.
11. Analyzed data on fluoride varnish education and outreach to 150 clinics through MN-CHIP.
12. Provided support and exposure to an Asian teen runaway prevention project through Healthy Tomorrows grant.
13. Increased the number of clinics involved in Reach out and Read from 45 to 64.
14. Developed curriculum for an elective on advocacy for pediatric residents.
15. Hosted Peds Day at the Capitol, matching 30 pediatricians with their legislators.
16. Partnered with MN Academy of Family Physicians and the MN Chapter of the American College of Physicians to promote primary care and health care home standards that included pediatric priorities.
17. Through our Foundation, brought in \$445,000 in new funds for Minnesota projects.
18. Increased chapter membership to more than 900 members.
19. Increased communication to members via an updated website, regular emails, and quarterly newsletters.
- 20. Selected as Outstanding Large Chapter of the Year by AAP for 2010!**

Upcoming Events

For details or to register, go to
www.mnaap.org

Thursday, May 20, 12 – 7 p.m.
**11th Annual Committee on
Rural Health Education**
BayView Event Center, Excelsior

Learn about current concepts in the care of children with cardiac issues, radiology procedures and epilepsy solutions. CME credit available.

Saturday, May 22, 8 a.m. – 12 noon
**H1N1 in Hindsight for Physicians with
Foresight: What Worked, What Didn't,
What's Next?**
Minnesota Department of Health, St. Paul

Provide your input and experiences with 2009-2010 H1N1 novel influenza. Listen to State Epidemiologist Ruth Lynfield, MD, describe the course of the pandemic and its current status.

Friday, June 4, 6:00 – 9:00 p.m.
MN-AAP Annual Meeting
Hilton, Bloomington (Mpls/St. Paul Airport)

The MN-AAP has much to celebrate this year! Join us as we receive the 2010 Outstanding Large Chapter of the Year Award from AAP, hear from legislative leaders on their plans for child health in the coming year, vote in our newest board members, and network with fellow member pediatricians and friends of MN-AAP.

Saturday, September 4, 6:00 p.m.
Peds Day at the Park (Twins Game)

Join pediatric residents and your colleagues for a baseball game in the new stadium! We have a limited number of tickets available in the left field family section. Bring the kids and your baseball glove!

**For details or to register for these events,
go to www.mnaap.org**

Missed the Webinar Series on Health Care Homes?

Download free recordings at
www.mnaap.org/projects.htm

Topics include:

Creating Effective Practice Teams

Getting Started with Limited Funds

Payment Methodology

Free and Low Cost Registry Resources

Did you know?

Employing a medical home approach for chronically ill children can reduce ED visits by more than half, according to a recent study published March 11 by the Journal of Pediatrics.

Welcome New MN-AAP Members

Jeffrey Bobrowitz	Stephen Kurachek
Chad Brands	Laura McCauley
David Casement	Jeffrey Nelson
Parvin Dorostkar	Richard Olsen
Patrick Enders	Randall Schmidt
Stella Evans	Kevin Sheridan
Tanya Halvorsen	Marlieke Van Tyn
Deborah Hans	



2010 Annual Meeting

Register online at www.mnaap.org

Friday, June 4, 2010

6:00 – 9:00 p.m.

Hilton in Bloomington
(Mpls/St. Paul Airport)

The MN-AAP has much to celebrate this year! Join us as we receive the 2010 Outstanding Large Chapter Award from AAP, hear from legislative leaders on their plans for child health in the coming year, vote in our newest board members, and network with fellow member pediatricians and friends of MN-AAP.

An exciting panel will address their plans for child health and the role of pediatrics in health care reform. *It will be an evening you won't want to miss!*

6:00 - 7:15 p.m. Reception, Exhibits and Networking

7:15 - 7:45 p.m. Dinner

7:45 - 9:00 p.m. Panel of 2010 Minnesota Gubernatorial Candidates and invited national policymaker. Presentation of awards.

To pay by check, send form and check by June 1, 2010.

To pay by credit card, register online at www.mnaap.org

Name _____ Designation _____ Company _____

Name of Guest(s) _____

Address _____ Phone _____ Email _____

Reservation:

- \$50 per member (or guest)
- \$10 per resident (or guest)

Meal Preference:

- Merlot Glazed Grilled Chicken Breast
- Panko Herb Crusted Walleye
- Tri-Colored Bowtie Pasta and Vegetables

Sponsorship/Exhibit Opportunities:

- STAR Sponsorship (\$3,500)
- Friends of Children (\$3,000)
- Platinum (\$1,500)
- Gold (\$1,000)
- Silver (\$500)
- Newsletters (\$500)
- Website (\$2,000)

For sponsorship/exhibit details, visit www.mnaap.org/annualmeeting.htm

Mail completed form and check to: MN-AAP, 1043 Grand Ave., #544, St. Paul, MN, 55105
Questions? Contact cairns@mnaap.org or call 651-402-2056. Or visit www.mnaap.org/annualmeeting.htm

Minnesota Kids' Integrated Depression System (MN-KIDS)

By Steve Sutherland, MD, Past President of the Minnesota Society for Child and Adolescent Psychiatry and staff of the Child, Adolescent and Adult Psychiatrist – Human Development Center in Duluth

By now, many of you have heard of the Minnesota Kids' Integrated Depression System (MN-KIDS) – if not by name, perhaps via the recent request for proposal announced by the Minnesota Department of Human Services. The RFP closed in mid-March, and the two grantee programs will be announced in the near future. Each applicant is a primary care clinic which has partnered with a mental health clinic as co-applicant. Below lies a description of the basic structure of the community education, screening, diagnosis, and treatment protocol which this project aims to promote.

The stated goals of the MN-KIDS project are to promote early detection, early treatment, improved outcomes, and improved collaboration between primary care and mental health providers in the care of child and adolescent depressive disorders.

Members of the Minnesota Chapter of the AAP, including Anne Edwards, MD, have been active in working with members of the Minnesota Society for Child and Adolescent Psychiatry (MSCAP), Department of Human Services, National Alliance on Mental Illness (NAMI), Minnesota Council of Health Plans, and others in moving this project from concept phase to action.

We have all seen efforts at integration come and go. We already know that the shortage of specialized children's mental health providers, including child/adolescent psychiatrists, places an extra burden on primary care providers such as pediatricians. Our goal is that having two robust "pilot programs" in place in our state will lead the way to improved, generalizable, and sustainable children's mental health care for depressive and other childhood disorders.

The project in each of the two selected communities will begin with a brief phase of education of community stakeholders (e.g. parents, school personnel, and public health/human services staff) and training of clinic personnel. Soon thereafter, all children between the ages of 6-17 who are suspected (e.g. by any of the aforementioned community members) of showing features of depression will, upon referral to the primary care clinic or the mental health clinic, receive depression-specific screening in the waiting room prior to their clinical assessment.

The Children's Depression Inventory (CDI) is a 10-item brief self-report test (also available as a 27-item sub-scaled test) validated for use in children ages 7-17. A first-grade reading level is required to complete the test. The test can be given individually or in a group, and can be quickly scored by a non-clinician. The CDI was selected for this project in part because it is the only depression scale validated for use across almost the entire school-aged population which this project aims to target.

The Pediatric Symptoms Checklist (PSC) is a 35-item psychosocial screen which the American Academy of Pediatrics has adopted for use as part of its Bright Futures toolkit. Many pediatrics offices in the state of Minnesota are already using this screen as a primary screening tool given to their entire school-aged population. As a result, the MN-KIDS project is recognizing the event of an elevated PSC score as being one of the triggers

which may result in use of depression-specific screening via the CDI.

All youth with an elevated CDI will be assessed at that appointment for differential diagnosis, and for care needs. If the assessment is occurring in the primary care clinic, and a referral for specialized mental health assessment is desired by the provider, this referral will be promptly arranged. At the end of either the primary care assessment or the first mental health professional assessment, a "complexity assessment" will be completed.

The Child and Adolescent Service Intensity Instrument (CASII) is a level-of-care/complexity assessment which was developed in community mental health settings. It is a clinician-scored instrument completed following a diagnostic assessment of a child/family. The instrument asks the clinician to score the child/family on variables such as: Presence of medical co-morbidity; supportive environmental factors; exposure to adverse environmental factors; and safety risks. A score is calculated, falling into one of six "level of care" categories. These categories range from "routine outpatient care" at the low end to intensive community outreach services at the midpoint, to "24-hour medically supervised care" (i.e. hospitalization) at the high end. Most often, it has been used by mental health clinicians, though it can also be completed by primary care practitioners who have completed a brief training in use of the tool.

As is currently the case, the more complex the care needs, the more likely it is that depression care will be primarily carried out in a mental health clinic setting. What the MN-KIDS project aims to ensure is that the care plan, as coordinated by in-clinic care coordinators, will be significantly more likely to be fully and quickly implemented. MN-KIDS addresses obstacles to care, such as:

- Need for insurance prior authorization for services
- Waiting lists
- Need for assistance with travel to location of care
- The tendency for families to become overwhelmed by both the emotional/behavioral condition of the child/family and by the treatment plan itself

Additional goals of the MN-KIDS project include outcome measurement (symptomatic, functional, and provider/family satisfaction), and improved skill and confidence of primary care providers in their care of depression, via development of close consultation relationships. A result of much time and many resources of so many groups focused on the well-being of Minnesota youth, the MN-KIDS project is being introduced by the working group as an important first step in improving the mental health of our youth far into the future.

Steve Sutherland can be reached at steve.sutherland@hdchrc.org

Psychiatric Referrals: What Child Psychiatry Needs from Peds

By Joshua Newman, MD, Child Psychiatrist, Medical Director, Wilder Child Guidance Clinic, St. Paul, MN and Marcia DeValk, APRN, BC, CNS, MS, Clinical Nurse Specialist, Wilder Child Guidance Clinic

Child psychiatrists need the collaboration of pediatricians to make a thorough psychiatric assessment. The psychiatric assessment process begins with clinicians gathering information from a variety of sources and ends with a diagnostic formulation and treatment recommendations. When referring a child for a psychiatric evaluation, psychiatrists need a medical history and a recent medical evaluation “to ensure that the child has no medical problems accounting for the psychiatric presentation and is healthy enough to participate in a medication trial with minimal risk.” (American Academy of Child and Adolescent Psychiatry, 2009, p. 964)

Psychiatric interventions, especially, but not limited to psychopharmacology, may also be impacted by ongoing disease processes and medications. Therefore it is not surprising that a complete medical examination and ongoing collaboration with pediatricians is considered part of “best practice principles” for child psychiatrists. (American Academy of Child and Adolescent Psychiatry, 2009, p. 961)

The scope of the data that needs to be collected for a psychiatric evaluation is summarized in Table 1 below. Specific data which should be forwarded by pediatricians to the psychiatrist is labeled with an asterisk in Table 1.

Table 1. Elements of a Psychiatric Evaluation

Relevant history of presenting complaints*	Screening tool*, deviations from developmental norms
Psychiatric Review of Systems	Screening for the historical presence or absence of symptoms of ADHD; Anxiety; Depression; Bipolar; Schizophrenia; et. al.
Previous Psychiatric Interventions	Previous psychotropic medication trials * therapies
Medical History*	Prenatal and Perinatal complications (substance use, birth weight, neonatal status)* Previous/current illnesses*, medications*, allergies*, seizures*, head trauma*, asthma*, diabetes*, etc.
Developmental History*	Fine/Gross motor, sleep, toileting, language, physical growth, social
Family History	Genetics of psychiatric and other major medical issues
School Performance	Grades, results of IEP testing, school interventions, screening tools, learning disabilities.
Social History	Including family make-up, traumas, losses, marital status, etc.
Mental Status Examination	The observation of the client by the Psychiatrist at the time of the visit.

While the psychiatrist can obtain much of the above information, we are not able to complete a medical evaluation, labs and EKGs. Once a patient’s baseline health and metabolic status has been established, then medication may be started immediately. Prior to their first visit we ask that new patients have a complete physical and the tests listed in Table 2.

Table 2. Labs Prior to Psychiatric Evaluation

Liver function tests	
Fasting Blood Sugar and Lipid Panel	This is particularly important for children treated with medications for Bipolar Disorder.
Thyroid Function Screening	Abnormalities in thyroid function can be caused by several medications that are used to treat Bipolar disorder. Underlying thyroid problems can cause or exacerbate a number of psychiatric presentations.
Serum Electrolytes, BUN, and Creatinine	Checking for kidney function as well as screening for disturbances that might suggest an underlying eating disorder or a reaction to Lithium.
EKG	Over the years we have had at least a couple of cases of Wolff-Parkinson-White syndrome discovered on routine EKG. A number of medications used by psychiatrists also have the potential to prolong the QT interval as well as cause other significant EKG changes.

Once a psychiatric evaluation has been completed, if psychotropic medications are prescribed, psychiatrists will continue to need ongoing collaborative relationships with pediatricians to monitor metabolic, cardiac, hepatic and renal function. Collaborative care of our shared patients needs to be a priority of child psychiatrists and pediatricians alike. Together we can provide the total care that our young patients deserve.

Marcia DeValk can be reached at MJD@wilder.org

References

American Academy of Child and Adolescent Psychiatry. Practice parameter on the use of psychotropic medication in children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 2009;48:9:961-973.

American Academy of Child and Adolescent Psychiatry. Practice parameters for the psychiatric assessment of children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 1997;36(10 suppl):4S-20S.

BLEND: A Central Minnesota Initiative Aiming to Reduce BMI Among Adolescents by 10 percent before 2016

In 2006, two CentraCare physicians approached the CentraCare foundation, saying they were seeing an alarming increase in overweight children and something had to be done in the community.

Later that year, Dr. Allen Horn, CentraCare Clinic president and family practice physician, and Dr. David Tilstra, a CentraCare genetics specialist, received a grant to develop a grassroots initiative aimed at reducing BMI among adolescents living in central Minnesota by 10 percent before 2016.



Physicians in Central Minnesota are taking action on childhood obesity through BLEND. From left to right: Weining Hu, MD, Pediatrics, CentraCare Clinic; David Tilstra, MD, CentraCare Clinic; Mark Halstrom, MD, Family Medicine, Williams Integracare Clinic.

Today that organization is known as BLEND or Better Living: Exercise & Nutrition Daily.

BLEND's coordinator, Jodi Rohe, said the organization's approach is multi-faceted. In addition to coordinating large, community-based events, BLEND works with the medical community to encourage BMI tracking and promote the 5-2-1-0 wellness program.

The 5-2-1-0 message is a simple way for families to remember to eat healthy and be active: 5 fruits and vegetables each day, 2 hours or less of screen time, 1 hour or more of physical activity, and 0 sweetened drinks each day.

BLEND's medical committee, comprised of physicians from CentraCare Clinic, St. Cloud Medical Group, HealthPartners Central Minnesota Clinics, and Williams Integracare Clinic, developed an algorithm for area providers to use when a child is found to be overweight or obese. The algorithm can help guide providers in



Each year BLEND hosts a 1K run for children under 12. Its goal is to reduce BMI among adolescents living in Central Minnesota by 10 percent by 2016.

addressing recommended screenings, treatment plans, readiness to change and follow-up visits.

In addition, the committee developed a "prescription pad" for healthy living. Now when a young patient comes in for an office visit, he or she is given a 5-2-1-0 "prescription" to post on their refrigerator.

Each year BLEND hosts a 1K run for children under 12 and a community and health expo that includes activities from its local partners, including YMCA, NorthCrest Gymnastics, Dance & Fitness, St. Cloud Tai Kwon Do, Scheel's, and the American Heart Association. The expo also includes a nutrition area with free samples of nutritious foods such as snap peas, apples, bananas and other healthy choices from Coborn's. Each child leaves the expo with new ideas and activities to do at home.

This summer BLEND is rewarding kids who participate in different races throughout Central Minnesota. The more races they finish, the more prizes they can earn. And this fall BLEND will attempt to break the world record for the largest parade of bikes with 2,200 people.

For more information, visit www.blendcentralmn.org

MN-AAP Pediatric Obesity Taskforce Update

The MN-AAP obesity taskforce, co-chaired Sarah Jane Schwarzenberg, MD, director of Pediatric Gastroenterology at the University of Minnesota, and Jessica Larson, MD, pediatrician at Fairview Elk River Clinic, is discussing ways to support the national initiative *Let's Move* by addressing the barriers that stand in the way with calculating and plotting BMI.

Currently the taskforce is developing a one-pager on how pediatricians can assess, prevent and treat pediatric obesity with links to local resources, such as weight management clinics and registered dietitians.

In addition, it is exploring the idea of hosting webinars from obe-

sity experts on topics such as initial assessments and coding, possibly with CME credit. For parents and school administrators, these webinars may focus on the link between exercise/nutrition and behavior.

Finally, the taskforce is exploring opportunities for pediatricians to reach out to their local schools, whether it's through joining their local district's nutrition task force, presenting to a classroom or encouraging local administrators to support a particular policy.

About a dozen pediatricians from across the state are participating in the task force. If you would like to participate or suggest additional ideas or resources, email debilzan@mnaap.org

I.EM.PHIT: A Non-Profit, Physician-Supervised Pediatric Exercise and Nutrition Program in Minnesota Opens in St. Paul

When the Kohl's Exercise Medicine Program at Children's Hospital in St. Paul closed its doors after six years in 2008, there were almost no options available in the area for children who needed help managing their weight.

Then Children's Hospital approached Dr. Cindy Garr, a pediatrician with St. Paul-based Pediatric and Young Adult Medicine, and her husband, Dr. Michael Garr, a cardiologist at St. Paul Heart Clinic, about re-opening the clinic as a non-profit at a different location.

In October of 2009 they officially opened the Institute for Exercise Medicine and Prevention, located off I-35E and Little Canada Road in St. Paul.

"We're doing this on a completely volunteer basis," said Dr. Cindy Garr, who leads a busy life with her husband, three kids and three dogs, "because we so believe in this mission of decreasing morbidity and mortality of kids and adolescents due to obesity."

Many of the kids they see have chronic conditions, such as diabetes, asthma, ADHD, depression and anxiety and are often afraid or embarrassed to exercise.

"It just becomes a vicious cycle for these kids and there really is no place for them to go," she said.

What makes I.EM.PHIT unique, she said, is that it is the only non-profit, physician-supervised pediatric exercise and nutrition program in Minnesota. It is intended to augment current medical treatment.

At the first visit, a child is assigned to an exercise physiologist who works with the child throughout the program, which typically lasts six to 12 weeks. The physiologist conducts a thorough review of the child's history (medical, social and nutritional) and then conducts a metabolic assessment to measure the child's VO₂ max and heart rate. Those tests help determine the child's potential and how hard he or she can be pushed.

After Drs. Michael and Cindy Garr review this information, they

put together an exercise and nutrition protocol for each child. Typically the child comes back two to four times a month to discuss his or her eating and exercise habits and track the progress being made.

The clinic's 5,000 square foot facility includes a wide open space for children as young as three to exercise through play. It also includes a variety of cardiovascular and strengthening machines for older children.



Since opening in October of 2009, I.EM.PHIT has treated more than 700 patients

At the end of the program, the child's exercise physiologist conducts a post-metabolic assessment to determine how much he or she has improved. This data is also used for research purposes, which is another big part of the program.

"For kids with depression, their counselors fill out an assessment before and after the program," Dr. Cindy Garr said. "For kids with ADHD, we're following up with their teachers. For kids with diabetes, they might use less medication as their weight comes down. For kids with asthma, if we can impact their lung capacity, they might have less care visits."

Since opening in October of 2009, I.EM.PHIT has treated more than 700 patients. Until recently, most of those visits have been without pay; however, the clinic recently began receiving reimbursements from HealthPartners, Medica, UCare and Medical Assistance. It is in active discussions with Preferred One and Blue Cross and Blue Shield.

"Eventually the goal is for these children to be happier, healthier and more productive in the community," she said. "We're definitely seeing excellent results so far."

For more information, visit www.iemphit.org

Submit CATCH Planning Grant Applications by July 30!

The Community Access To Child Health (CATCH) Planning Funds program provides grants in amounts from \$2,500 to \$12,000 for pediatricians to develop innovative, community-based initiatives that increase children's access to health care homes or to specific health services not otherwise available.

For more information, go to www.mnaap.org/projects/catch.htm

Four Ways to Stay Connected with MN-AAP

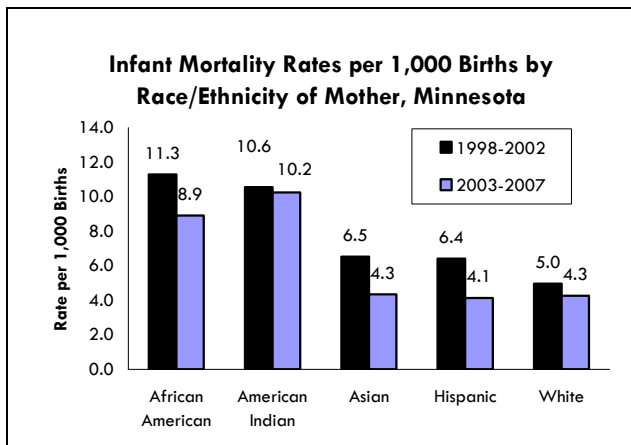
1. Join or renew your membership (Contact cairns@mnaap.org). Know someone who isn't a member? Encourage him or her to join.
2. Join a committee (cairns@mnaap.org)
3. Make sure you're receiving e-updates about important issues affecting pediatrics (debilzan@mnaap.org)
4. Make a contribution to the foundation. Visit our website at www.mnaap.org for details.

MN Infant Mortality Rates: Ways to Reduce Disparities

By Cheryl Fogarty, PHN, MPH, Infant Mortality Consultant, Minnesota Department of Health

The death of an infant in the first year of life has a profound impact on families and communities and is an indicator of the health and well being of a population. Minnesota has one of the lowest infant mortality rates in the United States, averaging fewer than five infant deaths per 1,000 live births annually.

While the overall infant mortality rate for Minnesota is low, disparities greater than two-fold exist among American Indians and African Americans. Eliminating the disparity in the two populations as compared to the white population has been a public health focus for several years. New strategies and resources that are culturally specific are needed.



The leading cause of death for American Indian infants is a combination of Sudden Infant Death Syndrome (SIDS) and other sleep-related asphyxia/suffocation deaths due to unsafe sleep environments. To reduce the disparity, families need education about SIDS risk reduction measures. Information should include the importance of placing babies on their backs to sleep in a crib of their own with no soft bedding, no smoking during pregnancy, and no secondhand smoke in the infant's environment. Minnesota has a *Safe and Asleep* campaign and parent education materials available at: <http://www.health.state.mn.us/divs/fh/mch/mortality/safeandasleep/index.html>

Messages to reduce African American infant deaths are more complex. Low birth weight and preterm births occur at higher rates among African American mothers and contribute to the disparity. Women who were born at low birth weight or were preterm themselves are more likely to have similar birth outcomes with their children. Such intergenerational effects are difficult to mediate.

Racism and higher rates of poverty experienced by some African Americans may result in life-long stress exposure. Stress has been shown to increase cortisol levels during pregnancy, contributing to preterm birth. A woman's accommodation to chronic stress compromises her health and childbearing. At a minimum, providing ongoing access to high quality health care, including pre and inter-conception care as well as early and adequate prenatal care, has the potential for addressing risk factors exacerbated by chronic stress such as pregnancy-induced hypertension and infections.

An additional intervention to reduce disparities in both populations is family planning to promote healthy pregnancy intervals and to reduce the number of pregnancies to sexually active teens. Prevention of obesity among women of childbearing age, breastfeeding promotion, and promoting the SIDS risk reduction and safe infant sleep messages noted previously are interventions with potential to reduce disparities.

Although African American women's rates of smoking in pregnancy are lower than both American Indian and white rates, they have high rates of exposure to secondhand smoke during pregnancy. Counseling pregnant women to avoid environmental tobacco smoke and protect their infants from such exposure is an important strategy to reduce SIDS. Brief counseling for pregnant women on the importance of smoking cessation reduces preterm and low birth weight babies in addition to reducing SIDS risk.

Minnesota has a comprehensive Family Home Visiting Program where best practice interventions to improve birth outcomes are implemented. For more information go to: <http://www.health.state.mn.us/divs/fh/mch/fhv/index.html>

Doula programs provide culturally specific labor support and pre and postpartum education. Community health workers provide outreach and cultural bridging services to help women and infants get needed health care and access other resources such as the Women, Infants and Children Nutrition Program (WIC).

In Minneapolis and St. Paul, the federally-funded Twin Cities Healthy Start program focuses on African American and American Indian families to reduce infant mortality. This program uses a well-tested model of outreach, assessment, case management, health education, father involvement, and inter-conception care. Support is provided from early pregnancy until the child is two years old. For more information call 612-673-3448.

Awareness of and referrals to these resources may make a difference in infant survival. Collaboration and partnerships are important and everyone has a role in saving Minnesota's babies.

Leading Causes of Infant Death by Race/Ethnicity of Mother 2003-2007

Rank	Wh, AA, Hisp*	American Indian	Asian
1	Congenital Anomalies	SIDS	Congenital Anomalies
2	Pretermaturity	Congenital Anomalies	Pretermaturity
3	SIDS	Pretermaturity	Obstetric Conditions
4	Obstetric Conditions	Obstetric Conditions	SIDS

*White, African American and Hispanic
Source of graphs: MDH

Screening Mothers for Depression: Reimbursement Support

By Jesse Kuendig, LGSW, Hennepin Women's Mental Health Program; Helen Kim, MD, Hennepin Women's Mental Health Program, HCMC; and Meredith Martinez, MPH, Maternal and Child Health Assurance, Minnesota Department of Human Services

Depression in pregnant and postpartum mothers impacts children and families and has been called the number one complication of childbirth. Though as many as 20 percent of women experience psychiatric problems during and after pregnancy, many at-risk women go undiagnosed and untreated. This is particularly concerning given the well-documented impacts of perinatal mental illness on women and children, including poor prenatal care compliance, low birth weight and preterm birth as well as developmental delay and behavioral difficulties in children.

Maternal mental illness is frequently undiagnosed and untreated for many reasons. First, the limited points of clinical contact for postpartum women beyond the standard obstetric check-up 6 to 8 weeks after delivery makes detection difficult. Second, research has shown that at-risk women often do not seek mental health treatment due to feelings of shame or embarrassment as well as childcare, transportation, and financial barriers. Third, many non-psychiatric providers feel ill-equipped to diagnose and treat psychiatric symptoms in their patients or rely on informal assessment strategies that overlook many at-risk women.

Pediatric and family medicine providers have a unique opportunity to identify at-risk mothers through screening given the frequency of newborn well-child visits and the non-stigmatizing nature of these visits. The American Academy of Pediatrics and the American Academy of Family Physicians support maternal mental health screening. Despite these advantages, there is the perception that screening is costly, time-intensive, and a liability concern. It is important to note that for maternal depression screening initiatives to be effective, pediatric providers must have enough support and resources to ensure effective diagnosis, treatment and follow-up. In Minnesota, there are important initiatives designed to address these concerns:

1. Effective January 1, 2010, Minnesota Health Care Programs (MHCP) cover maternal depression screenings as a separate service when performed during Child and Teen Checkups (C&TC) or other pediatric visits as a risk assessment for children. Providers may bill for maternal depression screenings when they occur during pediatric visits for MHCP-enrolled children under age 1, and one of the following standardized screening tools is used:

- Edinburgh Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire – 9 (PHQ-9) Screener Beck Depression Inventory (BDI)

Providers must bill using the child's MHCP recipient ID number and CPT code 99420. For more information about MHCP maternal depression billing and provider resources, please read the MHCP Maternal Depression Screening Provider Update.

2. In 2009, the Hennepin Women's Mental Health Program launched a Provider Education Service to support providers in their efforts to implement screening and treatment models in their clinics. The Hennepin Women's Mental Health Program is based at Hennepin County Medical Center. Part of their mission includes broadening the network of qualified providers in Minnesota to assess and treat women with reproductive-related psychiatric conditions. As part of this mission, they will provide screening and assessment tools, treatment guidelines and algorithms, and models of care that will help streamline processes and reduce liability concerns. For more information, please visit www.mnwomensprogram.org or call 612-347-5252.

Meredith Martinez can be reached at Meredith.martinez@state.mn.us

Autism/DD Community Partnerships Collaborative

The Minnesota Department of Health, the Minnesota Department of Education and MN-AAP sponsored the Autism/DD Community Partnerships Collaborative with seven participating clinic-community teams on March 25-26, 2010, in Plymouth, Minnesota. Each team was unique in that it included a pediatrician or pediatric nurse practitioner, parent partners, and representatives from their local school district and public health agency.

The goal of each team is to improve the systems of care for children ages birth-8 years of age with/at risk for autism and other developmental disabilities. Teams will identify concrete strategies they can test in their own communities to improve collaboration in referral and services.

Speakers included Tom Tonniges, MD, FAAP, Director of Boys Town National Research Hospital in Omaha, Nebraska, Dan Farkas from the Ohio AAP Autism Program, Allison Gol-

nik, MD, MPH, and Robin Rumsey, PhD, LP, in addition to speakers from the Minnesota Departments of Health and Education. Participating clinics include: Grand Itasca Clinic and Hospital, Children's Hospitals and Clinics, Fairview Children's Clinic, Duluth Clinic-Hibbing, CentraCare, South Lake Pediatrics, and Owatonna Clinic- Mayo Health System.



Seven clinic-community teams in Minnesota are working to improve the systems of care for children under 9 years with or at risk for autism.

Dental Caries: A Silent Epidemic

By Amos Deinard, MD

For those of us who are primary care practitioners, the mouth should be as much of a focus of our attention as the other organs, even though, for some children (primarily those who come from families with dental insurance or the ability to pay for care out-of-pocket), dentists, too, are involved in the care of their teeth.

Dental caries – the process, not the hole (cavity) – today has achieved “silent epidemic” proportions; its magnitude and reasons for it are described in a recent report by the GAO: “Medicaid - Extent of Dental Disease in Children,” which describes how the epidemic continues to involve more children annually, with millions estimated to have untreated tooth decay (September 2008).

About Caries

Caries is an infectious disease, caused by bacteria that are transferred primarily from the caregiver’s mouth to the child’s mouth (wetting pacifier with saliva before insertion; pre-chewing or pre-tasting food). The bacteria in plaque metabolize sugars in food and drink, creating acidic excrement which etches enamel and initiates the caries process.

Caries is the most common chronic disease of childhood, five times more common than asthma and seven times more common than hay fever. If care of asthmatic children can be on everyone’s short list of important conditions to address, similar attention should be paid to a condition that is five times more common.



Caries is the most common chronic disease of childhood, five times more common than asthma and seven times more common than hay fever.

Today, 80 percent of caries burden is found in 30 percent of children (Medicaid/CHIP enrollees and those from working-poor, uninsured families), despite the fact that many of those children who have caries live in communities with fluoridated public water. (Although Minnesota is 98.6 percent fluoridated, the water table is generally fluoride-poor.) This observation underscores the importance of access to a dental home (i.e. a clinic that will see a child whenever and for whatever reason).

Nationwide, private practice dentists generally are unwilling to care for Medicaid/CHIP-eligible children or to offer care on a sliding-fee schedule to the uninsured. To make matters worse, general dentists who see the majority of children in greater Minnesota have had little experience with one- and two-year-olds while in training and are thus uncomfortable caring for them, regardless of risk status, and so advise caregivers to begin dental care at age three or four despite the policies of AAP and AAPD that every child should have a dental home by age one.

Some may argue that since primary teeth are ultimately shed,

there is no need to worry about them. In reality, their retention is important for the correct eruption of permanent teeth. In addition, a child who has chronic pain from oral pathology of primary teeth does not eat well or attend well and may fail to thrive. Abnormal dentition may also affect development of speech and has a deleterious effect on self-esteem.

Taking Action

Those of us who are primary care providers can address this silent epidemic by introducing primary caries prevention intervention (PCPI) into the C&TC examination (or as part of an episodic visit). PCPI has five components: gross oral examination with referral of any child with apparent pathology, assessment of risk, caregiver education about caries etiology and the caregiver’s role in prevention, quarterly application of fluoride varnish to the teeth of high-risk children according to recommendations of the ADA, and advising the caregiver of the importance of a dental home by age one. Risk assessment (15 seconds, paper-and-pencil), anticipatory guidance (1-2 minutes) and fluoride varnish application (less than 5 minutes) should be delegated to a CMA or LPN, while a gross oral examination and promotion of the dental home should be done by the primary care provider (MD, NP, PA).

DHS and the Health Plans will reimburse a fee for the C&TC examination and, in addition, a fee for the application of fluoride varnish (must bill D-1206 along with the C&TC visit code to get reimbursed for the varnish application). PCPI is an instance of primary prevention which is, at its most basic level, the cornerstone of primary pediatric care (think immunizations), whether provided by pediatric or family medicine providers.

Despite availability of training and reimbursement, primary care medical providers have been slow to incorporate PCPI into the C&TC examination while still urging every parent to find a dental home for her/his child by age one. Providers should advise the caregiver to call the child’s health plan or Delta Dental (Doral for those enrolled with UCare) for a list of safety-net dentists.

Actions to improve oral health in Minnesota should occur before we have our own Deamonte Driver (the 12-year-old Maryland boy who, in 2007, died of a brain abscess secondary to an abscessed tooth which his mother could not get treated). Until dentists return to the pre-1995 era when they saw all children, PCPI is the best way to ensure healthy mouths of high-risk children.

For assistance initiating PCPI in your practice, contact Amos Deinard, MD, MPH at deina001@umn.edu, who has funding from the National Children’s Oral Health Foundation for this purpose.



Want to know what’s happening at the capitol with regard to pediatrics?

Email debilzan@mnaap.org to receive bi-weekly updates.

A Win-Win: MN Rural Physician Loan Forgiveness Program

By Amy Vallery, Loan Forgiveness Program Administrator, Minnesota Department of Health

Recruiting providers to rural communities is a challenge and student debt is a major factor. The average 2009 medical school graduate was more than \$165,000 in debt, according to the University of Minnesota. Students are eager to serve and explore practice locations, yet they are anxious about their educational debt load.

But this isn't just another article about the problems of rural recruitment. This is a success story!

For the last 20 years, the rural Physician Loan Forgiveness Program has been helping primary care physicians and the facilities and communities they serve. If selected to participate in the loan forgiveness program, a physician can receive \$100,000 to help repay qualified student loans. This is distributed as \$25,000 per year for up to four years.

Since the Minnesota State Legislature created and funded the program in 1990, nearly 200 primary care physicians have been recruited to work in rural and underserved areas.

Retention

The purpose of the Minnesota Loan Forgiveness Programs is to recruit and retain health care professionals to needed areas. Over 1,000 pediatricians are actively practicing in Minnesota. However only 1 percent are practicing in rural areas¹ where 12 percent of children live².

Over 1,000 pediatricians are actively practicing in Minnesota. However only 1 percent are practicing in rural areas where 12 percent of children live.

Many factors influence a decision about practice site and location—cost of living, employment for a spouse, raising children, recreational interests, their own background, as well as the opportunity to experience the community and see if it is a good fit. It is only when all these pieces come together that participants and the community they are serving benefit.

With salary being the top rural recruitment challenge, the benefit of the Loan Forgiveness Program is obvious for the physicians. But is it only a short-term gain for facilities and communities? The Office of Rural Health and Primary Care surveyed Loan Forgiveness Program participants in 2007. Of responding physicians who completed their service obligation, 86 percent remained at their sponsoring facility or placement site.

Often, if a physician stays in the rural community for the three- to four-year service commitment, they are rooted and stay for a lifetime. In fact, over 60 percent of physicians remained at their original practice site three years after their loan forgiveness service obligation was completed.

A few years ago, Keith Peterson was one of five newly graduating physicians selected for participation in the Rural Physician Loan Forgiveness Program. Keith still practices pediatrics and



Keith Peterson, a newly graduated physician who was selected for the Rural Physician Loan Forgiveness Program, practices in Ely today.

internal medicine in Ely, where he spent much of his third year of medical school through the Rural Physician Associate Program.

Keith wrote to me, *"Being in Ely for an extended time period gave me a sense of what it is like to practice medicine in a small town. I love the strong relationships many of the physicians have with their patients and I enjoy the challenge of a varied practice. Ely is a wonderful place with a strong sense of community. My wife and I are excited to become a part of the community and are very grateful to have been selected to be a part of the Rural Physician Loan Forgiveness Program. The program will greatly help us pay down our educational debt. Thank you to everyone who works to make the program possible."*

Eligibility

The Minnesota Rural Physician Loan Forgiveness Program is offered to primary care medical residents, which include Family Practice, Obstetrics and Gynecology, Pediatrics, Internal Medicine and Psychiatry.

Applicants must practice for at least 30 hours per week, for at least 45 weeks per year, for a minimum of three years in a designated rural area. Designated rural area maps are online at <http://www.health.state.mn.us/divs/orhpc/funding/loans/map.html>.

A prospective participant must submit an application to the Minnesota Department of Health, Office of Rural Health and Primary Care, during the application cycle of July 1 to December 1 while completing medical residency training.

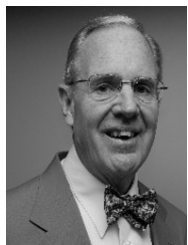
Minnesota Loan Forgiveness Program guidelines are online at <http://www.health.state.mn.us/divs/orhpc/funding/loans/index.html> or contact Amy Vallery at (651) 201-3870 or amy.vallery@state.mn.us.

¹Rural = 46 counties outside metropolitan or micropolitan statistical areas. According to the U.S. Census Bureau, "a metropolitan or micropolitan statistical area is...a core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core." http://www.census.gov/popest/geographic/estimates_geography.html

²Population in rural areas is under 18, according to U.S. Census Bureau population estimates for 2007

National Board Update

By Michael Severson, MD, District Chair



Outstanding Large AAP Chapter was awarded to our Chapter at the Annual Leadership Forum. Everyone in the Chapter should be proud and pleased with this coveted award. Each year the District Vice-Chairpersons review the annual chapter reports, score them, interview the chapter president, and vote. The result translates into national recognition from our peers, a \$1,000

award, and of course, recognition of the hard work that our Chapter leaders have done. That hard work has improved the lives of Minnesota pediatricians and the children they care for. Anne Edwards, MD, Marilyn Peitso, MD, and Kathy Cairns deserve special recognition for their tireless efforts on your behalf.

Legislative advocacy has been a large and important part of my 25 years of AAP involvement and leadership. We have worked a decade to accomplish this, and although not perfect, it is revolutionary for kids and their doctors.

Our President Judy Palfrey and Past President Dave Tayloe were back and forth to Washington working every position to advance our cause. Mark DeMonte and Bob Hall, leaders of our Washington Staff worked night and day for weeks to be sure that children were properly represented. Judy Palfrey summarized the legislation this way:

“The recently enacted health reform law and the reconciliation package will benefit children and the pediatricians who care for them, which is why the Academy endorsed the legislation.

“The health reform package provides age-appropriate benefits to all children in a medical home: All *Bright Futures* services—the definitive standard of pediatric well-child and preventive care—will now be covered for children with private and public insurance as an immediate benefit for no co-pay. There is also a new commitment in Medicaid to help fund the medical home, and health reform ensures health care coverage for children in the United States, including young people up to age 26.

“In addition, the reconciliation package will improve Medicaid payment to a floor of 100 percent of Medicare payment for preventive services codes for physicians with a pediatric designation starting in 2013. For the first time ever, there will be a new federal investment of \$8.3 billion over ten years, a historic new step in improving Medicaid payment rates.”

My new board assignments at the Academy are now strategic planning, information technology, finance and membership. I will elaborate on how these systems work next time.

Please feel free to contact me any time at mseverson@aap.org with your thoughts, needs and ambitions.

Promoting Safe Teen Driving

Submitted by Ted Jewett, MD, PROS Chapter Coordinator



A new \$1.3 million project from the AAP Pediatric Research in Office Settings (PROS) network seeks to test a leading-edge approach in the offices of primary care providers (PCPs) to promote parent-teen-driving agreements and safe driving.

The three-year project, funded by the Centers for Disease Control and Prevention, will adapt an evidence-based program called Checkpoints for promotion by PCPs, leading to better parental monitoring of teen driving.

During the first year of the study, a PCP training program will be developed to fit with the Web-based Checkpoints program. In the second year, a pilot test of the PCP training and the intervention program will be conducted in a small number of physician practices.

Changes to the PCP training, intervention and Web site will be made based on test results and feedback. A larger sample of PCPs subsequently will be recruited to participate in the full scale study, with participating PCPs trained to conduct the refined brief in-office intervention, including a streamlined referral of parents to the Checkpoints Web program.

Measures of intervention success with parents will include:

- dissemination: reach (hearing the PCP message), exposure (going to the Website), exploration (viewing the materials) and access (downloading the materials), and
- implementation: initiation (making the agreement), adoption (signing the agreement) and maintenance (using the agreement).

“This is not just about promoting teen-driving agreements; this is about saving lives,” said PROS Director Richard C. “Mort” Wasserman, MD, FAAP.

More information about the study can be found online at www.aap.org



Join AAP practitioners around the country...

... in generating knowledge about the best ways to care for children. Pediatric Research in Office Settings

(PROS) is looking for pediatricians to help develop and carry out primary care research in the practice setting. Any pediatric practice or clinic with at least one AAP member is eligible to join PROS.

For information, e-mail pros@aap.org

We have been – and always will be – committed to improving the health of children in Minnesota,” said Anne R. Edwards, MD, FAAP, chair of Park Nicollet Pediatrics, who has presided over MN-AAP for the past four years. “This award is a reflection of the dedication, hard work and progress of many pediatricians along with our child advocate partners across the state.”

MN-AAP is recognized for taking a visible leadership role in health care reform by supporting the adoption of health care homes for children in Minnesota, promoting newborn screening, improving pediatric oral health and raising awareness of autism, particularly within the Somali community. In addition, the Chapter partnered with several other organizations to advance state legislation of mandatory booster seats last year.



AAP Chapter Award Winners — 2010

Who will you vote to become the next AAP President?

The AAP National Nominating Committee has named Robert W. Block, MD, FAAP, and Wayne A. Yankus, MD, FAAP, as candidates for AAP President-elect. The election will take place from August 1 - September 1, 2010 (please note new dates, this year only) and the winner will take office as President-elect immediately following the annual business meeting at the National Conference and Exhibition (NCE). All vote-eligible members will be notified by e-mail when the on-line ballot is available. In addition, a telephone voting option also will be available for the first time.

Below are their responses to the following question: What ideas do you have to implement/foster mentoring in the AAP?

Robert W. Block, MD, Tulsa, OK

My first mentor was my father, a pediatrician in private practice in Iowa. Other mentors were clinicians and advisors, who encouraged me during my residency. My friend and career mentor, Dan Plunket, MD, FAAP, demonstrated teaching, clinical, and relationship building skills that have guided me for years. I try to emulate those qualities while mentoring students, residents, young faculty, and pediatricians new to our Tulsa, OK community. Mentoring within the AAP should focus on clinical and business needs of private practices, while fostering alignment between members in private practices and in academics, centering on connecting experienced members with newer members looking for ideas and advice.

A mentor supports another individual or group of individuals as they pursue common goals. Mentoring often is simply leading by example. Good mentors engage others through active listening, encouraging ideas, and by offering suggestions that are designed to support and energize another person. The AAP is a great resource for finding mentors among its many members, and can serve as an organizational mentor by listening to many opinions while guiding members' best ideas into policies and guidelines.

The AAP should continue to engage our trainees and young physicians, facilitating the acquisition of knowledge in medicine, business, policies, and politics. While advocating for children, the AAP supports members in practice settings through email list-servs, task forces, sections and other activities. Providing a way for pediatricians to learn about practice management from experienced and successful practitioners is important. The AAP continues to support senior pediatricians, many of whom can use their practice or academic experiences to mentor a new FAAP entering practice or academics.

The AAP can facilitate the development of mentors through a task force, section or council on mentoring. A task force could design methods for connecting interested members with a mentor in their area of interest. I suggest inviting a young physician to observe committee or section executive committee meetings to connect with leaders who might become mentors. Using new technologies, we can support mentor/mentee pairs across time and space, generating, developing, and reviewing ideas. AAP resources can support mentoring program evaluation and improvement.

Wayne A. Yankus, MD, Midland Park, NJ

Mentoring is about empowerment. To be a successful mentor, you must have experience in your field and be willing to share your expertise. Training encompasses anything that helps increase the realization of a person's potential. I believe in mentoring members to enable them in their work, and to assist in developing their careers while still meeting personal and family needs.

The work force has changed in pediatrics and many of our new pediatricians are women working part time. To have a successful mentoring program within the AAP, I would encourage chapters to identify willing members who would be available to new members. It would strengthen chapter value. Nationally, it can be done by using social media. Mentoring can happen anywhere and at any time. One person can mentor many people. Mentoring can be as simple as an email, "tweet," or linked-in message. I would promote use of existing services first and add to the AAP Website a "just ask" column that would be answered by volunteer pediatricians chosen by their councils or sections.

Listserves can also be tapped for mentoring. The Section on Practice Management listserv is a classic example of an interactive connection that section members use to exchange ideas and support.

Full mentoring contacts could be developed through the office of membership by request of the individual. Those who request mentors should find chapter administrators and officers also helpful in locating a pediatrician who could serve another pediatrician's need. Participation can be one question or a long term relationship between colleagues, and enrich the lives of both members.

Whether you are in direct patient care or academic medicine, members of the Senior Section locally and nationally hold a treasure of information and are often quite willing to mentor new pediatricians.

We are teachers by virtue of being students first and always. Mentoring colleagues follows our physician oath and should be a natural result of membership in our professional organization. It is with our peers we find our practice voice. The AAP is positioned to be influential in the workplace by developing new ways to mentor members.



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2010 Annual Meeting

Friday, June 4, 2010

6:00 – 9:00 p.m.

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