February 2014

MNAAP Pushing Legislation to Restore Newborn Screening

By Anne Edwards, MD, FAAP, chair of MNAAP's Policy Committee

In the midst of all drama and sports analysis of the Super Bowl of late, it seems fitting to speak of offense and defense.

As someone who has spent her fair share of time in legislators’ offices or testifying in front of legislative committees on behalf of our children and their health, I am thrilled to share with you a subtle but important shift as we approach the 2014 session. This year is different in one key way: We’re on offense.

Far too often in past legislative sessions, the MNAAP has been forced to play defense. We spent our resources battling proposals that were bad for our patients. From legislation to prohibit physicians from asking about firearms in our patients’ homes to defeating efforts to repeal the state’s minor consent laws that allow us to provide care to our young patients, the MNAAP has been at the Capitol working to defeat damaging bills. That is incredibly important work, but it often felt defeating to always be reacting to the dangerous agenda of others.

This year is different. With the start of the legislative session on Tuesday, February 25, we will be at the Capitol actively and proactively pushing our own legislation to protect our youngest patients. We’ll be focused on renewing our Newborn Screening Program.

Continued on page 8

Don’t Miss Out on Membership! Join Today!

This issue of Minnesota Pediatrician has been mailed to non-members as well as members of MNAAP. If you don’t receive this newsletter on a regular basis, you are likely not a member. Please consider joining! Turn to page 13 for more
Minnesota Pediatrician
The official publication of MNAAP

1043 Grand Ave. #544
St. Paul, MN 55105
Phone: 651-402-2056
Fax: 651-699-7798
www.mnaap.org

Editor
Melissa DeBilzan
debilzan@mnaap.org

Editorial Committee
Anne Edwards, MD; Lori DeFrance, MD; Julia Joseph-DiCaprio, MD; Robert Jacobson, MD; Elsa Keeler, MD; Wade Larson, MD; Rachel Lynch, MD; Mike Severson, MD; Emily Borman-Shoap, MD

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.

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.

To inquire about advertising, email debilzan@mnaap.org

Upcoming Local CME Opportunities

Sat, Feb. 8
Harold Katkov Tutorial in Pediatric Cardiovascular Medicine for the Primary Practitioner
Hosted by Children’s Hospitals and Clinics of Minnesota

Tues, Feb.11
Noon Webinar: ICD-10-CM Coding Part 1
Presented by Jeff Linzer, Sr, MD, FAAP, FACEP

Fri, Feb. 28
Topics in Pediatric Emergency Medicine
Hosted by Children’s Hospitals and Clinics of Minnesota

Fri, April 25
Pediatric Dermatology
The Commons Hotel, Minneapolis
Hosted by U of M

Thurs, May 1 - Sun, May 4
Child & Adolescent Psychiatry Practical Review for Primary Care and Mental Health Providers
Grand Superior Lodge, Two Harbors
Hosted by St. Cloud Hospital

Mon, May 5 - Wed, May 7
Moving Forward in the Treatment of Pediatric Neurological Disorders
Minneapolis Convention Center
Hosted by Gillette Children’s Specialty Healthcare

Thurs, May 8
Spring Pediatric Update
Bullying Risks and Response: A Primary Care Approach
Hosted by Children’s Hospitals and Clinics of Minnesota

Sun, Aug 17 - Fri, Aug 22
Pediatric Cardiology 2014 Review Course
The Ritz-Carlton, Calif
Hosted by Mayo Clinic

Thurs, Sept. 11 - Sat, Sept. 13
NPHTI Pediatric Clinical Hypnosis
Oak Ridge Hotel and Conference Center, Chaska
Hosted by U of M

Thurs, Sept. 18 - Fri, Sept. 19
Practical Pediatrics for the Primary Care Physician
Hosted by Children’s Hospitals and Clinics of Minnesota Mid

Mon, Sept. 29 - Tues, Sept. 30
Pediatric Days 2014
Chicago, IL
Hosted by Mayo Clinic

To register or for more information, visit www.mnaap.org/calendar.htm
PEDIATRICIANS’ DAY AT THE CAPITOL

MARCH 26 2014

TENTATIVE SCHEDULE:

1:00 - 2:30 p.m.  Welcome and “Advocacy 101”
MNAAP Pediatric Priorities
Group discussions with legislators

2:30 - 4:00 p.m.  1-on-1 meetings with individual legislators
Committee meeting attendance, pending space

5:00 - 6:00 p.m.  Legislative Meetings Debriefing and Appetizers at Axel’s Bonfire Grill at 850 Grand Ave. in St. Paul (optional)

LOCATION:
MN STATE CAPITOL
75 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

FIND OUT MORE AND REGISTER ONLINE AT:
WWW.MNAAP.ORG/PEDSDAYATTHECAPITOL.HTM

LAST YEAR MORE THAN 100 PEDIATRICIANS AND PEDIATRIC RESIDENTS GATHERED AT THE CAPITOL!

DON'T MISS YOUR OPPORTUNITY TO LEARN MORE ABOUT AND PARTICIPATE IN THE LEGISLATIVE PROCESS!
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Minnesota Chapter

2014 HOT TOPICS IN PEDIATRICS CONFERENCE

WHEN: Friday, June 13, 2014
WHERE: Hilton Hotel, St. Paul Airport-MOA

Visit www.mnaap.org for details and registration.
Register by Tuesday, April 15 for early-bird rates!

8:00 a.m. - 12:00 p.m.
Practical Approaches for Managing and Preventing Pediatric Obesity
Co-hosted by the Minnesota Pediatric Obesity Consortium
Discuss evidence-based practices for managing and preventing pediatric obesity with a special focus on co-morbidities and underserved populations. Presentations take a closer look at food insecurity; fatty liver disease; dyslipidemia and multi-cultural approaches to discussing healthy weight with Latino, Native American, Somali and Hmong families.

1:00 p.m. - 5:00 p.m
Eliminating Health Disparities: Pediatric Challenges and Successes
Minnesota is a leader in children’s health, but has one of the largest gaps in health disparities in the country. This session will focus on persistent disparities in health outcomes for minority children in Minnesota, including rates of immunization, obesity and infant mortality. Gain practical resources you can share with families in order to get them connected to the care and services they need.

6:00 p.m. - 9:00 p.m.
MNAAP Annual Meeting and Dinner: Breaking the Impact of Poverty on Child Health
More than 11 percent of all Minnesota children live in poverty. What can individual pediatricians do about this statistic and its impact on child health? Following our keynote by Renée Jenkins, MD, past president of AAP, hear a brief overview of newborn screening and other hot topics. This is a great opportunity to re-connect with colleagues and learn more from those who are leading the way to protect and enhance the health of Minnesota’s children.

Speakers include: Renée Jenkins, MD, past president of AAP and Professor of Pediatrics at Howard University College of Medicine; Diana Cutts, MD, assistant chief of pediatrics at HCMC; Nissa Erickson, MD, pediatric gastroenterologist at Minnesota Gastroenterology, P.A., Julia Steinberger, MD, pediatric cardiology at University of Minnesota Amplatz Children’s Hospital; Muna Sunni, MD, FAAP, assistant professor at the University of Minnesota in the division of pediatric endocrinology; Julie Boman, MD, FAAP, pediatrician at Children’s Hospitals and Clinics; Damon Dixon, pediatric cardiology fellow at University of Minnesota Amplatz Children’s Hospital. Additional speakers to be announced soon.
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

Minnesota Chapter

DON’T MISS OUT! REGISTER NOW!
2014 HOT TOPICS IN PEDIATRICS CONFERENCE
Friday, June 13, 2014

Register below or online at www.mnaap.org

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Please select the sessions you plan to attend:

☐ Practical Approaches for Managing and Preventing Pediatric Obesity

☐ Eliminating Health Disparities: Pediatric Challenges and Successes

☐ MNAAP Annual Meeting and Dinner: Breaking the Impact of Poverty on Child Health
   **Keynote:** Renée Jenkins, MD, FAAP, past president of AAP

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HALF DAY - includes 1 session plus 1 ticket to MNAAP’s annual meeting/dinner

FULL DAY - includes 2 sessions plus 1 ticket to MNAAP’s annual meeting/dinner

ANNUAL MEETING/DINNER ONLY - includes 1 ticket to MNAAP’s annual meeting and dinner

Total Enclosed: $ _______________

☐ MasterCard  ☐ VISA  ☐ Check (payable to MNAAP)

☐ I cannot attend MNAAP’s annual meeting/dinner. Please donate my meal ticket to a resident/medical student.

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Print Name as it appears on Card

Exhibiting Opportunities
Community non-profits and organizations that provide valuable pediatric tools and resources are encouraged to exhibit. Email debilzan@mnaap.org for details.

Mail completed forms with payment to:
MNAAP
1043 Grand Ave. #544
St. Paul, MN 55105
Or Fax to: 651-699-7798

Questions? Contact
Melissa DeBilzan
651-338-1823
debilzan@mnaap.org
What were the top ten events for our chapter in 2013? What would such a list look like, and what would we learn from it?

I ended up making such a list to help with our year-end reporting. At the end of 2013, our chapter submitted its annual chapter report for the national organization. The report details MNAAP’s accomplishments for the year. It’s a Herculean task of cleaning out the stables of the year gone by and trotting out accomplishments for a national audience. We ask the leaders of our workgroups and committees to participate in the reporting as well.

Each of us on the board would probably list different things. Perhaps many items would overlap but the order would vary greatly. My own top ten list includes the following:

1. Updated School and Daycare Immunization Rules. The successful adoption of the updated Minnesota School and Daycare Immunization Rules in August had been a long time coming. Katherine Cairns, our executive director, and I began meeting as representatives of the chapter in 2012 with the immunization rules task force that the state assembled. Dr. Dawn Martin, chair of the MNAAP Immunization work group, kept members informed of the updates at meetings and in the newsletter. We finalized that work in the spring of 2013 and waited with apprehension for the period of public notification and comment. In a tense administrative hearing this summer, I spoke on behalf of our chapter in support for the proposed rules, which included new vaccine requirements for Rotavirus, Hepatitis B, Hepatitis A, Tdap, Varicella, and Meningococcus. Our efforts paid off when the administrative judge ruled in favor of MDH, allowing the rules to become effective in September of 2014.

More info at www.mnaap.org/immunizations.htm

2. Pediatricians’ Day at the Capitol. This well-attended event involved more than 100 pediatricians meeting with legislators and successfully brought both of our state’s pediatric residencies together to participate in this show of legislative advocacy. The enthusiasm of the pediatricians-in-training was energizing and carried us through a rocky legislative season that saw the tabling of our efforts to stay the destruction of the newborn screening test data along with the blood spots themselves. The MNAAP’s efforts at the Capitol in regards to tobacco, however, were hugely successful as the MNAAP and our coalition partners advocated for – and won – a historic increase in the tobacco tax, a change that will result in far fewer adolescents smoking.

More info at www.mnaap.org/pedsdayatthecapitol.htm

3. Investments in Health and Education. We advocated for the successful approval of the state health budget with its support for pediatric and adolescent mental health as well as the approval of the state’s investment in early childhood education and the critical congenital heart disease testing requirement.

4. Successful Education Programs. Our Hot Topics in Pediatrics Conference, held the day of our annual meeting, successfully brought together nearly 150 attendees for our programming on obesity and motivational interviewing.

5. Dynamic Annual Dinner. Those in attendance won’t soon forget the 2013 annual dinner where our keynote speaker, Dr. Piero Rinaldo, spoke so passionately for the return of Minnesota Newborn Screening to where it was just several years ago: the best in the country and the world with so much promise for the future.

More info at www.mnaap.org/annualmeeting2013.html

6. New and Improved Website. We rolled out our new web presence in 2013. While it is easy to take a web site’s appearances and functionality for granted, we know that our organization depends on the ease of communication. Our web pages are central to our organization’s ongoing conversation across the state.

More info at www.mnaap.org/

7. Collecting Member Feedback. Every year we conduct an all-member survey. It is a big event for us because it provides our members a chance to weigh in on a variety of
New Immunization Laws for School, Child Care, and Early Childhood Programs

On Sept. 1, 2014, changes to the Minnesota’s Immunization Law will take effect for schools, child care, and early childhood programs. The changes were made to be more closely aligned with the current Advisory Committee on Immunization Practices (ACIP) recommendations. Medical and conscientious exemptions are still allowed under the law.

New vaccines requirements include:

- Hepatitis B – For all children over 2 months old enrolled or enrolling in child care or an early childhood program.
- Hepatitis A - For all children over 12 months old enrolled or enrolling in child care or an early childhood program.
- Tdap - For all students entering seventh grade. Students in eighth through 12th grade must show documentation if the school requests it. This replaces the Td immunization requirement.
- Meningitis (meningococcal) - For all students entering seventh grade. Students entering eighth through 12th grade must show documentation if the school requests it.

For more detail on all the changes to the law, visit the MDH website at www.health.state.mn.us/divs/idepc/immunize/immrule/index.html.
Newborn Screening, continued from page 1...

This life-saving program has been subject to dangerous changes since a 2011 Minnesota Supreme Court decision and subsequent legislative action.

Our message to legislators is a simple one, and can be summed up simply:

1. **RESTORE.** Minnesota’s newborns are being harmed by recent changes to newborn screening. Minnesota is the only state that destroys newborn screening data soon after birth, putting babies and families at risk.

2. **SAVE.** Storage of blood spots and data assure proper diagnosis and timely follow up for critically ill children. Additionally, storage supports quality improvement and the development of new tests that lead to life-saving treatments.

3. **LEAD.** If given the opportunity, Minnesota’s newborn screening program can once again serve as a national leader in saving as many lives as possible from death, disability and impairment.

At the risk of mixing my sports metaphors, we’ll need a “full court press” in 2014 to be successful. But to win, pediatricians have to be part of the game plan. MNAAP members need to pick up the phone or craft an email to your elected official to explain how this program saves lives. While visiting with legislators can be intimidating, no one understands this issue better than us. Stay tuned for opportunities to lend your support to our shared effort on behalf of our patients.

We’re in a new position at the Capitol this year. As advocates for children, defeat is not an option -- we have a very real opportunity to reverse the damage already done.

I, for one, think it feels good to have the ball in our hands for a change.

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**Newborn Screening by the Numbers**

- **5,000 newborns** have screened positive since the program’s beginning and have been saved from death or permanent disability
- **134 newborns** screened positive in 2013 and were saved from death or permanent disability
- **71 days** until a negative blood spot is destroyed; not enough time to complete testing or follow up in some cases
- **2 years** until a positive blood spot and all test results are destroyed; they are unavailable for future analysis or reference
- **2 newborns** are expected to test positive for SCID in 2014
- **unknown number of newborns** were missed for SCID during 2010-2013 because the test was delayed due to unavailability of blood spots...which must be destroyed after 71 days.

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**Stay Informed**

To learn more about MNAAP’s efforts in this area, email cairns@mnaap.org or visit www.mnaap.org/newbornscreening.html for the latest updates and fact sheets.

**Get Involved**

MNAAP is working with Rep. Kim Norton and Sen. John Marty to draft legislation to restore Minnesota’s newborn program. Watch for opportunities in the coming weeks to view the bill and express your support. Email cairns@mnaap.org to discuss specific ways to lend your support.
Minnesota prides itself on being one of the finest places to raise a family and has frequently been ranked as one of the healthiest states in the country. In 2004, the Annie E. Casey Foundation ranked Minnesota first overall in the well-being of its children using 16 measures of child well-being in the four major domains of economics, education, health, and family. But in its 2013 report, Minnesota had slipped to fourth overall and 15th in the health of children category. This decline in our state ranking is resulted in part to persistent disparities in health outcomes for minority children in Minnesota. Infant mortality and immunizations are two health outcomes that epitomize these disparities.

The Infant Mortality Rate or IMR is considered by many as a pre-eminent marker of the overall health of a community. Minnesota’s IMR is 4.61 infant deaths per 1,000 live births—better than the national average of 6.39. But this is largely the result of Minnesota’s IMR for non-Hispanic, white-infants, which is at is 4.14. For African American infants, Minnesota is worse than the national average—at 7.44. Minnesota is similarly worse than the national average for American Indian children—at 8.6.

Minnesota’s overall high ranking also holds true for immunization. Overall, Minnesota ranked seventh in the nation among children fully immunized at 19-35 months old. But stark differences in Minnesota’s immunization rates emerge based on a child’s race and ethnicity. The percent of children fully immunized was 85 percent for white, non-Hispanic toddlers but only 73 percent for American Indians, 66 percent for Asian/Pacific Islanders, 65 percent for Hispanics, and 63 percent for non-Hispanic African Americans.

These are just two of the measures. Others similarly demonstrate the disparities in health care across the state varying by race and ethnicity.

Minnesota pediatricians take pride in the access and quality of care we deliver to our children and their families. However, there is a danger when we, as Minnesotans, consistently see the overall health of our children held up as an example to the rest of the nation. We must celebrate the success but realize that the gradual slippage of our overall state as well as persistent disparities indicate that there is still work to be done.

“This decline in our state ranking is resulted in part to persistent disparities in health outcomes for minority children in Minnesota.”

First, we must continue to be cognizant of persistent disparities and translate that knowledge into action. This includes the ongoing promotion of “Back to Sleep,” smoking cessation, and breast-feeding in our practices as primary prevention strategies to reduce infant deaths. We know that the adoption of these strategies are not evenly utilized by communities of color due to access, poverty, non-financial barriers, and cultural differences.

With regard to immunizations, we must remain vigilant in the promotion of the efficacy of vaccines for children. We must also encourage participation in the Vaccines for Children program as well as Medicaid, MinnesotaCare, and MNSure. It will be through such efforts that we will be able to achieve the equity we as pediatricians strongly embrace.

References


3 Disparities in Infant Mortality, Minnesota Department of Health, January 2009

4 Immunization & Health Disparities, Minnesota Department of Health

Be sure to register for Eliminating Health Disparities Friday, June 13. Turn to pages 4-5 for details and registration.
For about 30 years, the AAP has recognized the importance of media in the lives of children and teens, but obviously the amount, complexity, and challenges of the various types of media continue to evolve. We all live in a world saturated with and surrounded by media, and even as I write this article, creative minds are at work on new products and programs!

More than 75 percent of teens have cell phones; some send more than 100 text messages daily, and millions spend hours on Facebook.

The impact of media on children and adolescents is a major focus of the AAP into the future and the Board has committed time, money, and energy to the ongoing task of educating pediatricians, parents, teens, and children about media: How do we recognize and mitigate the potential harm? How do we embrace positive and pro-social media? In this spirit, the executive committee of the Council on Communications and Media (COCM) revised and published the policy statement now titled “Children, Adolescents, and Media” last fall. There are several other COCM policy statements and reports relevant to the impact of media on our patients and families, including the recent “Media Use by Children Younger than 2 Years” and “The Impact of Social Media on Children, Adolescents, and Families.”

Although media continue to evolve, so much remains the same. Many children and teens have few rules about media use, but still spend many hours daily with media -- and television is still predominant. In 2013, children ages 8-11 years averaged 8 hours of daily screen time, while older children spent more than 11 hours daily with a variety of media. The amount of time spent with media concerns pediatricians and parents because during those hours children and teens are not socializing with family or friends, reading books, playing active games, enjoying creative pursuits, or just day-dreaming (still a valuable commodity!). Although TV captures the most hours, video games, social media, and other platforms are gaining in popularity.

Research confirms that media use for some youngsters is associated with negative outcomes, notably sleep disturbances, aggressive or antisocial behavior, obesity, and poor school performance. At the same time, positive and pro-social media has been shown to model empathy, tolerance, and a whole range of valuable interpersonal skills and can also teach valuable school readiness skills. Media can transport children and teens (and their parents!) to new places and open doors to learning and creativity. Social media allows teens to communicate and connect.
with friends and importantly, explore who they are. Media are not intrinsically good or bad -- what matters is how we choose and use programs and activities.

The new “Children, Adolescents, and Media” policy statement provides some new ideas and tools for parents and pediatricians as we navigate the ever-changing media world.

We encourage implementation of a family media use plan in every home -- ideally every member of the family can participate in creating this plan. This encourages families to think about a healthy media diet -- analogous to the readily-understood healthy food diet. We should make, as a family, wise media choices -- age-appropriate programs, games, and platforms -- and not allow media to be random event in the home.

Parents should also keep televisions and Internet connections out of kids' bedrooms and centralize media platforms, whenever possible. This allows parents to watch and monitor media use with children -- another important tenet of the family media use plan. Co-viewing media is a golden opportunity for parents to teach about their own values and be certain children can comprehend and deconstruct images and messages in media. Our kids often are far more media savvy than we are -- media education encourages parents to keep up to date on current innovations. Parents should also consider their own media habits -- limiting children to less than 1-2 hours daily while we watch TV for hours or use cell phones at the table is confusing at best!

We advise limiting children and teen to less than 1-2 hours of entertainment media exposure daily -- legitimate media use for homework not included! Another recommendation of the family media use plan is to implement and enforce a media curfew -- a clear time when everyone's devices are docked for the night (especially important considering the impact of late night media use on a good night's sleep).

Importantly, for good evidence-based reasons, we encourage no screen exposure for little ones under the age of 2 years. There is no evidence that media exposure is beneficial for these very young children and there is growing reason for concern about the potential adverse effects on language and other development. Parents beware: now infant seats, potty chairs, and other products are coming equipped with an iPad holder to keep baby or toddler transfixed. Our littlest children need real-life interaction with loving adults, not more screen time!

Parents can be advocates, whether by encouraging schools and communities to teach media education courses or by pressuring the media industry to create positive and pro-social products and programs for children and adolescents.

Media are never going away and will only become more pervasive and important in our lives. This policy statement hopes to encourage media educated parents and children to make wise choices, mitigate the potential harm, and allow all of us to recognize and embrace the positives media can offer.

Read the policy statement at: http://pediatrics.aappublications.org/content/132/5/958

More information for parents on creating a family media use plan is available on HealthyChildren.org.
Member Profile: Janice Rourk, MD, FAAP
Pediatrician at Grand Itasca Clinic & Hospital

What's your background?
I remember making the decision to go into medicine when I was 11. I spent most of that summer in the ICU waiting room hoping that my father would recover from a cerebellar hemangioblastoma. I realized then the power that a physician has to change not only the life of the patient, but the lives of everyone who loves that patient.

My dad lived another 5 years and I was grateful for the additional time I had with him. I didn’t go to medical school right away; I got married at 19, became a nurse and had two kids. When I found that the desire to pursue medicine wouldn’t go away, I applied to and was accepted into the University of Michigan Medical school. My first year pathology professor promised that we would be able to indulge our passion for disease. I did my residency at U of M as well. I had grown up in Michigan and had a lot of family support there, so it was a great fit. When I graduated from residency my husband and I wrote out a list of our dream requirements for a first job. My attendings were tearing their hair out for fear I was too picky and would never be hired, but the folks at Grand Itasca called and said they had just what I wanted. I was the first resident in my year to land a job.

What are some of the biggest advantages of being a rural practitioner?
Grand Rapids is a resort town, which makes it easier to balance my love of the outdoors with the long hours of a pediatrician. During the nice weather I bike to work. I’ve tried cross country skiing the 4 miles to work a few times in the winter, but that takes a lot more planning. The lake is in my backyard. I can remotely access our electronic medical record, so during the long daylight hours in the summer, I can go out for a run, swim or a spin on the wakeboard and do my charts after dark.

What do you enjoy most about being a pediatrician?
Kids are fun. They cheer me up. No two days are ever alike. I enjoy being able to solve a problem and watching the relief of the parents as they see their child getting better. There are few things as satisfying as resuscitating a newborn or reducing a nursemaid’s elbow. In both cases the fix is quick and you can see the relief during a single visit. I’m learning to enjoy the longer-term problems as well because of the huge impact they have on the child’s life.

If you weren’t a pediatrician, what would you be and why?
My daughter taught English in Thailand and my nephew was in the peace corps in Burkina Faso. I was able to visit both of them and I was fascinated on both trips. The opportunity to be able to help others while doing both of those things appeals to me, so I might try to find a fit in the peace corps.

Any hobbies/interests outside of medicine?
I’ve been married for over 30 years. My son is starting his own business training athletes. He took me on as a personal challenge, and with his help last summer I was able to complete our local timber man triathlon: a 1-mile swim, 24-mile bike, and 6-mile run. I learned all about muscle cramps, but finished in the time allotted for the race! In February 2014, I plan to skate ski my 5th Birkie, a 50 kilometer ski race. I’m also starting to develop a fondness for Oregon as my daughter and her husband live there.
Value of Chapter Membership

The chapters and national AAP have a unique relationship of respect and autonomy. The chapters are independently incorporated which allows them to pursue their own interests, but they depend upon the national organization for policy direction and support. Chapters serve as the connection to members at the local level, and assist in implementation of policy. The chapters also carry out the Academy’s mission in the states.

What Chapters are...
◆ Chapters are organized groups of pediatricians and other health care professionals working to:
  • Implement AAP policy at the state and local levels
  • Respond to the needs of their members
  • Address national priorities, but also handle issues unique to their specific regions and locales.

What Chapters do...
◆ Provide advocacy on a wide variety of local, state and national issues impacting children and the practice of medicine
◆ Provide leadership opportunities, such as committee participation
◆ Provide educational opportunities and resources, such as CME meetings, conferences and newsletters

Top 5 Reasons to join the Minnesota Chapter...

1. Minnesota resources for Minnesota providers
2. Free and reduced rates for local CME and MOC 4 programs
3. Local pediatric news
4. A constant presence advocating for child and teen health at the state Capitol
5. Leadership and networking opportunities connecting pediatricians from all areas of the state

For more information or to join, call 651-402-2056 or visit www.mnaap.org/statememberinfo.htm

Chapter dues are $130/year
**MNAAP Members, Let’s Hear Your Award Nominations!**

*Distinguished Service Award*
Recognizes a pediatrician for his or her outstanding efforts that contribute to the improvement of child health care.

*Child Advocacy Award*
In addition, MNAAP chooses an individual from the community who goes above and beyond his or her everyday routine to advocate for the health and welfare of children in Minnesota.

All nominations due May 1, 2014. Visit [www.mnaap.org](http://www.mnaap.org) for nomination forms and details.

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**Back by Popular Demand! Abstract Competition at Annual Meeting**

Once again this year, MNAAP will hold a resident and medical student abstract and poster competition at the annual meeting on Friday, June 13 at the Hilton MOA.

The goal of the competition is to foster community among pediatric trainees across the state.

Abstracts should number no more than 450 words and must be submitted electronically. Authors will be judged by Minnesota pediatricians; winners will receive a prize and their projects will be published in *Minnesota Medicine*.

Details at [www.mnaap.org/annualmeeting.htm](http://www.mnaap.org/annualmeeting.htm)

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**CHIPRA Center of Excellence Pediatric Quality Measure Project Update**

Over 400 parents in Minnesota have provided their input, and now it is your turn. MNAAP has sent out over $7200 to date to health care providers who have completed surveys on their patient’s social complexity. The national Center of Excellence is hoping to better understand significant social stressors which may interfere with a family’s ability to address a chronic medical condition. Two additional projects included written parent consent for abstraction of records for Minnesota children with chronic conditions are also underway.

Online CME produced as a part of this project is available for any physician. Topics include: “Pediatric Quality Measure Development,” “Pediatric Preventive Care: Adolescent Mental Health, Depression Screening” and “Minnesota Adverse Childhood Experiences (ACE) and social complexity.” CME information at [http://www.mnaap.org/pediatricqualityed.html](http://www.mnaap.org/pediatricqualityed.html) Pediatrician participants in this project may also participate in the Medical Home MOC4 module without charge. MOC4 information at [www.mnaap.org/healthcarehomemoc4.html](http://www.mnaap.org/healthcarehomemoc4.html)

Contact cairns@mnaap.org if you have additional questions about survey payment, the CME or MOC4 opportunity.

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**Thank you to the following clinics and hospitals for their participation in this project!**

| AFFILIATED COMMUNITY MEDICAL CENTERS, WILLMAR | FRIDLEY CHILD & TEEN MED CENTER | OLMSTED MEDICAL GROUP |
| ALLINA MEDICAL CLINIC COON RAPIDS          | FAIRVIEW MAPLE GROVE MEDICAL CENTER | OWATONNA CLINIC - MAYO HEALTH SYSTEM |
| ALLINA MEDICAL CLINIC HASTINGS             | FAIRVIEW RIDGES HOSPITAL          | PARK NICOLLET CLINIC BROOKDALE |
| FAIRVIEW CLINICS – BLOOMINGTON             | HEALTHPARTNERS ST. PAUL           | PARK NICOLLET CLINIC MINNEAPOLIS |
| CENTRACARE CLINIC-WOMEN CHILDRENS          | HENNEPIN FACULTY ASSOCIATES/HCMC  | PARK NICOLLET CLINIC ST. LOUIS PARK |
| CHILDRENS HOSPITALS & CLINICS PRIMARY CARE MINNEAPOLIS | LAKE REGION HEALTHCARE | PEDIATRIC & YOUNG ADULT MEDICINE |
| CHILDRENS HOSPITALS & CLINICS PRIMARY CARE ST. PAUL | MANKATO CLINIC | SANFORD SOUTHWEST CLINIC |
| EAST SIDE FAMILY CLINIC                    | MAYO CLINIC                      | SOUTH LAKE PEDIATRICS WEST |
| ESSENTIA HEALTH DULUTH CLINIC              | METRO PEDIATRICS                 | UMP BROADWAY FAMILY MEDICINE |
| ESSENTIA HEALTH HIBBING CLINIC             | NATIVE AMERICAN COMMUNITY CLINIC | UNIVERSITY OF MINNESOTA |
| ESSENTIA HEALTH - BRAINERD CLINIC         | NORTH POINT HEALTH AND WELLNESS CENTER | AMPLATZ CHILDREN’S HOSPITAL |
MNAAP's Health Care Home Project Updates

Work group chair Amy Burt, MD leads the bimonthly work group conference calls that are coordinating several projects:

- Two pediatricians have completed the Medical Home/HCH MOC4 module and earned ABP points in 2013 with several others in process. The work group serves as the virtual learning collaborative for MOC4 participants working on this module. There is still time to sign up for the MOC4 modules and complete it in 2014.
- A grant from the Minnesota Department of Health for a medical home learning collaborative was funded to support clinics, hospitals and a health plan work on transitions in sites of care. Thank you to the leadership of Dr. Abe Jacob (University of Minnesota Amplatz Children’s Hospital), Dr. Robert Payne (Children’s Hospital and Clinics of Minnesota), Dr. Randall Flick (Mayo Clinic Children’s Center), Dr. Mary Braddock (Gillette Children’s Specialty Healthcare), and Dr. Amy Burt (Medica Health Plan) for your work on this project. The project will be seeking primary care clinics who admit to these hospitals or serve children/teens with Medica coverage to work on this project.
- Communication with the Minnesota Department of Human Services regarding their plans to create a Behavioral Health Home continues. MNAAP has expressed concerns about a separate Behavioral Health Home for children and teens that is disconnected from their primary care clinic.
- Contact cairns@mnaap.org if you would like information about upcoming work group conference calls, the new learning collaborative project or Behavioral Health Homes.

2013 Member Survey Results

More than 100 members completed the chapter’s annual membership survey. Your responses and feedback are appreciated and have been shared with MNAAP board members to shape future activities and member benefits. Thanks for participating!

Some key insights:

- 78 percent of respondents are currently in practice; the remainder are in training (14 percent) or retired (7 percent).
- About half of respondents work in an urban practice as opposed to suburban (42 percent) or rural (8 percent).
- 85 percent of respondents say they are concerned about recent changes to Minnesota’s newborn screening program.
- 47 percent of respondents use social media for professional use on a regular basis.
- The top five topics members want more information about are pediatric obesity, child poverty and disparities, adolescent medicine, developmental and behavioral pediatrics and pediatric quality measures.
- The newsletter was cited as the most useful member benefit, followed by all-member emails, a newly redesigned website, opportunities to support chapter advocacy, discounted rates for continuing medical education programs, opportunities to participate in chapter work groups, and opportunities to apply for grants with chapter help.
- 86 percent of members would recommend MNAAP membership to a colleague.

View a summary of all results at http://svy.mk/1cc1RKk

Employment Opportunities

Pediatrician, Willmar
Affiliated Community Medical Centers

Developmental Behavioral Pediatrician
Minneapolis
HealthPartners

BE/BC Pediatricians, Southwest Metro
Lakeview Clinic

For details on these opportunities, visit www.mnaap.org
REGISTER NOW!  |  WEDNESDAY, MARCH 26, 2014

PEDIATRICIANS’ DAY AT THE CAPITOL

visit www.mnaap.org/pedsdayatthecapitol.htm

THANK YOU TO MNAAP’S 2013-2014 SPONSORS