



# VIRGINIA • PEDIATRICS

American Academy of Pediatrics • Virginia Chapter

Spring | 2014

## VA-AAP Legislative Update

AIMEE PERRON SEIBERT, CHAPTER LOBBYIST

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The 2014 General Assembly Session adjourned on Saturday, March 8<sup>th</sup>. However, they adjourned without a budget and returned for a special on Monday, March 24<sup>th</sup>. It was a successful session for us and we were pleased to see many of the bills we supported pass both houses.

One of our biggest priorities this year was our pulse ox legislation. HB 387 (Comstock-R) and SB 183 (McWaters-R) will make the administration of a pulse oximetry screening the standard of care in all Virginia birthing hospitals to ensure that all newborns are tested for congenital critical heart defects.

We have been working on legislation regarding concussion policy for a few years and are pleased to see these bills pass both the House and Senate. HB 410 (Anderson-R) and SB 172 (Stuart-R) will require every non-interscholastic youth sports program utilizing public school property to establish policies regarding identifying and handling suspected concussions.

We supported HB 720 (McClellan-D), which passed both the House and Senate. This bill will require school boards to develop a policy to set aside a non-restroom location that is shielded from public view to be designated as an area in which any mother who is employed by the school board or enrolled as a student may take breaks during the school day to express milk until her child reaches the age of 1.

We worked on legislation this year regarding indoor tanning and children under 18. Senator Barker (D) and Delegate Brink (D) carried legislation for the Joint Commission on Health Care that would have prohibited indoor tanning for children 14 and under and required parental notification for children 15, 16 and 17 years old. Delegate Yost (R) carried legislation that would have prohibited indoor tanning for all children under 18. Unfortunately, all three bills were tabled in the House Commerce and Labor committee. However, a few Republican members of the committee expressed interest to us about moving forward with a full ban next

year. We look forward to working with those legislators on full ban legislation in the 2015 session!

We supported HB 1023 (Kilgore-R), which would have banned smoking in cars with children under the age of 8. The bill was successfully reported out of subcommittee for the first time, but then was tabled in the full House Militia, Police and Public Safety committee on a very close vote. We are disappointed with the defeat of this bill, but are pleased with the progress it made this year.

We championed legislation this year, HB 1031 (Orrock-R) to update Virginia's immunization guidelines in the Code with the CDC's Advisory Committee on Immunization Practices recommendations and up-to-date science and evidence-based practices.

We also supported legislation this year to ban e-cigarettes for minors. HB 218 (Albo-R) and SB 96 (Reeves-R) prohibit minors from purchasing vapor products by adding them to the definition of tobacco products. We were pleased to see both bills pass unanimously.

Finally, the General Assembly returned to Richmond on Monday, March 24<sup>th</sup> for a special session to work on the budget. The new fiscal year starts July 1, so a new budget needs to be approved and in place by June 30<sup>th</sup>.

The impasse between the House and the Senate is over Medicaid expansion. The Senate proposed a plan called "Marketplace Virginia," which will use federal Medicaid funds to provide private insurance for uninsured Virginians. Governor McAuliffe has recommended in his proposed budget that Virginia simply expand the current Medicaid program. The House is strongly opposed to Medicaid expansion in any form and has rejected both proposals in their budget. Both sides are adamant and have not indicated any willingness to compromise at this point. The House has passed their version of the budget- HB 5002, but the Senate has refused to take it up in committee. The Senate has passed their version of the budget, SB 5003 and has sent it to the House. The House has indicated that they may also decline to take up the Senate's version of the budget. We will learn more soon and will keep you updated.



American Academy of Pediatrics  
DEDICATED TO THE HEALTH OF ALL CHILDREN™  
Virginia Chapter

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## President's • MESSAGE

William C. "Biff" Rees, MD, MBA, FAAP

President Virginia Chapter | American Academy of Pediatrics



To all my fellow Chapter members,

This has been a strong year for advocacy. Our legislative session was very successful. Bills regarding Breast Feeding, E-Cigarettes, Concussion

Policy, Congenital Heart Defect Screenings, and Immunization Code Updates were success stories. Legislation regarding Smoking in Cars, and the use of Indoor Tanning Beds met resistance and did not pass, but indications at the end of session were encouraging for next year.

Interestingly, I received some e-mail from some interested Chapter members regarding our political philosophy. I can sum them up by saying we were accused of a strong liberal Democratic bias. I really had to think if this was all true, and, surprisingly, just the opposite. Hard to believe, but most bills we supported this year were introduced or co-patroned by Republicans. I had never thought that was the case. Then I thought, perfect! We take issues as beneficial for kids, not political agendas. Call us liberal Democrats, or conservative Republicans, our mission is getting done. What is most important is that we advocate for kids.

I would like to note that my "pet" legislation this year was House Bill 147 (HB147) sponsored by Delegate John O'Bannon, an adult neurologist, that may open the door to increased compensation for pediatricians who care for Medicaid. The bill's final language allows for dentists who care for Medicaid to put payments for their services into the state's pension program called VRS (Virginia Retirement System) for public servants. This means that it is tax deferred much like an IRA or 401K. I hope everyone understands the concept,

but if not, it means no taxes are paid until money is taken out at or near retirement age. This can be a huge amount of saved money especially for our young physicians in savings mode. We hope to progress this concept, as does Delegate O'Bannon, to all Medicaid providers. We'll keep pushing.

Though more indirectly related to pediatrics, Medicaid expansion and insurance exchanges are getting the vast majority of political press in Richmond and nationwide this year. Recent studies make it appear that only 6% of children will be involved in either program as over 90% already are insured privately or through Medicaid. However, the political tone has important implications where Virginia goes in the next election cycle.

A very important issue at the federal level is the continuation of Medicaid/Medicare equilibration payments that are supposed to end in 2014. It is an important note that a one year continuation is now in the Obama budget. Let's hope it stays there and passes.

The Chapter remains active with partnerships with non-profit organizations such as the Virginia Chamber of Commerce (childhood health and school preparation), VECF (The Virginia Early Childhood Foundation, a strong proponent for early childhood education), The Virginia Foundation for Healthy Youth (dealing with tobacco cessation and childhood obesity), Reach Out and Read, Voices for Children Foundation (many aspects of childhood health with a recent focus on Mental Health). We contribute both financially and in-kind to these groups and others.

We entertained Dr. Sandra Hassink, The President Elect of the AAP, at our annual retreat "think tank" this past March. She was very informative as we discussed the

future trends of pediatrics and National's Strategic Planning. We have been fortunate that for the past two years we have been able to have both Presidents Elect visit us for a retreat. Last year of course was Dr. James Perrin, the current President. Also, we sponsored Dr. Andrew Garner, pediatrician and neurophysiologist, from Rainbow Children's Hospital for an extremely well received and erudite discussion on pediatric neurodevelopment and the effects of toxic stress. Andrew also is Vice President of the Ohio Chapter of the AAP. We continue to do our best to sponsor popular speakers from around the country.

We continue to keep close ties with our academic centers with our discounted CME programs. It has become a tradition in Virginia to offer discounts to Chapter members at the Birdsong, Peds at the Beach, INOVA, Williamsburg, and other smaller conferences such as on Breastfeeding, Sports Medicine, and Vaccines. Watch Member Alert for available discounts and curriculum at these conferences. Of special note is our planning of an Annual Meeting of the Chapter in Richmond next spring. It will be a rather unique selection of CME and also we plan discussion groups regarding the business aspects of pediatrics. The Annual Meeting was discontinued many years ago, but we believe it's time for a revival. We are also considering the Chapter developing MOC that could be as universal an appeal as possible for both the generalists and sub-specialists.

The Pediatric Council has been very active this year especially with Anthem Medicaid programs. There have been numerous complaints generally related to poor communication issues regarding payments, or lack thereof. There has also been a recent difficulty with defining the Washington Metropolitan Area as an area that receives

... continued from page 2

increased payment for services under the RVU system defining geographic location. Our Pediatric Council has been extremely active with Anthem recently and also with private insurers.

We sent our Chapter Officers to the ALF (Annual Leadership Forum) this year as always. There were six representatives, mostly voting, on resolutions regarding future AAP policy. The details can be found on the AAP website. It was an interesting mix of topics ranging from practice administration, health care, human trafficking, pharmaceuticals, etc. with over 50 resolutions passed with a noted Top Ten that must be reviewed and opinion given by the Executive Board of the AAP. It has always interested me how all states have so many similar problems, but also have unique issues that eventually may become universal. A good example this year is the legalization of marijuana in Colorado, and ER visits by kids who ate the "Pot Tarts", lollipops, and "Weedies" by accident. Google "marijuana candy" it's an eye opener!

Thanks so much to all my colleagues who make my job possible. It really takes a very activist Board and other volunteers to make the Chapter run properly. This will be my last newsletter article as President, and Barbara Kahler, our VP, is ready, willing, and very able to be taking office July 1<sup>st</sup>. I'll probably have one significant communication in June by Member Alert as a farewell message as I stay on board the Executive Committee as Immediate Past President.

Sincerely,



Twitter: @DrBiffRees



## Dates to Remember ...

### Virginia Maternity Care Quality Improvement Collaborative

Friday, May 16<sup>th</sup>, 2014 | 8:30 a.m. – 3:30 p.m.

Richmond Marriott West

*Register:* <https://www.eventbrite.com/e/virginia-maternity-care-quality-improvement-collaborative-tickets-10972823009>

*To reserve your room, please use this link:* [http://www.marriott.com/meeting-event-hotels/group-corporate-travel/groupCorp.mi?resLinkData=Virginia%20Department%20of%20Health%5Ericmw%60VDPVDP%A%6083.00%60USD%60false%605/15/14%605/16/14%604/25/14&app=resvlink&stop\\_mobi=yes](http://www.marriott.com/meeting-event-hotels/group-corporate-travel/groupCorp.mi?resLinkData=Virginia%20Department%20of%20Health%5Ericmw%60VDPVDP%A%6083.00%60USD%60false%605/15/14%605/16/14%604/25/14&app=resvlink&stop_mobi=yes)

Rooms will only be blocked until April 25<sup>th</sup>, 2014

### 8<sup>th</sup> Annual Pediatric and Adolescent Sports Medicine

#### Update for Primary Care for 2014

Thursday, June 19<sup>th</sup>, 2014 | 8:00 a.m. – 4:00 p.m.

CHKD/SNGH Brickhouse Auditorium

Children's Hospital of the King's Daughters | Norfolk, Virginia

Contact Rosalind Whitaker [Rosalind.whitaker@chkd.org](mailto:Rosalind.whitaker@chkd.org) for more information

### 35<sup>th</sup> Annual Pediatric Primary Care Conference

#### "Pediatrics at the Beach"

July 18<sup>th</sup> – 20<sup>th</sup>, 2014

Wyndham Virginia Beach Oceanfront Hotel | Virginia Beach, Virginia

Email: [cmeinfo@vcu.edu](mailto:cmeinfo@vcu.edu) for more information

### The Donald W. Lewis Pediatric Update 2014

September 19<sup>th</sup> – 21<sup>st</sup>, 2014

Williamsburg Lodge | Williamsburg, Virginia

Register online at [www.chkd.org/cme](http://www.chkd.org/cme)

[www.virginiapediatrics.org](http://www.virginiapediatrics.org)

## AAP Tobacco Study Now Recruiting!

The AAP Julius B. Richmond Center of Excellence is seeking primary care practitioners to join the Changing Pediatric Office Systems Nationally to Address Parental Tobacco Use (CEASE) research study. CEASE aims to improve the quality of care in pediatric practice by training clinicians to systematically address tobacco use with families and reduce children's exposure to secondhand smoke. CEASE is seeking primary care practices with:

- At least 4 FTE pediatricians who see patients for clinical visits
- An average patient flow of 50 families per day
- An adult population smoking rate of at least 15%

CEASE practices will participate in the study for two years. Over the course of their involvement, practices will be asked to temporarily incorporate a research assistant into their office (hired, paid and trained by the study team). If you would like more information about CEASE, please contact Liz Katta, MPH, Research Assistant at (847) 434-7164 or [ekatta@aap.org](mailto:ekatta@aap.org).

Like many people with other chronic diseases, especially those caused or exacerbated by lifestyle/behaviors, not everyone who smokes/uses tobacco is gung-ho about doing the hard work required to change. Sometimes they need our help to motivate them and increase their interest in and willingness to give it a try. That's not easy to do but there are quite a lot of resources available to assist you in learning how. Here are a few brief (and free) videos you might find useful:

- **Motivating Patients to Change Behavior (2008):** This 11 minute video from the American Medical Association defines principles of motivational interviewing and explains how motivational interviewing is different from traditional clinician-patient interactions. It provides examples of how clinicians may ask questions to help motivate patients to engage in behavior change. [http://www.ora.gov/ahrq/sms\\_training\\_clinician\\_02.asp?p=sms\\_home](http://www.ora.gov/ahrq/sms_training_clinician_02.asp?p=sms_home)
- **The Effective Physician (2009):** Demonstration of the motivational interviewing approach in a brief medical encounter (6.33

minutes). Produced by University of Florida Department of Psychiatry. Funded by Flight Attendant Medical Research Institute Grant #63504 (Co-PIs: Gold & Merlo). <http://www.youtube.com/watch?v=URIKA7CKtfc>

- **Motivational Interviewing: Evoking Commitment to Change (2009):** In this video clip, the Physician works together with the patient to develop a specific focus. The provider does this by asking open-ended questions, providing affirmation, using reflective listening and summarizing for the patients (OARS). He also helps the patient to scale the importance of the issue and the patients confidence level for change behavior (6.35 minutes). <http://www.youtube.com/watch?v=dm-rJJPCuTE>

Here are a few archived webinar presentations on e-cigarettes are available from the Tobacco-Related Disease Research Program (no cost to access to listen to any/all of them).

Go to <http://www.trdrp.org/event-link.php> or click the topic-specific presentations below:

Introduction by Phil Gardiner: Electronic Cigarettes: The Vapor This Time?  
<http://lecture.ucsf.edu/ETS/Play/8c3a1b0bc89b4fff896ee6e25d36bd961d>

Monique Williams: E-Cigarette Liquids and Vapors: Is it Harmless Water Vapor?  
<http://lecture.ucsf.edu/ETS/Play/005db638e1024d74ad1b4ab0adfca5dd1d>

Prudence Talbot: Electronic Cigarettes: How Will They Impact Human Health?  
<http://lecture.ucsf.edu/ETS/Play/b14229722f8941f68d4ac621c36fd93e1d>

Natalie Walker: E-Cigarettes: A 21st Century Cessation Device?; A Review of the Literature <http://lecture.ucsf.edu/ETS/Play/65add3d0fc944486acca56d0964d7b3c1d>

Jean-François Etter: The Profile of Vapers and How E-Cigarettes Should be Regulated  
<http://lecture.ucsf.edu/ETS/Play/f8e41c8c0f1048fbb43c89953dc286721d>

Stanton Glantz (Discussant): E-Cigarettes: Where are We; Where Should We Go? and Question and Answer session <https://vimeo.com/76543477>

More info: page 5...

[www.virginiapediatrics.org](http://www.virginiapediatrics.org)

## 2014 Pediatric General Assembly Day

The Pediatric Day at the General Assembly began 7 years ago with only 23 participants, but has grown steadily every year. One of the main goals is to provide hands-on advocacy training and experience to pediatric residents, fellows, and other child advocates in order to make sure that legislators are well-informed about important child health issues. We bring together seasoned advocates and those who are just beginning their careers, providing the support and experience of someone who has been there and can mentor and lead the way in this territory so unfamiliar to most. It is sponsored by the Virginia Chapter, AAP and the Medical Society of Virginia. The Virginia Chapter hopes to have many more members join us next year as we continue to promote the profession of pediatrics and further benefit the children we serve!



Virginia Chapter President William "Biff" Rees, MD Invited the newly elected Lt. Governor (and Fellow member of the VA-AAP) Ralph Northam to speak at the 2014 Pediatric General Assembly Day.



Lt. Governor Northam also answered questions from Dr. Diane Pappas, VA-AAP Advocacy Chairperson and other White Coat Day attendees.



Best Abstract in Breastfeeding Advocacy and Education African-American Women's Perceptions of Breastfeeding Over the Years Natasha K. Sriraman, MD, MPH, IBCLC, FAAP (Pictured to the right); Shalantae Hawkins, BS; Melodie Harrison, MD; Amy Perkins, BS, MS, Department of Pediatrics, Children's Hospital of The King's Daughters

## Recruiting Pediatric Practitioners to Participate in a Parent Smoking Cessation Study

<b>What:</b>	<p>You are invited to participate in a novel project from the American Academy of Pediatrics: Changing Pediatric Office Systems Nationally to Address Parental Tobacco Use (CEASE).</p> <p>CEASE is a research study that aims to improve the quality of care in pediatric practice, specifically related to tobacco cessation in adults.</p>
<b>Eligibility :</b>	<p>Pediatric Care practices with:</p> <ul style="list-style-type: none"> <li>• At least 4 FTE pediatricians who see patients for clinical visits</li> <li>• An average patient flow of 50 families per day/2000 families</li> <li>• An adult population smoking rate of at least 15%</li> </ul>
<b>Why:</b>	<p>CEASE:</p> <ul style="list-style-type: none"> <li>• Works to improve the quality of care in pediatric practice</li> <li>• Is easy to incorporate into busy offices</li> </ul>
<b>Where:</b>	In your office! CEASE can be tailored to fit your practice with minimal impact on patient flow
<b>How:</b>	<ul style="list-style-type: none"> <li>• Contact Liz Katta, MPH, Research Assistant at 1-800/433-9016, ext 7164 or <a href="mailto:ekatta@aap.org">ekatta@aap.org</a>.</li> <li>• Support is provided from a grant from the National Cancer Institute</li> </ul> <p>Need more information? Please visit our website for full study details:  <a href="http://www.aap.org/richmondcenter/cease.html">http://www.aap.org/richmondcenter/cease.html</a></p>

### Study Aims

The specific aims of CEASE are to:

- Implement and sustain adherence to tobacco-control guidelines in the clinical setting
- Facilitate behavior change among parents and evaluate cost per quit among parents who smoke
- Study systems changes and the processes that affect them at the practice level

### Protocol Overview

Participating practices will be assigned to one of three groups:

- CEASE intervention
- Control
- Replacement

We will ask participating **practices** in the intervention and control groups to:

- Host a Research Assistant to enroll 200 parents (current smokers and recent quitters)
  - All study materials are provided to your practice by the study team
  - Enrollment time is driven by patient volume

We will ask participating **practitioners** to:

- Learn the training materials
- Complete the online Quality Improvement module
- Use the training with their patients' parents
- Provide feedback throughout the study

We will ask participating **parents** to:

- Answer survey questions about their health and smoking behaviors at the time of their visit



*If you have questions or would like more information about CEASE, you can contact Liz Katta, MPH, Research Assistant at 1-800/433-9016, ext 7164 or [ekatta@aap.org](mailto:ekatta@aap.org).*

**CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS AND THE AMERICAN ACADEMY OF PEDIATRICS, VIRGINIA CHAPTER**

*Present*

**VIRGINIA PEDIATRICS NEWSLETTER  
American Academy of Pediatrics – Virginia Chapter**

Continuing Medical Education

This activity has been planned and implemented in accordance with the Essential Areas and policies of Medical Society of Virginia through the joint sponsorship of Children's Hospital of The King's Daughters and the American Academy of Pediatrics – Virginia Chapter.

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**How to Obtain Credit:**

Review the articles on pages 7 - 11. Complete the VA-AAP Newsletter Registration and Evaluation Form on page 12 and return to the Children's Hospital of The King's Daughters, CME Office, 601 Children's Lane, Norfolk, VA 23507 or 757-668-7122. You may also visit <https://www.surveymonkey.com/s/VAAAPSpring2014> and complete online. Please allow 6-8 weeks to receive your certificate.

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## A General Approach to Non-traumatic Joint Effusions

Bitu Arabshahi, MD, FAAP  
Chief, Section of Pediatric  
Inova Children's Hospital

**Objective:** Explain the differential diagnosis of non-traumatic effusions in children, plan appropriate work up and identify what to refer to specialist.

**ACGME Competencies:** Patient Care and Medical Knowledge

A joint effusion is the most specific sign of joint inflammation and, if untreated, often leads to irreversible joint damage. In absence of trauma, careful clinical assessment is necessary to determine if the patient has an acute infectious disorder or an exacerbation or presentation of a chronic disorder. Acute joint effusions are defined as those lasting less than 6 weeks, while chronic joint effusions persist over 6 weeks despite conservative treatment.

Acute non-traumatic joint effusions are most often seen with infectious or post-infectious diseases. Common infections include streptococcal, staphylococcal, and gonococcal septic arthritis, Lyme disease, and osteomyelitis. The latter two can also take on a chronic course. Post-infectious reactive inflammatory conditions such as acute rheumatic fever or enteric infections with Salmonella, Shigella, or Campylobacter can also cause joint effusions.

By contrast, chronic joint effusions are often the result of a rheumatologic or neoplastic process. These may include Juvenile Idiopathic Arthritis, Juvenile Dermatomyositis, Lupus, Sarcoidosis, vasculitic syndromes or periodic fever syndromes. Malignancies such as leukemia, osteosarcoma or neuroblastoma can also present with chronic joint pain and effusions.

### Clues to diagnosis:

Important elements in history and physical examination include demographic information such as sex, age and race, duration and pattern of disease, and presence or absence of symptoms such as warmth, redness and pain.

The presence of a chronic swollen knee in a 2 year old white girl may be consistent with Juvenile Idiopathic Arthritis (JIA) while the same presentation in a black female would make one concerned about Sarcoidosis or Lupus. A migratory pattern to joint pain

or effusions is generally only seen in Lyme disease, post-streptococcal reactive arthritis, Acute Rheumatic fever, or paraneoplastic conditions. The presence of warmth and redness helps differentiate septic arthritis from other causes of joint effusion. With the exception of streptococcal-related reactive arthritis or acute rheumatic fever, warmth and redness do not accompany joint effusions of rheumatic, reactive or neoplastic origin. Painful arthritis is an important hallmark of most infectious and malignant joint effusions. Joint effusions of rheumatic origin tend to be less painful. In fact, 25% of JIA cases are completely painless and only detected incidentally based on gait changes or inspection.

### Diagnostic Testing:

Analysis of the synovial fluid can often differentiate between infectious and non-infectious causes of joint swelling, although arthroscopy should only be performed if one suspects infection based on fever, leukocytosis, or elevations in serum CRP levels. A synovial White Blood Cell (WBC) count greater than 50,000 per mm<sup>3</sup> can be suggestive of infection while synovial WBC counts of 2000-50,000 per mm<sup>3</sup> tend to suggest an inflammatory orthopedic or rheumatologic process. Plain radiographs can be used to rule out bony tumors or erosions. MRI with contrast is often helpful in ruling out mechanical abnormalities such as disoid meniscus or ligamentous tears, versus a primary synovial process such as arthritis or pigmented villonodular synovitis.

Evaluation of the serum is not particularly helpful in differentiating causes of joint effusion. An elevated erythrocyte sedimentation rate (ESR) would be expected for all inflammatory conditions, but a very high ESR in the setting of low to normal platelets should raise concern for leukemia. Rheumatoid Factor is almost always negative in children and Anti Nuclear Antibodies (ANA)

are very non-specific unless one is suspecting lupus. It is important to remember that about 15-20% of the population has a positive ANA in absence of any rheumatic disease, and ANA levels can fluctuate over time. ANA is most commonly used by rheumatologist to help diagnose lupus and to determine the uveitis risk in children with known JIA. Therefore, its use as a general screening lab for rheumatic disease is of limited benefit.

### Treatment:

Septic joints often respond well to appropriate anti-microbial or anti-fungal treatment. One should keep in mind the possibility of osteomyelitis or Lyme disease which would require a longer duration of treatment. With the exception of streptococcal-related reactive arthritis which should warrant referral to a rheumatologist, other forms of reactive arthritis tend to get better over time with the use of a non-steroidal anti-inflammatory drug such as Naproxyn. Any joint effusion lasting greater than 6 weeks warrants referral to a pediatric rheumatologist for appropriate evaluation and treatment. It is important to avoid the use of steroids in treatment of joint effusions unless the possibility of malignancy has been ruled-out.

### Suggested Readings:

1. Malleson PN, Mackinnon MJ, and Sailer-Hoek M. What to do with a positive ANA test. *Pediatric Rheumatology Online Journal*, May 2004, Vol 2(3), pp. 295-305.
2. Johnson MW. Acute Knee effusions: A systematic approach to diagnosis. *American Family Physician*, 2000, Vol 61(8), pp 22391-400.
3. Cron RQ. Current treatment for chronic arthritis in childhood. *Current Opinions in Pediatrics*, 2002, Vol 14, pp 684-687.



## Are You a Physician Leader?

Leon E. Moores, MD  
 Director Pediatric Neurosciences, IWS  
 Inova Children's Hospital



**Objective:** Explain the significance of competent physician leadership at the provider level.  
**ACGME Competencies:** Patient Care, Practice-based Learning and Improvement, Professionalism, Interpersonal Communications Skills and System-based Practice.

I would like to suggest that you are, regardless of your job title.

A quick search for physician leadership yields thousands of articles, courses, and associations. There is widespread recognition that physicians bring something of great value to the board room as well as to the operating room. In fact, many healthcare organizations are developing leadership programs for their midcareer physicians to prepare them to assume recognized leadership positions years later.

However, I believe we have “misdiagnosed” physician leadership, resulting in a missed opportunity to substantially improve healthcare. We have misdiagnosed physician leadership because the aperture of our definition is too narrow. When we think of “physician leaders” engaging in “physician leadership” we envision service chiefs, department chairs, chief medical officers, and CEOs - and we fail to recognize that *all physicians lead*.

Leadership is the process of using acquired knowledge, skills, and attitudes to influence individuals or groups to achieve a desired result. If we agree that is a reasonable definition, it becomes clear that nearly all physicians lead every day. Each time you attempt to influence a patient to stop smoking or lose weight you are engaged in a leadership event. When you run a code in the ICU you are leading a high-performing team in a crisis situation with life itself at stake. A brief conversation with a clinic staff member in an attempt to improve patient flow requires that you use your leadership skills.

By virtue of our degree, credentialing, and legal authority we are placed in leadership positions from the day we first put on the long white coat. Leading does not imply barking orders, nor does it require a business card with a defined title. The intern on the ward who is trying to get the on-call

radiology technician to expedite a CT scan is leading. The brand-new attending surgeon is exercising physician leadership from the moment she walks into the OR, and the performance of the operative team can be profoundly affected, for better or worse, by the leadership skills of that surgeon.

This is an important concept for you, your hospital, and your patients because skilled leaders can have an enormous positive impact on organizational performance. Unfortunately, the converse is also true. Many human factors within our hospitals (individual performance, team morale, patient safety, patient and staff satisfaction, employee turnover) are influenced by the “everyday” physician leader’s communication skills, professional and collaborative personal presence, ability to motivate others to perform at their highest level, sensitivity to the culture of the hospital, teamwork, and understanding of the capabilities and limitations of the system in which they work.

We face two major challenges. First, it is very difficult to be an effective leader if you don’t recognize that you are, in fact, leading. Our cultural and semantic norms described above which define physician leadership starting at clinic chief or higher create this professional blind spot. The second challenge, tied to the first, is that the vast majority of physicians receive little or no formal training in the theory and practice of leadership. While various medical school and residency curricula include communication skills, professionalism, cultural sensitivity, and others, these skills are not taught within a cohesive framework of leadership education which builds throughout one’s career similar to the way we teach medical knowledge or technical skills.

The result for the physician is a level of discomfort and stress when placed in high-stakes leadership roles without the requisite education and experience. Based on my

observations over several decades I am convinced that much disruptive physician behavior is due to this lack of preparation - and that similar disruptive behaviors might occur if a physician were put into a cardiac cath lab and told to perform a complex procedure with no education, training, or experience. While the latter is something that we would never consider doing, we routinely send physicians into complex and challenging leadership situations with no educational foundation whatsoever.

Patients and staff can experience decreased satisfaction, increased turnover, lack of organizational alignment, and barriers to improving patient safety. I suspect most of us agree that patient safety can be compromised if a physician/clinician/leader is so overbearing and unapproachable that staff are afraid to alert him to a potential error he may be about to commit. Additionally, the costs to healthcare organizations for preventable staff turnover due to difficult physician bosses is likely both underappreciated and enormous. The common phrase “people join organizations but leave bosses” is as true in healthcare as anywhere else.

It is important that we change this unrecognized drag on healthcare effectiveness.

The good news is that this misdiagnosis can be corrected, and “treatment” is available. Recognizing that you are actually leading people dozens or hundreds of times each day is the first step. Next, acknowledge that you have had little education in this area, develop a sense of urgency to change it, and begin a course of self-study. With a relatively small investment of time and money you can read, assess, and apply the lessons from numerous great books on leadership. I have provided selected readings at the end, but keep in mind there are many additional entry level references available. Read a number of these until you become more familiar with the topic and can direct your learning

continued from page 8...

toward identified gaps. If you have read them, good for you – share them with your colleagues and move on to the next paragraph!

As you explore further and experience the benefits of improving your leadership skills you may seek external evaluations of your leadership style (formal and informal), attend leadership development courses, teach your colleagues, or create entire programs at your facility to improve the leadership skills of all physicians. Taking it to this level will require a greater investment, but it almost certainly pay significant dividends.

You *are* a physician leader. What are you going to do now?

- [The Seven Habits of Highly Effective People](#) Stephen R Covey
- [Primal Leadership](#) Daniel Goleman
- [Once an Eagle](#) Anton Myrer
- [Leadership and Self-Deception](#) Arbinger Institute
- [How to Win Friends and Influence People](#) Dale Carnegie
- [The Power of Servant Leadership](#) Robert Greenleaf
- [The Speed of Trust](#) Stephen M. R. Covey
- [Endurance](#) Alfred Lansing
- [Why Hospitals Should Fly](#) John Nance
- [The First 90 Days](#) Michael Watkins
- [It's Your Ship](#) Michael Abrashoff
- [Good to Great](#) Jim Collins
- [If Disney Ran Your Hospital](#) Fred Lee




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## *Fecal Microbiota Transplantation for Children with Clostridium Difficile Infection*

Suchitra Hourigan, MD  
 Assistant Professor, adjunct Pediatric Gastroenterology  
 Johns Hopkins School of Medicine  
 Inova Children's Hospital

**Objective:** Discuss use of FMT in children. Review the risks and benefits of FMT for children with Clostridium Difficile infection  
**ACGME Competencies:** Patient Care and Medical Knowledge

### The Intestinal Microbiome

The human intestine contains at least 10<sup>14</sup> bacteria, with hundreds to thousands of different species, which exist in harmony with their host. The role of this intestinal flora, or microbiota, in maintaining the health of an individual is increasingly being appreciated.

The composition of the microbiota is significantly affected by the use of antibiotics and certain diseases, causing microbial imbalances or “dysbiosis.” Fecal microbiota transplantation (FMT) is the transfer of fecal matter and its associated microbiome from a “healthy” individual to a recipient, to correct the dysbiosis and restore balance.

### Why FMT for Clostridium difficile Infection?

*Clostridium difficile* infection is the leading cause of hospital-acquired diarrhea in the U.S. and can cause significant morbidity and even be life-threatening, with the Center for Disease Control and Prevention (CDC) reporting 14,000 *Clostridium difficile*-related

deaths each year and increasing numbers of cases reported in children.

It is associated with the use of antibiotics, which can lead to dysbiosis that predisposes the host to *Clostridium difficile* infection. The number of cases over the last 20 years has more than doubled with increasing severity and resistance to standard therapy.

*Clostridium difficile* infection is generally treated with antibiotics such as metronidazole and vancomycin, which are effective against the bacterium but do not address the underlying dysbiosis which predisposes to the condition. Therefore recurrence of *Clostridium difficile* infection is high, with up to a 10-20% recurrence rate after initial antibiotic therapy and up to 40-65% in patients who are retreated for a second episode.

FMT has been successfully used to treat recurrent *Clostridium difficile* infection, with the rationale that reintroduction of normal

gut flora corrects the dysbiosis that can predispose to a recurrence of *Clostridium difficile* infection.

From combined analysis of all patient reports of FMT for recurrent *Clostridium difficile* infection in the literature, the effectiveness for cure is over 90%. Moreover, the first randomized controlled trial for FMT for this purpose was published this year and showed that FMT was significantly more effective than a standard antibiotic course of vancomycin for the treatment of recurrent *Clostridium difficile* associated diarrhea.

**We now offer FMT treatments for children suffering with recurrent *Clostridium difficile* infection at INOVA Fairfax Children's hospital. We are also conducting research examining the changes in bacteria that occur during the procedure to try and improve therapy for *Clostridium difficile* in the future for children.**

## Genomic Research and Medical Genomics at the Inova Translational Medicine Institute

**Benjamin D. Solomon, MD**

*Chief, Medical Genomics,  
Inova Translational Medicine Institute and  
Inova Children's Hospital*

**Objective:** Describe the use of current genomic technologies to investigate the molecular underpinnings of human health. Review the best practices for the integration of genetic data into healthcare.

**ACGME Competencies:** Patient Care and Medical Knowledge

Recent technological advances have made genomic sequencing more affordable, efficient, and available. The primary use of genomic sequencing to date has been to investigate the cause of a patient's (often rare and/or severe) medical condition, and has frequently taken place in a traditional research setting. Currently, genomic techniques are transitioning to questions related to more common medical disorders, and are starting to be explored in the general practice of prospective healthcare. However, to date, many of the challenging and important questions related to the implementation and effects of large-scale genomic sequencing in healthcare have been approached in a largely theoretical manner.

To address these questions and to harness the power and potential of medical genomics in both research and clinical arenas, the Inova Translational Medicine Institute (ITMI) has been built and developed within the Inova Health system. ITMI focuses on high-throughput genomic research and applications of medical genomics relevant to many areas of medical practice, including both general and subspecialty care, and aims to establish "best practices" in the rapidly growing field of genomic medicine. Many of the studies concentrate on pediatric patients and conditions. ITMI was started by the former head of the National Cancer Institute, Dr. John E. Niederhuber, MD, and is also led by Dr. Joe Vockley, PhD, Chief Scientific Officer, a scientist with extensive expertise and leadership in clinical and translational genomic investigations.

ITMI has initiated some of the world's largest genomic research projects to date, and has established a genomic repository that is rapidly building to tens of thousands of whole genome sequences, allowing the necessary statistical power to analyze complex

patterns of genomic variants in concert with other health-related factors. ITMI projects investigate the molecular underpinnings of both rare and common disorders, including preterm birth, birth defects, diabetes mellitus, immunologic disorders, and cancer. These studies employ cutting-edge genomic technologies through a trio-based (child and both parents) approach, using whole-genome sequencing and RNA, protein-based, and epigenetic investigations coupled with robust and sophisticated integration of personal medical and family history and environmental analyses. The enormous



amount of data generated is unified in a single cloud-based system (which includes both data storage and all analysis) that, in addition to all genomic and related biological data, captures all information through a single electronic health record system, supplemented by study-specific patient data.

In addition to condition-specific studies, ITMI is approximately one year into the largest longitudinal whole-genome (and transcriptome/proteome/epigenetic -based studies) research project, which involves

pediatric patients ascertained prenatally through a number of obstetric practices and clinics within the Inova Health System. This study presages what is widely anticipated to become commonplace medical practice in the relatively near future. This project has a current accrual of approximately 1,200 families out of an eventual goal of 5,000 trio-based families (sequencing of other family members is also conducted); the study enrolls 80- 100 new families per month. After enrollment, all participants are followed longitudinally (which will continue into adulthood) in order to investigate

the causes of a variety of pediatric and other medical conditions, as well as to determine best practices for prospective genomic medicine. Through the study, novel tools and mechanisms to analyze genomic data and deliver genomic healthcare are developed in order to optimize benefits and minimize risks and burdens to patients, practitioners, and the healthcare system. To address the needs of our study as well as to provide the required genomic services for the greater healthcare system, ITMI is building a dedicated genomics service (led by Dr. Benjamin D.

Solomon, MD) consisting of board-certified clinical geneticists, molecular geneticists, and genetic counselors.

Studies of this magnitude require enormous funding and logistic support, which would not be feasible even through the most generous of standard grant mechanisms. Inova Health System supports the long-term ITMI genomic endeavors in order to take advantage of modern genomic technologies and to determine optimal ways to deliver the best and latest healthcare to its patients and participants.

# VA-AAP NEWSLETTER REGISTRATION AND EVALUATION FORM

(Spring 2014)

You have the opportunity to claim up to .50 AMA PRA Category 1 Credit(s)™.

To claim CME credit, please complete the survey below.

NAME: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

For this activity, how many hours of CME are you claiming? \_\_\_\_\_ (Max. \_\_\_\_ hours)

As a result of reading the articles, will you make any changes in your practice?  Yes  No

Please list up to 3 strategies that you plan to implement as a result of reading the articles? (answer required for credit)

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

If you will not make any practice changes, did this activity reinforce your current practice of pediatrics?

Please explain:

How could this activity be improved?

Future Topic Requests (optional):

	Excellent		Average		Poor
Overall, how would you rate this activity?	5	4	3	2	1

This CME activity will expire on May 31<sup>st</sup>, 2015.

Please send form to: Rosalind Jenkins, c/o CHKD, 601 Children's Lane, Norfolk, VA 23507

Please allow up to 8 weeks to receive your certificate.

## *Children's National and Inova Health System Collaborate to Address Pediatric Specialty Care Shortage*

Ian Leibowitz, MD

*Associate Professor, Division of Endocrinology & Metabolism*

Jeffrey Hanway, MD

*Chief Medical Officer for Surgical Services  
Pediatric Specialists of Virginia*

Disparities in access to pediatric specialists continue to challenge not only pediatric specialists, but referring physicians and families in need of care. Every child who needs specialized pediatric care deserves access to necessary providers and resources, yet a nation-wide shortage of pediatric specialists has limited access for many families.

The Commonwealth of Virginia has been disproportionately affected by this lack of access. On average, families face wait times longer than five weeks and often have to drive more than 40 miles simply for their child to receive the pediatric specialist care they need. This places an undue burden on families, particularly those of limited means.

Recognizing the urgent need for pediatric specialist care in Virginia, Children's National and Inova have created an innovative partnership to address the shortage: Pediatric Specialists of Virginia (PSV). PSV began operations on September 30, 2013, providing local access to much needed, high-quality pediatric specialist care including the best physicians and resources Children's and

Inova have to offer.

PSV provides families with patient-centric and physician-led care, and supports both the patient and their family through the child's diagnosis and treatment. The partnership enables physicians to provide truly integrated care for their patients across multiple specialties, improving both quality of care and outcomes.

PSV currently employs 32 providers in seven locations across five pediatric specialties: Gastroenterology, nephrology, genetics, hematology/oncology and orthopedics. PSV will add an ambulatory surgery center to the practice this May in Fairfax, and plans are currently underway to add additional specialties this summer.

PSV is led by two Chief Medical Officers: Ian Leibowitz, MD, Chief Medical Officer for Medical Services, and Jeffrey Hanway, MD, Chief Medical Officer for Surgical Services. Both CMOs bring a wealth of experience to their roles at PSV. Dr. Leibowitz has been a practicing Pediatric Gastroenterologist for

more than 25 years and has been the Director of Inova's Pediatric Digestive Diseases Center for seven years. Dr. Hanway has served patients in the Northern Virginia area for 19 years and is also the Associate Chief of the Division of Orthopaedic Surgery and Sports Medicine at Children's National.

Doctors Leibowitz and Hanway are joined by Chief Operating Officer, Gregg R. Florentin. Loring Flint, MD, Inova's Chief Medical Officer, and David Wessel, MD, Executive Vice President and Chief Medical Officer for Hospital and Specialty Services, Children's National, who serve as CEOs.

Physicians at PSV are credentialed with both Children's National and Inova, providing access to previously unavailable resources. PSV physicians receive benefits for continuing medical education which is critical to improving patient care and outcomes. Headquartered in Fairfax, Virginia, PSV also has locations in Falls Church, Leesburg and Manassas, Virginia, as well as an office in Rockville, Maryland.



## *Switched at Birth: A Congenital Heart Patient's Story*

Lucas R. Collazo, MD

*Associate Director Pediatric Cardiac Surgery*

*Inova Children's Hospital*

Kim Zimmerman and Kamal Faour were joyfully expecting the arrival of their first child when their world turned upside down. A routine sonogram revealed the baby had transposition of the great arteries (TGA) – a rare and complex congenital heart defect in which the aorta and pulmonary artery are reversed. The infant would need open heart surgery at birth.

Kim and Kamal were in shock. “Everything had been going so well. It was the easiest pregnancy imaginable. To get this news just a few weeks before delivery was awful,” Kim says.

The couple had planned to give birth at Inova Women's Hospital. They'd toured the birthing center and attended childbirth classes. Kamal's two daughters had been born there. Would it be possible now, they wondered? The answer was a resounding yes.

They met with patient navigator Kelly Gallo and pediatric surgeon Lucas Collazo, MD, who reassured them that Inova's unique, comprehensive Fetal Care Program would provide everything they'd need under one roof. From prenatal consultation, high-risk pregnancy expertise and delivery at Inova Women's Hospital to advanced pediatric care and surgery at Inova Children's Hospital, the program ensures that families stay close during this critical time. In fact, it is the only program in the Washington, DC, region where mother and baby are cared for in the same place.

This was all Kim and Kamal needed to hear. What began as a world of frightening unknowns soon became a source of comfort and hope. “Kelly and Dr. Collazo were so encouraging and explained everything so well,” Kim says. “We were happy and relieved to know we could stay at Inova. It was the best place for our baby to be born.”





## Pros Pearls

### PROS Clinical Effort Against Secondhand Smoke Exposure (CEASE) Study

#### The Clinical Effort Against Secondhand Smoke Exposure (CEASE) Intervention: A Decade of Lessons Learned.

- The purpose of this article was to describe lessons learned in developing the CEASE tobacco control intervention.
- The CEASE program trains pediatricians and office staff to systematically provide cessation counseling and interventions to parents and other adults who smoke. Clinicians intervene with smoking families using a streamlined, 3-step version of the traditional 5-step approach (Ask, Advise, Assess, Assist, Arrange) recommended in the US Public Health Service guideline.
- The CEASE module includes tools to both change the pediatric health care office infrastructure and to facilitate pediatric health care providers' delivery of counseling, medications, and referral for tobacco cessation. These tools are a training manual and video, an implementation guide to use in structuring office responsibilities for accomplishing each stage of the CEASE intervention, posters for the office, and handouts for the parents that reinforce the importance of smoke-free families to children's current and future health and the availability of resources for quitting.
- Lessons learned included: 1) If you are developing an intervention, use several different perspectives when developing and implementing a practice change program, such as a programmatic perspective (focusing on sustaining the program), a practice perspective (focusing on the needs of the practice), or a patient perspective (focusing on the needs of the patient). Each one can enhance value and impact of the program; 2) simplify the intervention as much as possible; 3) be flexible and willing to learn from everybody, sometimes "non-experts," such as patients, parents, or administrators, can be the most authentic and useful collaborators; and 4) use inexpensive materials to conserve resources and enhance your ability to widely distribute them.

These preliminary findings are from the AAP's practice-based research network - Pediatric Research in Office Settings (PROS). Funding for the Clinical Effort Against Secondhand Smoke Exposure (CEASE) Study was received from the National Institutes of Health NCI (R01-CA127127), the National Institute on Drug Abuse, and the Agency for Healthcare Research and Quality. This study was also partially supported by a grant from the Flight Attendant Medical Research Institute to the AAP Julius B. Richmond Center, and the Pediatric Research in Office Settings (PROS) Network, which receives core funding from the HRSA MCHB (HRSA 5-UA6-10-001UA6MC15585) and the AAP.

The following article based on study results appeared in the *Journal of Clinical Outcomes Management*:

Winickoff JP, Hipple B, Drehmer J, Nabi E, Hall N, Ossip DJ, Friebely J. The Clinical Effort Against Secondhand Smoke Exposure (CEASE) Intervention: A Decade of Lessons Learned. *Journal of Clinical Outcomes Management*. 2012; 19(9): 414-419.





## **PROS Clinical Effort Against Secondhand Smoke Exposure (CEASE) Study Implementation of a Parental Tobacco Control Intervention in Pediatric Practice**

- This was a cluster randomized controlled trial of 20 pediatric practices in 16 states that received either CEASE intervention or usual care. The intervention gave practices training and materials to change their care delivery systems to provide evidence-based assistance to parents who smoke. This assistance included motivational messaging; proactive referral to quitlines; and pharmacologic treatment of tobacco dependence. The primary outcome, assessed at an exit interview after an office visit, was provision of meaningful tobacco control assistance, defined as counseling beyond simple advice (discussing various strategies to quit smoking), prescription of medication, or referral to the state quitline, at that office visit.

- Thirty-two RAs screened 8,598 parents exiting the intervention practices and 10,009 parents exiting the control practices. Self-reported smoking rates were 20% in the intervention and 17% in the control condition, respectively. Among 18,607 parents screened after their child's office visit between June 2009 and March 2011, 3228 were eligible smokers and 1980 enrolled (999 in 10 intervention practices and 981 in 10 control practices).

- Practices' mean rate of delivering meaningful assistance for parental cigarette smoking was 42.5% (range 34%–66%) in the intervention group and 3.5% (range 0%–8%) in the control group ( $P < .0001$ ).

- The intervention group, compared with control group, had a higher rate of providing counseling beyond simple advice by discussing various methods and strategies to quit smoking (24% vs 2%,  $P \leq .001$ ), prescribing nicotine replacement medication (12% vs 0%,  $P \leq .001$ ), and enrolling parents in the quitline (10% vs 0%,  $P \leq .001$ ).

- This study demonstrates that an intervention, including routine screening for parents who smoke, NRT medication prescription for parents, and enrollment in free state tobacco quitlines, can be implemented as part of routine child health care outpatient practice nationally. The findings suggest that a system-level intervention implemented in 20 outpatient pediatric practices led to 12-fold higher rates of delivering tobacco control assistance to parents in the context of the pediatric office visit.

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The following article based on study results appeared in the Pediatrics:

Winickoff JP, Nabi-Burza E, Chang Y, Finch S, Regan S, Wasserman M, Woo H, Ossip D, Klein J, Dempsey J, Drehmer J, Hipple B, Slora E, Weiley V, Murphy S, Rigotti N. Implementation of a Parental Tobacco Control Intervention in Pediatric Practice. *Pediatrics*. 2013; 132(1):109-117.

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