



# PEDS LINES

FALL/WINTER 2011

## Honored to Serve

by Claudia Preuschoff, MD, FAAP, Chapter President

It is with mixed feelings that I write my last "Message from the President" column. My term as President of the Missouri Chapter of the AAP ends in a few weeks. It has been such an amazing experience. I am honored to have had the opportunity to serve the thousands of member pediatricians in Missouri.

I started my presidency right at the beginning of the new and emerging H1N1 epidemic and am ending it on the heels of the Joplin tornado, which impacted so many pediatricians and patients. You will hear much more about both the impact of



**We are in the process of developing two new and exciting initiatives for Missouri.**

and response to the tornado from pediatricians directly involved in the tornado, including our AAP President Elect Dr. Robert Block, who visited the area shortly after the tornado as well as from those who participated in recovery efforts in this issue.

We are in the process of developing two new and exciting initiatives for Missouri. The first one is the Committee on Sports Medicine and Fitness, with its goal of developing a handbook for athletes, trainers, coaches, teachers, parents, and health care professionals covering some of the most common and important athletic

injury prevention and treatment strategies in children and adolescents. Topics that will be covered include concussion evaluation and management, overuse injury prevention, heat related illness prevention and management, nutrition and supplements as well as chest pain and syncope.

The other committee which is in the process of forming is in response to the AAP recommendations for routine pulse oximetry screening in the newborn nursery to evaluate each baby for cyanotic congenital heart disease. This committee will be charged with developing specific recommendations for pulse oximetry as well as the more challenging issue of appropriate follow-up. I think the biggest challenge will be making sure that each baby gets appropriate follow-up unrelated to whether they are born in a tertiary care center with pediatric cardiology support or in the smallest rural hospital.

As I finish my term as your president, I would like to thank the executive committee without whose help and hard work this job would be very difficult. Dr. Tom Tryon, as Immediate Past President, will rotate off the board of directors; Dr. Robert Steele will ascend from Secretary/Treasurer to President Elect; and Dr. Stuart Sweet will take the helm as your new President. It has been a great honor and a pleasure serving you these past two years.

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The Missouri Chapter  
of the American  
Academy of Pediatrics  
says

**THANK YOU**  
for renewing your dues  
for 2012.



# Legislative Session Just Two Months Away

by Jeffrey Howell, Dir. of Governmental Relations, Missouri State Medical Association



The 2012 legislative session, which begins January 4, will be interesting, to say the least.

Carrying over from last spring, discontent has continued between the House of

Representatives and Senate through the fall veto session and special session. There is no reason to believe it won't continue this winter, especially over such issues as job creation and the state budget. Add to this hodgepodge that it will be an election year, and it should be a fun year to watch the legislative current.

Many of the issues important to medicine that died last year will be back.

Most notably, the creation of a statewide health insurance exchange (HIX) will again be considered.

In accordance with the federal Patient Protection and Accountability Care Act, states are required to establish exchanges in an effort to reduce insurance costs and increase coverage. States that fail to enact exchanges run the risk of having the federal government step in to establish one in their stead.

Not only is there debate over whether exchanges will accomplish their stated goals, but there is also much discussion over whether having an HIX at all is the proper thing to do.

In 2010, Missouri voters overwhelmingly rebuked the federal health care law. There are certain elements in the legislature which interpret this voter mandate as a rejection of all aspects of the law, including the establishment of the HIX. It should provide for some interesting theater next year.

In the meantime, MSMA is busy working to ensure that any legislation

that establishes an HIX will be in the best interests of physicians and patients. This includes ensuring physicians are included in the HIX governance structure, exchange-sponsored plans are transparent and maintain adequate networks, and contract terms are fair to physician participants.

Although we predict the HIX will occupy much of our time, there will be other issues for us to deal with this year.

Once again, we anticipate the filing of a prompt credentialing bill, which will outline credentialing guidelines for insurers.

There will also be bills addressing mandatory parental consent for minors using tanning salons, midwifery regulations, and economic credentialing.

Of course, we'll deal with broad issues as well such as tort reforms, pharmaceuticals, scope of practice, and public health.

Contact Jeff Howell at [jhowell@msma.org](mailto:jhowell@msma.org)

## SAVE THIS DATE

# Annual Missouri AAP Pediatric Advocacy Day Wednesday, March 7, 2012 - Missouri Capitol

Join pediatricians, residents and physicians in training across Missouri to advocate for child health. This special event will focus on education and advocacy not only for legislators but also for providers. Participants in Pediatric Advocacy Day will learn about the legislative process, how to speak with legislators and advocate for children in Missouri. This event will focus on advocating for children in Missouri and educating legislators on key issues pertaining to children with the ultimate goal of giving Missouri's children a strong and united voice.

Pediatric Advocacy Day is coordinated by the Legislative Committee of the Missouri Chapter of the AAP. Please contact Dr. Sandra McKay at [Sandra.McKay@mercy.net](mailto:Sandra.McKay@mercy.net) if you have questions or are interested in participating. Stay tuned to the MoAAP website for updates!



## District VI/IX Meeting Highlights

by Johanna B. Derda, MoAAP Executive Director

It is always exciting to hear the announcement from the AAP where next year's meeting will be held. So when Anaheim was the official venue for 2011, and District IX became host to District VI, I planned to bring family and enjoy the delights of Disney, either before the meeting or after it ended. These good intensions have failed over the years, so I just concentrated on attending the meeting itself, soaking in as much as I could.

Our California hosts were gracious; all of us "Midwesterners" were treated to stimulating lectures and excellent western cuisine to keep up the stamina. The gourmet display of exotic fruits, appetizing meals, and a daily dose of freshly baked cookies seemed to immediately gather on one's waistline, reason enough to take a brisk walk once the work day ended.

A thick booklet was provided to attendees where one could find chapter successes and challenges. It's always an interesting read, and one can find out what other chapters are finding difficult, or what works and makes the chapter's efforts a success.

The sessions started off with the re-introduction of the candidates for AAP president. Missouri's own Dr. Daryl Lynch introduced the two candidates whose names by now are a household name, at least to pediatricians. Both candidates are unique in their own way; we hope you were able to cast your vote.

Our hosts planned joint sessions and separate sessions. We were updated by Mark Del Monte, JD, about current politics, and it was noted by all that the circus in Washington caused people to shake heads in disbelief and be annoyed with most of those elected to represent their constituents.

One of the more riveting sessions for me as a non-medical professional was the "Early Brain Development"

lecture by Dr. David W. Willis, as well as Dr. Wendy Sue Swanson's "Use of Social Media to Enhance Your Practice," which left attendees

**We "Midwesterners" were treated to stimulating lectures and excellent western cuisine to keep up the stamina.**

wishing for more detailed information. The lecture decidedly had a dramatic impact on how one feels about social media.

CATCH and PROS update were very informative. I had never heard the "Medical Home" and "Quality Improvement" explained with such clarity and passion. It seems to me Dr. Xavier Sevilla could make a great advocate to promote this concept wherever there is hesitancy on part of a medical office.

An exciting event which is comparable to fireworks is the presentation of special achievement awards. The Missouri Chapter received an award for organizing the Legislative Committee for Advocacy Day for residents. Dr. Molly Droge was cited for her outstanding leadership in keeping the chapter informed about health care reform and its potential impact on children. Dr. Kathryn Lynn Plax received an award for her years of service as chair of the legislative committee, keeping the chapter abreast of bills that may affect children, and advocating for all the children in the state. Dr. Kristin Sohl was recognized for her role as co-chair of the legislative committee. Congratulations to all! The Chapter appreciates everyone who is dedicated to Missouri's children.

## Next MoAAP Secretary/Treasurer Candidate Announced

Sandra McKay, MD, FAAP, is your nominee for the next MoAAP Secretary/Treasurer.

Dr. McKay is a General Pediatrician with Mercy Clinic, practicing in O'Fallon, Mo. She graduated from University of Missouri - Columbia School of



Medicine and completed her Pediatric Residency at Saint Louis University Cardinal Glennon Children's Hospital.

She joined the faculty at Saint Louis University where she focused not only on patient care but advocacy at the local, state, and national level. She implemented a revised resident advocacy curriculum, "Community Advocacy through Resident Education" which serves as the training module for all pediatric residents at SLU.

She also worked to build partnerships with local organizations in order to enhance not only resident education but also pediatric care. At Mercy, she has been active on several committees to promote advocacy and quality improvement within the Mercy System.

Dr. McKay works closely with the Maternal Child and Family Health Coalition of St. Louis in order to promote maternal and child health, along with bringing awareness of infant mortality and its consequences. She also works with the MoAAP on its Legislative Committee, helping to coordinate the Annual Advocacy Day, which brings providers together to educate legislators on a variety of topics. In her free time, she enjoys running, taekwon do, and spending time with her husband and two children.

## Awards & Honors

**Bernard A. Griesemer, MD, FAAP**, received the Thomas E. Shaffer Award given by the Council on Sports Medicine and Fitness "Recognizes lifelong contribution to the field of sports medicine." Dr. Griesemer will serve on the Missouri Chapter American Academy of Pediatrics Committee on Sports Medicine and Fitness.

**Katie Plax, MD**, Associate Professor of Pediatrics, School of Medicine, Washington University and The SPOT have received the Promising Practice Award for Promoting Adolescents' Strengths from the American Academy of Pediatrics' Adolescent Health Partnership Project. The award honors exemplary achievement on behalf of adolescents. Recipients are recognized for their innovative contributions to adolescent health. She also serves on the Legislative Committee MoAAP. Dr. Plax is shown here with **Stuart Sweet, MD, PhD**.



The Leonard P. Rome Visiting Professorship with Dr. Michael Warren, Tennessee, Director of Maternal Child Health, pictured here with **Kristin Sohl, MD, FAAP**, Medical Director at the MU Thompson Center for Autism, was an exciting opportunity to learn about the spectrum of advocacy for children's health. It was paired with the Spring AAP Board meeting and the University of Missouri Annual Common Childhood Problem Conference. Primary care providers, residents, and community experts learned how to weave advocacy into their daily practice.



### Notable Grant Activities

**Kristin Sohl, MD**, applied for a CPTI grant earlier this year; she also received a grant for the spring meeting.

The MoAAP Legislative Committee was awarded a Missouri Pediatric Foundation grant for the March 7, 2012, Advocacy Day.

**Maya Moody, MD, (R2)** has applied for an AAP Bright Futures Implementation grant.

**Dean Lassater, MD, Joplin**, received a Smoking Cessation grant from the Missouri Foundation for Health.

**Tracy Stroud, MD**, received a grant from the AAP Healthy Futures Improving Health Outcomes for Young Children Medication Administration in Child Care Curriculum Implementation Project, which disseminates a curriculum on the administration of medications in child care settings. The MU Department of Child Health is working with state partners such as Head Start and the Department of Health and Senior Services Child Care Health Consultation program to disseminate the curriculum. The curriculum is free and is available online at [www.healthychildcare.org](http://www.healthychildcare.org).

The Children's Trust Fund (CTF), in collaboration with the Bureau of Genetics and Healthy Childhood, has developed a new educational video for expecting or new parents. The DVD has chapters in English, Spanish, and English close-captioned titled "Never Shake a Baby/Preventing Shaken Baby Syndrome" and "Safe Sleep for Your Baby."

The DVD meets the qualifications of 191.748 RSMo, which requires all new mothers have an opportunity to view the dangers of shaken baby syndrome before the mother's discharge from the health care facility after delivery.

The DVDs are available free-of-charge through the CTF website at <http://ctf4kids.org/> and can be shown to parents by health care providers, home visitors, and parent educators.

## One Step At a Time

by Robert Harris, MD, FAAP

Upon returning from my medical mission trip to Southeast Missouri in July, my suspicions before the trip were unfortunately confirmed on my journey.

Existing in an environment of poverty created by lack of education and jobs are many children whose risk of mortality and morbidity is increased. But with "one step at a time" light shines at the end of the tunnel.

Some of the parents are making a real effort to further their education and increase their job opportunities.

Sister Anne Francioni, her staff and nurses at Whole Kids Outreach in Ellington, Missouri, continue to provide excellent whole child development and protective health care. These individuals are truly "angels on earth" dedicated in their mission. I will return there this coming year and, in the meantime, hope to recruit health care personnel and create a greater awareness among physicians and the general public about the opportunity to improve the accessibility and quality of pediatric health care in this area.

If physicians, nurses, nurse practitioners, optometrists or dentists desire to join the cause please correspond with me by email at [dokbob@yahoo.com](mailto:dokbob@yahoo.com) or at my office: Tiger Pediatrics 303 N. Keene Street, Suite 404, Columbia, MO 65201.

Because Whole Kids Outreach depends on grants and gifts for their funding they are beginning to experience some of the current economic crunch. If you choose to financially help this wonderful institution please send a tax deductible contribution to Whole Kids Outreach, Route 2, Box 301, Ellington, MO 63638, and please take time to visit their web site at [www.wholekidsoutreach.org](http://www.wholekidsoutreach.org)





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- Pediatric specialists in critical care, reconstructive surgery, orthopedics, cardiology, cancer, autism and more
- Second to none in providing care for your child

We are Mercy Children's Hospital, St. Louis County's only full-service pediatric hospital, located on the campus of Mercy Hospital St. Louis.

[mercy.net](http://mercy.net)

Mercy 

FALL/WINTER 2011



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# THE CHILDREN'S HEART CENTER AT WASHINGTON UNIVERSITY AND ST. LOUIS CHILDREN'S HOSPITAL



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# The Joplin Tornado:

## Perspectives from a Former Community Pediatrician

by Thomas W. Tryon, MD, FAAP, Immediate Past President, MoAAP Chapter



### Code Grey – Tornado Warning!

Each of us has practiced in hospitals with disaster preparedness plans in place to include contingencies and procedures to implement when the hospital is potentially in harms way from a tornado. As you know, on Sunday, May 22, at 5:42 p.m. an EF5 tornado touched down in Joplin, Mo. Almost immediately standing in the path of the tornado was St. John's Regional Medical Center, a tertiary care facility licensed for 367 beds, with 2,200 skilled employees and 600 volunteers on staff. At the time of the tornado, St. John's had almost 200 patients in the hospital, as well as a full complement of health care and support staff. The tornado left a one mile wide and almost seven mile long path of indescribable destruction through the most densely populated and developed portion within the city limits of Joplin, reducing almost 8,000 structures to rubble. What took place immediately before, during and after the tornado at St. John's is amazing. The heroic efforts of the St. John's staff to quickly work to protect the lives of patients, followed by their work to care for patients, family and staff members injured in the tornado is admirable. Dr. Kevin Kikta, one of the two physicians working in the St. John's Emergency Room at the time of the tornado wrote "45 Seconds: Memoirs of an ER Doctor from May 22, 2011." It is a heart-wrenching account of supreme professionalism, bravery and commitment to patient safety and health care by the entire health care team under unbelievable circumstances. Here is the link to the article: <http://www.mercy.net/joplin/stories-of-mercy/45-seconds>.

Just five blocks south of St. John's sets Freeman Hospital, part of the Freeman Health System of 389 beds, 3,844 employees and 250 volunteers. Fortunately, Freeman was unscathed by the tornado and was able to provide care for many of the injuries from

St. John's and the rest of the community. You may know I was employed by Freeman Health System from 1999-2006 and know Joplin well. Joplin is in the "four-state" area; within 30 minutes of Kansas, Oklahoma and Arkansas. While only listed as having around 50,000 residents, Joplin has almost 270,000 people in the community during the week, with around 400,000 people living in a 40-mile radius around Joplin. Joplin is the fourth largest metropolitan area in Missouri. Estimates are the tornado has destroyed about 30% of the city. Shortly after the tornado, I toured the impacted areas and was stunned by the enormity of the devastation. Imagine a one mile wide by seven mile long densely populated area, with homes, businesses, restaurants, daycares, schools, churches, parks and mature trees almost completely obliterated. Every tree either uprooted or reduced to standing five to six feet tall with seemingly every piece of bark and every leaf stripped off the tree. Every street sign missing. Every telephone pole and light pole leveled. Almost every structure completely flattened beyond recognition. As I toured the tornado's path while driving east away from St. John's Hospital, every time I would turn and look to the west, the only structure still recognizable and standing was the hospital. Amazingly, I passed a church with a cross which seemed to be 20 feet tall standing in front that was unscathed. Yet, the church had been destroyed. At one intersection, a Taco Bell and a McDonalds were recognizable with the buildings still standing, but with all of the windows and doors blown out of the buildings and with significant roof damage.

While St. John's is one of the few structures in the tornado's wake that was still standing, the hospital and the attached physician office building sustained massive structural damage. Pediatric Associates of Southwest Missouri, a four-pediatrician and two-nurse practitioner group, had their offices in the St. John's Physician Building and their offices were destroyed. However, within around a week, they had secured

temporary office space and were open for business. Through utilization of their office Facebook™ page, the practice was able to maintain communication with their patients and with their practice employees and was able to resume practice in a very short period of time. (Astonishingly, cell phones were still functional after the tornado, particularly for text messaging. Cell phone voice lines were overwhelmed.) In addition, with electronic medical records, none of their patient records were lost. One of the leaders in the practice, Dr. Fred Wheeler, is a member of our Missouri AAP Disaster Preparedness Committee, and has expertise from his service in the Navy with understanding the impact of a disaster. Without a doubt, his expertise was invaluable to decreasing the impact of the effects of the tornado on their practice.

Yet, everywhere were reminders of why I loved practicing in Joplin. The people in the four-state area are simply wonderful. At many of the home sites, with family members picking through the rubble to try and retrieve anything of monetary or memory value, there were signs of inner strength, resilience and perspective. Many had signs spray painted on the homes which read, "We are all SAFE!" Some had spray-painted "U.S.A.! U.S.A.!" on their rubble piles and planted an American flag in their yard. Everywhere you looked there were hugs, handshakes and community support for each other. It is the kind of community pride and human spirit which makes us great as a country and makes Joplin great as a community. While I know Joplin will never be the same, I know that community spirit will live on and will grow even stronger.

Almost five months after the devastating tornado, rebuilding efforts are still underway and will be for some time to come. I know you will join me in keeping the Joplin community and our colleagues in our thoughts and prayers as they continue the long process of rebuilding their practices, their community and their lives.

# Hour-by-Hour in a EF5 Tornado

by Jennifer Watts, MD, MPH

## About the Author

Jennifer Watts, MD, MPH, is a pediatric emergency room physician at Children's Mercy Hospital in Kansas City, Missouri. She's also very active in disaster relief as a member of state, national, and international disaster teams. On



May 23, just 12 hours after a devastating tornado struck Joplin, Dr. Watts and her teammates on the Missouri-1 Disaster Medical Team were in Joplin, treating the storm's victims in a mobile emergency room. Here are her reflections on the three days she spent on the front-lines of one of the deadliest tornados in U.S. history.

## SUNDAY, MAY 22

### 6:00 p.m.

The news media began to report the magnitude of the disaster. My phone started ringing as my DMT teammates and I wondered if we would be activated.

### 8:00 p.m.

Following most tornados, local hospitals are still intact and they can handle the influx of patients. Once we saw that St. John's Regional Medical Center had taken a direct hit, that's when we knew we were going.

### 10:30 p.m.

Since I had not yet received orders to respond to Joplin, I headed in to work my scheduled shift in the emergency department. When I arrived in the ER, I learned we were expecting seven patients from Joplin, all with traumatic injuries. We had activated the mass casualty plan and everyone was preparing for the children from Joplin while at the same time trying to take care of the current patients in the ER.

## MONDAY, MAY 23

### 12:30 a.m.

My official orders came through. When they called, they said, "You need to be at our meeting site within the hour." Fortunately, I was already packed. In this kind of work you keep what we call a "go pack." I have one for state response and one for federal response because we have different uniforms for each. This time, it was a state response.

### 1:00 a.m.

Our team gathers. There are about 12 DMT members in Kansas City. The other two units are in St. Louis and Springfield. Springfield was already on the ground in Joplin and St. Louis was also mobilizing people. With four large trucks packed with everything we need to set up a 24-bed ER tent, we left Kansas City.

### 4:30 a.m.

We arrived in Joplin. It took longer to get there than usual because I-44 was closed so we came into the city from the south. We immediately began to work with our Springfield team and assemble the mobile ER at the corner of 32nd Street and Rangeline, just south of the impact area and east of St. John's and Freeman hospitals. It was still dark when we arrived in Joplin to set up the mobile ER.

We had boxes and boxes of medical gear to unload and set up. Our equipment includes everything you would expect and need in an emergency room and more – med supplies, tents, a water purification system, generators ... we are a self-sustaining unit for at least 72 hours.

### 6:00 a.m.

We began seeing victims. It was slow at first. Freeman was taking all critical adults. However, Freeman typically refers critical children to Children's Mercy. Since I was on the ground with DMT, we coordinated with Freeman to take all critical children and arrange for CMH Critical Care Transport to assist with getting them to Kansas City. We were set up to do that but there were really very few rescued alive. Instead, we saw a lot of lacerations, fractures and other injuries from flying debris. We also saw a fair number of injuries from lightning strikes.

We had about 50 ambulances staged with us. They were being dispatched through the EMS system, bringing patients to us and also transporting our patients out who needed to be admitted. We coordinated with the hospitals in the area and across the state to make sure every patient had a place to go.

Later in the day, we started seeing people with chronic illnesses. For example, I had a gentleman who used CPAP at night. Due to the power outages, he had gone without his CPAP for two nights in a row and he was having difficulty breathing. I had another gentleman with a tracheostomy and multiple chronic adult illnesses who was having a hard time breathing because he didn't have his medications.



We also treated people for emotional trauma. After the tornado – and the pounding hail that followed – many survivors left what remained of their homes and began to walk but they didn't know where they were walking. There were no landmarks. When they got to us they would tell us about the screams they heard and what they saw. It was overwhelming listening to their stories but people just needed to talk.

One woman came to us with all of her belongings in a bag. The rescue workers found her sitting amid all the rubble that had been her home. She was refusing to leave, so they brought her to us. Her biggest concern was she didn't have an address for her Social Security check. I think that case resonated with me because it reminded me of all the things you don't even think about that people have to deal with.

One thing that stands out in my mind was the way the community pulled together. I don't know if it's a Midwest thing, or if it's a small town thing, but I think all of us were proud to be from Missouri when we saw the amazing way the community members responded. We had patients who waited 48 hours to come in because they thought their tendon laceration on their ankle was minor compared to others. They didn't want to be a "burden" on the system. "Treat others first," they said, "then you can take care of me."

We work in 12-hour shifts so it was finally time to get some sleep. Normally we stay in sleeping bags and tents, part of the equipment we bring. Fortunately though, a local hotel offered to let us stay there. There was no running water, but we did have beds.

## TUESDAY, MAY 23 Tuesday Morning

We came in to relieve our team members who worked the night shift. We continued to see patients throughout the day. There was another scare Tuesday night. We were used to the



constant noise of sirens because of the multitude of ambulances. But when the police drove around telling people to seek shelter, and when the tornado sirens went off again, the terror that gripped the patients in our mobile ER was impenetrable.

We were busy treating one mom when her three children, scared that the horror of Sunday was about to repeat itself, broke down into tears. Dad, in shock and scared himself, did not know how to help calm his son and little girls. It was intense and fearful enough for us that night as we sat in a tornado shelter. I can't imagine what it must have been like out amid the devastation.

Fellow doctors and I have described the scene in Joplin as "controlled chaos." There definitely was chaos, but people knew what to do. Many families we saw were in shock and had suffered traumas, but they were surrounded by caring people and it provided them a small sense of comfort.

## WEDNESDAY, MAY 24 Early Wednesday

We received orders that our 24-bed mobile medical unit would come down and resources would be moved. The larger, 60-bed mobile medical unit that we had assembled the previous week in Branson as part of a national FEMA drill was to be reconstructed on St. John's Regional Medical Center's parking lot. The 60-bed field hospital is a full hospital. They have x-ray, lab

capabilities, an ER, ICU, and inpatient beds. St. John's used the field hospital as its main care facility for several months.

After breaking down the 24-bed ER and packing up, it was time for us to leave. Since we arrived just before dawn on Monday and we hadn't had time to leave the hospital, we had not really seen any of the storm's damage; we'd only heard about it. When we finally saw the damage, it was incredible. Nothing but rubble and debris for as far as you could see.

Even though we are trained in disaster relief, the whole experience was emotionally draining for all of us. Most of us just keep going – you give a hug; you shed tears; you support one another. It's when you get home that it hits; that's when it's hard. Answering the simple question of "How was it?" was one of the most challenging parts for me. The patient's stories from the tornado resonated with me as I went back to work in the ER and tried to put a smile on my face. However, the care, concern, and compassion that I received from my own emergency department was overwhelming. I came home with much appreciation for the support I receive here that allows me to do my job there. That's why when I go somewhere to respond, it's really not just me going; it's a departmental response because I couldn't do it without them.

I made my career in pediatric emergency medicine because of the rewards it offers: we provide immediate care and are able to make a real difference. I also like working in chaos and with limited resources ... it makes you rely on your skills as a doctor and the basics of true medicine.

You also get to share people's lives at a time when they truly need someone. Isn't that what life – in chaos, in disasters and just day to day – is all about?

# Typical Sunday Becomes Worst Day in Joplin History

by Robert Steele, MD, St. John's Mercy, Springfield



May 22 was a warm, humid late spring day. It began as a typical Sunday, but became one of the darkest days and nights in Joplin's history. Earlier in the day, about 60 people had gathered at the Mercy Mile Walking Course

on the east side of the hospital campus for a health walk hosted by St. John's for "Weight Watchers at Work." That event wrapped up at about 3:00 p.m. Across town, graduation ceremonies for Joplin High School were underway at Missouri Southern's Leggett and Platt Athletic Center. Nearly 6,000 family and friends of graduates attended. The high school, located near the hospital, wasn't large enough to accommodate the crowd. Commencement ceremonies ended as storm clouds gathered; celebrations were still going on all across the city as the five o'clock hour approached. At St. John's Regional Medical Center, 183 patients and 117 Mercy co-workers were going about the business of caring, and being cared for.

At approximately 5:41 p.m. Sunday, May 22, an EF5 tornado with 200-mph winds scoured a one-mile-wide by seven-mile-long band of complete destruction. Later it was deemed one of the deadliest tornadoes in U.S. history. St. John's Regional Medical Center, the 367-bed hospital took a direct hit. Windows and walls were blown out, the roof pulled off, and irreparable damage was done to the building's infrastructure, including emergency generators and power distribution system. The storm destroyed nearly 8,000 structures – including about 400 businesses, eight schools, 18,000 vehicles and claimed 160 lives.

As people in Joplin and from outside the community watched helplessly on television, hospital co-workers valiantly sacrificed their personal safety, heroically evacuating patients and visitors from

the nine-story building. Near the hospital, fires broke out, and emergency workers headed to the hospital to help. The smell of natural gas permeated the hospital as the evacuation continued. Gasoline from damaged and destroyed cars flowed through the parking lots at the hospital. Intermittent rain and wind continued immediately after the storm while rescue and evacuation efforts were being implemented. Aid for the crippled medical center came almost immediately. First responders, co-workers who'd left their homes and families, citizens, and visitors all pitched in to begin the evacuation and start caring for the injured who began arriving at the hospital.

Every square inch of the hospital and surrounding campus was affected. Severely damaged were the main hospital, physician's office building and Brady Rehabilitation Center to the south of the main hospital. Debris and water covered the walls, floors and ceiling inside the buildings. Cars, trees and parts of buildings and homes littered the campus in the wake of the tornado, hampering access to the building and exits. Emergency power and communications were destroyed in the process. After the initial impact, the sounds from alerts of abandoned IV pumps and monitoring equipment powered by battery systems, broke the silence in the darkness throughout the building. For a brief moment after the storm, phones inside the Emergency Department rang eerily for a few minutes then fell silent. Water dripped from the ceilings due to damaged pipes and rain that had been forced through the building.

The 117 co-workers evacuated all 183 patients in dark, with unknown dangers surrounding them. St. John's co-workers who were not scheduled for work that day arrived by the hundreds to assist their fellow workers in the evacuation and at make-shift triage locations throughout the city. Many risked their personal safety and pushed aside worries of their own families' well-being as they continued to take care of patients. Visitors, family

members, and citizens who'd come to aid the evacuation helped one another as they never gave up – continuing until all patients were evacuated to safer ground in three evacuation points outside the main building. Within minutes of the disaster, a triage center was established outside the crippled emergency department, just steps away from the heavily damaged building. The injured from the surrounding area started arriving on foot. Many were confused and disoriented but expected the hospital to provide comfort. It was the only structure that remained standing for miles. In reality, the hospital was as injured as those who flocked to it.

The most critical patients were initially transported to Freeman Hospital, just a quarter of a mile south of St. John's. The Freeman facility was relatively undamaged during the storm but quickly became overcome with injuries from hundreds of walk-ins and 20 critical patients transported from St. John's. Many of the less critical who initially came to Freeman Hospital were transported to dozens of other facilities within a 75 -mile radius of Joplin. Every community within hundreds of miles of Joplin stood ready to take patients, some as far away as Springfield and Kansas City, and Wichita, and Tulsa.

A triage center and emergency care was temporarily established at Memorial Hall and McAuley Catholic High School in Downtown Joplin. The triage center at Memorial Hall remained in service for the first week after the storm until the St. John's Mercy Field Hospital was established. A command center was established at City Hall to coordinate rescue efforts across the city. Medical supplies, medications, and equipment were pulled from the damaged building to provide relief at emergency centers that had been set up across town at Memorial Hall and the McAuley High School Cafeteria. Volunteers in pick up trucks and SUVs helped transport the supplies and critical patients. The Mercy electronic health record, which had been implemented just weeks earlier,



never lost a beat. Records were already being printed in Springfield for all 183 patients as they were transported to other facilities. Disaster Drills practiced in the past became a real life scenario the night of the tornado. Incident Command Centers were quickly established at all major hospitals surrounding Joplin, as well as for the city of



Joplin. However, communication between individual centers was difficult due to the loss of phones and cell towers.

On Monday, May 23, the full extent of the devastation became even more apparent as experts entered the damaged hospital to start a full assessment. In the light of the new day, the devastation became crystal clear. The nine-story St. John's Regional Medical Center building and campus was perhaps a total loss. As the story of the town and its devastation spread across the globe, the images of the wounded hospital itself became an iconic symbol for the immense power of the vicious storm. It had been the tallest structure and now in the wake of the storm, it could be seen from the far across town with everything in view leveled to the ground – an eerie view never before seen. In a twist of fate, the MedFlight A-Star Helicopter would normally have been moved to the Joplin Regional Airport hanger on the north side of town in case of bad weather. An earlier forecast had expected storms tracking from the north with a potential strike to the airport with damaging winds and hail. Based on that forecast, the helicopter remained on the helipad at the hospital and was totally destroyed by the killer tornado. Rescue workers in lime-green jackets combed through the wreckage of the hospital. Search and rescue teams searched the building bottom to top with rescue dogs. The force of the storm had left some windows with debris and equipment hanging from the upper floors. Sadly, five patients who were on life support and one

visitor died as a result of the tornado.

Just one day after the tornado, Mercy leaders were rapidly developing alternative solutions for hospital service. One of the first activities on the afternoon of May 24, was to make a site visit to see a 60-bed tent hospital which had been coincidentally set up in Branson as a conference demonstration by the southern Missouri Disaster Medical Assistance Team. An agreement was made with the National Guard to immediately transfer the tent-based facility to a cleared area on the St. John's site. That facility was opened in Joplin on Sunday evening, May 29, exactly seven days after the tornado.

Governor Jay Nixon was on the ground in Joplin everyday for weeks after the tornado. He pledged his support, and on day three, met with Mercy leadership who promised to keep all 2,200 co-workers on the payroll, a gesture that community leaders say provided a symbol of hope to business leaders in the community. Since the tornado, a collaborative and productive process has been in place in Joplin with meetings of representatives of FEMA (Department of Homeland Security), the US Army Corps of Engineers, the Office of the Governor of Missouri, the Department of Health and Human Services, other state and federal regulatory bodies (Centers for Medicare and Medicaid Services), Aspen Street Architects and the entire Mercy team.

In July, McCune-Brooks Regional Hospital in Carthage, Mo., signed an assistance agreement with St. John's, and

finished out shell space in their new hospital, expanding from 25 to 52 beds. Equipment was installed and staff was employed for an additional surgery suite. With this arrangement, Mercy surgeons could continue providing care and St. John's clinical and support co-workers staff the additional care provision. Additionally, St. John's hospitalists are now providing coverage 24-hours a day, seven days a

week as a new service for McCune-Brooks patients. Other specialists, including surgeons, ENTs, and gastroenterologists have also joined the medical staff. This is all possible through a unique partnership and the talent sharing program that allows Mercy co-workers to fill jobs that match their skills.

The field hospital was the first of three temporary hospitals leading up to the permanent structure. A temporary fix, the tent-based facility was always a short-term solution. Along with the tent field hospital, trailer-based operating rooms were purposely equipped for better provision of surgical services. Providing extended ICU care in the field hospital also became a challenge. In addition, although the tent is constructed to withstand winds up to 100 mph, both staff and patients evidence heightened anxiety every time a storm approaches and wind causes the tent fabric to move. Plans began early to discover the next solution to progressing the recovery of Mercy service to Joplin. By November, the tent will be replaced with a hard-sided, modular facility. Individual sections have already arrived and are being assembled on a lot adjacent to the field hospital. Adjacent to the south of the where the field hospital is located, site work has now begun on the 120-bed component hospital with plans to open in Spring 2012. This fully functional facility will serve as the home to Mercy Hospital in Joplin until a new facility is constructed.

When the tornado struck, it completely destroyed two of the three Preferred Family Healthcare behavioral

health facilities in the area – an adolescent female group home and a treatment center. What's more, Preferred Family Healthcare was only eight weeks away from completing a 32-bed adolescent substance abuse unit. Fortunately, the new building was not damaged by the tornado which touched down less than an eighth of a mile away. A few days after the storm, with the help of the Missouri Department of Mental Health, Preferred Family Healthcare partnered with St. John's to restore mental health services to the community. This fall, the building will be completed and Mercy Behavioral Health will make this building its temporary home and reestablish inpatient psychiatric services until the new Mercy hospital is built.

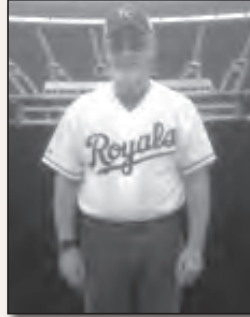
The spirit of caring is alive and well across the world. The devastation of Joplin is matched only by the amazing offers of support from communities near and far. Three months after the tornado, Mercy continues to receive new contributions to the Joplin co-worker relief fund every week. Nearly 2,300 donors have given at least \$1.4 million to help with immediate needs like groceries, or long-term necessities such as lodging and transportation. Meanwhile, other donors have given a total of \$2.2 million in cash and in-kind donations to help co-workers with scrubs and other supplies, as well as equipment for the hospital.

On August 16, Mercy announced plans to build a new state-of-the-art hospital. The plans call for a new medical campus located at I-44 and Main Street, roughly three miles from the current hospital campus. A second location on the north side of Joplin was also announced. The costs are substantial – nearly \$950 million for restoration of services to Joplin. The opening of that hospital will mark the end of a long road from disaster. A number of lessons have been learned along the way; the people of Joplin, Missouri, and the nation have showed compassion beyond imagination.

## Rising From The Storm

by Fredric R. Wheeler, DO, FAAP

May 22, 2011, started like any other Sunday on call. Fortunately, when I went in to the hospital that day, I was able to dismiss almost all the patients at St. John's, and was looking forward to an easy start to the "call week" Monday.



We heard the tornado warnings, but we were used to that in May, and my wife and I went to the basement so it could "blow over." Which it seemed to do from our house, one and a half miles south of St. John's. Then my daughter called and said she heard the tornado had hit St. John's, and I drove in expecting that they may need me on the ward or in the ER. When I topped the hill just before 32nd street I saw something I did not expect. I could see the cross for my church, because most of the buildings and all of the trees were gone. At first, I thought the hospital had been spared as it looked like there was damage to the roof and I hoped that was all. When I got within a half a mile though, I could see the cars on top of cars in the parking lot, and smoke coming from the emergency generator. As I got close, I learned the patients were all in the stairwells, having been evacuated from the upper floors.

Fortunately Freeman Hospital, less than one mile south, was structurally intact, and patients were able to be evacuated there, almost all in private vehicles. A lot of heroic and high and low tech medical care was provided there all night and the next day. It was clear that we didn't need more caregivers at that time; we needed a place to provide that care.

The EMS system provided transport to and often from Freeman, and the

regional hospitals took our patients that we needed to transfer. I know patients were treated from Tulsa and Wichita, to Kansas City and St. Louis, and probably more places.

A lot has been written about our community response, and I feel very good about that, but the impressive thing to us was the response from the whole country. We actually had so many offers to help that we had to coordinate them. More impressively we are still getting help. We have not been forgotten.

The city allowed St. John's to run makeshift clinics and ER in Memorial Hall; the schools, churches and the "Community Clinic" provided triage, shelter, food, and water. Numerous groups came in to help with debris removal, clean-up and repair; and they are still coming.

There are hundreds of people I need to thank, but the staff at Children's Mercy in Kansas City was especially helpful for our practice, and coordinated the delivery of a medical and office supplies, from pediatricians in the Kansas City area, to help us be up and seeing patients in new rented space within eight days of the storm.

We are not yet back to where we were, but we are all functioning, and we all will be better than we were in a couple of years.

After a disaster, we find out just how great a country and community we live in. As Yakob Smirnoff says, "WHAT A COUNTRY!"

It also allowed the medical staffs of two very competitive hospitals the opportunity to work closely together for a common good and to develop an appreciation of each other. This will be a good thing.

I don't want another disaster, and there are hundreds of people that suffered tremendous losses of life, health and property; some of which will never be recovered, but overall we are rising from the storm.



# Preparation & Training: What It's All About

by Jennifer Watts, MD, MPH

When I went to work the overnight shift in the Children's Mercy emergency room on Sunday evening, May 22, I had no idea the shift would last for three days. I had no idea the emotional toll would last for much longer. And the memories will last a lifetime.



As a member of the Missouri Disaster Medical Team, I know the importance of being prepared. Just the week before, we'd gathered in Branson to set up and run our 60-bed Mobile Medical Unit (MMU) as part of the National Level Exercise with FEMA. We doubted we would ever use it for real.

Then that fateful Sunday tornadoes ripped through southeast Kansas and southwest Missouri. The call went out for help and my shift in the Children's Mercy ER morphed into a shift in a 24-bed ER tent 120 miles to the south of Kansas City, in Joplin. For three days we worked in a place of healing and refuge for people who survived the carnage.

It is not all the wounds from flying debris that I will remember. I'm a pediatric emergency doctor so the medical care we provide isn't hard or unusual; it's what we do every day. The emotional toll is what wears you down, seeps into your heart and sticks with you.

From the moment we arrived in total darkness, we began our jobs in the mobile ER. We were so busy that I didn't even see the majority of the damage for two days. I didn't need to: I heard about it, over and over. We were living it through the stories ... and when we finally did see it, it made sense. The destruction is hard to grasp. The pictures tell only part of the story;

pictures can't show you broken hearts and dreams.

We train and prepare for these types of scenarios. But, this is real. There is no way to prepare for the emotional trauma. What am I supposed to say to the man in shock who walks in, holding two bags with all his worldly possessions and asks me, "What do I do next?" I am a doctor, I can tend to his cuts, but I cannot mend his whole shattered life.

The people of Joplin are amazing, stronger in the face of this crisis than I have seen at any other disaster. Several, with serious injuries, waited days to seek help so they wouldn't "burden" the system. We were there for them to "burden," but they were thinking of their neighbors first. Relief aid from large businesses began pouring in. But the five people from the community standing on the street corner with a cooler handing out free dinner showed the true spirit of living in the Midwest.

Two nights after the tornados destroyed lives and turned others

upside down, there was another scare. We were used the constant screaming of sirens because of the multitude of ambulances were busy bringing people in to see us or transporting patients to other, more suitable hospitals. But when the police were driving around telling people to seek shelter and when the tornado sirens went off again on that Tuesday night, the terror that gripped the patients in our mobile ER was impenetrable.

I also must say a word about the professionals at Children's Mercy who answered the call at home. The support from my department and colleagues makes it possible for me to respond with the Missouri DMT. You took care of some of the sickest children and their families who made the trip to Kansas City. You continued to prepare the hospital in the event that more children would arrive. We all play a part in disaster response for the children even if everyone is not in the field. I couldn't do what I do without you.

## Missouri State Medical Association Establishes Joplin Relief Fund

In the wake of the devastating tornado that destroyed a number of physician practices in Joplin on May 22, 2011, MSMA has established a special relief fund to aid your physician colleagues and their staffs there.

You need not be an MSMA member to request funds or to contribute.

The MSMA Health Education Foundation, which is a 501(c)(3) charitable organization, was set up to receive contributions and coordinate the distribution of funds to physician practices that were

affected by the storm.

All proceeds will be used to provide needed assistance to physicians and their practice employees who suffered significant property loss, suffered significant physical injury, lost immediate family members, or face months of unemployment due to the storm.

To request funds, contact MSMA's EVP Tom Holloway at [tholloway@msma.org](mailto:tholloway@msma.org) or call 800-869-6762. Contributions are tax-deductible. Go to [www.msma.org/joplinrelieffund](http://www.msma.org/joplinrelieffund) to contribute.

## September 27, 2011 – Four Months Later

by Laura Henness, MD, FAAP, MoAAP Communications Committee Member

Life has been interesting. Today one of my families brought me some tornado debris, actually a charge receipt with all the credit card information, expiration date and signature still readable. It was an old receipt, 4/1/2003, from one of the pharmacies that was completely destroyed. What was interesting was that it was my credit card and my signature.

My house didn't get destroyed, my family wasn't injured and luckily all the pediatric offices at Freeman Health System, including mine, didn't sustain damage. Some lost vaccines because of power outages, but we were up and operational two days after the storm. Our colleagues at St. John's weren't as lucky, and they got to rebuild their office completely from scratch. They did have their electronic medical records so all was not lost. They didn't whine but rather just got down to business and within a week were connecting with their families. They really rocked!

The tornado continues to impact our lives almost daily. Numerous families have moved out of the area, phone numbers are disconnected and of those families remaining they are busy and checkups in general are way down. Some of the families most affected by the storm have done their counseling and are thriving. Others that never sought help are just starting to deal with anxiety, depression

and the somatic body complaints which often accompany psychiatric issues. We actually are referring more to counseling now than in the first month after the tornado.

We had a national motivational speaker in town last week to work with the first responders and I was able to attend the meeting. Pediatricians are not typically first responders, but that night of the tornado wasn't typical. Two pediatricians, myself and Dr. Fred Wheeler, worked at Freeman. Dr. Sherri Smith went into her St. John's office to salvage what she could. Dr. Grote drove and ultimately walked to Memorial Hall to help triage. Lorie McCreary, PNP, (my right hand), helped her neighbors by bandaging and stabilizing wounds in her devastated neighborhood. We didn't do surgeries, nor complex laceration repairs, but we did make a difference by splinting simple arm and leg injuries, simple lacerations, some triage and then we did nursing duties. I found socks (note to self: no flip flops in a tornado warning), blankets, scrubbed and sterilized suture tools, wiped up blood and provided comfort and assistance where needed. I didn't feel useless.

We are trained in residency that general pediatricians are not the first line defense in a natural disaster, or huge trauma but some of us in our lifetime will be put in that situation. What will you do? It may come in the town you live

in, it could happen on vacation. Do you remember how to suture? What about placing a splint? Do you know your hospital disaster plan? Most importantly do you have a plan in place if the phones and internet do not work? They didn't in Joplin, not that night, nor very well in the first week. Cell phones and the internet didn't work well in Vermont with their severe flooding from Hurricane Irene.

I want to share some advice I received in a thank you from Lorie McCreary, PNP. The night of the tornado she sent me a text saying "My house is gone" I got the message seven days after the tornado.

### The 5 things I've learned from being in an EF5 tornado

1. You cannot predict what a storm will take or what it will leave behind.
2. Even after an EF5 tornado, you could tell that I was a poor housekeeper.
3. Dorothy was right, "There's no place like home."
4. The memories that a house holds are not gone just because the house is no longer there.
5. The only thing you can build to withstand an EF5 tornado are relationships.

Rebuilding has started but it will never look the same in Joplin during my lifetime just because of the sheer number of mature trees and houses that are gone. Much of the area at night remains dark because there are no homes and some of those that are rebuilding still don't have electricity restored. The schools are up and running, we are learning all sorts of new things about how to transition to computer classrooms rather than using textbooks. I am extremely grateful at the outpouring of assistance both financial and hands on that came from all over the United States. I'm proud to be part of this community and will continue to volunteer in whatever capacity is required. You may think something like this will never happen to you but so did we. Be prepared.



**Disaster Preparedness to Meet Children's Needs**  
**[www.aap.org/disasters/index.cfm](http://www.aap.org/disasters/index.cfm)**

*a website of the American Academy of Pediatrics*



## When Disaster Strikes, Our Members Are Ready

by Robert W. Block, MD, FAAP, 2011-2012 President, AAP



I was born and raised in Iowa, and I have lived in Oklahoma for 36 years, so I am no stranger to tornadoes. However, I was not prepared for what I saw when I visited Joplin a few days after

this year's devastating storm. The vast wasteland that was created in only a few minutes was a stark reminder of the power of nature. The emergency relief hospital, food stations, and volunteers of all varieties were wonderful reminders of the power of human beings.

I have the distinct honor and privilege to serve as President of the AAP between October 2011 and October 2012. Holding this office allows me to see first-hand the ability of our organization, representing over 60,000 members, when disasters strike. My visit was a very small symbol of the AAP standing behind its members.

The discussions that day with local pediatricians focused on the immediate and continuing needs of children, especially the need for ongoing trauma-informed counseling and support for rebuilding and sustaining emotional strengths. I was also able to see how quickly pediatricians can regroup, opening new offices with help from a very active state chapter leadership and members.

The AAP's Friends of Children fund receives unrestricted funding

from individuals and others. It also receives funds specifically earmarked for disaster relief. The MoAAP is encouraged to discuss options with the Department of Development at the AAP, to determine what resources are available to meet continuing needs.

I think the most important lesson I took away from my day in Joplin is the strength I saw and heard from Joplin pediatricians and others. I did not hear whining and sorrowful submission to nature's whim. I came away with a sense that this community may never be the same, but it will continue to be a community that cares for its children, their families, and for each person. Even though I visited only a few days after the winds swept a vast area clear of almost everything, I found people looking toward the future with positive ideas and expectations.

I have known some of the pediatricians in Joplin for many years. I am proud to be their friend, as I am proud to represent the AAP for all the pediatricians in the area. The state chapter leadership is to be congratulated for excellent and immediate communications and coordination. The AAP, at our national level, is ready to assist when we can.

Best wishes for continuing success and rebuilding. Condolences to the families whose children perished in the storm, and to families of the other storm victims. And thank you to the physicians, other medical and nonmedical relief workers, and to all the citizens of Joplin for demonstrating the power of the human spirit.

## Community Access to Child Health

by Sarah Garwood, MD, FAAP

Congratulations to Dr. Kristin Sohl on her successful Leonard P. Rome Visiting Professorship with Dr. Michael Warren in May. The event was a tremendous educational opportunity for the University of Missouri-Columbia's pediatric residents!

Two CATCH planning grants, one from St. Louis and one from Kansas City, as well as one resident grant from St. Louis Children's Hospital, are currently being reviewed for potential funding. The topics addressed include energy insecurity, vaccination in Amish communities, and increasing adolescent access to health care.

CATCH grant funds are available to support pediatricians who work with communities to ensure that all children have medical homes and access to other needed health care services. Funds are available for pediatricians or pediatric residents in the planning stage of a project, as well as for the implementation/pilot stage. Other opportunities for resident educational program funding also exist.

Currently, a related program, the Community Pediatric Training Initiative has an open call for proposals to support four pediatric resident-faculty training pairs (eight people) to attend the AAP Chapter Advocacy Summit on March 14-16, 2012, in Schaumburg, Illinois. Each faculty-resident pair will be required to implement an educational activity on child advocacy in coordination with their local AAP chapter following the conference. Local chapters will receive up to \$1000 toward completing the educational activity in conjunction with the faculty-resident pairs. See the AAP website for application information: <http://aap.org/commpeds/cpti/opportunities.htm>

For more information about CATCH or CPTI, please see the AAP website: [www.aap.org/catch/funding.htm](http://www.aap.org/catch/funding.htm) or contact the Missouri CATCH grant facilitators: Kristi Canty, [kmcanty@cmh.edu](mailto:kmcanty@cmh.edu) or Sarah Garwood, [garwood\\_s@kids.wustl.edu](mailto:garwood_s@kids.wustl.edu).

# Improving Pediatric Disaster Response

by Theodore M. Barnett, MD, FAAP, FACEP

Watching the crumpled buildings, fires, flooding, and steam pouring from nuclear sites in Japan, we were all reminded of the suddenness with which life changes or ends and how difficult it is to cope with catastrophes. Then we watched the south get hit with tornadoes and we were reminded that this can happen here. Flooding in southeast Missouri was next. Then there was Joplin, the worst tornado toll in 50 years, and one of the better emergency responses to a disaster in recent American history. Of course, that was not the end; there were still Sedalia tornado and the Missouri River floods. Disasters will not stop happening, but our ability to respond can keep improving.

Studies confirm that children are one of the most vulnerable populations in a disaster. They are developmentally and financially limited, dependent on others for routine care, and have health problems not seen in adults, such as need for routine immunizations. Disruption of routine health care has a substantially greater impact on children than it does on adults.

A great deal of time and money is spent on disaster preparedness each year, but primary care providers as a group are rarely involved in planning. Existing disaster plans make little mention of practice preservation and continuation. As noted above, this lack of recognition, involvement, and planning does a particular disservice to our children.

Earlier this year, Missouri was one of ten states (out of 29 applicants) to be asked to attend the AAP/CDC

Enhancing Pediatric Partnerships for Pandemic Preparedness meeting in Chicago.

We were first contacted in November and asked to submit a brief proposal as to why our state should be included in the initial phases of a joint AAP and CDC initiative. Fortunately, Dr. George Turabelidze had received a grant several years ago to create a

April, ironically due to severe winter weather. We had an intense schedule, with presentations from the teams starting on Wednesday, April 27, continuing with a dinner meeting that night, then feedback from both AAP and CDC officials and main reports from all the state teams on Thursday morning. We had summaries and wrap up presentations that afternoon.

## Areas that deserve further exploration include:

- Educating state chapter members and state health leaders
- Establishing multidisciplinary state chapter committees for preparedness issues
- Improving county and local physician/health department relationships
- Making state Pediatric Advisory Committees a true partnership
- Linking with existing processes if those exist
- Partnering with children's hospitals whenever practical

Pediatric Advisory Committee to the Missouri DHSS. While the committee ended when the grant expired, it did lead to personal contacts that made assembling a team easier and the concept seemed sound.

Our traveling team included Dr. Fred Wheeler, a pediatrician in Joplin; Jeannie Ruth, then Chief of the Bureau of Immunization Assessment and Assurance with DHSS; Dr. Turabelidze, who is a state epidemiologist and practicing pediatrician in Saint Louis; and myself, a pediatric emergency physician in Kansas City. In addition, Dr. Claudia Preuschoff, a pediatrician in Poplar Bluff, was instrumental in our preparations and ended up staying home dealing with the ongoing flooding disaster in her region. I must also mention Johanna Derda who helped put us all in contact and assisted with coordination and communications.

The meeting was originally to occur in February and postponed to

It was very clear that despite the diversity of the involved states, the issues were very similar. Only a couple of the states had even rudimentary pediatrician-state health interaction. Budget constraints, lack of available time for practicing physicians, and absence of a focus seemed to be the major reasons for the dearth of standing committees. Internet resources for information gathering and dissemination, education, and communication have been under-utilized.

I look forward to continuing to help improve our state's and our pediatrician's ability to prepare and respond to future disasters. If you are interested in learning more or becoming involved, I would love to hear from you.

## About the Author

Dr. Ted Barnett developed an interest in EMS and Disaster Medicine while in the Army, and has continued to be involved in both to this day.



## REDEFINING PEDIATRIC HEART CARE | ONE CHILD AT A TIME

### Educational Conferences sponsored by Children's Mercy Hospitals and Clinics

Clinical Advances in Pediatrics 2011  
November 15-18, 2011  
Children's Mercy Hospital  
To Register: [www.childrensmercy.org/caps/](http://www.childrensmercy.org/caps/)

"Teen Aches and Pains: A Practical Office-Based Approach"  
February 25, 2012  
Children's Mercy Hospital Auditorium  
Check the Children's Mercy website for more details: [www.childrensmercy.org](http://www.childrensmercy.org)

Pediatric Pharmacogenomics and Personalized Medicine Conference  
March 28, 29 and 30, 2012  
Children's Mercy Hospital Auditorium  
Check the Children's Mercy website for more details: [www.childrensmercy.org](http://www.childrensmercy.org)

First Annual Regional Health Care Conference, A Psychosocial Perspective  
March 30, 2012  
Westin Crown Center Hotel  
Kansas City, Mo.  
Check the Children's Mercy website for more details: [www.childrensmercy.org](http://www.childrensmercy.org)

Child Abuse Conference  
April 26 and 27, 2012  
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Check the Children's Mercy website for more details: [www.childrensmercy.org](http://www.childrensmercy.org)

### GRAND ROUNDS ONLINE

Health care professionals can now register to view Children's Mercy's Grand Rounds Online and those that wish to earn Continuing Medical Education credit can do so by completing a short pre/post test and evaluation. Go to the following link to access Grand Rounds Online:

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# Pediatricians Have Role in Requirements of New Laws Regarding Youth Concussions

by Sarah Alander, MD

In 2006, a 13-year-old football player from Washington named Zackery Lystedt became one of the estimated 300,000 young athletes who suffered a concussion that year. Thinking he merely “got his bell rung,” coaches allowed him to return to the game after 15 minutes of rest. Shortly after, he collapsed. Zackery had suffered a devastating brain injury that left him in a prolonged coma with permanent neurologic sequelae, a victim of a second impact syndrome head injury.

As a result, Zackery’s family and supporters led the charge for legislation addressing the problem. In 2009, the state passed one of the country’s first “when in doubt, sit it out” laws regarding student athletes and concussion. These laws are intended to ensure the safety of young athletes and protect them against long-term injuries.

In the past 10 to 15 years there has been an increasing amount of media attention and research directed at the problem of adolescent sports-related concussion and a concurrent rise in reporting of concussion. Research shows that many cases are not reported, either because the symptoms may be subtle and go unnoticed or because the athlete is worried about being disqualified from play.

This past summer, Missouri joined the ranks of some 40 other states with laws (or pending legislation) similar to the one passed in Washington. The Missouri legislature passed HB 300, or the “Interscholastic Youth Sports Brain Injury Prevention Act (IYSBIPA),” which went into effect on August 28. It has three basic tenets:

1. To inform/educate coaches, parents and student athletes about concussion and require them to sign a form acknowledging the delivery of this information.
2. To immediately remove from play student athletes who appear to have suffered a concussion.

They must not play for at least 24 hours.

3. A requirement that athletes must be cleared by a licensed medical professional trained in the evaluation and management of concussion before returning to play.

Additionally, the law requires the Missouri State High School Activities Association (MSHSAA) to publish an annual report regarding the impact of concussions on student athletes, and detail efforts made to minimize injuries sustained by students participating in school sports. MSHSAA-sponsored sports in the public and private secondary schools and Catholic Youth Council (CYC)-sponsored sports are covered by this law. Private club sports participants are not.

As a result of the law, coaches and athletic trainers are receiving additional training through video courses from MSHSAA and the National Federation of High School Activities. Parents and students are given a three-page fact sheet published jointly by MSHSAA and the CDC referencing [www.cdc/Concussion](http://www.cdc/Concussion).

What role do pediatricians play? Pediatricians who evaluate a concussed student-athlete will be required to complete a “Return to Play” form that is supplied to the student by his or her school. This form has been adapted from the Acute Concussion Evaluation (ACE) care plan on the CDC website ([www.cdc.gov/injury](http://www.cdc.gov/injury)). While state laws vary about the qualifications of the licensed medical professional providing medical clearance, the Missouri law allows for any licensed professional-- an athletic trainer, nurse, chiropractor, physician-- who claims to have expertise in concussion management to assume this responsibility.

As public awareness about concussion increases, pediatricians may also be asked to decipher “overreporting.” In the first month of the IYSBIPA, I personally cared

for a teenager who superficially bumped her head on a car door and was removed from school pending medical evaluation for concussion.

As pediatricians, we are responsible for understanding the current science of concussion diagnosis and treatment. Research has shown that individualized treatment plans are more effective to safely get young patients back to activities than simply following one of the many published guidelines for releasing athletes back to play.

Here is more information to guide diagnosis and treatment decisions:

- ◆ The 3rd International Conference on Concussion in Sport released a consensus paper in 2009 that concurs with the IYSBIPA ruling on removal from play for at least 24 hours. In addition, this consensus recommends medical evaluation that may include neuroimaging, objective balance assessment and neuropsychological assessment. Management includes physical and cognitive rest followed by a program of gradual return to play.

- ◆ Use of “sideline” assessment tools such as The Sport Concussion Assessment Tool (SCAT2) (available as a \$3.99 app for smartphones), may be of use in the ambulatory setting. The SCAT2 measures symptoms, memory function and balance testing. Routine neuroimaging does not contribute to the diagnosis of concussion and should only be used when a structural problem, such as hemorrhage, is suspected. Pediatricians have an opportunity to educate patients and parents about its risks and benefits.

- ◆ Neuropsychological testing has been shown to be of value in measuring cognitive recovery in concussion and may be a useful tool in determining return-to-play decisions. There are several web-based tests available, the most popular of which is called the ImPACT™ test. This is a 20-minute exercise taken on the computer and includes measurement of working memory, reaction time and attention



span. It is most useful if the patient has taken it prior to injury and then repeated after the concussion, although there are normative values for comparison if no pretest is available. The ImPACT™ test offers another piece of clinical information to guide management, but should not be used alone in making clinical decisions. Several high schools in the St. Louis area have started to use this for pretesting athletes involved in high-risk sports. There are currently 14 offices and clinics in Missouri offering this testing and they are concentrated in the St. Louis and Kansas City metropolitan areas.

- MSHSAA offers education for coaches and trainers about gradual return to play, which also concurs with the international consensus recommendations. Generally, the athlete is given a period of cognitive and physical rest until free of symptoms, and then taken through a systemic plan that includes light aerobic activity followed by sport-specific training, non-contact practice, and full-contact practice before return to play. In usual cases, 80-90 percent of patients with concussion will recover with cognitive and physical rest in 7-10 days. The pediatrician

has an important role in fostering this healing process (the patient should be reminded that cognitive stress includes not only school work, but the use of video games and text messaging!).

The minority group of patients with concussion who do not recover quickly with conservative management pose a special challenge, both in terms of accurate diagnosis and individualized management. The pediatrician plays a central role in early identification of these kids and in coordinating their treatment plans with a multidisciplinary team that may involve teachers, coaches, trainers, neuropsychologists and other physicians with specialized training in head injury.

With the incidence of reported concussions in young athletes increasing each year, pediatricians bear a dual responsibility for both education and treatment. Educating students, parents, coaches, trainers and sports organizations about the potential dangers of concussion will be vital in reducing negative outcomes for kids.

Keeping abreast of treatment options will ensure that the most effective care is given to each young patient who suffers a concussion.

**About the Author**

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Annual Chapter Business Luncheon*

*Thursday, November 17, 2011 - Noon*

during the 44th Annual Clinical Advances in Pediatrics Symposium presented by Children's Mercy Health Network

**MoAAP is privileged to sponsor Guest Speaker David Tayloe, MD, AAP Past President**

*Luncheon Awards & Highlights*

Dr. Tayloe will present the "AAP Perspective" during the luncheon. MoAAP Chapter President Claudia Preuschoff, MD, will present the Child Advocacy Award & deliver the annual report of MoAAP activities and highlights. Box lunch provided.

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# Resident Duty Hour Restrictions: Implications for Patient Care and Resident Education

by Kyle Schulz, MD, Ashley Steed, MD, Jacqueline Walker, MD, and Andrew White, MD

Resident duty hours first came to national attention with the 1984 death of Libby Zion, whose death called into question patient safety in the face of long resident work hours. Her death led to the Libby Zion law, which restricts New York state residents from working more than 80 hours per week. Nineteen years later, the ACGME adopted a similar 80-hour work week policy for all residents. This year, the ACGME again enacted new regulations regarding resident duty hours. Specifically, intern duty hours were limited to no more than 16 consecutive hours during any duty period. Furthermore, PGY-2 and above residents were restricted to 24 consecutive hours with an extension of four more hours in order to maintain patient care or for educational opportunities. These changes have led to the restructuring of many residency programs' call and coverage models and have created challenges in patient care and resident education.

By limiting the time for patient care exposure, the new duty hour restrictions pose challenges for pediatric residency programs in preparing future pediatricians. In past training models, interns were designated as the front-line care providers which established a strong foundation of experiences as they were granted increasing autonomy. With the new regulations, interns have less direct responsibility for patient care, and, thus, may not accrue the experience necessary to accept the additional responsibilities traditionally assigned to more senior residents. Another challenge generated by the new regulations is the increased number of transitions of care. This increased number of hand-offs limits patient ownership, which was a staple of prior coverage models and is indeed a key feature of practicing pediatricians. One potential solution to the duty

hour restrictions is the incorporation of physician extenders, specifically nurse practitioners, physician assistants, or hospitalists, into the coverage models. However, this solution also comes with its own challenges inherent in the integration of care providers with diverse medical and educational backgrounds into a cohesive health care team.

In order to minimize the impact of these challenges, residency programs have formulated coverage models that maintain the integrity of the medical profession. At St. Louis Children's Hospital, we focused on several guiding principles to construct our coverage models. First and foremost, we wanted to maintain our excellence in patient care. We envisioned a model that would minimize transitions and maximize continuity for both the patients and residents. Secondly, we aimed to preserve all educational opportunities for the residents, with a special emphasis on continuing to provide the traditional autonomy of nighttime call experiences. Lastly, we desired a way to integrate seamlessly all care providers, in our case nurse practitioners and hospitalists, into traditional resident teams.

Mindful of these guiding principles, we developed several potential models for our inpatient wards. Particular attention was given to our general pediatric ward resident teams, which had traditionally consisted of one senior resident supervising four interns who shared night call on an every fourth night basis. Not only are our general pediatric wards the busiest patient care areas in the hospital, but they also are the wards on which interns spend much of their core educational time. Thus, successful implementation of a new coverage model in these areas was crucial for the hospital as well as the residency program. After careful consideration, the two potential models that emerged

were a night shift schedule and a modified call schedule. In January and February 2011, we instituted trial runs of both models, utilizing the 2010-2011 intern class. Interns who followed the night shift schedule generally worked one string of night shifts and three weeks of day shifts per four-week block. In any given week, one intern with a supervising senior resident was assigned to nights. In contrast, on the second ward, interns continued to take call every fourth night; however, when on call, they did not begin working until the evening, thereby remaining within the 16-hour consecutive duty limit. Again, a senior resident was assigned a night supervisory role.

During the trial, the pediatric residents provided frequent feedback, which highlighted the models' strengths and weaknesses, some of which were anticipated and some unforeseen. The night shift schedule afforded continuity of the night care provider. However, in this shift work model, the post-night shift intern did not stay through rounds the next morning. As a result, morning sign-outs were exceptionally busy, with the post-night shift intern handing off all the patients, including new admissions, to the day shift interns, who presented these patients on morning rounds. Hence, the rounding team could miss key information about overnight events and new admissions. Moreover, the night interns cited missing rounds as a lost educational opportunity and as the single most negative aspect of the night shift schedule.

In contrast, with the modified call schedule, work hours were structured such that interns stayed through rounds the following morning without violating the 16-hour limit. The primary criticism of the modified call was the irregular work flow and the inconsistent care which frequently resulted. In a typical



four-day cycle, a given intern worked traditional day shifts on days one and two. Then, the intern took call on the third evening, having not attended rounds that morning, and stayed through rounds on the fourth morning before transitioning care. The resulting lack of consistency in patient care was viewed as detrimental for both patients and resident education.

Given this feedback, we ultimately developed a hybrid model, perhaps best described as a modified night shift schedule. On the general pediatric wards, the day team now consists of a supervising senior resident and five main care providers, composed of interns, pediatric nurse practitioners, and hospitalists. This team represents an expansion in the number of care providers compared to previous years. The night team includes a senior resident or hospitalist supervising an intern or nurse practitioner. For a given four-week block, each individual care provider works day shifts of various lengths and at least one string of consecutive night shifts. These night shifts begin at 8:00 p.m. and are targeted to conclude by 10:00 a.m. This schedule allows the post-night shift care provider to present patients admitted overnight on morning rounds. However, to ensure an appropriate number of hours off between shifts, rounds must be treated as sign-out. There is not sufficient time for a separate sign-out between individual providers following work rounds.

This new coverage model utilizes a diverse group of care providers, including nurse practitioners and hospitalists. Pediatric nurse practitioners were first integrated into a general pediatric ward team at St. Louis Children's Hospital in July 2010 but have been a successful part of our NICU for decades. The program arose from the realization that the impending duty hour restrictions would pose staffing challenges and that nurse practitioners, embedded on a particular floor, would provide desired continuity for patients, their families, and staff. In July 2011, the program expanded to two additional pediatric wards, with nurse

practitioners now incorporated into the primary care provider teams six days and one night per week. Meanwhile, on one general pediatric ward, hospitalists also were incorporated into the primary care provider team, working alongside interns in the daily care of patients. Additionally, hospitalists have assumed supervision of interns and nurse practitioners on some overnight shifts. Integration of these medical professionals into the traditional resident teams has allowed the teams to handle similar patient volumes while adhering to the revised duty hour guidelines.

After three months working under our new coverage models, we have assessed both the positive and negative aspects. First, patient care opportunities are maximized with our expanded day teams, and the opportunity for evolving resident autonomy continues, particularly during night shifts. Secondly, resident education remains a priority, and the ability of the post-night shift care provider to present patients during morning rounds provides an excellent opportunity for feedback. Additionally, the post-night shift residents participate in morning report and teaching sessions led by attending physicians on the floor, both held prior to rounds. We recently have begun providing audio recording files along with visual presentations of our didactic lecture curriculum for residents who must miss noon conference. Finally, we have successfully incorporated physician extenders into cohesive health care teams. The diversity of individuals in these teams has enhanced education for all team members; the nurse practitioners have provided continuity by working on specific wards, while residents rotate throughout the hospital.

However, the inherent increased number of hand-offs has posed challenges and led to decreased individual resident ownership of patients. We continue to strive for effective transitions in care and educate the residents on complete, yet succinct, sign-outs. Formal teaching aimed at transitions in care is necessary

and vital to patient safety. Lastly, we continue to evolve our mind set of individual resident ownership of patients toward that of team ownership.

While the new ACGME duty hour restrictions have posed challenges, we have tailored our coverage models to optimize patient care, maximize resident education, and incorporate physician extenders into traditionally resident-only teams. As the duty hour restrictions change the nature of residency, particularly internship, we will continue to monitor their effect on patients and resident education and will evolve accordingly.

### About the Authors

**Kyle Schulz, MD**, was born in Topeka, Kansas. He received his BA in psychology and MD from the University of Kansas. **Ashley Steed, MD**, was born in North Carolina. She received her BA in biology at Duke University and her MD/PhD from Washington University School of Medicine. **Jacqueline Walker, MD**, was born in St. Louis, MO. She received her BA in Biology and Sociology from the University of Kansas and her MD from Washington University School of Medicine. After completing their general pediatric residencies at St. Louis Children's Hospital, they currently serve as chief residents. Kyle and Jackie intend to pursue careers in hospitalist medicine. Ashley plans to pursue an academic career in intensive care medicine.



# Proposed Pediatric Requirements Emphasize Flexibility & Competencies

by Denise Bratcher, DO, University of Missouri - Kanasas City/Children's Mercy Hospital

Just as the new duty hour requirements were being implemented in July of this year, the Accreditation Council for Graduate Medical Education (ACGME) released the latest revision of the Program Requirements for Graduate Medical Education in Pediatrics in draft form for comment.



Overall, the proposed requirements emphasize training flexibility and competency-based education. Major changes proposed surround modifications in required procedural competencies and the overall structure of the pediatric residency training curriculum, which would include no more than 16 months/blocks of inpatient experiences and a requirement for six months of individualized curriculum for each resident. Many pediatric organizations, including the American Academy of Pediatrics (AAP), have responded with formal comments.

The proposed six-month individualized curriculum would be determined by the learning needs and career plans of each resident and would require development through the guidance of a faculty mentor. Comments generally endorse the emphasis individualized requirements place on flexibility and the opportunity for individual learners to consider their own personal learning need. Concerns were raised, however, regarding unpredictability for overall program scheduling, appropriate faculty mentorship of residents, and adequate early knowledge of career needs and curriculum structure to assure a meaningful individualized career focus.

Maintaining the requirement for demonstrating competency in multiple pediatric procedures, the proposed program requirements also suggest that residents must complete Pediatrics Advanced Life Support (PALS) training, including neonatal resuscitation and simulated

intraosseous line and umbilical venous catheter placement. However, other currently required procedures, such as endotracheal intubation and peripheral intravenous catheter placement were reduced to a competency in understanding of the indications, contraindications, and complications for such procedures unless important for a resident's post-residency position. Many who commented suggest that these procedural requirements are too limited and create the potential for other pediatric providers to displace the role of pediatricians.

Another significant change proposes a minimum requirement of two months of Neonatal Intensive Care Unit (NICU), decreased from three months in previous versions. Additionally, no maximum requirements were incorporated in the newly proposed requirements for either NICU or Pediatric Intensive Care Unit (PICU) experiences as opposed to previous requirements of a maximum of six total months of intensive care unit experience. Many residency program directors voiced concern regarding the ability to balance service to educational demands if maximal limits were not maintained.

Additional modifications surrounded the longitudinal outpatient or continuity clinic experience which allow for 36 half-day sessions over a minimum of 26 weeks. This revision allows for greater flexibility than current requirements which mandate one half-day session per week for a minimum of 36 clinic weeks per year. The new requirements also suggest that third year pediatric residents may continue their continuity experience in a longitudinal subspecialty clinic or alternate primary care site rather than their traditional continuity clinic if appropriate for their career goals. Feedback related to this latter revision appears mixed, but the overall sentiment of comments reflects the importance of three years of primary care experience to avoid deficiencies in general pediatrics training. Many commented that this option may abort the development of advanced skills of complex patient care among senior

residents and may be simply redundant for residents pursuing subspecialty fellowship training. In their response to the ACGME, the Association for Pediatric Program Directors (APPD) suggested that "the added flexibility of these requirements" might allow some residents "to participate in a longitudinal subspecialty clinic experience in addition to their primary care clinic." The organization endorsed a three-year longitudinal experience in outpatient primary care pediatrics. Other proposed modifications included faculty development and program leadership requirements, competency-based curriculum and structured evaluation processes, and subspecialty elective experiences.

Further detail related to these requirements is anticipated at the time of their formal release in the form of definition of the intent of requirements in the ACGME's Frequently Asked Questions (FAQs) section and in program information form (PIF) documentation. The formal comment period for these proposed requirement revisions concluded in late August. The AAP invited all of its committees, councils, sections, and task forces to review and respond to the proposed revisions. Eighteen groups provided feedback in addition to survey responses from the AAP's Section of Medical Students, Residents, and Fellowship Trainees (SOMSRFT). In the cover letter summarizing these responses, the AAP suggests that there were "two themes that transcended these individualized recommendations" including "a serious concern that many programs are not large enough to allow residents to develop recommended procedural competencies and an anxiety that the new requirements will not provide trainees with a solid foundation in general pediatrics."

The draft Pediatric Program Requirements are available on the APPD website at [http://www.appd.org/home/PDF/ACGMEPediatricRequirements7\\_2011.pdf](http://www.appd.org/home/PDF/ACGMEPediatricRequirements7_2011.pdf).



# Points of Light Program Brightens Missouri

by Craig Hollander, MD, DDS

There is a new program that has come to Missouri that I am excited to tell you about. It began in Michigan in 2004 and I am in the process of duplicating its success here. The project, called Points of Light (POL), has a



goal to connect children to a dental home. The dental home concept was the topic of my very first article in the Winter 2004 edition of *Peds Lines*. This was shortly after the AAP and the American Academy of Pediatric Dentistry collaborated to create a policy statement that made several recommendations to pediatricians and family practitioners concerning infant oral health:

1. Every child should begin to receive oral health assessments by six months of age from a pediatrician or a qualified pediatric health care provider.

2. Referring a child for an oral health examination by a dentist who provides care for infants and young children six months after the first tooth erupts or by 12 months of age establishes the child's dental home and provides an opportunity to implement preventive dental health habits that meet each child's unique needs and keep the child free from dental or oral disease.

3. Pediatricians, family practitioners, pediatric nurse practitioners and physician assistants should be trained to perform an oral health risk assessment on all children beginning by six months of age to identify known caries risk factors for early childhood dental disease.

4. Infants identified as having significant risk of dental caries should be entered into an aggressive anticipatory guidance and intervention program provided by a dentist between six and 12 months of age.

Waiting until age three for a child's first visit is not only against AAP guidelines and recommendations, it doesn't make sense. The best time to establish a dental home would be prior to any occurrence that would warrant the surgical intervention of a dentist and instead, allow an opportunity for preventive intervention and anticipatory guidance. By the time a child is age three, lack of brushing and improper feeding habits may already be well established and causing

harm to the primary teeth that have been erupted in the toddler's mouth for two or more years. In fact, there are a significant number of children who should be seen before their first birthday due to their high risk assessment of developing dental caries.

The Points of Light project will help to eliminate the barrier of access to care because pediatricians and family practitioners will be able to find dentists in their community who are seeing children at a year of age. Pediatric dentists and general dentists are being recruited as Point of Light dentists by going to the Point of Light website [www.pointoflightonline.org](http://www.pointoflightonline.org) and registering. Unfortunately, there will not be many Medicaid providers on this list because there are not that many Medicaid dental providers in the state that are seeing these young patients, but one-year-olds who are not on Medicaid deserve a dental home as well, and it is my hope that once this POL dental network gets established, legislators will take notice that there is not an access to dental care problem, but an access to Medicaid dental provider problem. The Missouri Dental Association (MDA) is working hard to have Medicaid carve outs and higher reimbursement rates passed, but until this happens, won't you, as a health care provider help to establish a dental home for a majority of young kids in your practice?

## Here is all you need to do:

1. Support the AAP policy that the ideal time for a dental referral is no later than 12 months of age. The goal of this is not about increasing the dentist's patient volume, it is about improving the quality of care provided to the community. Early referrals offer the dentist the ability to prevent pathology, rather than react to it.

2. Become a Point of Light partner by filling out the application on the Missouri Academy of Pediatric Dentistry's website at [www.moapd.org](http://www.moapd.org). Once you sign up, you will receive posters to hang in your reception area and examination rooms. These posters inform parents that like vaccines and well-child checks, a dental examination is important for their child's overall health. Brochures can also be given to parents, which describe the importance of infant dental care and direct the parent to go to the POL website and enter their zip code to find a POL dentist in their area.

3. Put your office in the spotlight. Be one of an increasing number of pediatricians that are utilizing the dentist as a community resource. Dentists who are in the preventive mode can treat a greater number of patients than those needing restorative care. You can even go to the parent resource section of the website yourself and see if there are dentists already signed up in your area. If there are not any, please be patient. This project was just brought to Missouri the beginning of May and more dentists are being recruited to sign up and register every week.

4. Become a beacon of hope for your existing patients. There are resources available to help you with infant oral health issues such as anticipatory guidance and recognizing dental disease. When you sign up as a POL partner you will also receive an infant oral health screening guide made available by the Missouri Academy of Pediatric Dentistry (MAPD) and the MDA as well as an infant oral health questionnaire you or your nurse practitioner can use to assess the caries risk of your patients.

5. Becoming a shining example for your peers. Discuss this project with your medical colleagues. MAPD has dental presenters to give infant oral health talks and fluoride varnish application given to your study clubs or Grand Rounds.

Together, medical health providers and dentists in Missouri can collaborate to provide dental homes for children before dental problems begin. The CDC put out a report a couple of years ago that the only age group that dental caries is on the rise is in the two to five-year-old range. Physicians should inform parents about the POL website before their child has their one year molars present, so they can find a dentist who can offer comprehensive/restorative oral health to the youngest and most vulnerable patient population. You are in the perfect position to do that since infants are seeing you several times during their first year of life. It is inappropriate to wait until children have significant, although preventable, oral disease before being referred to a dentist. With your support, more parents will learn about infant oral health and make the Points of Light project in Missouri a glowing success.

Contact [craighdds@msn.com](mailto:craighdds@msn.com).



# PEDS LINES

Missouri Chapter  
American Academy of Pediatrics  
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## PEDS LINES FALL/WINTER 2011

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