Kansas City has a lot to offer beyond great food, arts and jazz - we have lined up a fantastic CME program for pediatricians to renew, refresh and enjoy. We start out with an OMM Workshop on the campus of Kansas City University of Bioscience and Medicine (KCUMB). Attendees will receive hands-on teaching with OMM professors and students by your side. After the OMM Workshop, all attendees are invited to enjoy some great Kansas City BBQ at KCUMB.

Our didactic sessions on Friday, Saturday and Sunday include topics in emergency medicine, allergy/immunology, endocrine, dermatology, pharmacokinetics and hematology/oncology. These sessions will present the latest research, treatment, and diagnostic skills you need to update and refresh your clinical practice.

The ACOP will present the 2014 Harold H. Finkel DO and Arnold Melnick DO Community Pediatrician of the Year Award, Poster Awards and Student Club of the Year Award during a reception on Friday evening. Join your colleagues for the Member Lunch and Business Meeting on Saturday.

We know that this CME course will be clinically useful for all pediatricians. Along with providing quality CME course work, we have included several opportunities to join an existing committee. Participating on a committee will help you to meet other members in your professional college, provide a great opportunity to showcase your interests and talents and give you an easy way to get more involved with ACOP.

Kansas City here we come!
Why, you ask, is the United States moving to ICD-10-CM? The ICD-9-CM with only 5 positions is out of space for meeting current and future diagnostic requirements. The classification system is organized scientifically; each three-digit category can only hold up to 10 subcategories and most numbers in the categories have been assigned diagnoses. As medical science expands to make new discoveries, the system can no longer accommodate the new associated diagnosis code. Also, more detailed coding is available in ICD-10-CM to enable better examination of disease patterns and treatment outcomes. This improvement can aid in advancing US medical care, as well as streamlining claims submissions by making the initial claim much easier for payers to understand the services provided. The latter can be a double-edged sword and makes many physicians and hospitals concerned that payers can use this information to decrease or withhold payment in the future.

The codes are mostly numeric with the current ICD-9 CM. The new ICD-10 codes will all be alphanumeric, beginning with a letter and then including a mix of numbers and letters. ICD-10, using alphanumeric coding and seven possible digits will allow for greater specificity. The ICD-10 coding system will have some of the old language from the ICD-9 system that has been converted to an ICD -10 number code as well as having codes for laterality. For example, the code for otitis media will have a code for right, left and bilateral otitis media. The code will also have recurrent and initial for the right, left and bilateral. So, you get the idea why there might be so many codes. ICD-10 was originally to be rolled out October 1, 2013, but for many reasons, Centers for Medicare and Medicaid Services postponed the implementation until 2014. The planning for implementation of ICD-10 began back in 2011 and difficulties with all levels created the postponement. According to my US Senator, the overall cost to change the system is somewhere around 18 billion dollars.

Physicians and allied health providers, hospitals and outpatient facilities, EMH and EMR vendors, clearing houses and payers, including the government (which as you know is the largest payer in the US), all played a part in delaying the implementation of the new coding system. Many issues at many levels created the delay, but the implementation

Continued on page 15
I would guess that most pediatricians (maybe all) understand the need for early education of our children, that is, from birth to five years of age. At the risk of being redundant, let me re-state a few of the many reasons that early education is so important. And it is so often totally neglected.

First, we know that 85% of brain growth occurs by three years of age. This probably makes them the most important years in the process of learning. We also know that of children who cannot read in first grade, 88% will still be poor readers by the end of fourth grade; they account for many of those students who never finish high school. On the other hand, 79% of children who complete voluntary pre-kindergarten (VPK) will be ready for kindergarten learning, as opposed to 55% who do not.

Current popular thinking seems to be that education of a child begins with kindergarten or first grade; in fact, our formal educational systems (K-12) are based on that. But research show that real education starts at birth. They suggest that the strongest boost to the education of our children is to have these youngsters arrive at kindergarten or first grade well prepared, so that they can meet the necessary educational milestones. Today about 30% of our children are way behind that entrance point and many never catch up. In Florida, 44% of public school third-graders cannot read at grade level.

Understanding some of the results of being left behind, we need to remember that, on average, pre-K education costs $2,583 a year – as opposed to incarceration costs of $51,000 annually.

Why is all this happening? For one, newer developments in our lives and today’s insights create some additional concerns and standards. Second are the changes in the life of children today: In more than 40% of births today, the mothers are single and half of them have no significant other. In addition, two-thirds of mothers with children under five years of age work outside the home. In one way or another, less time with mother means children have no significant other. In addition, two-thirds of mothers with children under five years of age work outside the home. In one way or another, less time with mother means children are deprived of much of the mother-teachings that occurred in the past.

So what does that have to do with pediatricians? We exert our influence and provide our expertise in medical, developmental and illness fields. But do we directly concern ourselves with the educational aspects of those to whom we provide service?

Not in any unified way. Why should physicians, especially pediatricians, be interested in this? Because physicians are, in most cases, the only helpful professional that a child sees in the first few years of life. If no assistance is available or offered, ultimate intellectual and educational progress may be endangered.

But what can we do – or should do? Besides the services we now universally offer, perhaps we should have a more dependable mode to give aid to parents. I am thinking of an analogous situation which many older pediatricians will remember: the long gap in practical evaluations of development starting with the signal work of Arnold Gesell, MD, to the many-years-later concrete evaluation tool of the Denver Developmental Screening Test – an examination that on a practical basis gave us an easy-to-use tool.

I don’t want to pretend that I have the immediate answer but I visualize something like this: A carefully studied and standardized aid for pediatricians, with age levels (as in the Denver Developmental Test), appropriate and easy for pediatricians to use routinely to assist them in assisting parents with educational needs, goals and guidance. Such a group needs to include pediatricians, reading specialists, early childhood educators and developmentalists.

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Continued on page 15
By Stanley E. Grogg, DO, FACOP, Associate Dean and Professor of Pediatrics, OSU-CHS, Tulsa, Oklahoma.

Using the term, icon, as synonymous with idol, Arnold Melnick fits the definition easily. During his 93 years of a highly productive and creative lifestyle, he has been, and continues to be a strong advocate of the osteopathic profession since his acceptance to the Philadelphia College of Osteopathic Medicine (PCOM) in the early 1940’s. If you “Google” Arnold Melnick, DO, you will quickly see some of his many professional articles, books and distinguished service awards from professional groups. When one opens an osteopathic magazine or the Journal of American Osteopathic Association (JAOA), Arnold’s picture and articles are frequently found.

That being said, I would like to take you on a “virtual trip” through Dr. Melnick’s home in Aventura, Florida, just north of Miami. The purpose of our visit (myself and my wife, Barbara) was to collect ideas for publishing original works. I have been “toying” with the thought of writing a book about our many adventures including such topics as, “Around the World in a Jet Plane,” “Circumnavigation of the US’s Great Loop,” and a subject dear to our hearts, “Medical Students and Global Health Outreach.”

I emailed Arnold and told him I would like to visit with him, face to face, to discuss the topic of “Getting Published.” He welcomed us with open arms to come visit him at his home in Miami, Florida. Coincidentally, I had made plans to visit relatives in Florida over New Year’s and on December 30, 2013 at 9:30 am, we arrived at Arnold’s fabulous residence.

From the floor level, where he met us in the lobby, one could not envision that the ocean was within viewing distance. Barbara said if we lived in this area, she would want to be able to see the ocean. Surprise, as we arrived to his home on the 24th floor, this was the view awaiting us:

And of course, Arnold had coffee, tea and donuts waiting for us. We were very intrigued by all of the maternal-child art work and other relics and family pictures on the walls and tables. Barbara and I were not ready to sit down. I asked if we might have a tour of his art museum. His eyes expressed a “happy notion” and we were off to view his vivacious home.

As many of you might know, Dr. Melnick, along with the late Harold Finkel, DO, owned, published and edited a monthly journal/magazine called Maternal and Child Health, which was the journal for the American College of Osteopathic Pediatricians and the American College of Osteopathic Obstetricians and Gynecologists.

Knowing this fact, we were not surprised at Arnold and his deceased wife, Anita's,
collection of maternal/child paintings, sculptures and collector items. On further questioning, we discovered that Arnold had over 100 pieces of maternal-child art works.

Dr. Melnick is very proud of his family. He has many family pictures. As we discussed DOCARE global health outreach, he noted that his son, a psychiatrist, was involved with interviewing and caring for the “displaced people” from the New Orleans Katrina catastrophe.

Arnold’s continues to use his office to write and edit publications, including the ACOP’s PULSE.

Arnold then politely suggested that we talk about “getting published.” Sitting down with coffee and tea in hand, we were amazed at all of the changes that have occurred with publications. Arnold had many articles and suggestions for us. In the past, a printing company required a minimum number of books to be printed, which resulted in a substantial cost. Now with computers and printers, one can obtain POD (publish on demand). By “googling” POD, we found several companies that could utilized for publishing at a very low cost.

All too soon, our time was coming to a close and we needed to depart. Barbara and I were so intrigued with Arnold and the discussions of osteopathic past, present and future and all of the incredible memoirs, that we had almost forgotten why we had come to visit. Subsequently, I received in the mail “afterthoughts” and several suggestions for getting started when publishing a book.

Thank you Dr. Melnick for all of your contributions to the Osteopathic profession, and in particular for your “fathering” the American College of Osteopathic Pediatricians. You will always be part of our memories.
There are documented benefits of breastfeeding for the infant, mother and our society both in the short and long term. The greatest health impact is found with early initiation, exclusive breastfeeding for the first six months of life, and continued breastfeeding with appropriate complementary foods for the first year of life and beyond. Breastfeeding is a basic and cost-effective healthcare measure. Unfortunately, many healthcare practitioners do not have sufficient knowledge to support their families and communities.

The Core Competencies in Breastfeeding addresses the relative paucity of professional training in human lactation and breastfeeding. Several years ago the American College of Osteopathic Pediatricians (ACOP) endorsed the document Core Competencies in Breastfeeding Care and Services for All Health Professionals created by the United States Breastfeeding Committee (USBC).


Over 40 professional organizations now support the Core Competencies. Many of these organizations have started to address this educational need. The American Academy of Pediatrics has developed an educational module that is now mandatory in the training programs of ACGME Pediatric residents. This module is also available to other resident-student training programs (www2.aap.org/breastfeeding/curriculum/).

In 2010, Lori Feldman-Winter (PEDIATRICS Vol. 126 No. 2 August 1, 2010 pp. 289 -297) documented improvements in exclusive breastfeeding rates at 6 months of age for mothers who had intervention provides by residents who had participated in residency education. The study included obstetrical and family practice residents.

Now is the time for our Osteopathic colleagues to get on board. The AAP curriculum was given to the ACOP. Now is the time to ensure that all of our residents participate. We need to champion this to the AOA, ACOOG and ACOFP. We are in the process of engaging the American Association of Colleges of Osteopathic Medicine (AACOM). The health and well being of our nation depend on the ability of its practitioners to help and support these mothers and infants entrusted to our care.

In 2011, the Surgeon General Regina Benjamin in her Breastfeeding: A Call to Action again identified the paucity of support provided by physicians and healthcare workers, also noted in an earlier 1984 document by then Surgeon General, C. Everett Koop. This needs to change.

We now have the opportunity, as professionals, to provide our help and support. We realize that there are some women who cannot, should not, or chose not to breastfeed. They need, and deserve, our emotional support as well as our permission to wean or not nurse. But the majority of mothers who decide to breastfeed their infants (70 – 90%), expect and deserve to have an knowledgeable pediatric practitioner.

The USBC Stated:

At a minimum, every health professional should understand the role of lactation, human milk, and breastfeeding in:

• The optimal feeding of infants and young children.

Enhancing health and reducing:

• Long-term morbidities in infants and young children.

• Morbidities in women.

All health professionals should be able to facilitate the breastfeeding care process by:

• Preparing families for realistic expectations.

• Communicating pertinent information to the lactation care team.

• Following up with the family, when appropriate, in a culturally competent manner after.

• Providing breastfeeding care and services.

USBC proposes to accomplish this by recommending that health professional organizations:

• Understand and act upon the importance of protecting, promoting, and supporting breastfeeding as a public health priority

Educate their practitioners to:

• Appreciate the limitations of their breastfeeding care expertise.

• Know when and how to make a referral to a lactation care professional.

• Regularly examine the care practices of their practitioners and establish core competencies related to breastfeeding care and services.
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When you are not participating in the stimulating CME activities, get out and explore the “Paris of The Plains.” Kansas City’s prestigious nickname comes from the city’s rich culture, famous jazz music, and coveted barbecue restaurants, with Sheraton Kansas City Hotel at Crown Center at the epicenter of it all.

Located in the heart of Kansas City’s Crown Center, near the downtown business and government district, the hotel is just a walkway away from the Crown Center Shopping Center. A city within a city, the center offers 85 acres of destination shopping, dining and entertainment, including the Sea Life Aquarium and Legoland Discovery Center. The Power and Light District and the Crown Center Exhibit Hall are just minutes away.

Branch out a little bit further and you can catch a Royals baseball game at Kauffman Stadium or the Kansas City Symphony at the Kauffman Center for Performing Arts. For history buffs, visit the Liberty Memorial.

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TALES FROM ADOLESCENT MEDICINE

Dr. Castonguay is a physician at the Adolescent Health Center, Division on Adolescent Medicine, Department of Pediatrics, Akron Children’s Hospital, Akron Ohio. She has completed a Fellowship in Adolescent Medicine and a Masters of Public Health at Nationwide Children’s Hospital and Ohio State University School of Public Health. Questions or suggestions for future topics to be covered in this column? Write us at acopublications@gmail.com.

What is Normal?

By Jessica S. Castonguay, DO, MPH

By far the most common curbside questions I receive relate to heavy vaginal bleeding. Is she bleeding too long? Is her bleeding too heavy? That’s not enough time between periods? What labs should I check? Before we know what is abnormal, it is good to know what can be expected around the time of menarche and the following year…or two.

The average age of menarche in the US is 12 years with a range of 9-15 years. During the first year after menarche, 80% of cycles are between 21 and 45 days in length and bleeding lasts from two - seven days. Menstrual flow can vary from cycle to cycle. In general, using six or less sanitary products daily is considered acceptable. Many young women experience irregularity due to anovulation, a result of an immature hypothalamic pituitary ovarian (HPO) axis. Full maturation of the HPO axis can take more than two years.

Abnormal uterine bleeding is painless, heavy and/ or irregular. The differential of abnormal uterine bleeding includes hypothyroid conditions, polycystic ovarian syndrome, bleeding disorder, STI such as cervicitis, and anovulation.

Getting this history can be difficult from an adolescent. Everything is heavy, periods happen twice a month and they last forever. Important information to obtain includes age at menarche, usual menstrual pattern, sexual activity, use of contraceptives, bleeding and bruising history. Determining the usual menstrual pattern tends to be the most difficult portion of this history to obtain. In this case, a menstrual calendar may be helpful. Many of your patients have smartphones and there are lots of free apps to track menses. If not, there are printable versions available online.

What happens when the history is not compatible with “normal?” What should you do? When bleeding occurs more frequently than every 21 days, if the patient is saturating more than six pads per day, or if she has to wake at night to change her protection, further work-up is needed. This type of bleeding can result is significant anemia and resultant symptoms such as tachycardia, postural orthostasis, and syncope.

Common labs include CBC, TSH, hCG. If the patient is sexually active, screening for a sexually transmitted illness (STI) is imperative. If there is a history of bleeding in the patient or family, include PT/PTT and a von Willebrand panel with platelet function analysis.

ATTENTION! ALL STUDENT CLUBS

PULSE wants to know about your club activities. If you would like to publicize what you are doing to inspire others, please send a short article, photos (no more than two) and be sure to include captions for any photos sent in. These can be sent to the PULSE editor by email at ACOPublications@gmail.com.

Handle patients with a positive pregnancy test per your office policy. Many are sent to the ER or to a local OB/Gyn. Refer abnormal bleeding studies for work up from hematology. Further evaluate an abnormal TSH. Treat STIs per the most current CDC guidelines. If these are otherwise normal, your care is based on the level of anemia.

Normal hemoglobin
- Reassurance
- Menstrual calendar
- Follow up in two to three months

Anemic, hemoglobin >10
- Monophasic, combined oral contraceptive pill, daily
- Iron supplementation
- Follow up two months

Anemic, hemoglobin <10
- Monophasic, combined oral contraceptive pill, taper
- Iron supplementation
- Transfuse if hemoglobin <7
- Follow up one week post transfusion, one month otherwise

Many of my patients come in convinced that they are bleeding to death. Some mothers are over anxious about their daughters having normal periods. Some are just so active that the irregular or heavy bleeding impacts their ability to participate in sports or other hobbies. Whatever the reason, this is something that can be fixed. Patients are generally happy with the results of using combined oral contraceptive pill (COCs) to control menses. COCs should be continued for at least six months before stopping them. These are very satisfying visits.

Visit www.acopeds.org for the latest issue of eJACOP
Louis J. Schaner, DO, FACOP
Harold H. Finkel, DO and Arnold Melnick, DO
Community Pediatrician of the Year

Louis J. Schaner, DO, FACOP, has been a leading force in the care of children in Ohio since the 1960’s. Despite the economic challenges in Ohio, Dr. Schaner expanded his personal practices and those of the county health department to deliver top quality pediatrics to children and families of all economic strata.

Dr. Schaner was also a driving force in establishing a strong osteopathic presence in Ohio. He was the first osteopathic physician to obtain privileges at Doctor’s Hospital. He helped establish a safe working environment for osteopathic physicians that permitted other osteopathic physicians to join the community.

Dr. Schaner is highly involved mentor of junior osteopathic physicians and students. He was one of the original faculty members of the Ohio University College of Osteopathic Medicine and Northeast Ohio Medical University.

Across the span of five decades, he was consistently dedicated to his patients, community and the osteopathic profession. A true leader and model physician-citizen, Louis J. Schaner, DO, will accept his award as the ACOP’s Community Pediatrician of the Year at the ACOP Spring Meeting in Kansas City.

Martin A Finkel, DO, FACOP
American Osteopathic Foundation’s 2013 Physician of the Year

Martin Finkel, DO, FACOP, has received the distinguished honor of being selected the American Osteopathic Foundation’s 2013 Physician of the Year. Dr. Finkel, physician-scientist-advocate, is an international expert in the field of child sexual abuse. Starting with the first scientific paper published in the medical literature on the science of diagnosing sexual abuse in 1989, through his recent co-authoring of the internationally recognized global standard textbook, AAP’s Medical Examination of Child Sexual Abuse: A Practical Guide, Dr. Finkel has been a scientific leader and advocate for children. Dr. Finkel is the founding director of the Child Abuse Research, Education and Service Institute (CARES). The CARES Institute is a comprehensive full-service provider of medical support and care to children who have experienced sexual abuse. Dr. Finkel is an active member of the ACOP and former ACOP President and Trustee. He is also a Professor of Pediatrics at Rowan University School of Osteopathic Medicine (formerly known as UMDNJ-SOM) and faculty educator to many members of the osteopathic and allopathic pediatric community. Additional information on the American Osteopathic Foundation can be found at https://aof.org/home. For more information on the CARES Institute go to http://www.caresinstitute.org/.

In the JOURNALS

ACOP Members in Print

Erik Langenau, Scott Cyrus, Lisa Ryan
Osteopathic Manipulative Treatment (OMT) for Pediatrics
[E-Letter], Pediatrics (July 26, 2013). Available at http://pediatrics.aappublications.org/content/132/1/140.abstract?reply=pediatrics_el_56064

Stanley E. Grogg, DO
It’s All About the Footnotes: 2014 Vaccine Schedule
J Am Osteopath Assoc February 2014 114:e76-e83; doi:10.7556/jaoa.2014.017

Erik E. Langenau, DO
Patterns of Misrepresentation of Clinical Findings on Patient Notes During the COMLEX-USA Level 2-PE

If you or someone you know has an article in print, share the good news and let us know at ACOPublications@gmail.com.

Prescription Pads are Available to ACOP Members

These prescription pads can be used to deliver clear, consistent messages to your patients during the well child exam. This simple tool can help you get your patients and families to start making changes. You can help educate, motivate and encourage all patients to live healthy lifestyles. Visit www.acopeds.org to order.
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Lia Cruz, DO .......................................................... Camden, NJ
William Emanuele, DO .............................................. Camden, NJ
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Greg Leasure at greg@societyhq.com
Physician Presence on Social Media

By Tami Hendriksz, DO, FACOP

The surge of social media over the last decade has been enormous – if Twitter and Facebook were diseases, we would call them epidemics. The Pew Internet & American Life Project, a nonprofit with goals of providing information on issues and trends shaping America, reports that 72% of internet users in the United States have searched online for health information in the last year. Combine that fact with the knowledge that there are more than 1.1 billion people on Facebook, and 218 million monthly active Twitter users, and it comes as no surprise that many patients are expecting their physicians to have an online presence.

The American Academy of Pediatrics recommends that pediatricians ask children and adolescents about their internet and social media usage. Inquiring about kids’ usage of different social networking sites (Facebook, MySpace, Twitter, etc), as well as gaming sites and virtual worlds (Club Penguin, Second Life, and the Sims), and video sites (ie, YouTube) helps to screen children and adolescents for potential problems with cyberbullying, “Facebook depression”, sexting and exposure to inappropriate content. Educating children, adolescents, parents, and families about the potential dangers of the internet and social networking sites is an important goal. Is asking patients about their usage, and educating about the risks of social media enough?

Not according to some physicians and internet enthusiasts who say that having a positive image and active presence on social media sites is also an important goal for the physician. The Internet is abundant with inaccurate health-related information and potentially dangerous medical advice from non-medical sources. Trained physicians have the opportunity to help educate, dispel such propagated myths, and offer accurate health information. A well-meaning first-time parent may do an online search for the safety of vaccines, and without knowing which sources are reputable and trustworthy, may be overcome with a number of sites and reports of the dangers of vaccines. Physicians who direct patients to reputable websites, offer educated opinions and useful stories could help to balance out the health-related information inequities online. The internet and social media are such vast resources that it can be difficult to know where to start.

Dr. Kevin Pho, the self-proclaimed “social media’s leading physician voice” and the physician responsible for the health-related site kevinmd.com, recommends LinkedIn as an excellent starting point for physicians who are interested in developing an online presence. LinkedIn is “the World’s Largest Professional Network”, and creating a LinkedIn profile is equivocal to building a digital CV. The benefit of a profile on LinkedIn is that the profiles tend to get ranked highly on search engines, so that when a patient performs a search on a physician’s name, their LinkedIn profile (which the physician has created and controlled the content of) usually shows up first, above profiles from physician rating sites. According to Dr. Pho, “if that’s all a doctor has time for, that’s fine. That simple act (of creating a LinkedIn profile) will already put him or her ahead of many of his or her peers.”

If physicians do want to go further, and create an active public Facebook account, Twitter feed, YouTube channel, healthcare blog, etc., then they are encouraged to proceed – with caution. The move from posting a profile that contains autobiographical data about where you trained and currently practice to offering advice or recommendations to patients should be handled carefully. The American College of Physicians and the Federation of State Medical Boards have both recommended that doctors should use caution when talking to patients on social media. One important recommendation is for the physician to view social media as a way to connect with patients collectively, and NOT individually. Speak to the patients as a group, potentially discussing health-related news stories, or changes in screening guidelines. If a patient (especially one that is unknown to the physician) reaches out with a personal health question, then the physician should not answer (other than to recommend that an appointment be made with the physician, or if an emergency, call 911 or go to the nearest emergency department.)

In April of 2013 the Annals of Internal Medicine published “Online Medical Professionalism: Patient and Public Relationships.” The purpose of this policy paper was to provide guidance to physicians online on best practices and code of professional conduct. The recommendations delivered in the paper include:

• Not “friend” or connecting with patients on social media
• Not using text messaging for medical interactions, unless doctors exercise extreme caution and have consent from the patient
• If using e-mails or other electronic communications, keep them within an established patient/physician relationship and with patient consent
• If a person reaches out to a doctor through electronic means and are not a patient, physicians should use their judgment and usually encourage the person to schedule an office visit or go to the emergency room – whichever is more appropriate.
• Creating a professional profile that will show up first on a search instead of results from a physician-ranking site in order to control your image.
• Being cautious of what material doctors post and what online content is attributed to them.
• Encouraging education programs that take a pro-active approach to a person’s digital image or online reputation.

Dr. Pho worries that these recommendations, although sound, may scare off more doctors from using social media. He discusses the benefits that patients receive from using doctors’ social media accounts which link to accurate health information websites and important health stories. “Social media can help better connect doctors and patients. It’s a shame that a lot of doctors are shying away from it,” concludes Dr. Pho.
By Steven Snyder, DO, MS, FACOP

Steven Snyder, DO, MS, FACOP
(ACOP President: 2002-2004)

The years leading up to becoming the President of our College and during my Presidency were transformational. When I was elected to serve on the Board, the ACOP was going through a difficult period. Residency Programs in allopathic hospitals were opening up for our graduates and our membership was declining. As a newly elected Board member, I was asked to chair the Membership Committee. Not a fun task. Nevertheless, with the help of several loyal volunteers and Board support, we created many opportunities for many DOs to come back and opened opportunities for DOs in allopathic programs to become members of the ACOP. This was possible only with the hard work and dedication of the Board to champion this initiative with the AOA.

At the time I became Chair, the College’s relationship with the AOA was strained. The number of residency slots was insufficient to provide the educational opportunities needed by the College. As mentioned previously, allopathic hospitals had opened their doors to our graduates. The college needed to develop a relationship with the osteopathic colleges and those students interested in pediatrics prior to them starting a residency. Under the leadership of Mike Musci, DO, the Board approved bylaw changes to allow a new membership category - Student Members. With the help and support of the Board, student chapters were developed, complete with their own by-laws. We also had the opportunity to improve our relations with the AOA. John Crosby was extremely helpful in trying to keep the doors open for our members. Finding ways to allow members with allopathic training to come back was critical to our growth.

Another challenge for the College was its executive management. We were financially limited as to what we were able to accomplish. David Kushner, CAE, CMP, positioned us well to face the altered landscape of organizations. Unfortunately, we could no longer afford his services. Several good things happened. The Board needed new direction and we were able to utilize the AOA executive management services. With the help of the AOA, we were able to better create manageable budgets and set out to create a strategic plan for the College. Mike Musci, DO, was influential in this task, making good use of his recently earned MBA. Lee Herskowitz, DO, convinced the Board that the College’s financial holdings were not helping as much as they could. The ACOP was able to develop a financial portfolio and plan to better face the challenges of the future. Unfortunately, within a few short years, our management with the AOA started to falter. At the request of Martin Finkel, DO, I, along with Stan Grogg, DO and Lee Herskowitz, DO, started a process that led us to Stewart Hinckley. Stewart’s organizational skills helped to transform our college to our current position.

Communication with our members has always been a challenge. The PULSE mailings were getting more expensive and there was a desire to end publication. Fortunately, the Board was convinced that we could not stop communication with our members. Arnold Melnick, DO, was called upon to champion The PULSE and serve as Executive Editor. Robert Locke, DO, was made Assistant Editor and has recently taken over from Arnold as Editor. They have made terrific improvements in the publication and maintained the vital link we have with our members.

A major function of the College has been education. Over the years we have enjoyed world class educational programs from our members and invited guests. Planning for the CME programs and soliciting support was becoming more difficult. In an effort to try to improve this process, I created a CME Czar. The purpose was to have someone oversee the process and develop processes that would easily provide members who wanted to “get involved”. To make this work, the position was designed as a five-year position. Scott Cyrus, DO, had done a fantastic job as CME Chair, so I asked him to hold off moving up on the Board to tackle this important challenge. Scott does not do anything halfheartedly. He threw himself into the position and gave us a solid block of quality CME programs. He is a hard act to follow.

The ACOP also has a strong history of advocacy. While on the Board, I was allowed to represent the College on the United States Breastfeeding Committee. I still serve on the Committee and have been joined by Robert Locke, DO. Together, we have been able to introduce our public and private partners to osteopathic pediatricians. I think we have represented our College well. During my time on the ACOP Board, I got to represent the ACOP at the AOA House of Delegates. With help from Drs. Stan Grogg, Scott Cyrus, Laura Stiles, Gregg Garvin and many others, the ACOP had a noticeable presence at the House of Delegates. Many resolutions and committee involvements made the ACOP truly the voice of Pediatrics within the AOA. This allowed the ACOP to have several of our members serve Federal Public Policy Fellowships.

A final area of pride is the work done by Fernando Gonzalez, DO, with the American Board of Osteopathic Pediatricians (AOBP). The Board was in trouble. Stan Grogg, DO, was helpful in setting up meetings with the Bureau of Specialists. We were able to work collaboratively with the Bureau to recruit Fernando Gonzalez, DO, who took over leadership. We went from a collapsing Board to one of the strongest and finest in the profession. The hard work and dedication of our AOBP is to be commended.

Although we made a great deal of progress, there were two areas I felt could use ongoing improvement. The first was trying to expand the numbers of our members involved with the Colleges’ activities. Our Board and Committees are composed of volunteers. Some members stood out and performed admirably. It was difficult for me to bring a common vision and provide inspiration to continue the work we needed to accomplish. This was most profoundly noted with our involvement with the Colleges, through the AACOM (American Association of Colleges of Osteopathic Medicine) and advocacy with the AOA and the AAP. I attended several of the AACOM meetings and had difficulty enlisting an ACOP representative to try take over to improve our presence and influence with this important group. We surveyed how the
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in October is firm, as I understand it from my meetings with CMS. I was selected as one of six physicians to meet with CMS and explain the situation that physicians face regarding the implementation of ICD-10. I represent our hospital as the “Physician Champion” for the system and have had numerous meetings to prepare physicians, along with their office staff, for momentous change in our coding system. Just as a side note, the change to ICD-10 will NOT affect the HCPCS, or “hicks picks”, which include Current Procedural Terminology (CPT) codes used in outpatient settings.

Physicians will need to take an active role in understanding the ICD-10 system and should be working with their hospital, outpatient facilities, vendors, and payers to make sure that they are ready. One of the biggest concerns voiced in my most recent meeting with CMS is the lack of communication regarding “payer readiness” in claim submission. The likelihood of increased accounts receivables “AR”, because of the inability of payer to understand the new code system, could delay payments severely and put a strain on cash flow. The US is one of the last countries to convert to the international coding system and so many countries have already experienced slowdowns in reimbursements. To help prevent this, tests should be run on the system with vendors, clearing housing and payers to discover any problems that will cause slowdowns in payments. There is a worry that there will be a “mad scramble” after implementation to correct system problems and that could be disastrous. October 1, 2014, is a Wednesday and no ICD-9 CM codes will be accepted after that date. The claims for dates of service prior to October 1 will need to be on the ICD-9 coding system and therefore if it is possible to send in your claims on September 30th on the old system, that might not delay payment and upset your accounts receivables. As a good Boy Scout once said, “Be Prepared” for these changes and lessen the possible damage.

Register for the ACOP 2014 Spring Conference in Kansas City April 25-27, 2014 and enjoy the fellowship of the ACOP as you increase your knowledge in the world of Pediatrics.

The last area of concern is advocacy. Most of the advocacy issues for the AOA are pushed by Family Practice, Internal Medicine and Surgery. The AAP does not seem to consider us an equal partner in supporting their agenda. We have an opportunity with both to improve. On the AOA side, we must make inroads with the Federal Health Council. We need to be an active part of their organization and planning. We were wonderful in support of SCHIP, but there is more to do to help America’s children. Within the AAP’s Section of Osteopathic Pediatrician (SOOP), we have the opportunity to use our influence to improve our status. Our involvement with the AAP should not just be an easy way for their members who didn’t have an osteopathic residency to get Osteopathic CME credits for licensure. We need to deepen our partnership.

My wish for our leaders, now and in the future, is the courage and energy to strive for what the College can become. I offer my help and support for our future.

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With such an instrument, the pediatrician could screen a child’s reading skills and focus on further advice regarding reading and education, maybe even giving some concrete suggestions. There is enough published research to justify and support such a schedule. Just as an example, a possible item on such a schedule might be: 

Four year check-up: Ask parent whether the child is being read to? How much and how often? (Goal: Child at this age should be read to 6-7 times a week.) If this goal is not met, recommend this frequency and suggest actual books.

I feel strongly feel that this is the next important step in the pediatrician’s armamentarium for helping each patient reach his or her potential, something that will aid pediatricians in helping parents care for the educational needs of their children-- in addition to all other services they provide -- because usually this is the only line they have before starting school. And better educated children means healthier children--and grown-ups.

I am indebted to David Lawrence, Jr., Chair of The Children’s Movement of Florida (see related article, page 3), for much of the statistics quoted here.

Do you have some favorite anecdotes? Personal? Office? Are you willing to share them with me? I’d like to collect them and maybe share them with others. Please send them to melnick5050@comcast.net and be sure to include your name and address (street or e-mail). They will be appreciated.

As would be expected, early meetings of the ACOP were sparsely attended because the initial membership was so low. When organized in 1945, and for a few years later, it was really a local group – made up of that handful of DO pediatricians who were the founders. After a couple of years, other sections of the country were included and the annual meeting became “national” – still with low attendance. The earliest noted annual meeting was in 1946 in New York City with 8 or 10 members present. Helen Hampton was the ACOP President.