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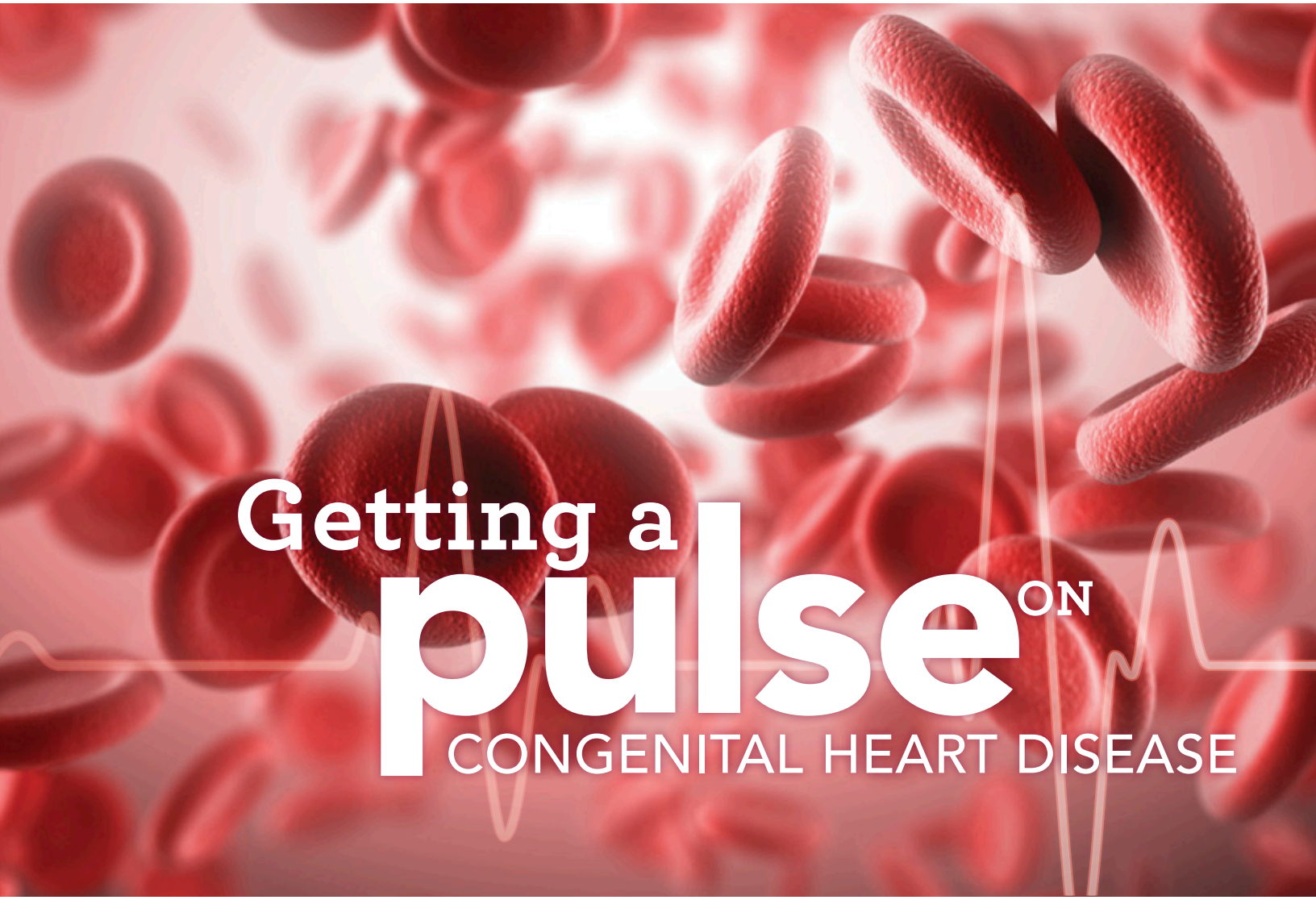

Getting a pulse ON CONGENITAL HEART DISEASE

Providers incorporate pulse oximetry into routine screenings to help prevent delayed diagnosis of critical congenital heart disease

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Children's℠ Healthcare of Atlanta
Dedicated to All Better

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MedClips feedback
Send your feedback to Katie Tanner at katie.tanner@choa.org or 404-785-8832.

Visit the Physician Portal at www.choa.org/md for access to key resources, news and important announcements.

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Dan's column

Inspire the best in people

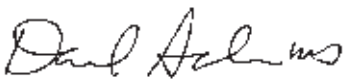
In May, I started the first of four columns reviewing our new strategic plan, starting with our first strategic focus area—Delivering the Best Care. This month, we focus on how we engage and support our people, including our physicians.

Last month, MedScape released the results of their annual Physician Compensation Report, which tracks physician satisfaction in addition to income. Pediatricians, as usual, ranked at the bottom of the list in pay, but interestingly, ranked highest in overall satisfaction. Still, in one year, the number of physicians overall who would choose medicine again as a career dropped from 69 percent to 54 percent.

For those who heard Tait Shanafelt, M.D., hematologist from the Mayo Clinic, speak at the April Professional Staff meeting, this news should not come as a shock. For many, the pressures of practicing in today's environment are becoming overwhelming to many of our colleagues. At Children's, we take pride in being ranked by FORTUNE magazine as a great place to work for our staff, but we also want to be an organization that attracts and retains the best physicians—and builds the physician workforce of tomorrow through our affiliations with medical schools.

While we are committed to building a great clinical, research and teaching organization, it's also critical that we build the leadership skills of our physician leaders, cultivate the next generation of physician leaders and address the personal and emotional needs of staff. After our spring Professional Staff meeting, we received feedback encouraging Children's and the Medical Executive Committee to create a Physician Wellness Program. We are currently assessing the feasibility of that kind of program.

Ultimately, we believe that inspiring the best in our physicians translates into the best care for our patients.



Daniel Salinas, M.D., Chief Medical Officer

Pulse oximetry can help prevent delayed diagnosis of critical congenital heart disease

Several studies evaluated the use of pulse oximetry screening on newborns before hospital discharge to detect life-threatening critical congenital heart disease (CCHD). William Mahle, M.D., pediatric cardiologist, Sibley Heart Center, helped conduct a lengthy review process that examined the effectiveness of expanding the newborn screening process to include pulse oximetry.

The current approach to detect CCHD relies primarily on prenatal ultrasound and physical exams in the newborn nursery. CCHD is not detected in some newborns until after their hospital discharge. Mahle's team found that clinicians can easily incorporate the readily available, noninvasive and painless technology into routine screenings, which can prevent the delayed diagnosis of CCHD that can result in injury or death to infants.

Studies showed that routine pulse oximetry performed on healthy newborns in the hospital nursery 24 hours after birth may detect CCHD. However, a child with normal results may still have a CCHD. Negative test results do not necessarily mean that the child will never have heart disease.

"Right now, pulse oximetry is the best tool that we have to screen for CCHD, but it's not perfect," said Matt Oster, M.D., MPH, pediatric cardiologist. "In the future, I think we may have newer and better ways of detecting CCHD, but for now, I'd like to see all newborns be screened for CCHD using pulse oximetry after 24 hours of age."

Mahle also led the development of the 2009 AAP/AHA statement and chaired the Secretary of Health and Human Services workgroup to develop *Strategies for Implementing Screening for Critical Congenital Heart Disease*. As a result, Secretary of Health and Human Services Kathleen Sebelius recommended that pulse oximetry be added to the recommended uniform screening panel (RUSP) last September.

Within 24 hours after birth, providers can obtain oxygen saturations in the right hand and one foot by performing pulse oximetry screening with motion-tolerant pulse oximeters

If put in place, hospitals with onsite pediatric cardiovascular services could perform routine pulse oximetry 24 hours after the baby's born—at a very low cost and minimal risk of harm. In the meantime, researchers continue to collect and review data on how pulse oximetry impacts outcomes for newborns with CCHD.

Visit www.choa.org/pulseoxscreening for more information, including the full AAP recommendations for implementation.

NEWSandNOTES

TeleTracking upgrade

Children's will implement the new Capacity Management Suite for TeleTracking June 26 at our Scottish Rite hospital. The Suite allows patient care units and the Transfer Center to place and track patients' movements throughout the System with greater transparency and includes:

- BedAhead and Discharge Milestones, which provide a real-time snapshot of expected admissions and the steps completed in discharge planning
- Viewable discharge orders entered by physicians in real-time to expedite patient discharge
- The ability for nursing unit leaders to accurately and appropriately prioritize a patient placement based on unit resources and physician's preference

The system went live at our Egleston hospital, May 22. Contact Cheryl Stokes, 404-785-8906, for more information.

Mt. Zion urgent care services relocating to Hudson Bridge

To better serve the needs of pediatric patients with minor illnesses and injuries, Children's is opening a new urgent care center in August. This location will house urgent care services previously available at our Mt. Zion location, while rehabilitation services will remain. The move will allow us to offer specialized pediatric care to a larger number of families from surrounding counties. We will provide a summary of each patient's visit to his pediatrician to help facilitate continuity of care, and visits will be accessible via accessCHOA. Visit www.choa.org/urgentcare for more information.

1510 Hudson Bridge Road
Stockbridge, GA 30281
404-785-8660

Monday to Friday:
11 a.m. to 9 p.m.
Weekends: 9 a.m. to 9 p.m.
Holidays, 9 a.m. to 7 p.m.

Webcast on childhood obesity co-morbidities

The Strong4Life Provider Program will present a roundtable discussion designed to help physicians identify, diagnose and manage hypertension in overweight and obese children. The live streaming webcast starts at 12:15 p.m. on Thursday, June 28. Speakers include Stephanie Walsh, M.D., Donald Batisky, M.D. and Geoffrey Simon, M.D. Registered attendees will be able to ask questions remotely. Continuing medical education (CME) credit is available for physicians. Visit www.choa.org/webcast to register.

Children's Healthcare of Atlanta is accredited by the Medical Association of Georgia to provide continuing medical education for physicians.

Children's designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)TM Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Q&A

Sudden cardiac arrest

Contributing author Robert Campbell, M.D., Chief of Cardiac Services, Children's Healthcare of Atlanta Sibley Heart Center

You recently co-wrote an American Academy of Pediatrics policy statement on pediatric sudden cardiac arrest (SCA). What do you hope physicians see as the takeaway?

Our primary goal is to become better at diagnosing the rare disorders that predispose pediatric and young adult sudden cardiac arrest. Learn the warning signs and symptoms that may be present in patients or families affected. Warning signs and/or symptoms can be very subtle and misinterpreted, and many of the disorders that can cause SCA are genetic, which makes taking a detailed family history critical.

What is your advice for when people have sudden cardiac arrest?

Help ensure in advance that individuals know how to activate an emergency response system, including an automated external defibrillator (AED). When someone goes down suddenly and unexpectedly, assume they are having cardiac arrest and respond that way.

How can the public be better prepared?

The Centers for Disease Control and Prevention estimated that approximately 2,000 people younger than 25 will die of SCA every year in the United States. While the risk is low for a young athlete to have an arrest, we should remember all of the adults—referees, the principal, school board, parents, boosters and coaches. What if one of them has an arrest?

What is Children's doing to help prepare school systems?

Through Project S.A.V.E., we provide training to help ensure schools have an emergency action plan. We have educated about 1,000 schools, and we have seen more than 30 lives saved at these schools.

Visit www.pediatrics.org/cgi/doi/10.1542/peds.2012-0144 to read the AAP policy statement.

See www.choa.org/projectsave to learn more about Project S.A.V.E.

Outcomes research program looking to improve cardiology results

It had been a long day in the cardiac intensive care unit for Matt Oster, M.D., MPH, a pediatric cardiologist. Fatigued, and sitting in the unit, he polled his co-workers about their long-term predictions for their patients.

Caregivers prepare a baby for open heart surgery.

"It was a dismal view," he said. "And at that moment, I knew we needed to think about ways to improve the long-term outcomes of our kids."

That was more than three years ago while Oster was a fellow at the Sibley Heart Center at Children's, and a guest researcher with the Centers for Disease Control and Prevention. After finishing his Masters of Public Health last year, he joined Sibley Heart Center to help build the outcomes research program.

In determining what factors—from clinical to public health solutions—providers can modify to change long-term outcomes for pediatric cardiology patients, the program has three main strategies:

- Determine what gives most children an improved quality of life
- Prevent later complications tied to their cardiac condition
- Harness electronic medical records to do research and improve tracking of these patients

With data and ideas in plentiful supply, he points out that they are mindful of being medically effective and cost-effective. For example, pulse oximetry newborn screening can pick up low oxygen levels, which could also indicate a heart defect. However, the team is evaluating how the chance of finding a rare defect with this newly recommended program compares with the cost of conducting this test on every newborn. So far, as the national infrastructure to collect this data establishes, a handful of babies in the United States have been found to have previously undiagnosed problems, including one child in Georgia.

There are also clinical research challenges. From residual heart problems, such as arrhythmia, to neurological delays and weakened livers and kidneys, children who survive heart surgeries still must overcome a great deal to make it to a healthy adulthood.

"It's simply not enough anymore to get them out the door," Oster said. "We need to study the data to see what kind of developmental problems these kids are having, and figure out what we can do earlier in the process to improve results."

For now, Oster details projects on a white board, including nearly 30 endeavors. With key focus areas of pulse oximetry screening in newborns, health disparities, appropriate resource utilization and value and long-term outcomes, he has a positive outlook for the future.

"Our results are improving," Oster said. "But now the question is, 'How high can we go?'"

Contact Matt Oster, M.D., MPH, at osterm@kidsheart.com for more information.

Aortopathy Program team emphasizes benefits of early intervention

Each year, thousands of children are born with a bicuspid aortic valve (BAV)—the most common congenital heart defect affecting 1 to 2 percent of the population. In many cases, the defect can go undetected for decades, even with significant aortic dilatation being present. In rare cases, complications may include aortic dissection and even death.

What makes many aortic disorders or aortopathies, such as BAV, so troubling is its genetic predisposition. For BAV, up to 30 percent of first-degree family members can have abnormal aortas/aortic valves. Because BAV is highly heritable, if one family member has it, any first-degree relatives are also at risk—even if they're asymptomatic.

"Early screening is so important with family history being an early predictor of an aortopathy," said Erin Demo, M.S., certified genetic counselor for the Aortopathy Program for children with diseases of the aorta at the Sibley Heart Center. "If you have a patient whose father has an aortic dissection at age 42, we should screen that child—and any siblings."

Denver Sallee III, M.D., director of the Aortopathy Program added that early diagnosis and treatment could delay or even prevent the disease from progressing.

"While I can't make a dilated aorta any smaller with medication, I can often prevent it from getting bigger and dissecting," he said.

But convincing a mom or dad to be screened themselves when they feel well and their children don't look sick isn't that easy. Still, Demo and Dr. Sallee recommend parents get tested so they can receive treatment and extend their own life expectancy should they share the same genetic defect.

The Aortopathy Program provides screening and treatment for a range of aortic disorders, including Marfan syndrome, Turner syndrome, Loeys-Dietz syndrome, vascular Ehlers-Danlos syndrome and familial aortic aneurysms/dissections. When these conditions are suspected, even if there's no family history, pediatricians should contact the program to schedule a screening.

Just as important as the clinical intervention are the social and emotional services that the program provides, including access to social workers, support groups and education to help kids understand what their limitations are.

"Our goal is to make a diagnosis and start treatment early so kids can live as normal—and healthy— of a childhood as possible," said Demo.

Visit www.choa.org/aortopathy for more information.

Library Services UPDATE

Visit www.choa.org/medicallibrary to see the latest content added to our medical libraries.

Share your interest in committee leadership by August 15

The Medical Executive Committee (MEC) represents and works on behalf of the physicians, dentists and psychologists with appointments and clinical privileges to treat patients at any of the Children's facilities. As the primary leadership and deliberative body for the professional staff, the MEC is directly accountable to the Children's Board of Trustees for the quality of care we provide our patients.

The bulk of the MEC's work is done through committee structures:

- System Credentialing Committee reviews all requests to join the Children's professional staff and makes recommendations for approvals
- Departmental Peer Review Subcommittees and System Peer Review Committee evaluate care concerns and seek opportunities to improve processes and educate staff to improve patient care

Nominations for MEC positions are frequently drawn from those physicians who have participated on medical staff committees or served in a director's role. We encourage you to consider serving on the Credentials, Bylaw or Peer Review committees to enrich your understanding of medical staff governance and how it benefits patient care.

Qualifications and responsibilities are outlined in the professional staff documents posted on the Medical Staff Governance page on the Physician Portal. The respective campus or System Nominating Committee will select nominees in late August and early September for professional staff committee, department and section positions.

Physician leadership is critical, and we encourage you to contact Bobbi Henderson in Medical Staff Governance at bobbi.henderson@choa.org by August 15 if you have an interest in being considered for an available role.

PROFESSIONAL Staff Applications

The following applicants have applied for membership to the Professional Staff at Children's. Current Professional Staff members who have information bearing on the applicant's qualifications for staff appointment or clinical privileges may fax that information to the Credentialing Services Office at 404-785-7498 or mail to 1584 Tullie Circle, Atlanta, GA 30329, attention Lisa Kuklinski, CPMSM, CPCS.

Name	Specialty
Baldwin, Elizabeth M.D.	Pediatrics
Berhane, Medhanie "Chi-Chi" M.D.	Craniofacial (Fellow)
Bruce, Barbara M.D.	Neurology
Chien, Bruce M.D.	Urgent Care
Duxbury, Gilbert M.D.	Orthopedics (Fellow)
Elder, Robert W M.D.	Cardiology
Enmon, Constance M.D.	Pediatrics
Fairlie, Tarayn M.D.	Pediatrics
Fishman, Felicity M.D.	Hand Surgery (Fellow)
Gatlin, Scott M.D.	Cardiology
Habte, Sara M.D.	Anesthesiology
Joiner, Clinton M.D.	Hematology
Kasoff, Willard M.D.	Neurosurgery (Fellow)
MacConmara, Malcolm M.D.	Transplant (Fellow)
Merritt, Tasha M.D.	Pediatrics
Natarajan, Nirupama M.D.	Psychiatry
Popoli, David M.D.	Rehabilitation Medicine/Sports Medicine
Quarmyne, Maa-Ohui M.D.	Hematology/Oncology
Sachdeva, Ritu M.D.	Cardiology
Thomas, Ruby M.D.	Urgent Care
Thornhill, Chad M.D.	Emergency Medicine
Wojewnik, Bartosz M.D.	Orthopedics (Fellow)
Yin, Hong M.D.	Pathology

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JUNE Calendar

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Recurring Events

Pediatric Grand Rounds at Scottish Rite (GR-SR) occurs the first, second and third Tuesdays of the each month, Main Auditorium, 7:30 a.m.

Grady Pediatric Grand Rounds (GPGR), Clinical/Pathological Conference, Thursdays at Steiner Auditorium, 68 Armstrong Drive across from the Grady Emergency department, 8 to 9 a.m. Contact Jackie Riley at jrile2@emory.edu or 404-778-1415 for more information. These sessions have been approved for CME credit through Emory University.

Pediatric Grand Rounds at Egleston (GR-EG), Wednesdays, Classrooms 3, 4 and 5, 7:30 a.m.

Pediatric Surgery Conference (PSC), Fridays at 7:30 a.m., Egleston, Classrooms 3, 4 and 5 (video-conferenced at Scottish Rite). Contact Nancy Richardson, Program Specialist, at 404-785-7843 for CME information.

5 **GR-SR:** An Update on Healthcare Reform, presented by Jay Berkelhamer, M.D.

6 **GR-EG:** Medical Nutrition Management: A Key to Successful Outcomes for Newborn Screening of Inherited Metabolic Disease, presented by Rani Singh, Ph.D., R.D.

8 Marcus Autism Center Grand Rounds, 12 -1 p.m., marcus.org/grandrounds

12 **GR-SR:** Is it the Sugar or the Fat? An Update on Cardiovascular Health Promotion Starting in Childhood, presented by Miriam Vos, M.D.

13 **GR-EG:** Evaluation and Management of the Limping Child, presented by Michael Schmitz, M.D.

15 **PSC:** Trauma Lecture of the Surgery Conference—Pediatric Eye Trauma, presented by Amy Hutchinson, M.D. (Video-conference at 1st Floor Sleep Lab conference room)

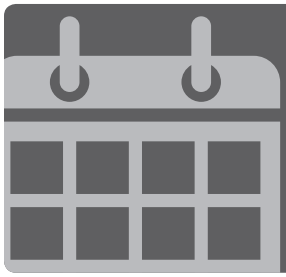
19 **GR-SR:** The Role of the Environment in Transmission of Infection: A Preventative Approach, presented by Hudson Garrett, M.P.H., M.S.N., Ph.D.

20 **GR-EG:** Research Grand Rounds—Team Science: Unraveling the Mysteries of CF Diabetes, presented by Arlene Stecenko, M.D., Medical Director, the Children's Pulmonary Function testing lab at Egleston

21 Cobb CME Dinner, 6:15 p.m., Maggiano's Little Italy at Cumberland Mall, www.choa.org/cmedinner

27 **GR-EG:** Common Office Orthopaedic Problems, presented by Robert Montero, M.D.

28 Institutional Review Board Meeting, 7 – 9 a.m., Marcus Autism Center, 3rd Floor Boardroom



MedClips on summer break in July

You will not receive a printed copy of *MedClips* for the month of July, and publishing will resume August 1. Look for your weekly *MedBytes* email for news, event information and updates. Contact **katie.tanner@choa.org** to be added to the e-newsletter distribution list.

For previous editions of MedClips, visit www.choa.org/medclips