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90 Years of Caring for Children—1930–2020

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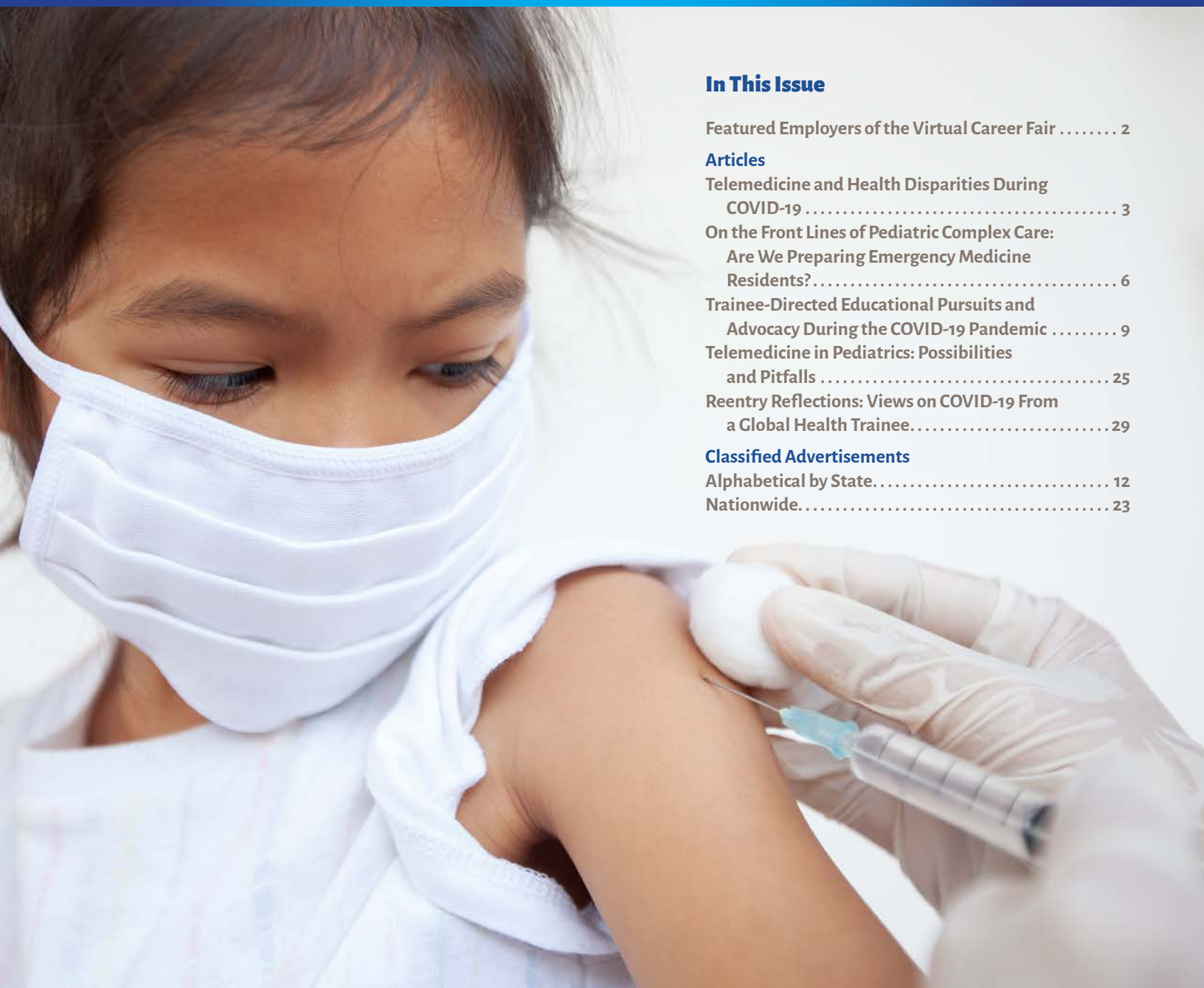
2020 AUTUMN EDITION



In This Issue

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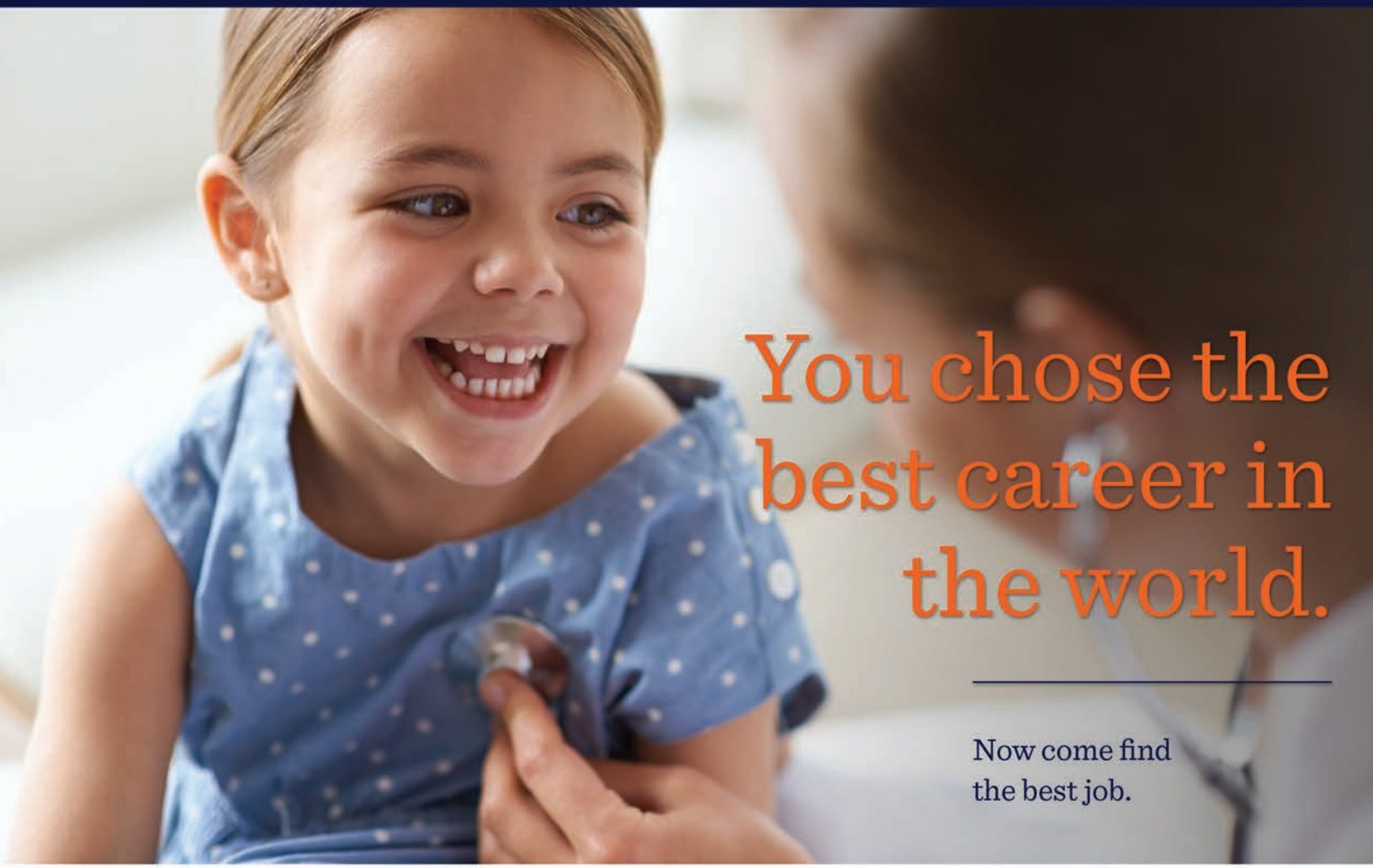

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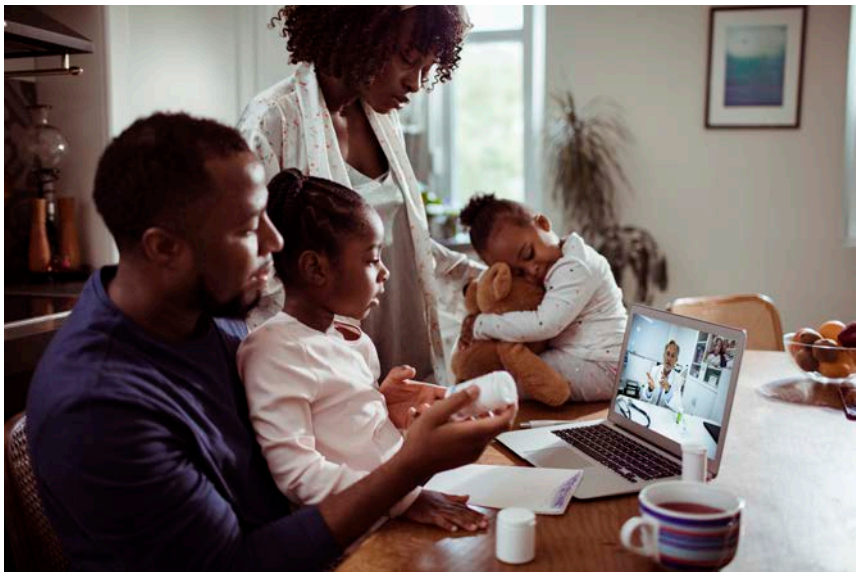
Telemedicine and Health Disparities During COVID-19

Michelle W. Katzow, MD, MS, Caren Steinway, LMSW, MPH, Sophia Jan, MD, MSHP
Reprinted from Pediatrics. 2020;146(2): e20201586

The coronavirus disease 2019 (COVID-19) pandemic has resulted in rapid and large-scale expansion of telemedicine. At a time when physical contact with the medical system poses a risk of infection, telemedicine offers a vehicle for delivering medical care at a safe social distance. It allows for attention to acute concerns as well as routine screening for medical and social needs, which may be heightened during this time. For families with limited resources, telemedicine offers particular advantages, obviating the need for transportation, child care, and additional time needed for inperson office visits. For these reasons, telemedicine has been proposed as a solution to health care inequities in the past and implemented with success in select populations.[1] Although the promise of telemedicine is an expansion of access, reliance on technology is likely to highlight existing vulnerabilities and widen disparities if precautions are not taken. Previous reports have outlined how technology-based solutions are highly susceptible to intervention-generated inequalities driven by underlying inequalities in access and uptake.[2] Because rollout of telemedicine on this scale is unprecedented, the use of telemedicine in ambulatory settings during this time may illuminate important lessons for the field of telemedicine as a whole.

As medical systems have shifted resources to COVID-19 management, acute concerns and preventive care unrelated to COVID-19 are at risk of being foregone. Several health systems have recently reported large increases in telemedicine use, particularly as a mechanism to screen for COVID-19 and provide appropriate guidance on follow-up care.[3] As a general pediatrics practice, we are also using telemedicine to provide vital preventive and chronic care, including newborn follow-up visits, developmental screening, nutrition counseling, asthma management, behavioral health, and management of children who are medically fragile and technology dependent. After initial implementation of telemedicine for our large, academic, pediatric primary care practice, we have identified barriers to telemedicine that may exacerbate existing health inequities.

A successful telemedicine encounter requires access to an Internet-enabled device compatible with the platform that the medical practice is using. Although 80% of adults in the United States have access toa smartphone and 75% have access to broadband Internet at home, these numbers are lower among those with lower educational attainment and those with a low income, precisely those who already suffer from various health disparities.[4,5] In our practice, only two-thirds of patients have an e-mail address in the health system database. As an example, we received a call from the mother of a toddler with a complex, chronic illness reporting that he was vomiting up blood. Before COVID-19, this family would have been directed to go to the emergency department (ED); but the risk and benefit calculation of ED use in the COVID-19 era is different, so we planned for a telemedicine visit. The patient's mother was undocumented, did not speak English, and did not have an iPhone, data plan, or e-mail address. However, this mother did have an alternative, free and internationally popular chat application that functions on all mobile devices. Typically, applications not designed for telemedicine would not be available options for communication of personal health information, but, given the state of emergency and relaxed restrictions,[6] the provider was able to use this application to place a video call, easily see the slightly blood-specked sputum on a paper towel, and visualize the happy, well-appearing, playful child wrestling with his cousins, clearly not in need of emergency medical attention. Not only was an ED visit avoided, but the patient did not have to leave his home to be adequately evaluated that evening. Our practice has put a policy in place to prioritize patient



access over the use of any one specific application; this degree of flexibility is necessary to deliver quality care to communities across the spectrum of socioeconomic status and digital proficiency. Once the state of emergency is lifted and regulations on allowable digital platforms is more restrictive, strong advocacy efforts will be required to maintain this levelof access to medical care for vulnerable populations.

Limited English proficiency and the need for appropriately trained medical interpreters add an additional layer of complexity to delivering care via telemedicine. Although the applications designed for telemedicine theoretically have the functionality to use interpreters, adding a third party to the call requires additional resources and time. For the patient discussed above, there was no simple way for the provider to use an application familiar, acceptable, and accessible to the patient and use an interpreter simultaneously, so she improvised, calling the patient by phone with a medical interpreter service to get the history and following-up with a video call to perform the physical examination. For another family in our practice whose head of household is deaf, an American Sign Language (ASL) interpreter is typically present for their health care visits. Because ASL interpretation is only available in person or via a particular video platform loaded on its own machine, the office staff had to set up one computer with the remote providers on telemedicine and another computer with a video ASL interpreter. This worked but was extremely resource intensive. We have worked to recruit staff and volunteers with diverse skill sets to assist families who need additional help with telemedicine access; to prevent the worsening of disparities in health care access, practices that plan to use telemedicine should consider doing the same.

Uptake or use of telemedicine as a platform depends on digital literacy to navigate the application or Web site, influenced by previous experience, technical skills, and knowledge that telemedicine is available. Low-income families and those with less education may have more difficulty downloading, installing, and using unfamiliar software or applications, requiring more hands-on support in preparation for the visit. Trust in technology and health care in general, which can be lacking in lower socioeconomic groups, can also impact uptake of telemedicine. Additionally, the family must have access to sufficient Internet speed and bandwidth to accommodate audio and visual data. Because families have quickly become limited by the number of Internet-enabled devices in the household, engaging in a telemedicine visit for one family member may require sacrificing work or school for other family members. In addition to the quantity of digital devices in the household, the quality of the camera and microphone on the device will impact the quality and diagnostic accuracy. Some of these barriers are surmountable with appropriate staffing, outreach, and education, spearheaded by the health care system. Solving issues around limited quantity and quality of technological devices and broadband Internet, however, would benefit from more creative cross-sector collaboration and public-private partnerships. We believe that health care systems, local governments, and private companies can and should work together to develop solutions and advertise these services across a broad range of diverse outlets.

As data emerge that COVID-19 is disproportionately impacting low income families and communities of color,[7] it is critical that innovative care delivery solutions are implemented thoughtfully to avoid further exacerbating these disparities. First, additional staff and volunteers from diverse backgrounds should be recruited to assist families who may need additional help accessing telemedicine platforms. Second, diverse media outlets popularly used by racial minority groups, low-income, and low-literacy families should be used to advertise telemedicine services. Finally, healthsystems and regulatory bodies need to be flexible in the platforms they use to deliver telemedicine based care. ■

Abbreviations

ASL: American Sign Language
COVID-19: coronavirus disease 2019
ED: emergency department

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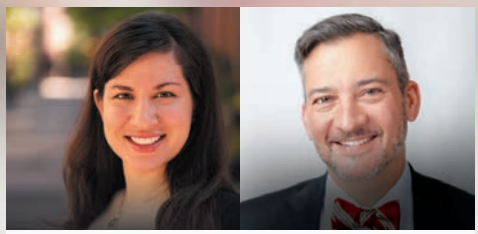

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90 Years of Caring for Children—1930–2020

On the Front Lines of Pediatric Complex Care: Are We Preparing Emergency Medicine Residents?

Audrey Kamzan, MD, Esther Jun-Ihn, MD, Deepa Kulkarni, MD
Reprinted from Hospital Pediatrics August 2020, 10 (8) 712-714; DOI: https://doi.org/10.1542/hpeds.2020-0141

On another typical call night at the hospital, I open up the emergency department (ED) board and recognize a familiar name: "Emma, 4-year-old female in respiratory distress." A moment later, my pager buzzes: "Please call back regarding a consultation and potential admission." Emma, well-known to our institution, is a 4-year-old girl with methylmalonic acidemia who is tracheostomy-dependent, ventilator-dependent, and gastrostomy tube–dependent, and nights like tonight are all too familiar for her and her mother. Emma's story began not here with us, but rather, 4 years ago and 50 miles away in a community hospital ED, as 2 frightened first-time parents stood in the waiting room holding their four-day-old infant girl. All had been well during the pregnancy and nursery stay, but by her third day of life, Emma had become more and more difficult to rouse to feed. Her breathing had begun to appear labored, and her body seemed limp. This family, who had never had occasion to visit their local ED, found themselves suddenly surrounded by a team of physicians and nurses with worried expressions. The team had worked earnestly to stabilize her, first treating her glucose level of 24 mg/dL and bicarbonate level of 5 mmol/L and ultimately intubating her when her breathing became too rapid to support oxygenation. After she failed to improve despite the initial resuscitation, the ED physicians had consulted the in-house pediatric hospitalist, who had requested an ammonia level, which returned at 480 mg/dL. The hospitalist had recommended changing the fluids to include dextrose 10%, increasing the rate to suppress catabolism, and finally transferring Emma to the quaternary care pediatric center where I work and where Emma now gets most of her care.

Tonight, Emma's mother had had to make a difficult decision, should she call 9-1-1 and be brought back to that nearby ED where her story began, or should she drive the 50 miles to our center and hope Emma's breathing does not get worse along the way? She knows that the community ED likely will not have access to her full medical record or to subspecialty consultants, but she would be able to get care for her medically fragile child right away. Community ED physicians like the ones in Emma's neighborhood will care for complex pediatric patients every day, both before and after their diagnoses are made, in the face of limited resources. Access to nearby and prompt emergency care is vital for children who are medically complex. It is incumbent on emergency medicine (EM) training programs to ensure that their graduates are appropriately prepared to care for this growing patient population in all clinical contexts. The field of pediatric hospital medicine (PHM) is in a time of growth and redefinition of our role within the health care system. Hospitalists are well poised to aid not only in the acute care of these patients in community and quaternary care EDs but also in the education of our EM trainees.

Children with medical complexity (CMC) are defined as having at least 1 chronic and severe clinical diagnosis that leads to functional impairment, significant family-identified health care service needs, and high health care use.[1] These patients compose up to one-third of all pediatric health care spending.[2] Chronic illness accounts for the majority of all pediatric inpatient days, and the proportion of inpatient care provided to children who are medically complex is increasing over time.[3,4,5] Pediatric hospitalists play an ever-growing role in the care of CMC, often serving as the leader and coordinator of a team of physicians and other care providers.[6] Fittingly, the topic of CMC has been emphasized as an Accreditation Council for Graduate Medical Education program requirement in training PHM fellows and is 1 of the 13 core content domains represented on the PHM board certification examination.[7,8]

With the rise of medical home–based comprehensive care models, the care of CMC is frequently centralized within tertiary and quaternary care centers.[9–12] However, many children do not live near these centers.[13] Even children who receive much of their care at specialty centers may, at times, present to community EDs first because of the severity of their illness or the geographic distance from a pediatric hospital. In 1 study, the absolute number of pediatric visits by children with at least 1 complex condition was almost 6 times higher in general EDs compared with pediatric EDs (2 711 289 vs 465 137 visits).[14] These encounters may present opportunities for CMC to receive more aspects of the care they need within their own communities, but the resources available to care for CMC at community and general EDs are highly variable. Some of these EDs have access to experienced community pediatric hospitalists, whereas others lack dedicated 24-hour pediatric support, much less the availability of pediatric subspecialists. When available, pediatric emergency medicine (PEM) faculties are ideally suited to care for CMC because their board certification requires knowledge of pertinent topics, such as transplant medicine, chronic illnesses, and technology dependence.[15] However, there are only an estimated 1.6 PEM-trained

physicians per 100 000 people in the United States, and their geographic distribution is heavily concentrated in urban settings.[16] Only 23% of EDs in the United States have PEM coverage, and 40% of EDs have pediatric coverage. Even among children's hospitals, not all ED providers have PEM training, so CMC arriving in the ED may be triaged and stabilized by EM physicians first.[16]

Because of fragmented care, parents report taking on the burden of coordinating their child's care to bridge the informational discontinuity between systems.[17] One existing means of aiding EM physicians in the care of CMC is with emergency information forms (EIFs), which summarize the patient's medical history and recommend management strategies.[18] EIFs can serve as an educational tool for EM residents as well as a management tool for all ED physicians and have been shown to improve performance in simulated ED scenarios of CMC by trainees and attending physicians.[19] However, EIFs have limitations: they may not be available in emergent situations if the medical record has a different platform or if families do not have copies with them, they may not be updated regularly, and although they include many likely emergencies, they do not include all possible clinical scenarios for which a patient may present to the ED. Thus, competency in the care of CMC in the acute setting is a necessity for all EM trainees. Although all EM residency programs require training in the care of pediatric patients, the training dedicated specifically to the care of CMC is variable because there is no standardized curriculum.[16] Furthermore, the care of CMC is not specifically addressed in the content specifications for the EM board certification examination.[20]

To better assess this knowledge gap, we surveyed the ED residents at 2 local institutions that are nonfreestanding children's hospitals. In both groups, ED residents overall described a lack of confidence in caring for CMC; on a 5-point Likert scale in which 1 represents not at all confident and 5 represents very confident, the mean confidence reported was 2.4 (SD 5 1; n 5 44). Specific clinical scenarios related to the care of CMC in which the mean confidence was ,3 included the care of patients with transplanted organs, those at risk for adrenal suppression, those in metabolic crisis, and those dependent on technology. Importantly, we found ED residents' interest in receiving more didactic education on CMC to be high; the mean score was 4.4 (SD 5 0.7; n 5 43), with 1 representing not at all interested and 5 representing very interested. This presents a valuable opportunity for PHM faculty to address this educational need. At our institution, pediatric hospitalists have piloted a successful educational partnership with our EM program to implement a pediatric complex care curriculum, beginning with a lecture series dedicated to addressing the topics in which ED residents felt least confident. We have also expanded our pediatric hospitalist resident elective to include EM residents, which has been well received. As PHM enters a new era as a board-certified subspecialty, pediatric hospitalists should be recognized as an important resource to fill this critical knowledge gap, especially at institutions without dedicated pediatric EDs or PEM specialists. We would therefore advocate for a greater role of pediatric hospitalists in the education and training of EM residents to ensure they are equipped with the knowledge they need to care for children like Emma, regardless of where their careers take them. ■

Acknowledgments

We thank Kelly Young, MD, MS (Division of Pediatric Emergency Medicine, Department of Pediatrics, Harbor–University of California, Los Angeles Medical Center), for her contribution in collecting data.

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Trainee-Directed Educational Pursuits and Advocacy During the COVID-19 Pandemic

Danielle G. Rabinowitz, MD, MM, Kathryn M. Sundheim, MD
Reprinted from Pediatrics. 2020;146(3):e20201564

Despite its devastating effects on adult populations globally, the impact of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) on children has been comparatively mild.[1] Whereas adult hospitals have been confronted with bed and ventilator shortages in the face of large upticks in patient volume, many pediatric institutions have remained largely immune to these stressors given the small percentage of children positive for coronavirus disease 2019 (COVID-19) warranting hospitalization.[2,3] As pediatric trainees who once braced for the possibility of a rapid onslaught in cases warranting our direct care on the frontlines, we personally feel an overwhelming sense of relief that our pediatric patients are predominantly spared from the effects of the virus. Notwithstanding, widespread social distancing practices, stay-at-home restrictions, and school closures have transformed the current landscape of pediatric practice and have consequently impacted our patients and families as well as our residency training. Inherent in this shift has been a reduction in opportunities for hands-on learning for trainees as well as modifications to structured teaching. Pediatric residents have nonetheless rallied around these changes to the traditional residency curriculum and developed innovative ways to connect with and advocate for our patients while simultaneously promoting the advancement of medical education.

Across clinical settings, trainees are engaging less in person because of decreased emergency department visits, lower inpatient censuses, fewer outpatient appointments, and reduced clinical staffing models. Although we have witnessed few hospitalized children with COVID-19 infections, we have also seen a drop off in presentations for other more common pediatric illnesses. This is likely due to the impact of societal distancing in reducing transmission rates of communicable diseases and the presumed hesitancy of parents to bring children in for evaluation amid a pandemic. A smaller number of patients under resident care correlates with decreased diagnostic diversity, shortened time frames devoted to bedside rounding, and consolidated provider teams, all contributing to a less dynamic educational environment. Moreover, altered staffing needs have left a pool of residents from our program at home in reserve. As members of this corps on standby, we have covered various clinical shifts when needed. In doing so, we have come to recognize that isolated clinical encounters cannot replace the continuity, rigor, and camaraderie that characterize dedicated time on service or in clinic. Importantly, our own experiences do not represent those of all pediatric practitioners, as the pandemic has obligated numerous pediatricians across the country, our own colleagues and superiors among them, to transition their skills and resources toward the care of hospitalized adults with COVID-19.[4]

Postponement of nonessential clinic appointments and the rise of telehealth have similarly shifted resident-directed engagement with patients. Attending-resident precepting in a typically high-volume clinic context was not easily replicated virtually at the outset. Instead, computer-based visits conducted by a group of attending physicians tackled the intricacies of the routine pediatric visit from afar and provided a safety net for children with more urgent concerns. While attending physicians took the lead, residents lost opportunities to conduct visits independently and to build ongoing relationships with patients and families. All these necessary clinical changes have occurred in parallel with our continued pledge to provide the highest-quality care for our patients and families in the community, many of whom are facing significant emotional and financial hardships during this unprecedented time.

Because residency training is inherently clinical, educational innovations during the pandemic have naturally been patient centered. Although attending physicians initially took on virtual visits alone, now pediatric trainees are gradually being integrated into virtual interfaces to partake in clinic appointments, conduct inpatient consults, participate in bedside rounds, review discharge teaching, and follow-up with patients and families in a posthospitalization context. Beyond direct patient encounters, trainees have been able to assist colleagues from home by pre-rounding, conducting chart review, and note templating virtually. These clinical workarounds have enabled trainees to provide excellent patient care and continue learning while adhering to social distancing guidelines and minimizing unnecessary exposures.

As child advocates, trainees have of necessity developed new ways to connect with patients and families to ensure their general well-being from afar. Residents in our program have organized live online question-and-answer forums related to COVID-19, published pamphlets on anticipatory guidance and screen time, and called families to encourage in-office visits to combat the declines that we

have seen in vaccine rates in our own clinics and across the nation.[5] We have also collaborated with local youth mentorship groups and provided opportunities for conversation between trainees and community youth virtually. Other members of our residency program have presented on COVID-19 disparities at hospital-wide grand rounds, used social media to highlight data trends, and collaborated with other pediatric residency programs to discuss solutions for COVID-19–related health inequities. The voice of the pediatric trainee as advocate has taken center stage, amplifying an already essential aspect of our role as pediatricians in the community.

In addition to changes to clinical training and to the ways in which we interact with and support our patients, formal resident education has also transformed, with traditional in-person didactics now delivered online. This has necessitated new ways of promoting participation such as through use of "chat" and "hand raise" functions on virtual conference platforms. Some trainees have recruited attending physicians and fellows to participate in daily onscreen "chalk talks," an opportunity for didactic learning and candid conversation now guaranteed every afternoon. Others have created an electronically accessible compendium of medical resources encapsulating key system-specific instructional videos and literature. Virtual education has also inspired engagement with pediatric residents from other institutions through COVID-19 basic science and advocacy journal clubs. Although opportunities to develop skills as in-person medical educators and supervisors have been more difficult, with medical students pulled from clinical rotations, many have led online teaching sessions, provided feedback via e-mail on various aspects of documentation relevant to patient care, and offered virtual mentorship for medical students. Overall, these new forms of learning and teaching have all further integrated technology as an educational tool.

As this pandemic continues, we must consider its effects not only on our patients and families, through introducing numerous emotional and psychosocial stressors and altering access to and engagement with physicians, but also on our pediatric training. This is particularly true given the anticipated implications of this time period on vulnerable and at-risk children, who will be critically reliant on future well-trained pediatricians to protect their health and welfare moving forward.[6,7] We are optimistic that despite the redirection of clinical and structured learning, numerous bright spots have emerged that may favorably impact resident education and enhance pediatric care. Trainee-directed educational pursuits and advocacy have highlighted the myriad possibilities that exist for our growth as physicians and for our educational advancement both during and after the pandemic. These endeavors have also cemented the role of the trainee as integral to creatively structuring the educational framework moving forward. Consequently, and despite much remaining uncertainty as to the full impact of SARS-CoV-2, we are hopeful that while continuing to provide robust and compassionate care that families deserve, we can also facilitate positive advancements in our medical education. ■

Abbreviations

COVID-19: coronavirus disease 2019
SARS-CoV-2: severe acute respiratory syndrome coronavirus 2

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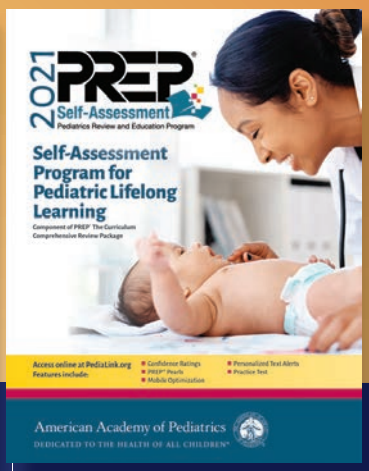

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Come and build your practice as part of a premier pediatric only medical group in the growing, family centric communities located in the Temecula Valley, heart of California's South Coast wine region. The area boasts a great climate, safe communities, has excellent schools, is well suited for active lifestyles and is within driving distance of attractions and activities in San Diego and Los Angeles. Children's Primary Care Medical Group (CPCMG) is seeking energetic, board eligible pediatricians to join our offices in Riverside County, key offices in our growth initiatives.

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LOUISIANA

Chief Quality Officer
New Orleans, Louisiana

We're seeking a Chief Quality Officer to join the rapidly growing team at Ochsner Hospital for Children in New Orleans, Louisiana. The ideal candidate will be board certified in general pediatrics as well as the pediatric subspecialty in which they are fellowship-trained, if applicable, and will have administrative experience. MBA, MHA or MMM degree is desirable. Ochsner Hospital for Children offers a level of pediatric care unmatched in Louisiana for everything from well-child check-ups and immunizations to cancer care and heart transplants. Ochsner Hospital for Children provides care to nearly 300 open heart pediatric cases per year, along with liver transplants, BMT, advanced spine surgery, craniofacial and other quaternary services. Located in one of our most vibrant cultural cities, this nonprofit, academic, multi-specialty institution is the recipient of numerous awards, including Healthgrades Distinguished Hospitals for Clinical Excellence, which places Ochsner in the top 5 percent of U.S. hospitals for clinical outcomes. Ochsner Hospital for Children is the only children's hospital in Louisiana or Mississippi ever recognized by U.S. News and World Report as a specialty top 50 hospital for pediatric heart care. Ochsner physicians care for over 80,000 children each year at 14 sites across Louisiana including a large, state-of-the-art dedicated pediatric ambulatory campus located at the main hospital campus. The primary care pediatric network throughout the region currently has more than 40 general pediatricians in addition to a large outside referral base and treats more than 55,000 unique pediatric patients annually. Ochsner Hospital for Children includes: ·125-bed children's hospital within a hospital ·54-bed Level IV Regional NICU, the highest level available in Louisiana ·14-bed Level I Pediatric Intensive Care Unit, the highest level available ·12-bed state-of-the-art Pediatric CVICU, the only unit of its kind in the Gulf South dedicated to the care of children with

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- Pediatric mental health nurse practitioner
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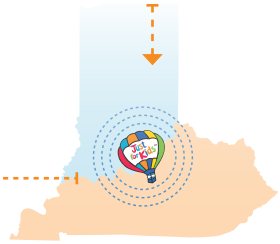

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cardiovascular and congenital heart defects ·46-bed Pediatric Acute Care. This nonprofit, academic, multi-specialty institution also has a combined pediatrics residency program with Tulane University Medical School. Medical students from Tulane and the University of Queensland/Ochsner Clinical School rotate through the division. Academic and research opportunities are available. New Orleans exudes a character all its own and offers a lifestyle that no other U.S. city can match. It's home to an unparalleled blend of cultures. World-class music, dining and shopping are just the beginning. Professional sports, gorgeous city parks, year-round festivals, prestigious academic centers and universities, and Southern hospitality await you. It's easy to understand why residents take great pride in calling New Orleans their home. You'll fall in love the minute you set foot here, both personally and professionally. For complete details and consideration, please forward your CV and cover letter to Glenda Church Smith, Principal, Pediatric Search Partners via email to glenda@pediatricsearchpartners.com. Please contact Glenda by phone at 877.440.3832 or call/text to 214.850.3094.

Associate Chair, Pediatric Primary Care New Orleans Region

Pediatric Search Partners is pleased to partner with Ochsner Hospital for Children, on a newly created leadership opening. We are seeking an Associate Chair, Pediatric Primary Care for the New Orleans Region to continue Ochsner's growth and development of primary care pediatrics. For the fourth year in a row, Ochsner Hospital for Children has been ranked in 2020-21 among the Top 50 Children's Hospitals in the country for pediatric cardiology and heart surgery by U.S. News and World Report. Ochsner Hospital for Children is also Louisiana's only ranked children's hospital. Based on the campus of Ochsner Medical Center in New Orleans, you'll find an exciting opportunity to join a rapidly growing team of more than 140 pediatric physicians and advanced specialty care in 30 pediatric specialties and subspecialties at 15 locations throughout Louisiana. Responsibilities include continuing the development of a geographically broad network of pediatric primary care providers practicing at the highest possible quality standards on behalf of children throughout the Gulf South Region; and maintenance of solid relationships with the pediatric primary care community outside the Ochsner system, providing the support and communication they need in order for Ochsner Hospital for Children to function as the comprehensive system of care for their patients. The ideal candidate will be a board certified Pediatrician with administrative experience who has successfully developed and/or overseen a multisite pediatric primary care practice. MBA, MHA or MMM degree is desirable. The Associate Chair will report to the System Chair/AMD, Pediatrics and will lead a team of Pediatric Primary Care Site Directors and Physicians. Ochsner Hospital for Children offers a level of pediatric care unmatched in Louisiana for everything from well-child check-ups and immunizations to cancer care and heart transplants. Ochsner Hospital for Children provides care to nearly 300 open heart pediatric cases per year, along with liver transplants, BMT, advanced spine surgery, craniofacial and other quaternary services. Ochsner physicians care for over 80,000 children each year at 15 sites across Louisiana including a large, state-of-the-art dedicated pediatric ambulatory campus located at the main hospital campus. The primary care pediatric network throughout the region currently has more than 40 general pediatricians in addition to a large outside referral base and treats more than 55,000 unique pediatric patients annually. Ochsner Hospital for Children includes: ·125-bed children's hospital within a hospital ·54-bed Level IV Regional NICU, the highest level available in Louisiana ·14-bed Level I Pediatric Intensive Care Unit, the highest level available ·12-bed state-of-the-art Pediatric CVICU, the only unit of its kind in the Gulf South dedicated to the care of children with cardiovascular and congenital heart defects ·45-bed Pediatric Acute Care ·The Michael R. Boh Center for Child Development, dedicated to improving the lives of children and adolescents with developmental disorders ·Pediatric Emergency Room. This nonprofit, academic, multi-specialty institution also has a combined pediatrics residency program with Tulane University Medical School. Medical students from Tulane and the University of Queensland/Ochsner Clinical School rotate through the division. Academic and research opportunities are available. New Orleans exudes a character all its own and offers a lifestyle that no other U.S. city can match. It's home to an unparalleled blend of cultures. World-class music, dining and shopping are just the beginning. Professional sports, gorgeous city parks, year-round festivals, prestigious academic centers and universities, and Southern hospitality await you. The north shore of Lake Pontchartrain offers lakefront living with quaint historic town centers and the number-one school district in the state. It's easy to understand why residents take great pride in calling New Orleans their home. You'll fall in love the minute you set foot here, both personally and professionally. For complete details, please forward your CV and cover letter to Glenda Church Smith, Principal, Pediatric Search Partners who is handling the search at glenda@pediatricsearchpartners.com, dial directly at 877.440.3832 or text to 214.850.3094.

Neonatology New Orleans and Region

Pediatric Search Partners is seeking Board Eligible/Board Certified Neonatologists for Ochsner Hospital for Children in New Orleans, Louisiana. With the assistance of an experienced group of neonatal nurse practitioners, Ochsner's team of seven board-certified neonatologists directs the Neonatal Intensive Care Unit at Ochsner Baptist Medical Center. Ochsner's NICU was ranked in the top 60 in the United States and features 54 beds, including both private and care by parent rooms. They participate in the Vermont Oxford Network, have received the level IV designation by the State of Louisiana and have long been commended for taking an innovative approach to caring for the sickest newborns in the region. At Ochsner, you will find an incredibly exciting opportunity to join a rapidly growing pediatric team of more than 120 physicians, including subspecialists covering all medical and surgical fields. The group is the region's leading integrated provider of multispecialty care for infants, children, adolescents, and young adults offering a full range of pediatric services, including solid organ transplantation and pediatric cardiovascular surgery. Ochsner Hospital for Children includes: ·125-bed children's hospital within a hospital ·54-bed Level

IV NICU ·14-bed Level I Pediatric Intensive Care Unit, the highest level available ·12-bed CVICU, the only unit of its kind in the Gulf South dedicated to the care of children with cardiovascular and congenital heart defects ·45-bed Pediatric Acute Care ·Dedicated state-of-the-art center for child development, the only facility to offer this type of comprehensive care in the region under one roof. Located in one of our most vibrant cultural cities, this nonprofit, academic, multi-specialty institution is the recipient of numerous awards, including Healthgrades' Distinguished Hospitals for Clinical Excellence, which places Ochsner in the top five percent of U.S. hospitals for clinical outcomes. New Orleans exudes a character all its own and offers a lifestyle that no other U.S. city can match. It's home to world-class music, dining and shopping. A city of neighborhoods, New Orleans is best traveled by foot, but you can also hop on one of the city's historic streetcars or join the growing legion of commuters by bicycle. NOLA's neighborhoods each have a distinct architectural flavor and include everything from traditional Antebellum style to historic bungalows and cottages to modern lofts. Professional football and basketball, gorgeous city parks, year-round festivals, prestigious academic centers and universities, and Southern hospitality await you. If you're craving the beach, the Gulf shores of Alabama are about two and a half hours away by car; and the white sands of Pensacola, Florida, are just three hours away. It's easy to understand why residents take great pride in calling New Orleans their home. You'll fall in love the minute you set foot here, both personally and professionally. If you are seeking an exceptional opportunity with a growing organization, please contact Glenda Church Smith, Principal, Pediatric Search Partners for complete details at glenda@pediatricsearchpartners.com, or call directly at 877.440.3832.

System Medical Director, Neonatology New Orleans

We're seeking a Board Certified Neonatologist for a newly created position as the System Medical Director for Neonatology to join the growing team at Ochsner Hospital for Children in New Orleans, Louisiana. Primary responsibilities: The System Medical Director, Neonatology will serve in a strategic clinical leadership role that will collaborate with senior clinical and administrative leadership across the Women's Services and Pediatrics Centers of Excellence to lead clinical transformation and integration of Ochsner's NICU services (at Baptist, Kenner, West Bank, Slidell and St. Tammany) and staffs into a Ochsner NICU system delivering standardized care of a consistent high quality at the units best matched to the appropriate level of patient care and the family's home location. The focus will be on value creation for care delivery of both high risk and normal newborns utilizing a single team of neonatal providers, current and new digital health technologies, and robust education to support of Ochsner's "birthing platforms" across the New Orleans, North Shore and Bayou regions and resulting in improved care of all babies in the Ochsner system, greater retention of healthy babies at their home hospitals and level-of-care appropriate utilization of higher level nurseries. This includes but is not limited to: Direct oversight of clinical care, including physician and NNP recruiting and retention at the system's Level IV NICU at Ochsner Baptist Hospital as well as recruiting and retaining top neonatal talent to Ochsner's Level IIII and II NICUs; Creating a NICU network-wide staffing plan; recruiting and retaining to that plan and its growth; and Advancing the group's role in the application of telemedicine to improve the care of babies across the system, both in traditional nurseries and NICUs. Practice Location: The System Neonatology Medical Director will be based at Ochsner Baptist Hospital in Uptown New Orleans with responsibility for 4 lower-level units in the Greater New Orleans area. The position will require local travel. Reports to: System Chair and AMD for Pediatrics with matrixed responsibility to System Chair for Women's Services and Maternal Fetal Medicine. About Ochsner: Ochsner Health System is Louisiana's largest non-profit, academic, multi-specialty, healthcare delivery system with 30 owned, managed and affiliated hospitals and 60+ health centers. Ochsner employs more than 1,100 physicians in over 90 medical specialties and subspecialties and performs over 600 clinical research studies. Ochsner for Children is a vertically integrated health system, with a pediatric primary care network, a dedicated pediatric emergency department, in-house pediatric intensivists and hospitalists, as well as a dedicated, full-time, pediatric transport team providing ground, rotary and fixed wing transports across the entire Gulf South. Ochsner Hospital for Children has a 33 pediatric bed unit, along with a 14 bed PICU, 12 bed CVICU, and 54 Level IV NICU beds. Ochsner sponsors the combined Tulane-Ochsner pediatric residency program and teaches medical school students from Tulane as well as the University of Queensland. The Location: New Orleans exudes a character all its own and offers a lifestyle that no other U.S. city can match. It's home to world-class music, dining and shopping. Professional football and basketball, gorgeous city parks, year-round festivals, prestigious academic centers and universities, and Southern hospitality await you. If you're craving the beach, the Gulf shores of Alabama are about two and a half hours away by car: and the white sands of Pensacola are just three hours away. It's easy to understand why residents take great pride in calling New Orleans their home. You'll fall in love the minute you set foot here, both personally and professionally. For complete details, please forward your curriculum vitae and cover letter to Glenda Church Smith, Principal, Pediatric Search Partners at glenda@pediatricsearchpartners.com, or contact by phone at 877.440.3832 or cell/text to 214.850.3094.

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Penn State Health is a multi-hospital health system serving patients and communities across central Pennsylvania. The system includes Penn State Health St. Joseph Medical Center in Reading, PA, Penn State Health Milton S. Hershey Medical Center, Penn State Children's Hospital, Penn State Cancer Institute, and Penn State Health Rehabilitation Hospital (jointly owned), based in Hershey, PA, as well as more than 1,300 physicians and direct care providers at 78 medical offi ce locations. The system also has jointly owned health care providers, including Hershey Outpatient Surgery Center, Hershey Endoscopy Center, Horizon Home Healthcare, and the Pennsylvania Psychiatric Institute. Penn State Health shares an integrated strategic plan and operations with Penn State College of Medicine, the University's medical school.

Photo was taken before March 2020 when COVID-19 precautionary measures were not in place.

For more information, contact Anderson Smith,
Physician Recruiter at
asmith50@pennstatehealth.psu.edu.

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PENNSYLVANIA

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Genetic Pediatrician

Penn State Health Milton S. Hershey Medical Center is offering an exciting opportunity for a genetic pediatrician at our Hershey, PA campus. What we're offering: Competitive salary and generous benefits, a collaborative environment rich with diversity, participation in resident and medical student education, a high quality program with a national reputation for teaching, research, and state of the art patient care, interaction with dynamic clinicians across departments and participation in innovative educational approaches and rank commensurate with experience. What we're seeking: MD, DO, or foreign equivalent, completion of accredited training program, ability to acquire a license to practice in the State of Pennsylvania, BC/BE in pediatrics/clinical genetics and must be able to obtain valid federal and state narcotics certificates. About Penn State Health: Penn State Health is a multi-hospital health system serving patients and communities across 29 counties in central Pennsylvania. It employs more than 14,000 people systemwide. The system includes Penn State Health Milton S. Hershey Medical Center, Penn State Children's Hospital, and Penn State Cancer Institute based in Hershey, Pa.; Penn State Health St. Joseph Medical Center in Reading, Pa., and more than 2,000 physicians and direct care providers at more than 100 medical office locations. Additionally, the system jointly operates various health care providers, including Penn State Health Rehabilitation Hospital, Hershey Outpatient Surgery Center, Hershey Endoscopy Center, Horizon Home Healthcare and Pennsylvania Psychiatric Institute. In December 2017, Penn State Health partnered with Highmark Health to facilitate creation of a value-based, community care network in the region. Penn State Health shares an integrated strategic plan and operations with Penn State College of Medicine, the University's medical school. With campuses in State College and Hershey, Pa., the College of Medicine boasts a portfolio of more than $90 million in funded research and more than 1,700 students and trainees in medicine, nursing, other health professions and biomedical research. This job description is a general outline of duties performed and is not to be misconstrued as encompassing all duties performed within the position. All individuals (including current employees) selected for a position will undergo a background check appropriate for the position's responsibilities. Penn State Health is an equal opportunity, affirmative action employer, and is committed to providing employment opportunities to all qualified applicants without regard to race, color, religion, age, sex, sexual orientation, gender identity or expression, national origin, disability or protected veteran status. If you are unable to use our online application process due to an impairment or disability, please call 717-531-8440 between the hours of 8:30 AM and 4:30 PM, Eastern Standard Time, Monday - Friday, email hrsolutions@pennstatehealth.psu.edu or download our Accommodation Instructions for Job Applicants PDF for more detailed steps for assistance. Please contact Anderson Smith at asmith50@pennstatehealth.psu.edu for additional information.

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Staff Physician
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TENNESSEE

Medical Director, Neonatology, Level II NICU
One Hour from Nashville

We're seeking a Medical Director, Neonatology to join Vanderbilt University Medical Center's team overseeing the Level II NICU at Maury Regional Medical Center in Columbia, Tennessee, located just a 50-minute drive from Nashville. The position will also allow the Medical Director to also spend time at the Level IV NICU at Vanderbilt Hospital in Nashville, if desired. Vanderbilt offers a very competitive salary and benefits package. Maury Regional's 255-bed facility is home to more than 200 physicians, has been compared to some of the nation's most prestigious medical centers and has been recognized consistently for performance on publicly reported quality measures. The hospital's NICU team includes Board Certified Neonatologists and Neonatologist Nurse Practitioners provided by Monroe Carell Jr. Children's Hospital at Vanderbilt in Nashville, along with Neonatal Registered Nurses certified by the American Heart Association's Neonatal Resuscitation Program (NRP), respiratory therapists, international board certified lactation consultants, speech/physical/occupational therapists, registered dieticians, and social workers. The Vanderbilt University Medical Center neonatal transport team can provide transfer of babies to the Level IV NICU at Monroe Carell Jr. Children's Hospital. Columbia has been named among Southern Living magazine's Best Small Towns of 2019, and after a visit here, you'll quickly understand why. Located just 45 minutes south of Nashville and 75 miles north of Huntsville, Alabama, this charming town includes an historic town square and Main Street with plenty of shops, restaurants and a lively music scene. The new Columbia Arts District, located just blocks from Columbia Town Square, was designed as a haven for artists and includes a variety of eclectic galleries along with additional shops, cafes and other retailers. You'll enjoy the best of small-town life with easy access to Nashville and all of its attractions, from the Grand Ole Opry, Johnny Cash Museum and Country Music Hall of Fame to professional sports, shopping, nightlife, top-notch restaurants and culture. And here's one of the most attractive perks of Columbia life: Tennessee residents pay no state income tax and enjoy a competitive cost of living. For complete details and confidential consideration, please contact Glenda Church Smith, Principal, Pediatric Search Partners: 877.440.3832; 214.850.3094 (cell/text); or email to glenda@pediatricsearchpartners.com..

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Looking for a great place to live and practice? Your search can end now. We're seeking Developmental-Behavioral Pediatricians who are board certified or board eligible to join Siskin Children's Institute growing team in beautiful Chattanooga, Tennessee. Serving children with special needs and their families since 1950, Siskin Children's Institute achieves its mission through education, pediatric healthcare services, home and community-based programs and outreach services in the field of developmental

disabilities. Siskin Children's Institute is affiliated with the Children's Hospital at Erlanger. Founded in 1889, Erlanger is the seventh largest public healthcare system in the United States with more than half a million patients per year. The Children's Hospital at Erlanger is a Comprehensive Regional Pediatric Center, the highest state designation for pediatrics and offers a full complement of pediatric subspecialists. Outside magazine searches the country annually to rank cities with great access to trails and public lands as well as great restaurants and wonderful neighborhoods. Chattanooga is the only city to be recognized as Best Town Ever more than once! Surrounded by mountains with a river running through the heart of its downtown, Chattanooga is a nationally renowned destination in the Southeastern United States with recreation for people of all skill levels and hundreds of miles of trails, world-class events, thousands of acres of conservation and national recognition. The city is also noted for the renaissance of its beautiful downtown and redevelopment of its riverfront. With its scenic beauty, stable population, growing economy, and cooperative, friendly people, it is truly one of the most progressive mid-size cities in the United States. Within a two-hour drive of Atlanta, Nashville, Birmingham and Knoxville, Chattanooga uniquely offers a quality of life that is hard to duplicate anywhere in the country. And it provides an opportunity to join an established program committed to serving the needs of children in cooperation with a growing, world-class children's hospital. The Siskin Children's Institute includes the following: The Siskin Early Learning Center provides a high-quality preschool education to young children with and without disabilities, including children with developmental delays, autism spectrum disorder, chromosomal abnormality and brain injury. All children learn and play side by side in an environment that celebrates the accomplishments of every child. The Siskin Center for Developmental Pediatrics is a regional developmental pediatric center led by a board-certified developmental-behavioral pediatrician. Children are referred to the center for medical, psychological and cognitive assessment, diagnosis and treatment, including physical, occupational, speech and language, and other therapies as well as counseling and social skills groups. The Siskin Home & Community-Based Early Intervention program is designed to help parents, other caregivers and children with special needs gain the knowledge and confidence they need to be successful in life. Through visits with a developmental therapist, families receive information, support, guidance and consultation about improving quality of life both for children and their families. The program can be provided in the home, child care center, the park or other natural settings in the community. Siskin Outreach Services provide disability information to families, college students and professional through a dynamic array of programs that weave through the Institute's other areas of focus. Outreach Services offer a lending library, family support and training, consultation services, and professional training in fields related to special needs and early development. In addition to the four-season climate and affordable housing, there is no state income tax on salaries, wages, bonuses or any other type of income for work. Chattanooga is also home to several well-known private and parochial schools, including Baylor School, McCallie School and Girls Preparatory School. With a world-class aquarium ranked No. 4 in the country and No. 8 in the world, a variety of urban and outdoor activities, and 57 trail heads within a half-hour drive, you'll be pleasantly surprised by this gem of a town, if you aren't already a fan. For complete details and confidential consideration for this exceptional opportunity, please contact Glenda Smith, Principal, Pediatric Search Partners at glenda@pediatricsearchpartners.com, or by phone at 877.440.3832.

Developmental and Behavioral Pediatrics/Neurodevelopmental Pediatrics

We're seeking a Board Certified or Board Eligible Developmental and Behavioral Pediatrician and/or a Neurodevelopmental Pediatrician to join the expanding team at Siskin Children's Institute's brand new office in Nashville, Tennessee, opening in January 2020. This new facility will offer medical services including developmental assessments and treatment as well as applied behavior analysis therapy for children with special needs. Based in Chattanooga, Siskin Children's Institute is a nonprofit organization with a mission to increase access to assessment, diagnosis, and early intervention for children with developmental disorders including autism spectrum disorder, ADHD, Down syndrome, cerebral palsy and genetic disorders. The organization's expansion into the Nashville area will help shorten wait times and reduce the distance families of special needs children have to travel to see developmental pediatricians who can provide the care their children deserve. You'll join a group of specialists and experts in the areas of developmental pediatrics, behavior psychology, and applied behavior analysis, all of whom work collaboratively with families and take an interdisciplinary approach to identification and intervention for neurodevelopmental concerns. Leading the Nashville practice is Dr. James Van Decar, a neurodevelopmental pediatrician with more than 30 years of experience helping children with special needs and an expert in the evaluation, diagnosis, and management of developmental disabilities in children. You'll love living in Nashville, one of the country's hottest cities and ranked No. 15 on U.S. News & World Report's Best Places to Live based on quality of life, job market, value and desirability of the area. Dubbed "Music City, U.S.A.," Nashville enjoys a booming and diverse economy, lower cost of living than other major U.S. cities, great neighborhoods and an entertainment scene that's second to none, from the Grand Old Opry, Country Music Hall of Fame and a slew of live music venues to professional sports, world-class museums, even a thriving craft beer industry. Nashville's central location puts you within two to four hours driving distance of Atlanta, Chattanooga, Knoxville, the Great Smoky Mountains and the Kentucky Bourbon Trail. Plus, as a resident of Tennessee, you'll pay no state income tax. For complete details and confidential consideration, please contact Glenda Church Smith, Principal, Pediatric Search Partners, at 877.440.3832 (office), 214.850.3094 (cell/text), or via email at glenda@pediatricsearchpartners.com.

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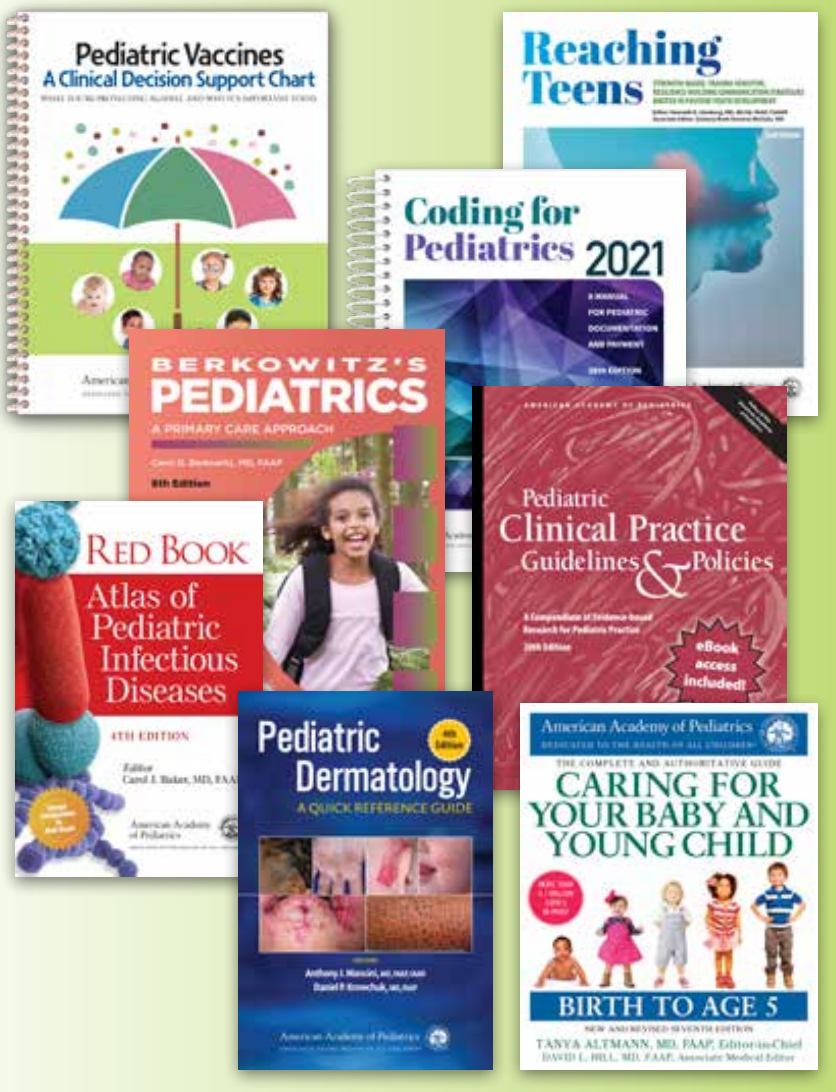

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Telemedicine in Pediatrics: Possibilities and Pitfalls

Angela L. Chandler, MD, Jared C. Beavers, MD, Richard Whit Hall, MD
Reprinted from Pediatrics in Review 2020;41;376. DOI: 10.1542/pir.2019-0171

Telemedicine has been defined as "the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status." The most common clinical application and the greatest potential of telemedicine lie in its ability to connect patients with providers in underserved areas with pediatric subspecialists, saving time and travel expenses for the patient while supporting community providers. Educational applications lie in the ability to connect academic with community practices, allowing bidirectional flow of information. Research applications include the ability to recruit patients and engage community providers as well as study an intervention's usefulness in the community. Subsequently, telemedicine can be used to disseminate research findings. A growing area for telemedicine is commercially available direct access for patients, but this application will need modification. Barriers to wider adoption do exist, including technical issues, which are typically less significant, time demands and reluctance by providers, and reimbursement and political concerns such as licensing issues, which vary from state to state.

Telemedicine provides an avenue to imbed general pediatric care in the community. Many programs have been able to implement telemedicine in schools, child care centers, summer camps, youth homes, and juvenile detention centers. Despite initial concerns regarding lack of communication with the primary care physician, telemedicine, when used in the context of the medical home, has significant advantages: enhanced patient satisfaction, cost savings, fewer emergency department visits, and less time off work for parents.

Current subspecialty uses for telemedicine include pediatric dermatology, emergency medicine, intensive care, neonatology, cardiology, surgery, and psychiatry. The primary benefit for patients who receive pediatric subspecialty care via telemedicine is better access, largely because of inadequate subspecialty coverage in some areas of the country. Rural communities are typically the most underserved, but some inner-city urban populations lack adequate subspecialty care as well. Teleconsultation allows community physicians to provide care for patients locally with the support of subspecialists. In addition, teleconsultation allows for more appropriate transfer of care, saving money and limited tertiary care resources. The reasons and potential for subspecialty use are listed in the Table.

TABLE. **Primary Uses for Telemedicine in Subspecialty Care**

SUBSPECIALTY	MAIN USE AND POTENTIAL
Dermatology	Visual examination is critical to accurate diagnosis
Emergency medicine	Ability to visually assess key findings, such as respiratory distress; emergency providers are more accepting of advice from subspecialists
Intensive care	Support community hospitals in keeping more critically ill patients
Neonatology	Support community hospitals in keeping more critically ill patients; assist in resuscitation; teleconsultation
Cardiology	Tele-echocardiography; teleconsultation
Surgery	Follow-up care; burn assessment; mentoring
Psychiatry	Videoconferencing is perceived as less threatening than face to face

Videoconferencing through telemedicine provides a convenient way to acquire education and continuing medical education credits while allowing bidirectional flow of information. Arkansas' Peds PLACE (Pediatric Physician Learning and Collaborative Education)

model allows academic physicians to teach and learn interactively with community providers. Participants and discussants can participate from distant sites without the time and expense of travel or disruption to busy clinical practices. Other means of education include interaction with other subspecialists, such as working through a national collaborative, or the knowledge acquired from the interaction of community providers with pediatric subspecialists.

Increasingly, telemedicine is being used by patients for direct access to providers from mobile devices and computers. Commercial direct-to-consumer (DTC) applications outside a medical home are not recommended for children younger than 2 years. Busy parents (typically in metropolitan areas) are opting for the convenience of obtaining medical care day or night and with less delay. Acute respiratory illnesses are among the most common diagnoses, followed by dermatologic infections/abnormalities, gastrointestinal problems, and fever. Notably, there is a higher incidence of antibiotic drug prescribing via DTC telemedicine encounters compared with office visits with primary care physicians. Although many users of DTC platforms receive preventive care, they are more likely than nonusers to visit urgent care centers or emergency departments, often without communication with the child's medical home.

Community research is important because the needs of patients from local and rural communities are often very different from the needs of patients living in an urban setting. However, research in that environment is challenging because community providers often lack familiarity with research methods and are primarily focused on patient care. Telemedicine can be used effectively to recruit and retain study participants from local practices while imbedding academic research rigor in community practices. Research into effective implementation is now gaining traction in funding and design because of the importance of instilling known evidence-based practices into actual patient care and management. Telemedicine can facilitate implementation of best practices and can also integrate best research practices into community (and academic) settings. Infrastructure and cost without reciprocal reimbursement remain the largest barriers restricting the more widespread adoption of telemedicine. Hardware, software, setup fees, and ongoing maintenance fees are substantial, often costing tens of thousands of dollars per telemedicine unit. However, infrastructure costs continue to fall as the required technologies become more widespread. The overall cost burden of telemedicine in the health-care system is difficult to assess because technology and connectivity costs, savings from travel time and costs, and not having to miss work must all be taken into account. Some studies have demonstrated cost savings when overall use is considered (eg, fewer emergency department visits), and others have demonstrated a net increase in costs given increased use and technology costs.

The long-standing fear that a rise in telemedicine consultations could lead to increased litigation, increased medical errors, and increased malpractice burden on the health-care system as a whole has not materialized. Recent studies have demonstrated that telemedicine can decrease the number of medical errors in rural hospitals with consultation from critical care specialists and does not lead to an increase in malpractice awards. However, care in the DTC model shows a significant tendency to deviate from recommended guidelines, with a near 10% to 20% drop in adherence to recommendations, which affects the quality of patient care and could open the door to future legal concerns.

Reimbursement standards and regulations have been developed in most states, although the amount of reimbursement is highly variable. The rate of reimbursement can also be tied to the type of technology used, with most states defining telemedicine as the use of "advanced telecommunications technology" rather than as a simple phone call. Reimbursements are more often tied to the modality used rather than the level of care or time spent in consultation. Reimbursement rates also tend to be higher for Medicare and Medicaid claims than for private insurers in rural settings, although many states have passed regulations requiring all insurers to provide a more

favorable reimbursement structure. Medicare reimbursements are limited outside the rural setting.
Telemedicine promotes clinical access to patients in rural and other underserved areas. DTC telemedicine has been problematic because it may result in overprescribing and may not communicate well with the medical home. Telemedicine has been useful in providing education to community practices, and it has fostered community research. Generally, barriers are becoming less problematic, but reimbursement and licensing issues remain. ■

Update
This In Brief was submitted prior to the recent pandemic caused by SARS-CoV-2, the novel coronavirus responsible for Covid-19. The pandemic created a unique opportunity for enhanced use of telemedicine in all specialties, including pediatrics, offering solutions to protect patients, families, and healthcare workers from exposure to coronavirus.

The urgency of dealing with Covid-19 has toppled more barriers in two months than all the efforts over the last decade. Although only 20% of states require equal payment, CMS and most private insurers have recently relaxed reimbursement requirements, allowing virtual visits to be paid as in-person visits. Crossing state lines using telehealth has been a barrier because licensing is under the state's purview, and thus practitioners are required to obtain (expensive) licenses in all states where they practice. Now, the Licensure Portability Grant Program has set aside $5 million to aid licensing boards and national compacts in developing a streamlined process for telehealth providers to obtain multi-state licensure and credentialing. Previously, ancillary health care providers were required to see their patients in person for reimbursement. Now, health care providers in occupational, physical, and speech therapy are able to see their patients virtually with equal reimbursement. HIPPA requirements have been relaxed, and smart phones are now routinely used.

Understandably, there are positives and negatives to such a rapid integration of telehealth. Security has quickly come under scrutiny as providers turn to the large market of videoconferencing software that is commercially available but untested in telemedicine. Scaling telehealth has also been a challenge for many health systems; some institutions have been able to build upon existing infrastructure but others have scrambled to implement the tremendous infrastructure required for system-level telehealth applications. Technical difficulties related to devices, interfaces, and internet connectivity have frustrated both providers and patient families, as many families simply do not have reliable internet access. On the other hand, many families have embraced telemedicine visits due to their ability to attend virtually rather than missing appointments due to lack of transportation or fear of the virus.

On March 14, 1942, penicillin was given to the first patient in World War II, using up half the US supply of the antibiotic. By D-Day in 1944, over a million doses were available for our troops. The catastrophe of war had a lasting impact in our fight with bacterial illness. In the ever-changing climate of medicine, this pandemic has led us to adaptation and innovation in telemedicine. It remains to be seen if the changes in the virtual way we relate to patients brought about by this catastrophe will persist.

Comments
The foundation of the doctor-patient relationship is fast changing. Medicine is becoming ever more business oriented and less personal, and electronic technologies, whether the Internet, health-care records, or telemedicine, for all their benefits are also fundamentally altering the nature of the medical encounter.

The good news is that information is easily and widely available to patients on the Internet; the bad news, of course, is that misinformation is easily and widely available to patients on the Internet: witness the rise of vaccine refusal based on fallacious claims of harm. The electronic health record promises easy access to important patient information, but too often doctors face the computer screen, not their patients, as they have to take time to enter data to maximize billing at the expense of exploring their patients' needs. Certainly it is a blessing that telemedicine gives access to expert subspecialty support to pediatricians and their patients in rural areas distant from a children's hospital, but in an era that promotes the medical home it also provides DTC services that bypass any personal contact and continuity, not to mention a lack of rigor in following recommended guidelines for care.

We need to decide whether the intimacy and trust of the traditional doctor–patient relationship is worth whatever effort and creativity it may take to resuscitate it.

– Henry M. Adam, MD
Associate Editor, In Brief

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Reentry Reflections: Views on COVID-19 From a Global Health Trainee

Michelle Javier, MD, Andrea L. Dean, MD
Reprinted from Pediatrics August 2020, e20201611; DOI: https://doi.org/10.1542/peds.2020-1611

It is a warm day in Kampala. I walk through the pediatric emergency center, taking stock of the day's supplies before the shift begins. The medicine drawer holds one vial of dexamethasone and a few vials of adrenaline, atropine, furosemide, and phenytoin. The head nurse greets me as she does every morning and informs me of the somber news from the last shift; a child with generalized tetanus was admitted in the late afternoon and quickly decompensated. We shake our heads sadly, acknowledging that it was a difficult case. There are no ventilators in the emergency center.

I spent one year in Uganda through my combined residency program in pediatrics and global child health, acclimating to a vibrant culture and nuanced pathology. Often I encountered the logistical challenges brought on by resource limitation and the tragedies that frequently accompanied them. On reentry to the United States in January 2020, I, like many physicians and trainees who spend significant time abroad, grappled with the vast differences between medical systems and the applicability of my international experiences to my practice here.[1] At the same time, a disease was emerging that would blur the line between global and domestic health and would give my training new relevance on home soil.

On January 30th, 2020, the World Health Organization declared coronavirus disease 2019 (COVID-19) a public health emergency of international concern. In just a few months, the disease was recognized as a pandemic, and the United States felt the deep strains of resource limitation: testing capacity was severely limited, ventilators were in short supply in epicenters, and novel techniques of reusing N95 masks were investigated. Hospitals prepared for the surge in cases by adding physical bed space and sought ways for medical providers to "un-specialize" to care for the broader population.[2] Pediatricians in community and children's hospitals planned for the care of adults as it became clear that the disease disproportionately affects older populations.[3] In what seemed to be the blink of an eye, the United States had to quickly adapt and operate with relative resource constraints.

Physicians in the United States are being stressed and stretched in unprecedented ways. Those in disease epicenters are working with an ever-depleting pool of providers in what has been described as "war-like" conditions.[4] The rest of the medical workforce, including many pediatricians, wait to be summoned as the surge predictions in states, cities, and counties change daily. Individuals' moods fluctuate between eagerness to help, anxiety of exposure, and uncertainty in abilities to care for patients affected by this novel virus. Although nothing can fully prepare clinicians for these extraordinary challenges, I believe that the resilience and flexibility learned while training in a low resource setting has given me a mental and clinical framework to face challenges presented by COVID-19.

In resource-limited settings, where advanced pathology and lack of testing mean that diagnostic uncertainty is common, physicians need to use their medical expertise to the fullest extent. Patients often present with immediate needs without alternatives to care, and learning to serve these patients is, perhaps, the cornerstone of global health clinical training. One busy afternoon at the pediatric HIV clinic, while I was seeing expectant mothers, young adults, and school-aged children for routine HIV care, an elderly woman appeared in my doorway, handed me her medical booklet, and reported worsening headaches. After flipping through her records

and obtaining a set of vital signs, I suspected hypertensive emergency. The clinic did not have antihypertensive medications in stock, and unsure of resources available for this patient who had encountered several barriers to services, I called my Ugandan internal medicine colleague.

Together we crafted a plan for the patient. These experiences made me appreciate my medical education, which taught me how to assess, recognize, and find answers, even when outside my typical scope. I regularly leaned on the expertise of my local colleagues, scoured the literature, and reached out to specialists from home to discuss cases. In the COVID-19 pandemic, pediatricians may face similar circumstances in caring for adults and patients with unfamiliar symptomatology with few other options for care, and these same skills will allow me to care for patients with competence and compassion.

Global health physicians regularly risk their own health and safety to care for patients, and as such, my experience serves as a backdrop on which to consider the risk of exposure to COVID-19. Physician with high tolerance of risk may work in disaster zones and remote global locations. Yet even physicians providing routine care in tuberculosis endemic settings, where N95 masks are often in short supply, accept the risk of acquiring latent infection.[5] Each time I placed an intravenous line or performed a lumbar puncture on a patient with AIDS, I balanced my personal risk of a needle stick with the value of the procedure for the patient. This type of decision-making process, until COVID-19, was not readily apparent to me in my US-based pediatric training. As I encounter patients amid the pandemic, I will use these skills to weigh personal risk and beneficence into patient care.

Lastly, my global health experience has taught me to cope with grief that accompanies frequent and untimely deaths, which pediatricians may experience during the pandemic. Ventilators were difficult to access for pediatric patients in Uganda, and the staff and I witnessed infants and children passing because of the lack of this vital resource, including the child with generalized tetanus. Although no physician becomes immune to the sorrow of watching patients die because of the lack of medication or therapy, I adopted coping mechanisms that allowed me to continue to see patients, day after day, in such dire situations. I sought support from networks of colleagues, mentors, and friends with shared experiences, who lent comfort in my frustration and distress. I learned to celebrate victories, even those that were small or rare, and to attend to those moments of joy as much as to my pain, which I will continue to do during the COVID-19 pandemic. Carrying my experiences with me, I offer a unique empathy to my colleagues struggling with despair during this crisis and hope that with t me, we can also celebrate the victories.

In the face of this pandemic, I am grateful for my global health training in East Africa and for how it has shaped my personal response to COVID-19. As pediatricians across the country respond to the surge in patients with COVID-19, it will be more important than ever to lean on experiences and expertise as we address the novel needs of the pandemic. For those who have worked in resource-limited settings, providers can take an active role in sharing their mental and clinical framework to bolster health care systems in this ever-changing landscape. Building on experiences abroad, we can support our colleagues and teams as pediatricians extend care to a broader range of patients, empathize with those balancing the inherent risks of patient-facing roles, and comfort our teams as the effects of the pandemic come close to home. During the COVID-19 pandemic, I will face the challenge and embolden my colleagues with the pragmatism, ingenuity, resilience, and compassion that my international mentors, colleagues, and patients have imparted to me. ■

Acknowledgement

We thank Dr Stephanie A. Marton for her review of the article.

Abbreviations

COVID-19: coronavirus disease 2019

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