

To Improve, Put Practice Under the Microscope

The Bright Futures and Practicing Safety projects are cited, along with the value of an outside facilitator.

BY FRAN LOWRY
Orlando Bureau

ATLANTA — Delivering optimal well child care in the office depends on teamwork, teamwork, and more teamwork.

And the best way to determine how well your “medical home team” is working is to look at how you are doing with the help of an outside observer, Dr. Paula Duncan, professor of pediatrics at the University of Vermont, Burlington, said at the annual meeting of the American Academy of Pediatrics.

Dr. Duncan, cochairperson of the Bright Futures Pediatric Implementation Project, outlined some strategies that individual practices can use to improve the preventive and developmental services they offer their young patients and families.

First and foremost, each practice has to put itself under a microscope to see just how it actually functions, she said.

“Many of these strategies come from the Bright Futures Implementation Pro-

ject and [from] Practicing Safety, spearheaded by Dr. Steven Kairys, chairman of pediatrics at Jersey Shore University Medical Center, Neptune, N.J. He has done outstanding work in this regard,” Dr. Duncan said.

A well-trained outside facilitator can be extremely helpful, she added. Dr. Duncan gave the example of one practice that hired an observer to detail exactly how it operated.

“This practice was obviously interested in improvement. They were willing to look at how everyone in the practice—from the receptionist at the front desk, to the nurse practitioner, to the physicians—interacted with each other and with patients. The observer noted how patients were moved through the office, how work was actual-



ly done in this office, and how patients were treated. The results highlighted where improvements could be made and also showed what they were doing that was absolutely right,” she said.

As part of this process of looking inward, the practice also had meetings once a week. In addition to the personnel of the practice and the facilitator, the meetings included a parent. “I love having a parent

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DR. DUNCAN

as part of the team. The partnership between parents and the medical home is very important,” Dr. Duncan said.

It is essential to be able to learn what is on the parent’s mind. The logical way to assess this is via questionnaires, but the practice team must be alert to those parents who may have difficulty filling out these questionnaires for one reason or another.

“One way to make sure we are getting this information is to have the nurse, or physician, or both, ask: ‘What are you concerned about today?’ Once we learn the

parents’ concerns, we then have to make sure we address them,” she said.

The aim of Bright Futures is to promote the best well child or preventive care, using certain strategies including:

- ▶ Use of recall and reminder systems, such as questionnaires.
- ▶ Development of a registry of children in the practice who have special health care needs.
- ▶ Use of a questionnaire at every visit to ask about parental and youths’ concerns.
- ▶ Use of a confidentiality policy for adolescents.
- ▶ Use of a list to prompt essential preventive services.
- ▶ A referral follow-up system.

While Bright Futures may appear ambitious in scope, its goals can be achieved when the practice acts as an integrated team, Dr. Duncan said.

“For practices to be able to implement changes in well child care, or preventive services, they need to realize that everyone in the practice is important, and has something real to contribute. The way to make improvements is to get the whole office involved, and to get everybody working together,” she said. ■

Going From Pediatric to Adult Care for Diabetes Is a Problem

BY FRAN LOWRY
Orlando Bureau

ATLANTA — Children with type 1 diabetes tend to get excellent, dedicated care from diabetologists who specialize in working with children and adolescents with juvenile diabetes.

But when it comes time to “graduate” to adult care, these kids may find themselves with no one to care for them, Dr. Leslie Plotnick said at the annual meeting of the American Academy of Pediatrics.

“I worry that we do not have enough endocrinologists to carry on with these kids when they leave our centers. Even though you are 18, it doesn’t mean that you are an adult, and these kids can sometimes fall through the cracks through no fault of their own,” said Dr. Plotnick, a professor of pediatrics at Johns Hopkins Medical Institutions, Baltimore.

The transitioning of children with juvenile diabetes from the pediatric setting to adult endocrinologists is problematic for many reasons, Dr. Plotnick and Loretta Clark, R.N., a certified diabetes educator who works with Dr. Plotnick, said in a later interview.

One big obstacle to continuing on to good care is insurance. Unless a child is attending college full time, they may be dropped from their parents’ insurance. Even a full-time job is no guarantee of health insurance.

“It’s a big problem. If you work for a big company, or for a large institution, preexisting conditions may not eliminate you from health insurance. But if you are working in a small business, preexisting [medical conditions] can mean that you are not eligible to get health insurance, even if it

might otherwise be offered,” Dr. Plotnick and Ms. Clark said.

This is true for all older children who have chronic medical conditions, Dr. Plotnick added. “Kids who have developmental delay may continue on their parents’ insurance for a longer time, but this is not true for medical conditions. This problem goes way beyond diabetes and includes all pediatric chronic diseases.”

Children becoming young adults who see an adult endocrinologist may encounter other difficulties, because adult practice tends to differ considerably from the team approach to type 1 diabetes to which they have become accustomed.

“Here at Hopkins the kids usually see a nutritionist, a diabetes educator, and a physician. That isn’t always true when [as young adults] they go to see an adult endocrinologist. And if they don’t feel like there is a good match with the adult endocrinologist, they sometimes don’t go back. And then they don’t follow up. Sometimes a parent will call me and say their child went to see a particular doctor, didn’t feel comfortable with that doctor, and hasn’t been to see him again,” said Ms. Clark.

It would be ideal if there were enough pediatric endocrinologists to continue to see children well into their young adulthood.

“When kids finish high school, there are many changes in their lives. Having to change to a different physician as well is very tough,” added Ms. Clark.

Over the past year, Dr. Plotnick and her colleagues have started a program with an adult endocrinologist who has agreed to see their type 1 “grads.” So far, the program has been a success, she said. ■

Obesity Costs \$49 Billion for Every 4 Million Born in U.S.

BY TIMOTHY F. KIRN
Sacramento Bureau

SEATTLE — Obesity costs the United States \$49 billion for each group of 4 million children born, according to findings presented by Dr. Matthew M. Davis at the annual research meeting of AcademyHealth.

That \$49 billion figure reflects the present rate of obesity, not the expanding rate actually occurring, said Dr. Davis of the department of pediatrics and internal medicine at the University of Michigan, Ann Arbor.

Dr. Davis’ research involved constructing a model that calculated the longitudinal costs of being obese—from ages 3 to 65—for the percentage of individuals who are obese at every age. Currently, the average number of children born annually is 4 million.

The model suggests that the percentage of individuals who are overweight or obese does not really change much before age 16, because some individuals gain and lose weight as they grow and cycle from being overweight to normal weight. But that percentage begins to climb at age 16 years, as the likelihood of being overweight or becoming overweight at that age and then returning to a normal weight declines. The rate begins its steepest climb when individuals are about 25-35 years of age.

Significant differences in health care costs for persons who are obese do not begin to occur before age 40 years, Dr. Davis said. But then they

continue to increase so that by age 50 each individual incurs excess costs averaging \$2,000 a year.

The \$49 billion extra spent for obese individuals between the ages of 3 and 65 is composed of \$44 billion in direct health care costs and \$5 billion in days of lost work.

Dr. Davis also attempted to predict what impact various proven obesity interventions would have if they were implemented nationwide. However, he found he could not, because none of the studies about those interventions had any longitudinal information on the individuals once the intervention was stopped.

He said there are five public health interventions that most experts agree have been shown to work to reduce obesity rates. All of those interventions involve targeting children, most between 9 and 12 years of age. The intervention shown to have the biggest impact is eliminating the sale of soda in schools, Dr. Davis said.

In his study, Dr. Davis had to assume the effect of the interventions stopped when the intervention ceased; in such a scenario, the interventions had minimal impact. Getting soft drinks out of schools would save only about \$650 million. All of the other four interventions combined would save another \$300 million.

Dr. Davis’ data were culled from a variety of sources, including the National Longitudinal Survey of Youth and the Medical Expenditure Panel Survey. ■