The first round of H1N1 vaccines are expected to be ready in October, and the Centers for Disease Control has prioritized five groups of people who should be vaccinated first. First are Pregnant Woman. “Pregnant women have a deficiency in that protective mechanism so in fact they get much worse influenza than non-pregnant women,” explained Meg Fisher, MD, FAAP, Chair, Department of Pediatrics, Medical Director of Monmouth Medical Center when interviewed by Sara Lee Kessler for NJN News.

The remaining groups to receive the vaccine first should be: people who are in close contact with babies under 6 months of age; healthcare workers and first responders; children 6 months to 18 years and 19 to 24 year olds; and adults 64 and under with underlying medical conditions such as asthma, diabetes and heart disease. People ages 25 through 64 years of age can be at higher risk for 2009 H1N1 because of chronic health disorders or compromised immune systems. The CDC does not expect that there will be a shortage of 2009 H1N1 vaccine, but availability and demand can be unpredictable. There is some possibility that initially the vaccine will be available in limited quantities, and the top priority groups should be vaccinated first.

H1N1 Immunization Updates for New Jersey Pediatricians

The following information was provided at the September 3, 2009 meeting between State of New Jersey Department of Health, NJ Council of Children’s Hospitals and American Academy of Pediatrics NJ. The State of New Jersey Department of Health and Senior Services (NJDHSS) has developed the following plans for administration of H1N1 vaccine. Please stay tuned for updates.

The NJDHSS has been working closely with the CDC, FDA, NIH, vaccine manufacturers and commercial suppliers to ensure safe, efficient and streamlined distribution of vaccine in the state. Vaccine will be administered in private practices, FQHC and other large clinical settings, hospitals schools, and by commercial providers (e.g. pharmacies).
I hope all of you had a nice summer vacation. We experienced some of the H1N1 flu this spring and as school and the fall return we all expect another outbreak. AAP NJ will try to keep you informed about H1N1 in NJ with our new weekly E-Newsletter, and on our Web site www.aapnj.org. At this time we do not know how the vaccine, if and when it becomes available, will be distributed. Also look at www.cdc.gov/h1n1flu/ and www.aap.org for the latest national news about H1N1.

The upcoming election for National AAP President began on August 31st and is ending on October 1st. Please visit the member center at www.aap.org to view the two candidates: Anne Francis from Rochester NY, and Marion Burton from Columbia SC. Voting this year will only be done online.

The final stages of the AAPNJ Purchasing Alliance are coming together. Soon the AAPNJ Purchasing Alliance will be incorporated and then we will file with the Department of Banking and Insurance. We have had discussions with the medical malpractice insurance carriers. After these discussions we had one medical malpractice company, MD Advantage, willing to enter an agreement with the Purchasing Alliance. MD Advantage is willing to give members of the AAPNJ Purchasing Alliance a 20% discount. Currently about 200 pediatricians already have MD Advantage as their carrier. This discount would apply to current insurance members as well as pediatricians who decide to purchase insurance from MD Advantage as long as they are members of the AAPNJ Purchasing Alliance. If you do not have MD Advantage as your medical malpractice insurer then you should discuss this with your insurance broker because you could be looking at saving about $1800 or more depending on your limits and tier rating on current MD Advantage rates. To join the Purchasing Alliance you must be an AAP/NJ chapter member. There will also be a membership fee ($125). The membership fee covers administrative costs, advertising and insurance for the Purchasing Alliance.

We will be sending details on how to join the AAPNJ Purchasing Alliance when all of the final details have been worked out.

Hopefully, I will be seeing you at the NCE in Washington DC from October 17 to 20. The programs look interesting and the speakers are very good and informative. The District III breakfast is on Sunday October 18th and is a way for you to meet District and Chapter officers.

President’s Address

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Fall 2009

Official Newsletter of the American Academy of Pediatrics New Jersey Chapter

The AAP NJ Web site has been completely updated to include news, opportunities, resources, important forms and a section for parents.

Please visit www.aapnj.org and let us know what you think!
Please access both the CDC and NJDHSS websites for all H1N1 information, the linkages and updates are also provided on our website at www.aapnj.org. Sites are updated frequently (links below). It is estimated that there will be 45 million doses of H1N1 vaccine available nationwide. NJ is allocated 1 million doses for the first distribution to the five CDC prioritized groups (described at www.cdc.gov/h1n1flu/). There is expected to be AMPLE vaccine for all of these groups as shipments arrive weekly throughout the season. All H1N1 vaccine will be available for free from the federal government. Please warn your patients against any so-called H1N1 vaccine that is either supposedly currently available or is obtained through non-standard routes.

Obtaining the H1N1 vaccine for your clinics and practices will be EASY. All participants will register electronically, in three easy steps. Webinar training will be available multiple times throughout the day – only 15 minutes to complete.

Registration will be through a special H1N1 New Jersey Immunization Information System (NJIIS) website open to all practitioners and independent of whether the practice is using the NJIIS to register routine immunizations.

Although the State will distribute the vaccine through the Vaccine for Children (VFC) storehouses, all practitioners regardless of VFC status are eligible to receive H1N1 vaccine. If you are already a VFC provider you will also register for H1N1 vaccine. Your provider PIN will be the same but with an additional H1N1 tag. If your practice is both a VFC and non-VFC vaccine provider you will use your VFC PIN to order H1N1 for the entire practice. If you do not participate in VFC you will still register through the system to obtain H1N1 vaccine. Licensed and certified providers whose names are listed at the time of registration will be protected from tort liability through the PREP Act (see: http://www.hhs.gov/disasters/emergency/manmadedisasters/bioterrorism/medication-vaccine-qa.html).

Medical home: All participants will have the ability to electronically track their patient’s H1N1 vaccine status regardless of where child was immunized. The H1N1 vaccine can be administered at the same time as the seasonal flu vaccine. The H1N1 vaccine will probably be a two-dose vaccine given 21/28 days apart.

The H1N1 vaccine is free and provided by the government. It is being distributed in packages with a minimum of 100 doses each. Each kit will come complete with alcohol swabs, syringes and needles as well as biohazard sharp containers. Please contact your local county department of health to find out if and where community-based immunizations will be given and how you can assist.

Please view the following links:
Centers for Disease Control www.cdc.gov/h1n1flu/
NJ State Department of Health www.state.nj.us/health
AAP New Jersey www.aapnj.org

The AAP NJ Chapter will provide updates through weekly E-Newsletters, web sites, upcoming conferences and a soon to be announced teleconference.

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### H1N1 Information for The Developmentally Disabled Community & General Guidelines for Protection

**An Important Message from The Division of Developmental Disabilities and The Arc of New Jersey**

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| Anyone who is caring for, or cares about, someone with a developmental disability should be aware that certain underlying medical conditions often found in people with these disabilities can make them susceptible to more severe complications from the flu virus than individuals without these conditions. This is of particular concern since the World Health Organization recently declared a global H1N1 flu pandemic. It is important to note that a pandemic declaration is based on the sustained worldwide spread of H1N1, not the severity of illness caused by the virus.

Any individual who has a developmental disability that affects respiratory function has a higher risk of complications.

Any individual who has chronic pulmonary (including asthma) cardiovascular (except hypertension), renal, hepatic, hematological (including sickle cell disease), neurological, neuromuscular or metabolic disorders (including diabetes mellitus) has a higher risk of more severe complications.

Because of these complication risks, individuals with developmental disabilities should be vigilant about taking preventative measures that can help them avoid the flu. This is especially critical because there is no vaccine currently available for H1N1, and seasonal flu vaccinations do not provide protection against H1N1.

Wash your hands frequently, preferably with soap and water. An alternative is to use alcohol-based hand sanitizers, but first refer to facility policies around their use, especially in regards to individuals who have a habit of placing their fingers or hands in their mouths.

Cover coughs and sneezes with a tissue, or practice the habit of coughing or sneezing into your inner elbow if you don’t have a tissue. Wash your hands or use hand sanitizer after sneezing or coughing into a tissue.

Keep the environment around you as clean as possible. Studies have shown that influenza virus can survive on surfaces such as books and doorknobs for as long as eight (8) hours. To prevent the spread of the virus, dispose of tissues and similar items in the trash. Clean and sanitize frequently-touched surfaces (such as desks, doorknobs, computer keyboards and toys) regularly.

Individuals with the H1N1 virus may be infectious for approximately 24 hours before they develop symptoms. While you do not want to avoid all human contact, be alert and even cautious about attending events that may involve large crowds or groups of people. Avoid contact with anyone who is sick until that person becomes well.

Talk with your primary care physician about any steps he or she thinks you should take to be prepared including where to take the individual if he or she becomes ill when the doctor is not available, such as the ER on the weekend.

In some cases, physicians may recommend antiviral medication for individuals who are at high risk for complications from the flu. If your physician recommends medication, she/he will tell you when and how to take this medication.

People with flu-like illnesses usually have temperatures of 100° F and a sore throat or cough in the absence of another known cause (e.g. strep throat). If the individual you are caring for develops a flu-like illness, take him or her to the doctor, or the alternative location suggested by the doctor, as soon as possible and follow the doctor’s instructions.

Keep the individual with a flu-like illness at home for seven (7) days and until all symptoms have resolved.

Finally, we encourage you to become knowledgeable about the H1N1 virus and stay abreast of any new developments or recommendations. Some very good sources on the Internet include:

- The World Health Organization: www.who.int/en/
- The Federal Centers for Disease Control: www.cdc.gov/h1n1flu/guidance/
- The New Jersey Department of Health and Senior Services: www.state.nj.us/health/er/h1n1/
Fran Gallagher, MEd, voluntarily became a jailbird on August 19, 2009 when she was "arrested" by the Muscular Dystrophy Association and brought to "jail" for having a big heart! PCORE raised $1,275 for the Southern New Jersey MDA, which is enough to send a child with Muscular Dystrophy to summer camp and to pay for half of the tuition for a second child.

As a "most wanted" leader, Fran was transported by Trenton Police to join other local business and community leaders as they joined together to raise funds for MDA as part of the "Help Jerry's Kids Telethon," to be held in September. This creative fundraiser united local leaders to help families being served by MDA in the Mercer County area, furthering PCORE’s mission to provide pediatric expertise for systems of quality care for all children.

PCORE Corner; How are AAP NJ and PCORE working on your behalf?
Cont. from page 1

Specifically, leadership will discuss planning strategically to ensure that PCORE’s infrastructure and systems will support the ability to continuously adapt to meet the challenges below:

**Maintenance of Certification**
PCORE will work to adapt its programs to meet MOC requirements and to market its potential programs to NJ Pediatricians in collaboration with AAP NJ. The potential exists for programs of benefit to specialists as well as general pediatricians. Funding will be sought to be able to offer PCORE programs at no /low cost to Chapter members as one of their member benefits.

**Electronic Medical Records**
AAP NJ and PCORE will seek opportunities to provide support and training as practices gear up for Electronic Medical Records in 2011 and beyond.

**Patient Centered Medical Home**
This will continue to be a major priority at the federal and State levels. AAP NJ and PCORE will develop a collaborative strategy so that the political and financial aspects are developed in sync with the continued growth of programs and projects to support, and provide continuing medical education and technical assistance to primary care pediatric practices at community and state levels. Efforts to support NJ Medical Homes will include improved linkages to public data bases such as the Immunization Registry and improved linkages between community pediatric practices and New Jersey’s children’s hospitals.

**Comparative Effectiveness**
PCORE will track and bring to New Jersey results of national work in comparative effectiveness. Experts will translate that work so that what becomes new standards at CMS matches expectations with the State’s managed care companies.

**Continued Partnerships**
AAP NJ & PCORE work collaboratively to improve children’s healthcare across New Jersey with many partners! A few include the NJ Department of Health & Senior Services, NJ Department of Children and Families, Medicaid, NJ Statewide Parent Advocacy Network (home of NJ Family Voices and the Family to Family Health Information Center), Family Support Centers, Parents Anonymous, Federally Qualified Health Care Centers, Children’s Futures, RWJ Foundation, NJ Academy of Family Physicians, child psychiatry, Maternal and Child Health Consortia, Council of Children’s Hospitals and many more. We aim to expand partnerships to include the medical schools, and increased involvement with residents and fellows. We will continue collaborative efforts to explore opportunities for AAP NJ and PCORE to work with the managed care organizations around quality of care, financial support for successful medical home care, joint care coordination, and developing healthy communities through prevention outreach.
Dissemination of Best Practices
We have our first IRB application approval for the Healthy Habits, Healthy Living Program! We will continue efforts to have strong data for each project that can be used for publications, state, regional and national presentations. We will also work to seek national funding opportunities and apply for support.

Integration Innovation

AAP NJ Chapter and PCORE Integration Plan
In the past few newsletter issues we’ve focused on a plan to integrate … we would like to share a few examples of success in bringing together pediatric leadership, expertise, resources and teamwork

AAP NJ & PCORE Volunteer Training Program
Lisa Makai completed a six week (one day per week) course with Volunteer Connections. The AAP NJ and PCORE Volunteer Program has been launched and several volunteers are on board in response to posted volunteer positions. An investment of 15-20 hours per week of volunteer time and resources has already saved AAP NJ Chapter members and PCORE. An AAP NJ Chapter 4000 piece mailing for the School Health Conference cost $6,000 last year due to management fees. That same mailing this year will be completed for under $2,500. These savings are invested into priorities related to realizing the AAP NJ Chapter mission.

AAP NJ Chapter Committee & PCORE Program Team Work in Alignment
The newly revived AAP NJ Ad Hoc Committee on Improving the Quality of Healthcare for Children in Foster Care and in Other Out of Home Placements is co-chaired by Elizabeth “Sooze” Hodgson, MD, FAAP & Cathy Ballance, MD, FAAP and supported by an AAP Technical Assistance Grant. The PCORE Child Abuse and Neglect Team with our NJ Department of Children and Families partners have expanded the Ad Hoc Committee to include an interdisciplinary group to work collaboratively on both efforts. We will highlight our plans at the Pediatrics 21st Century, Conference October 16th prior to the AAP National Conference and Exhibits.

Support AAP NJ’s Transition
The AAP NJ and PCORE Team are working tirelessly to ensure that this first year of joint management promotes support for AAP NJ committees, political advocacy, state wide meetings, teleconferences, and support of District and national priorities.

PCORE Corner

AAP NJ & PCORE Product / Publication / Pre-publication
● Prevention First Children’s Everyday Foods vs Sometimes Foods (Healthy Choices, Healthy Living)
● Executive Summary of the NJ Childhood Obesity Prevention Program (March 31, 2009) Downloadable at njpcore.org
● IRB awarded for the PCP Obesity Prevention Pilot Program

Communication and Support for Our AAP NJ Chapter Members & PCORE Program Partners
There are so many more examples and program progress updates… please visit both websites www.AAPNJ.org and www.NJPCORE.org for updated information. The AAP NJ Chapter Executive Council and the PCORE Board of Trustees are highlighted and you may reach out to leaders in your area to share concerns or successes.

● Weekly AAP NJ E-Newsletter goes out every Thursday bringing you the latest information available on health alerts, resources, and continuing medical education opportunities … many are cost free!
● The NJ Pediatrician Newsletter comes out quarterly and is disseminated via e-mail alert and link to the Web posting. Would you prefer a hard copy mailed? Let Lisa Murison know lmurison@aapnj.org and we are happy to accommodate. We have new phone lines and extended central office hours from 7:30 a.m. to 5:30 p.m.. Feel free to call or stop by the central office!

SAVE THE DATES PCORE FUNDRAISERS!

November 7, 2009
Theatre Fundraiser, ArtsYOUUniversity Presents Hair Spray and School Daze Tickets and 50/50 Raffle Tickets on sale now! Theatre tickets are $25 each and 50/50 raffle tickets are $50 each, e-mail lmurison@aapnj.org.

May 3, 2010
6th Annual Golf Outing, Neshanic Valley Golf Course. Plan to join us and tee off to support PCORE—shaping childcare for the 21st century!
As you are assessing a teenager for his annual back-to-school physical, his mother pulls you aside and shares some concerns she isn’t comfortable talking about in front of her son. Mom begins by stressing that “John” is a great student; college bound with lots of friends. She just doesn’t understand, though, why he’s become so irritable over the summer. She sees him go out with friends, but also notices that he’s sleeping more in the early evening. John seems to get easily upset over little things that normally wouldn’t bother him. He’s also arguing a lot with his girlfriend, then storming out of the house after brief phone conversations with her. When asked, John tells her that “everything is fine.” Mom wants to believe he’s just going through “hormonal changes,” but she’s also anxious since there’s a history of depression in his father’s family that no one talks about openly.

As John’s doctor, you know you only have a brief time to meet with him. Initially, you downplay Mom’s concerns because John’s a bright accomplished kid and in all the year’s you cared for him, he’s never shared anything negative about his life. But your gut tells you to take time to explore this with John, and you have recently been reading up on teenage depression and suicide risk. Mom’s report of increased irritability, changes in sleep, and some apparent drama with his girlfriend stays with you as you ponder the best way to approach your concerns with John.

As you’ve learned, irritability is common in teens who may battle depression, and many kids who are at risk of suicide don’t have the same symptoms of adults you’ve known with clinical depression.

You’ve also learned, unfortunately, that the traumas faced by teens can push a truly vulnerable kid to act on an impulse in a moment of pain to harm themselves. Good kids, accomplished kids do kill themselves!

Adults don’t always “get” that events such as a broken romance, bullying, legal trouble or struggles with sexual identity are suicide risk factors for many adolescents.

So, after you complete your exam, you sit with John and share his Mom’s concerns, creating an opening to talk, while practicing your best active listening skills. After a few minutes, you finally ask “the question.” Yes, John says, he has had thoughts of wanting to die. In fact, he actually looks relieved that you asked him…

What we have Learned
Statistically, most young people who attempt or complete suicide have been assessed by their primary care physician within six months of their attempt, but rarely has this assessment included a comprehensive mental health checkup or screening. We now have several excellent evidence-based screening tools and resources available to PCPs.

Suicide is the most preventable form of death, yet the numbers are on the rise in adolescents. Several important research studies, as well as medical associations, have highlighted the critical importance of screening in the primary care setting.

Camden County, NJ, established a Youth Suicide Prevention Task Force in 2006 under the leadership of Freeholder Carmen Rodriguez, who became deeply concerned after statistics for teen suicide in NJ between 2002-2006 were released. At that time, Camden County had the highest incidence of teen suicide in the state. The efforts of public and mental health professionals, educators, community leaders and clergy within this task force continue to strengthen our resolve to keep children and adolescents safe in our communities.

We have brought Question Persuade Refer (QPR) to our county,
Teen Suicide

(continued from page 6)

through the generosity of the Ian Oliu Foundation -- and we are working with area schools to ensure that state legislation requiring all educators be trained in suicide prevention be carried out. We have reached out to pediatricians at a quarterly Advocare (Pediatrics Group) meeting, and to members of the southern region of the National Association of Pediatric Nurse Practitioners (NAPNAP). One great hope remains, by reaching out to pediatricians throughout New Jersey, we can emphasize the critical role your practices can play in preventing teen suicide and support you in your efforts. In addition to using screening tools, having access to current information about mental health resources in your community will prove to be critical in the prevention of teen suicide.

Where to Refer

Each county in New Jersey offers 24-hour crisis screening, along with the ability to provide mobile crisis assessments. In Camden County, these services are provided by Steininger Behavioral Health Care. In addition to crisis services, mental health treatment facilities such like Kennedy Health System’s Behavioral Health Services offer comprehensive mental health assessments, whereby patients are evaluated and placed at an appropriate level of care. For a complete listing of New Jersey’s Crisis Screening Centers, visit: NJ Department of Human Services – Division of Mental Services at: http://www.state.nj.us/humanservices/dmhs/services/centers/

Additional Resources

The Strengths and Difficulties Questionnaire (SDQ) [www.sdqinfo.com](http://www.sdqinfo.com)

KYSS Guide to Child and Adolescent Mental Health Screening, Early intervention and Health Promotion [www.napnap.org](http://www.napnap.org)


QPR Institute [http://www.qprinstitute.com](http://www.qprinstitute.com)


National Center for Mental Health Check Ups of Columbia University – Teen Screen

AAP Policy Statement

Suicide and Suicide Attempts in Adolescents

Benjamin N. Shain, MD, PhD and the Committee on Adolescence

Suicide is the third-leading cause of death for adolescents 15 to 19 years old. Pediatricians can take steps to help reduce the incidence of adolescent suicide by screening for depression and suicidal ideation and behavior.

This report updates the previous statement of the American Academy of Pediatrics and is intended to assist the pediatrician in the identification and management of the adolescent at risk of suicide.

The extent to which pediatricians provide appropriate care for suicidal adolescents depends on their knowledge, skill, comfort with the topic, and ready access to appropriate community resources. All teenagers with suicidal thoughts or behaviors should know that their pleas for assistance are heard and that pediatricians are willing to serve as advocates to help resolve the crisis.
Plan to Attend

The 18th annual School Health Conference of the AAP NJ ‘Community Medicine and School Health,’ will take place at the Pines Manor in Edison, NJ on Wednesday, October 28, 2009.

This year’s plenary speakers are Jeffrey Boscamp, MD, FAAP on vaccine safety and influenza expectations, Beverly Stern, RN discussing legal issues for medical staff, and Paul Yellin, MD, FAAP on brain development.

Workshops this year will include sports and infections, injury protection, and a special workshop on gangs and what we need to know in caring for our patients. Members are urged to take advantage of our chapter’s largest and most successful meeting. The conference is a great opportunity to earn CME’s and share experiences.

Wayne Yankus, MD, FAAP, Chair, School Health Committee and Conference Chair

How to Register

Log on to www.aapnj.org
Click on “Events”
Click on “School Health Conference”
Download brochure
Fax with payment to: 609-842-0015
Mail with payment to:
AAP NJ SHC
3836 Quakerbridge Road, Suite 108
Hamilton, New Jersey 08619

Do you know any organization that would potentially like to sponsor or exhibit to an audience of over 500 School Nurses and Pediatricians?

Kindly direct them to aapnj.org or have them e-mail Lisa Murison, Membership and Events Coordinator at lmurison@aapnj.org.

18th Annual School Health Conference Program

7:00 am Registration, Continental Breakfast, Exhibit Showcase
7:45 WELCOME
Wayne A. Yankus, MD, FAAP, Conference Chair
Michael Segarra, MD, FAAP, AAP/NJ President
Marie Peppas, RN, MPH, CSN, NJSSNA President
8:00 Plenary Session #1:
Immunizations: Safe and Very Necessary! - Jeffrey Boscamp, MD, FAAP
This plenary session will focus on the extraordinary impact that immunizations have had on the prevalence of infectious diseases. It will review the clinical characteristics of vaccine-preventable diseases and discuss vaccine safety issues, components of vaccines such as adjuvants and preservatives, immunological components of vaccines and current information to support the safety of vaccines.
9:00 Plenary Session #2:
Hot Topics for 2009 - Legal Issues - Beverly Stern, RN, BSN, CSN
The differentiation between Code, Statutes, Protocols and Guidelines will be explained along with the actual legal requirements presently mandated. The dilemma of maintaining “best practice” in the absence of updated Guidelines will be covered.
10:15 Break and Exhibit Showcase
11:00 WORKSHOPS

1. Gizmos and Gadgets - Hearing Safety - Pat Connelly, PhD, CCC-A, ABA and Jason Surow, MD - Since the advent of personal music players such as the ipod, parents are no longer bothered by the stereo blasting from their child’s bedroom. How can they know when the music is too loud, and when the child’s hearing is at risk. This workshop will help the school nurse counsel children and their parents as to how to protect their hearing from noise induced trauma.
2. Hit the Showers - Sports and Infections - Julia Piwoz, MD
This workshop will address common infections seen in young athletes. How infections are transmitted, which infections are common, and how they may be prevented will be discussed.
3. Heelies and Wheelies - Injury and Protection - Todd Mastrovitch, MD, FAAP
This workshop will review common pediatric injuries in school age children along with prevention and protection strategies. Discussed will be national statistics involving common pediatric injuries.
4. Ganges of NJ - What We Need To Know - Chris Hill
As gang activity continues to increase, your staff needs to be prepared to recognize gang related activity. NJHA Strategic Partner McNamara & Associates Inc., will offer the sensitivity issues when gangs are present at your school. The presentation will provide you with a basic overview of gang awareness so that your staff can become more alert to potential gang related activity.
5. Pediatric Assessment: Essentials for School Nurses - Patri Lucarelli, APN,CPNP
When a child needs medical attention in the school setting, school nurses need to be able to perform quick but effective nursing assessments to make accurate treatment decisions. This workshop will review the essential components for school nurses to include when conducting a focused pediatric assessment, to help ensure appropriate triage & care of their pediatric & adolescent patients.

12:15 pm LUNCH - Networking & State Proclamation - Exhibit Showcase
1:15 Plenary Session #3:
Resiliency and Neuroplasticity - Helping Our Children Overcome Early Challenges - Paul Yellin, MD, FAAP
Based on emerging research into resilience and neuroplasticity, Dr. Yellin will share practical strategies for helping every child overcome early struggles in school and life to find lasting success and satisfaction.
2:15 WORKSHOPS REPEAT
3:45 Adjournment
AAP NJ Chapter Members Discuss National Health Reform in Washington, D.C.
By Pierre Coant, MD, FAAP

Members of the AAP NJ Chapter traveled to Washington, D.C. to attend the Central New Jersey Primary Care Day on June 17, 2009. Jeanne Craft, M.D., FAAP, Nancy Pinkin, MPA, CHE and Pierre Coant, M.D., FAAP were present for the all day program organized by Congressman Rush Holt and held at the Library of Congress.

AAP NJ joined other physician and nurse organizations, AARP, pharmacists, Robert Wood Johnson Foundation, and many health and business entities in discussing healthcare issues. Congressman Holt and his staff brought together a diverse and experienced group of speakers to address healthcare reform in the United States.

Healthcare experts provided information and views on improving Primary Care. Fitzhugh Mullan, M.D., Murdock Head Professor of Medicine and Health Policy at the George Washington University spoke on establishing Medical Homes for Primary Care and increasing medical payments to attract medical students into Primary Care. Congressman Holt and his staff brought together a diverse and experienced group of speakers to address healthcare reform in the United States.

Five Members of Congress joined the group at various times to discuss healthcare reform and explore ideas. Members of Congress actively involved with the group were Representatives Rush Holt, Pete Stark, Tammy Baldwin, Lois Capps and David Wu. Discussions between these Members of Congress and the audience were well received by all attending as the Congress considers legislation in this area. Congressman Wu brought smiles to the audience when he explained that a bumper sticker for Congressman Holt indicated, “My Congressman is a rocket scientist!” since the Congressman is also a physicist.

A Member of President Obama’s Administration also attended the Central New Jersey Primary Care Day at the invitation of Congressman Holt. Michael Hash, Senior Advisor, White House Office of Health Reform presented the Administration’s objectives to the conference. Providing all Americans with healthcare insurance was a prominent theme. Also, expanding the Electronic Health/Medical Records was stressed along with multiple principles on improving healthcare in the United States.

Risa Lavizzo-Mourey, M.D., M.B.A. President and CEO, Robert Wood Johnson Foundation also spoke to the attendees. Various points were considered including strengthening the Medical Home and promoting Primary Care to reduce infant mortality and improve chronic care. David Hunt, M.D., Office of the National Coordinator for Health Information Technology, spoke about new developments in Electronic Medical Records (EMR). Improving patient safety with EMR and creating standards for providers and systems to communicate with each other were discussed. The Congressional Research Service and Committee Staff of Education & Labor and Energy & Commerce also provided insights into the Congressional process on healthcare reform. The discussions between the Legislative and Executive Branches of Government will lead to healthcare reform.

AAP NJ reminded the group of the very low Medicaid reimbursements in New Jersey and the need to support Primary Care Pediatricians with an increase in Medicaid payments. The importance of Pediatricians and AAP in participating with the Congress and the Obama Administration to provide the best healthcare for children and support for Pediatricians will be critical for the future. AAP NJ, under the leadership of President Michael Segarra, M.D., F.A.A.P., the Executive Council of Officers and Councilors, and Fran Gallagher, MEd, Executive Director AAP NJ, is engaged in the process of supporting our members in New Jersey with healthcare reform. Those Pediatricians interested in becoming involved in this process are encouraged to contact AAP NJ.

Many groups, organizations, and lobbyists are using their influence to input their own interests on healthcare reform. AAP NJ is actively involved to make sure that children and their Pediatricians have their voices heard.

AAP NJ thanks Congressman Rush Holt for organizing Central New Jersey Primary Care Day and looks forward to working with AAP National and the Congress and the Administration in promoting healthcare reform – and in supporting the 1700 Pediatricians in the State Of New Jersey who are critical in providing primary care now and in the future.
Leading national health and nutrition organizations have come together to urge child nutrition advocates, school food service organizations and health organizations to support the use of “nutrient density” as the cornerstone of dietary recommendations and meal planning. Taking this step will help Americans of all ages choose more healthful diets and help to reduce the risk of obesity and chronic disease beginning in childhood.

The Importance of Nutrient-Rich Foods in Planning Nutritious Meals for Children

Americans Consume Nutrient-Poor Diets

The diets of most Americans fall far short of current dietary recommendations. The Healthy Eating Index (HEI), a tool developed by the USDA’s Center for Nutrition Policy and Promotion to assess the nutritional quality of diets, has demonstrated that approximately 74% of Americans need to improve their diets. Among children, the situation appears to be even worse. According to the 2007 National Youth Risk Behavior Surveillance, only 14% of adolescents in grades 9-12 consume three servings of milk per day, while only 21% consume at least five servings of fruits and vegetables per day. Overall, only 2% of school-aged children consume the recommended daily number of servings from all major food groups.

With these disturbing statistics as a backdrop, the long-standing debate over the best way to improve the diets of Americans—children in particular—continues unabated. In the meantime, obesity rates continue to climb to record numbers, putting children and adults at increased risk for diet-related chronic diseases such as type 2 diabetes, metabolic syndrome and cardiovascular disease. Many public health dietitians and nutritionists are concerned that we have become an overweight, yet undernourished nation, consuming too many high-energy foods that are low in critical nutrients, such as vitamins, minerals, protein or fiber. The relationship between consuming high-calorie, nutrient-poor diets and overweight and obesity is of immediate concern for American children. According to the Centers for Disease Control and Prevention, an estimated 17% of American children are either overweight or obese. Another 34% are at risk for becoming overweight.

Nutrient Density as a Tool for Improving Diets

Nutrient density is a concept that has been used by registered dietitians (RDs) for many years and is already a cornerstone of the 2005 Dietary Guidelines for Americans and MyPyramid. Though there is no generally accepted definition for what constitutes a nutrient-dense (nutrient-rich) food, it is typically defined as foods that provide substantial amounts of nutrients for relatively few calories. MyPyramid and the Dietary Guidelines, upon which MyPyramid is based, urge Americans to get more nutrition from their diets by choosing nutrient-rich foods and beverages within each basic food group—Fruits, Vegetables, Grains, Meat & Beans, and Milk. The Dietary Guidelines provides examples of nutrient-rich meal plans using the DASH Eating Plan. Choosing naturally nutrient-rich foods and beverages based on their complete nutrient package, can help children and adults to meet their nutrient requirements without consuming excess calories. The more low-nutrient-dense foods children include in their diets, the more difficult it becomes for them to meet their nutritional needs without gaining excess weight. That becomes even more problematic for sedentary children. In 2002, the CDC conducted the YMC Longitudinal Survey (YMCLS), a national survey of children aged 9-13 years and their parents. This report found that 61.5% of children aged 9-13 years do not participate in any organized physical activity during their non-school hours and that 22.6% do not engage in any free-time physical activity.
Adoption of nutrient density as the basis for dietary guidelines for the National School Lunch Program, and the School Breakfast Program will improve the nutritional quality of foods sold in schools. Engaging and educating children on making more nutrient-rich food choices is also a key part of the solution.14

The concept of nutrient density must also be applied to meals and snacks eaten at home and when dining out in order to have the desired effect on the overall nutritional quality of the diets of children. The concept of nutrient density provides an easy-to-understand way for children to get the nutrients they need within recommended calorie allowances. However, focusing only on nutrients to limit, such as sugar, saturated fat, cholesterol, or sodium, without regard to the beneficial nutrients a food might provide, as some nutrient profiling systems have done, may unintentionally limit nutritious food choices, such as flavored milk, in schools. Foods and beverages should be evaluated on their complete nutrition content, not only on nutrients to be limited. Selecting foods from the Food Groups to Encourage that are rich sources of nutrients in short supply in children’s diets (calcium, potassium, magnesium, vitamin E, and fiber)15 is also an effective way to put the concept of nutrient density into practice.15

Recommendations

There is compelling scientific justification for using nutrient density as the basis for dietary recommendations.16 Educating the public, parents and children on how to choose nutrient-rich foods is a positive approach that emphasizes a food’s total nutrient content and teaches how to make healthy food choices. Helping children select nutrient-rich foods from the basic food groups allows them to get proper nutrition now, and to establish life-long healthy eating habits.

These health and nutrition organizations support the nutrient rich foods approach, which considers the total nutrient package of a food or beverage, as a way for Americans to build and enjoy a healthier diet by getting the most nutrition from their calories.

Endnotes


12 http://www.cdc.gov/nutrition/dietaryguidelines/ (Accessed August 6, 2008)


Steering Committee on Quality Improvement and Management
Chair's Comments, By Dr. "Sooze" Hodgson, MD, FAAP

With Health Care Reform as one of the hottest topics in Washington and in the press, this is a crucial time for the Steering Committee on Quality Improvement and Management (SCOQIM) to be active and advisory to the Academy and to this country. May 2009 was the last meeting at which I was the Chair of SCOQIM, and I thank the Academy for the honor of having chaired this vibrant committee. SCOQIM’s accomplishments and strategic plans for the future could not have occurred without the dedication of amazing Academy staff; Junelle Speller, Caryn Davidson, Linda Walsh, Keri Theissen, Vanessa Shorte, Lori Morawski, Alison Baker, Pat Wajda, and many others who helped us forge ahead this past year.

Likewise, we could not have forged ahead without the continued support from the amazing Academy executive staff who have always been so available: Roger Suchyta, Ed Zimmerman, Fan Tait, Jody Dolins, Bob Hall, Ramesh Sachdeva, and so many others. And most of all, a huge round of thanks to the members of this committee and the liaisons for your hours of work between meetings, on e-mail, conference calls, as SCOQIM representatives to national stakeholder meetings, and at sidebar meetings at national meetings. It has been an honor to work with such a marvelous group of thinkers and doers.

As Federal health care initiatives and quality measurements are folded into proposals for universal health coverage, I fear that the Academy’s fiscal need to cut back Committee meetings to one face-to-face meeting a year will negatively impinge on the advisory strength and accomplishments of SCOQIM. Regardless of these concerns, SCOQIM is a clever and unique group of thinkers. Under Dr. Sevilla’s guidance and with the energy of its current and new members, SCOQIM will find a way to meet the goals set forth in our first Balanced Scorecard.

Thank you for the pleasure of serving with this group. The Academy now has “Quality Improvement” in just about every department/division in its infrastructure, a change that has occurred since the inception of SCOQIM back in 2002. It has been exciting to have been part of this growth.

Fondly,
Dr. “Sooze” Hodgson, MD, FAAP

Patient Safety: SCOQIM’s three year grant project, Safer Health Care for Kids, sunsseted in the spring of 2009. SCOQIM will continue to expand on the successes from this grant project. Patient safety webinars through the Academy’s website continue to be tremendously popular. The Committee is creating a Patient Safety sub group to help with the work of implementation of patient safety initiatives. The Committee is submitting a revision to the Academy’s Patient Safety statement. The Committee discussed the need to engage payers in recognizing physicians who prevent adverse events, and who demonstrate real savings by delivering safe care.

Strategic Planning: SCOQIM finalized its strategic plan over this past year and harmonized SCOQIM’s strategic plan with the Academy’s Quality Cabinet strategic plan and developed plans for improved communication between the Committee and the Academy’s executive branches. Along with our strategic planning came a natural segue into developing our Balanced Scorecard, with new ways to look at measuring our progress towards the Committee’s goals for improvement in Quality and Safety. We are one of the Academy’s Committees which is submitting this year’s annual “report” in the new format of a Balanced Scorecard.

Committee Growth: While there still are plans for SCOQIM to evolve into a Council, this goal will not be accomplished in the next year. Instead, sub-groups have formalized to provide a broader member-driven cadre of expertise to assist SCOQIM in many of the Committee’s and the Academy’s Quality initiatives. SCOQIM has a very active Measurement Interest Group (The “MIGS”) who will be VERY busy in weighing in on CHIPRA measures. “MIGS” have participated in many of the AMA’s PCPI work groups on measure development, “MIGS” have assisted the Academy in providing advice on measure sets developed by other organizations, such as NCQA measures, etc. SCOQIM’s Evidence members now will have a group of Evidence sub-group expertise, largely drawn from the Section on Epidemiology.

Partnership in Policy Implementation (PPI) has become a formal group attached to the SCOQIM, a wonderful blending of expertise on IT/electronic health records knowledge with SCOQIM’s mandate to oversee evidence-based guidelines and clinical policy. Dr. Kairys, the Academy’s medical director for Quality Improvement Innovations Network (QuINN), as a liaison to SCOQIM, attended our May meeting, and reported on many of the projects that Academy members who are “Quinnovators” are doing as they test quality improvement change packages. Many of the SCOQIM members themselves are in QuINN projects. There will be a Patient Safety sub-group to SCOQIM to support the SCOQIM’s patient safety goals.

Evidence - Transparency in Clinical Policy: At the request of the Committee on Forum Management, SCOQIM provided an invitational presentation to Board members and other leadership at the ALF on the importance of having transparency on the strength of evidence behind recommendations for clinical care made in all Academy clinical reports and policy statements, as well as in the Academy’s Medical Management Guidelines.

As a result of this presentation the SCOQIM will develop a “white paper” with guidance on how the Academy’s reports should grade evidence and be transparent in the strength of evidence behind recommendations made in the Academy’s clinical policy. Once this white paper is done (see the Balanced Scorecard) the SCOQIM will bring the issue of transparency to the Board as a Mega issue.
### Mobile Snapshot Creates Immunization Trail

**By Anjuli Suda, MD, FAAP**

**As a practicing pediatrician for more than 25 years, I often have struggled to obtain complete and accurate immunization records in a timely fashion.**

The trail of this record search has extended across state lines, time zones and sometimes across continents. Frequently, the information obtained is inaccurate, incomplete or suboptimal. As I watched the tech-savvy generation playing with their cell phones in my office, it dawned on me that I could use these electronic devices to improve patient care.

I asked my teenage patients to take a picture of their "shot record" on their cell phone. In seconds, they had the entire record in the palm of their hand.

**Share your Tips**

Share advice on a simple or unique way to improve patient care or practice management. Send a brief explanation and any relevant photos to the editor at lmurison@aapnj.org

With a toggle of their finger, they could zoom in and read the illegible. I was thrilled with their enthusiasm to participate in this endeavor. They shared it with their friends, who then asked for their own copy. They compared records and wondered why theirs sometimes did not match their peers'. Some even asked for what was missing on their records.

I started this project as a gift to my graduating seniors, and it blossomed into something I could not have imagined. I have extended it to the parents of my younger patients. The benefits go beyond the obvious, i.e., easy to capture, easy to reproduce, easy to download and get a hard copy. The record is portable and available at all times. As the phone is upgraded, the shot record can be transferred to the new device.

**Taking responsibility through ownership of records not only keeps patients involved in their health, it also reduces confusion for health care providers. It is time to put this cost-effective technology to work for our patients.**

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### PROS Update

**Office Based Pediatric Research**

**By Harris Lilienfeld, MD, FAAP**

Would you like to help answer practical questions that you encounter every day in the office? Do parents remember and act on your advice? What would reverse an overweight child’s trend toward obesity?

Answer parent’s questions on when their child will enter puberty and what can you offer parents of children with mood and behavioral problems when they cannot get access to a mental health professional. These and other practice questions are the subject of prior, current, or pending PROS studies.

PROS (Pediatric Research in Office Setting) is a nationwide collaborative network of Pediatric Professionals who conduct office based research. What questions do you have?

PROS practices have an incredible central staff in the Department of Research at the AAP office in Elk Grove.

By participating in studies, personal and professional rewards await those who are willing to join. There is minimal compensation which can be used to offset having someone in the office coordinating the project.

Check out the PROS Web site at www.aap.org/pros. See what we have done and are doing now. Click on JOIN PROS. If you have any questions, contact PROS at National AAP or the New Jersey Coordinator, Harris Lilienfeld, MD at 609-896-3808 or e-mail lilienfeld@aol.com

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Pediatric Research in Office Setting (PROS) Mission: To improve the health of children and enhance primary care practice by conducting national collaborative practice-based research.
The Federal Trade Commission has promulgated rules requiring physicians to implement written policies to help prevent identity theft. Any physician’s office that extends, renews or continues credit for a patient (i.e., any practice that bills patients for services rendered) is subject to the Red Flag Rules. Even if you first bill an insurance carrier, if you ultimately bill a patient for any portion of a bill, you are considered a creditor subject to the Rules.

The Rules take effect on November 1, 2009. In order to comply with the Rules you must develop a program that allows you to:

1. Identify relevant Red Flags
2. Detect Red Flags
3. Prevent and mitigate identity theft, and
4. Update your program periodically.

Your program must spell out how your program will be administered, and must be appropriate to the size and complexity of your practice. It must be approved by your Board of Directors, or if your practice does not have a Board, by a senior employee. The healthcare law firm of Kern Augustine Conroy & Schoppmann, P.C., in conjunction with the American Academy of Pediatrics, New Jersey Chapter, has developed a free template available on its website to assist you in developing your own program. It can be found at www.aapnj.org. These new Red Flag Rules place yet another burden on medical practices, many of which are already struggling to survive under increased regulatory pressure, reduced reimbursement and increased costs. Hopefully this guide, and the free template available through Kern Augustine Conroy & Schoppmann, P.C., will assist physicians in reducing this new burden.

What is a “Red Flag”?
A red flag is basically something that should alert your practice to suspicious activity that may indicate identity theft. The FTC guidelines identify four categories of warning signs that must be identified and addressed:

1. alerts, notifications, warnings from a consumer reporting agency
2. suspicious documents
3. suspicious personally identifying information
4. suspicious activity relating to a covered account; or notices from customers, victims of identity theft, law enforcement authorities, or other entities about possible identity theft in connection with covered accounts.

How Often Must I Update My Program?
The Rules simply require that you update it “periodically”. However, your program should specify that it will be updated when the methods of identity theft threats change or new risks and trends develop.

How do I Prevent and Mitigate Identity Theft?
You must develop a written program to include appropriate responses to Red Flags, in order to prevent and mitigate identity theft. Among the actions you may take are increased monitoring of accounts, contacting the payor, contacting law enforcement agencies, changing account numbers to prevent misuse, or a combination. Preventive action may be also required if there has been a breach or attempted breach of your database.

How are “Red Flags” Detected?
Red Flags may be detected when you verify a patient’s identity, review medical records, verify insurance forms, or receive alerts or information of suspicious activity from outside agencies.

How Must the Program be Administered?
Your program must describe how it will be administered, including how you will get the approval of your management, maintain the program, and keep it current. It must also provide that the Board or designated senior employee approve any material changes to the program. The program should include appropriate staff training and a way to monitor staff to assure that they are all following the program. Administration requires continuing oversight of the program, assuring that the program remains current and relevant as methods of identification theft change. Put another way, writing a program and putting it on a shelf to collect dust is not an acceptable program.

What are the Penalties for Noncompliance?
A violation of the Red Flags Rule can subject your practice to significant civil monetary penalties.

Michael J. Schoppmann, Esq. Kern Augustine Conroy & Schoppmann, P.C., General Counsel AAP NJ Chapter

Kern Augustine Conroy & Schoppmann, P.C., Attorneys to Health Professionals, www.drlaw.com has offices in NJ, NY, FL, PA and IL. The firm’s practice is solely devoted to the representation of health care professionals. Mr. Schoppmann may be contacted at 1-800-445-0954 or schoppmann@drlaw.com.

Have a Question?
This section is a new feature of the NJ Pediatrician. We welcome your feedback, especially topic suggestions or general council questions and issues you would like to see addressed by Michael Schoppmann, Esq.

Please e-mail Fran Gallagher, MEd at fgallagher@aap.net
Today’s marketplace is very competitive. The United States is the only country where highly educated pediatricians provide frontline primary care. In fact, most families expect that their children will receive health services from pediatricians. This could change, however, if we do not invest time, energy, and resources in promoting the value of pediatrics to patients, families, the general public, and government leaders.

We know pediatricians are the most highly educated child health professionals, and we believe all children should have access to a pediatrician for comprehensive primary and subspecialty care. It is essential that we promote these concepts to the larger community. As my longtime friend, David Bruton, MD, former president of the North Carolina (NC) Medical Society and secretary of the NC Department of Health and Human Services, likes to say, we must pay our “civic rent” or we will have no one to blame but ourselves if we are replaced by less-qualified child health professionals.

In reflecting on 3 decades of community practice and years of work with the American Academy of Pediatrics (AAP), I am convinced that the medical home concept is the key to our survival and that pediatricians must retain the privilege of directing it. To that end, I recommend that young pediatricians who want to pay their “civic rent” and do their part to ensure that our children have access to the best child health system possible consider the following:

1. Organize a regularly occurring community forum for the discussion of child health issues. In our practice, we started a journal club in 1984 after our fourth pediatrician joined the group. During each Tuesday morning meeting in the hospital, one of the group would function as the teacher and review a portion of the current pediatric literature. Over the years, the practice partnered with a nearby medical school and developed an accredited Category 1 continuing medical education program. The group selects topics and community coalition partners are invited to join us to discuss important child health issues. A number of child health projects have resulted from discussions begun during these early morning think tank sessions.

2. Develop a working relationship with the local department of social services to assist with child abuse issues and the care of foster children.

3. Offer medical consultation services to the local school district, child care coordinating agency, and Head Start program.

4. Get to know at least one local media representative.

5. Ensure that the practice has an up-to-date Web page that provides families with links to AAP resources.

6. Consider joining the AAP councils on Community Pediatrics and Communications and Media, where you can share ideas with likeminded peers to advance the cause of pediatrics.

As you take these actions, keep in mind that the community needs to understand that your practice really cares about child outcomes. If the community perceives value in what the practice does, it will support the practice and make it more likely that our specialty will survive the pressures of today’s health care reform environment. Some pediatricians are afraid to become involved with child advocacy projects because they may take time away from patient care and family activities. My experience in starting a pregnancy prevention program in the schools, a family support project within Head Start, and a network of school-based health centers has been that community partners ultimately take over these projects. Very soon after we launch, I am needed only to serve as a consultant for, at most, an hour a month. My role is that of the visionary pediatrician who cares enough to focus the community on significant children’s issues and who is available to serve as a child health consultant.

Thank you very much for caring enough about our profession to invest your time and talents in valuable child advocacy initiatives wherever you may practice. If we all do our part to convince others of the value of pediatricians, our profession will indeed survive and thrive.

David T. Tayloe, Jr, MD, FAAP
President
American Academy of Pediatrics

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Chapter Advocacy

AAP NJ Chapter Member Advocates for Healthcare Reform with Senator Menendez

AAP NJ would like to thank Dr. David M. Namerow, M.D., FAAP of PediatricCare Associates, Fairlawn, New Jersey for participating in Senator Menendez's press conference at Holy Name Hospital on the need for national healthcare reform. The program, which had great media coverage by the national media outlets, demonstrated the importance of partnering pediatricians and their patients and families to advance support for providing access to care for children. Dr. Namerow referenced the AAP Endorsed Principles on Access, in his remarks. Fran Gallagher, MEd, AAP and PCORE Executive Director, and Nancy Pinkin, AAP NJ's advocate, also attended the important press conference.

Senator Menendez expressed his strong support for national healthcare reform, noting that health insurers have experienced record profits, while the number of uninsured rises, and the out-of-pocket costs and denials of care to those who are insured also climbs. He stated he favors the "public option" in an effort to push greater competition. Senator Menendez stated that insurers are using multiple methods of spreading falsehoods about the national reform package including references to the Canadian and British systems that are said to ration care and have long waiting lists. He commented that our insurers have their own form of rationing via long waiting periods for authorization of services, denials of care, and payment delays. He stated that he supports an exchange of a series of private insurance companies that must offer coverage that meets a common set of standards. In his opinion, the public option will drive competition, and decrease health insurance premiums which are currently increasing at unsustainable rates of 7% per annum. He stated that all private sector options would remain.

Chapter Awards

Congratulations! 2009 National AAP Special Achievement Awards

Margaret "Meg" Fisher, MD, for taking a leading role in the chapter in the areas of education and advocacy, and for her leadership in the Healthy Choices Project, aimed at improving food choices and eating styles in school aged children.

Larry Frenkel, MD, for re-invigorating the Senior Section and taking leadership in immunization advocacy in Trenton.

Dan Notterman, MD, for organizing the New Jersey Child Health Summit, where he brought together the major stakeholders in children's health in the state to examine the aspects of health enterprise in New Jersey, including education, access, quality, and research.

Paul Schwartzburg, MD, for developing the legislative education program to be given to pediatric residents throughout the state of New Jersey.

CATCH Corner:

Congratulations to Dr. Sunanda Gaur from UMDNJ-Robert Wood Johnson Medical School for being awarded a CATCH Implementation grant! Dr. Gaur’s grant will develop a program for integrating psychiatry into HIV/AIDS specialty care.

The next call for proposals will be posted on the national AAP site at: http://www.aap.org/catch/planninggrants.htm

For more information or if you have any questions, you may either contact Paul Schwartzberg, D.O. at pschwartzberg@meridianhealth.com or
Emergency Department Preparedness for H1N1

Ethan Wiener, MD, Associate Director, Pediatric Emergency Medicine, Morristown Memorial Hospital
Michael Gerardi, MD, Director, Pediatric Emergency Medicine, Morristown Memorial Hospital

Flu season is upon us. Recognizing that a typical flu season begins in the Fall and continues deep into the Winter, this year will be different. With the emergence of the novel influenza A (H1N1) strain, this Summer has seen a level of influenza in the community that is unusual for this time of year. There are indications, if the experience of the Southern Hemisphere is any predictor, that the upcoming months could see a surge in cases that could stretch local resources in many communities. Recognizing that the predominant cause for this higher than normal level of influenza is attributable in large measure to H1N1 (98% of all subtyped influenza A viruses being reported to CDC were novel influenza A (H1N1) viruses for the week ending August 1, 2009), emergency departments (ED’s) and all providers of healthcare should lay out some plans and communicate amongst other interested parties (hospitals, community physicians, schools, local departments of health) in advance of the potential onslaught. Some predictions have estimated that as much as 40% of the population could be infected during this upcoming season.

ED’s in particular must be poised to deal with a major influx of patients who may be highly contagious. Many of these patients will be mildly ill with influenza-like illness (ILI). Some will be seriously ill and require extensive resources to manage their medical condition. These will be joined by a larger-than-usual cohort of the “worried well” who will be responding to local media and word-of-mouth information and misinformation that will likely contribute to a considerable public sense of anxiety in the face of a spreading epidemic.

Plans for this potential flood of patients must take into consideration a number of serious logistical issues. Where will the patients wait? Is there space and facility for a separate triage and waiting area for febrile patients or those experiencing ILI? Is there a way to identify patients who belong in this “flu zone” before they even enter the hospital, preventing contact with uninfected patients, some of whom may be vulnerable to serious disease from novel H1N1 influenza? Where will the patients be seen once they are identified? Finally, where will the patients go who need to be admitted if the wards and ICU’s are already full? These issues, if the predictions of a major surge in patients comes to fruition, will strain the system – the hospitals, offices, schools, clinics, and all facilities where patients are cared for – to levels not recently experienced.

What to do then with the majority of these patients? Requests for testing will be rampant. Expectations and emotions will run high because the media will likely report on the most serious cases fueling a rush to the ED. Based on these circumstances, an approach that measures patients’ interests and also takes into account the public health recommendations for testing and treatment is essential.

As it currently stands, the CDC is not recommending routine testing of immunocompetent patients with ILI who do not have severe enough illness to be hospitalized. Therefore, there is no need for patients with ILI to come to a hospital or an ED unless they are sick enough to be admitted. It should be noted here that the rapid test for influenza A is not sufficiently sensitive in any event to rule out the diagnosis of H1N1 influenza. Most reports are quoting a 70% sensitivity. Even if rapid testing for H1N1 becomes available and more accurate than it is now, there are few if any changes this will have in management.

Therefore, in the face of an epidemic and signs and symptoms consistent with ILI, novel H1N1 influenza infection should be assumed and testing for the vast majority of patients will become obsolete. It would be best for us to develop plans to manage patients at highest risk for complications.

Included in the patients at high risk for complications from H1N1 influenza are children under 5 years of age with particular risk for those under 2 years old. Others include patients with chronic medical conditions: cardiac, respiratory (including asthma), renal, hematologic (including sickle cell disease), metabolic (including diabetes mellitus), and any immunocompromised patient. Other patients that may present to the pediatric ED are those who live in chronic-care facilities. This list is the same as the one the CDC uses for complications from seasonal flu and includes pregnant women as well who, it seems based on recent epidemiologic evidence, are at particular risk with novel H1N1 influenza A.

Cont. on page 18
The Pediatric Council on Research and Education, (PCORE), the foundation of the AAP NJ Chapter, is now recruiting Pediatric and Family Practices in Monmouth and Ocean County to participate in an exciting educational opportunity to identify and refer young children with Autism early on as part of strengthening the medical home. The Early ID of Autism program will provide your practice with on site trainings using an EPIC (Educating Practices in their Communities) format. The trainings will focus on identifying young children 18 months - 5 years with signs and symptoms suggestive of Autism Spectrum Disorder (ASD). Early Identification will lead to early and appropriate referrals for children in need of further evaluation and/or other community resources such as early intervention.

Opportunity for Practices

Early Identification of Autism
Are you a Primary Care Physician in Monmouth or Ocean County?

The Pediatric Council on Research and Education, (PCORE), the foundation of the AAP NJ Chapter, is now recruiting Pediatric and Family Practices in Monmouth and Ocean County to participate in an exciting educational opportunity to identify and refer young children with Autism early on as part of strengthening the medical home. The Early ID of Autism program will provide your practice with on site trainings using an EPIC (Educating Practices in their Communities) format. The trainings will focus on identifying young children 18 months - 5 years with signs and symptoms suggestive of Autism Spectrum Disorder (ASD). Early Identification will lead to early and appropriate referrals for children in need of further evaluation and/or other community resources such as early intervention.

Free On-Site trainings focused on identifying young children 18 months- 5 years with signs and symptoms suggestive of ASD. (CMEs/CEUs will be provided)

Link to community and state organizations providing family supports and resources
Networking opportunities between Practices; Team building within the practice
Shared electronic webspace for posting of Community Resources, events and tools for Early Identification and Referral of Children with Autism.

Collection of pre and post intervention data to evaluate improvement process

Help Give Children with Autism the Chance to Reach their Fullest Potential!

Cont. from page 17

One additional subset of patients must be identified at particular risk: patients who are 18 years old or younger and who are on aspirin therapy. They must be considered at risk for Reye’s Syndrome should they contract influenza and serious consideration must be given to suspending their aspirin therapy during an outbreak of any magnitude continues.

Not surprisingly, the CDC recommendations for treatment of influenza with oseltamivir or zanamivir, both of which demonstrate in vitro activity against H1N1, very much mirrors the patients who are at risk of serious complications. Routine treatment of mildly to moderately ill patients with oseltamivir or zanamivir is not currently recommended. In addition, chemoprophylaxis is recommend only for those people who have been exposed and could then either manifest a more protracted or severe course, or who are in close contact with people who fit this description.

All of this begs the question: can we avoid all of this? Is this going to turn into a much ado about nothing scenario? Hopefully so. It appears that a vaccine specifically for novel H1N1 influenza A, in addition to the seasonal vaccine, is going to be available fairly early in the season. If this is the case and a large number of people can be vaccinated, perhaps we can avert some of the issues that we are currently anticipating. One of the recommended interventions that the CDC is advocating is the widespread immunization of pediatric patients, particularly those between the ages of 6 months through 24 years of age as well as all pregnant women and all household contacts and caregivers of children younger than 6 months. It is suggested that all healthcare providers stay abreast of the CDC recommendations for vaccination and do so early and often.

In the ED, we are busily preparing ourselves and our facility to handle a significant surge. Areas are being identified both for cohorting patients with similar symptoms and to handle patients who need ongoing care who may not be able to obtain an inpatient bed secondary to crowding. Masks, testing kits, and treatments are being readied and stockpiled. Staffing is being carefully examined to prepare in case of both the increased volume and absence from work on the basis of one’s or one’s family’s illness.

Ultimately, we may be overrun with patients of all varieties seeking treatment for a condition that they may not have or for which such treatment is not recommended. Testing, treatment, and prophylaxis should be reserved for hospitalized patients and those patients who are at high risk for complications from the flu.

All of this leads to a situation that could get rather intense rather quickly. A calm and reasoned approach must prevail and that can only occur if we are prepared to deal with and plan for a “worst case scenario”. Obviously, we all hope that does not occur.
**5TH ANNUAL**
**NEW JERSEY VACCINES FOR CHILDREN PROGRAM**
**PROVIDER EDUCATION CONFERENCE**
“Medical Home: Immunizations for Healthy Lives”

7:30-8:25 AM  Registration, Continental Breakfast, Exhibitor Showcase

8:25-8:30 AM  Welcome and Flow of the Day  
**Fran Gallagher, MEd,** Executive Director, American Academy of Pediatrics/ NJ Chapter and New Jersey Pediatric Council on Research and Education, The Foundation of the American Academy of Pediatrics/NJ Chapter

8:30-9:00 AM  Immunizations for Healthy Lives  
**Christine Armenti, BSN, MS** - NJ Vaccines for Children Program

9:00-10:15 AM  Keynote: Immunization Action  
**Margaret “Meg” Fisher, MD** and **Alison Singer, MBA**, Moderator: **Steve Kairys, MD**

**Plenary**

10:15-10:35 AM  1: ACIP 2010 Seasonal Influenza Recommendations for Children  
**Christine Armenti, BSN, MS**

10:40-11:00 AM  Facilitated Networking  
Community Resources Exhibited

**Plenary, Continued**

11:00-11:20 AM  2: Healthy Beginnings Prevention, Maternal Depression, Obesity & Development - **Steve Kairys, MD**


11:40-12:00 PM  4: Electronic Perinatal Hepatitis B Case Management  
**Christine Armenti, BSN, MS**

12:00-1:00 PM  Lunch, Door Prizes & Awards Ceremony  
Facilitated Networking Community Resources Exhibit, Open until 2:00 PM

1:10-2:10 PM  **Ask the Experts - Question and Answer Panel:**  
**Margaret “Meg” Fisher, MD**; **Everett Schlam, MD**; **Jeffrey Boscamp MD**; **Charles A. Scott, MD**; **Lawrence Frenkel, MD**  
Moderator: **Steve Kairys, MD**

2:15-3:00 PM  Workshops:  
A: Coding for Immunizations with Concurrent Practice Management  
**Charles A. Scott, MD**

B: Ensuring Data Quality: New Jersey Statewide Quality Assurance Initiative - **Velva Dawson, MPA**

C: NJIIS Practical Applications: Scenarios for the Beginner & Active User - **Dorothy Williams McCall**

D: VFC Case Scenarios: MRSA - **Everett Schlam, MD**  
VFC Case Scenarios: Influenza - **Jeffrey Boscamp, MD**

E: Achieving Immunization Compliance in Schools: Interventions That Work - **Marguerite R. Leuze, DMH**

3:00-3:15 PM  Conference Concludes/Evaluations

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**Early Bird Registration Fee - **$45.00** (valid through 10/15/09)**

Registration fee after 10/15/09 - $75.00

Fee includes: CMEs, EB CMEs, Nursing Contact and Professional Development Hours, All Training Materials, Breakfast and Lunch

2009 **ONE** Conference ONLY - Space is Limited - Register Today!

Online registration available: Log on to **www.njpcore.org** for more information

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Thank You!

The AAP NJ would like to thank the Chapter members and PCORE staff members that responded to our request to completed a brief survey on the Chapter, its mission, goals, and future.

One survey question asked responders (n=27) to:

“Imagine you are traveling to a dinner celebrating the breakthrough successes that NJ AAP/PCORE achieved in the three years after its strategic plan was implemented in 2009. You can’t help but reflect upon some of the achievements and outcomes NJ AAP/PCORE has delivered. List the three outcomes or achievements of which you are most proud”

Below are the top three answers:

- Increased access/improved health for NJ children
- More effective advocacy (legislation and payment)
- Increase in number & geographic distribution of grant programs

AAP NJ Sponsors

AAP NJ would like to acknowledge sponsors who make it possible for the AAP NJ Chapter to further our mission and aid us in providing quality programs, meetings, conferences and CME opportunities.

The AAP NJ Executive Council Strategic Planning Retreat on September 15, 2009 at Highlawn Pavilion in West Orange, NJ was sponsored by:

- **MDAdvantage**
  (www.mdadvantageonline.com)
- **Main Street Vaccines**
  (www.mainstreetvacs.com)

And a special thanks to the **The American Dairy Association and Dairy Council** for helping to keep our leadership healthy and donating dairy products to provide an afternoon snack.