The New Jersey

# Pediatrician

Summer 2010

Official Newsletter of the American Academy of Pediatrics New Jersey Chapter

## "What They Didn't Teach You in Med School"

### AAP NJ Begins Business Series of Free Workshops for Pediatricians

The American Academy of Pediatrics, New Jersey Chapter (AAP NJ) and Continuum Health Alliance (CHA) held their first joint workshop, "What They Didn't Teach You in Med School" on May 25, 2010 and invited New Jersey Pediatricians and Subspecialists. The cost-free, interactive workshop and dinner was held at CHA's headquarters in Marlton, NJ.

*Attendees at the AAP NJ/Continuing Health Alliance Workshop on May 25, 2010.*

Michael Segarra, MD, FAAP, President of the AAP NJ Chapter, Dr. John M. Tedeschi, MD, President and CEO of CHA, and Kevin King, MD, FAAP, kicked off the evening, welcoming both members and non-members of the Chapter. Jim D'Onofrio, Senior Vice President Strategic Business Initiatives for CHA, presented on the "Business Intelligence impact on the Revenue Management Cycle" and shared an excel file / practice analytics tool that he has developed. Joseph Coyne, President, Information Technology/Chief Information Officer closed the evening by presenting on how healthcare providers can choose the right EMR (Electronic Medical Records) System and shared information on the federal ARRA (American Recovery and Reinvestment Act) funding that will become available.

The workshop, sponsored by Merck and Sanofi Pasteur, was the first in a series of three to be held in South, Central and North Jersey. Stay tuned to AAPNJ.org and your weekly e-newsletter to find out when the next free workshop is scheduled!

## NJ FamilyCare Express Applications in the Mail...Help Spread the WORD!

Families throughout New Jersey who have a child with no health insurance should know that help is on the way. It is coming via U.S. mail. The State of New Jersey recently began mailing easy-to-complete applications for health insurance to thousands of families who indicated on their tax returns that their children are uninsured.

Visit the Association for Children in New Jersey (ACNJ) web site (http://www.acnj.org/main.asp?uri=1003&di=1639) for more information and to download informational flyers that you can distribute to parents, written in both English and Spanish.

## PCORE CORNER

*Pediatric Council on Research and Education*

*Steve Kairys, MD, FAAP*
*Medical Director/Chair PCORE Board of Trustees*

*Fran Gallagher, MEd*
*Executive Director, AAP NJ & NJPCORE*

Childhood obesity is an epidemic throughout the United States and New Jersey is no exception. New Jersey actually ranks worst in the country for the percentage of obese 2 to 5 year olds. PCORE has been very active in programs and collaborations that target the prevention of childhood obesity.

PCORE recently ended a three year Robert Wood Johnson grant that targeted preschool children. Dr. Meg Fisher was the MD Champion for the project, incorporating community pediatricians in the Long Branch area to partner with schools to improve nutrition education and increase activity for the young students. Evaluation included tracking BMI's and there was a significant reduction in the BMI over the course of the program.

PCORE co-sponsored the first statewide obesity symposium last year with major presentations from local champions and State government as well as updates from national leaders Scott Gee, MD and Sandra Hassink, MD. There are plans for a second symposium.

PCORE has developed a prevention of obesity and an obesity management EPIC (Educating Practices in Their Communities) program and has been working with 11 practices that comprise the primary care service in the Trenton area, in collaboration with Children's Futures and the RWJ Foundation.

*Cont. on page 4*

*AAP NJ was recently awarded a childhood obesity prevention grant in partnership with the Englewood Community Foundation - see page 5 for more information!*

PCORE
Pediatric Council on Research & Education
Foundation of the American Academy of Pediatrics / NJ Chapter

# American Academy of Pediatrics

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2nd Quarter Spring 2010

Official Newsletter of the American Academy of Pediatrics New Jersey Chapter




## President's Address

Michael Segarra, MD, FAAP

Well, this is my last hurrah. Starting July 1st, Dr. Steve Rice will become the AAP NJ Chapter President. I know that I am leaving AAP NJ in good hands. We (the AAP NJ Chapter officers, councilors, executive director and staff) have created a new environment for pediatrics in New Jersey.

The Chapter now has a new office and once the merger of the Chapter and its foundation, PCORE (Pediatric Council on Research and Education) is complete, we will have a staff of fourteen, including program consultants.

The Chapter has engaged the State government effectively. When issues regarding children are involved, AAP NJ is more likely to be engaged in the process. I think that this will continue to improve as time goes on because of the efforts we have made with the State in our immunization efforts. Hopefully, we can work with the State on the Medical Home and immunization registry.

We are currently working together with other groups such as the Academy of Family Physicians, the New Jersey Medical Society and the Statewide Parents Advocacy Network on such projects as the immunization action coalition and the Medical Home. AAP NJ is also working with pediatric dentists on oral health and fluoride varnish programs.

The Chapter has become more active with the National AAP and has received grants for immunization advocacy, foster care, obesity prevention, and the New Jersey resident advocacy programs. AAP NJ continues to work together with PCORE on Educating Practices in the Community (EPIC) programs with projects in asthma care, autism identification, child abuse and neglect, and postpartum depression.

The Chapter continues to identify more programs that will benefit our members, such as the AAP NJ Purchasing Alliance for medical malpractice insurance. (www.aapnj.org/purchasingalliance)

The Government Affairs Committee and our lobbyist, Nancy Pinkin, continue to do an excellent job working on legislative issues. The issues that come before the legislature are challenging, with topics ranging from immunization exemptions to bills that would criminalize the waiving of co-payments.

I would like to thank the current officers, Steve Rice, Meg Fisher, Elliot Rubin, Jeff Bienstock and Janice Prontnicki for their excellent work, effort and advice.

My special thanks go to Fran Gallagher for her energy and foresight in her capacity as AAP NJ Executive Director and to Lisa Murison who puts together the newsletter and puts up with my procrastination in writing the President's Message.

Wishing you all the best,

Mike Segarra, MD, FAAP

## Get Involved!

### Calling all AAP NJ Chapter Seniors (55+ yrs)…

The AAP NJ Chapter wants you! As a "senior" you have a lot to offer the Chapter and the Chapter would like to offer you benefits you feel are worthwhile. We need your input to ensure we accomplish this goal together.

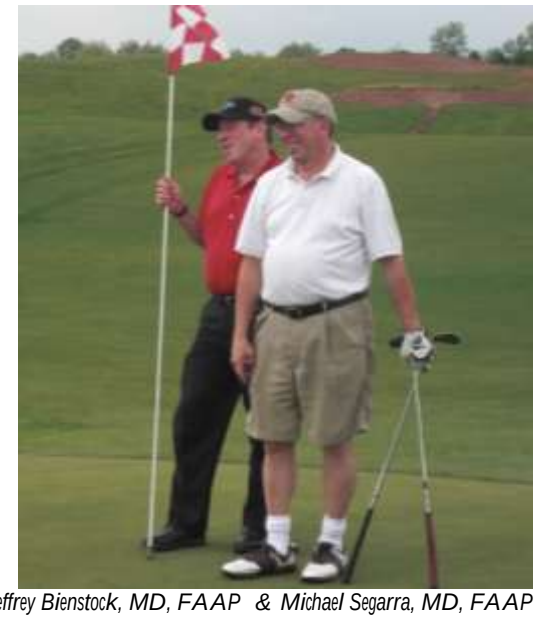
What would you like to see the Senior Section promote and how it could be most valuable to you? What benefits matter to you? We are looking forward to a conversation with you and the opportunity to hear your ideas and thoughts.

Seniors were invited to join us at a special Senior Section breakfast at the AAP NJ CME Conference and Annual Meeting on Tuesday, June 8, 2010 at the Princeton Marriott at Forrestal Village. If you were not able to join us, but would like to get more involved in your Chapter, please contact Larry Frenkel, MD, FAAP, Chair of the Senior Section, at lfrenkel@uic.edu.

## Thank you for Joining us for PCORE's 6th Annual Golf Outing — May 3, 2010!

*Hugh McGinn, Mitch Wexler, Pierre Coant, MD, FAAP and Charles Scott, MD, FAAP*

*Karen Dewitt, RN, Ed.D, Janice Prontnicki MD, MPH, FAAP, Anne Maher, MS, M (ASCP), CIC and Sue Winning, R.P.T. all from Children's Specialized Hospital, with the hole-in-one prize - a Volkswagen Passat CC.*



*Jeffrey Bienstock, MD, FAAP & Michael Segarra, MD, FAAP*

Once again, the PCORE golf outing proved one thing - Golfers are truly dedicated athletes! A great group of golfers joined us on the course on Monday, May 3, despite a dreary forecast, and helped to support the Pediatric Council on Research and Education at our 6th Annual Golf Outing at Neshanic Valley Golf Course.

The weather held out, the sun peeked through, and golfers were treated to a fun-filled day on the course, competing for two cars and a $10,000 hole-in-one prize. We did not have any hole-in-ones, but we did see some great foursome scores, straightest drives and closest to the pin winners!

A special thanks to Jim Watkins and the Golf Committee for their continued support of PCORE's work to improve the quality of health-care for children in New Jersey. Thank you to all who purchased raffle tickets. We had a grand prize 50/50 Raffle winner of $1,462.00!

PCORE would like to thank all of our sponsors, staff, volunteers and our faithful golfers for all of the support and dedication it took to make our 6th annual Golf Outing a major success!

### THANK YOU TO OUR SPONSORS!

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## AAP NJ & PCORE Working Together

Together, AAP NJ and PCORE will achieve a vision to *Shape Child Health in New Jersey for the 21st Century.* This vision drives PCORE's *mission* - to affect health policy and primary care practice improvements through a medical home focus, to provide education for parents and primary care provider teams, and to foster partnerships that integrate sustainable systems of care.

(Cont. from cover )

The programs have been very well received and there has been interest in further training in motivational interviewing by the primary care practices.

PCORE, in collaboration with the State Department of Health will be a subcontractor for a statewide effort to improve breast feeding as an early feeding practice that helps to reduce early childhood obesity. Dr Lori Winters is the MD Champion for this project. AAP NJ and PCORE have recently recommitted to a continuous partnership with the NJDHSS Office of Nutrition and Fitness *Shaping New Jersey* statewide planning and implementation processes addressing obesity issues and promoting sustainable prevention and wellness efforts in communities throughout New Jersey.

PCORE has partnered with the Council of Children's Hospitals in many areas relating to childhood obesity prevention. Several children's hospitals including St. Joseph in Paterson have been very innovative and active in their communities. St Joseph's Children's Hospital, for example, has demonstrated how pediatric leadership and advocacy can make a difference in improving safe areas for exercise and activity.

PCORE hopes to spread the obesity EPIC program and to continue to place pediatricians at the forefront of state efforts to decrease the epidemic and improve healthy living.

Please visit www.AAPNJ.org & www.NJPCORE.org to learn more about our healthy living programs.

## Meet your AAP NJ & PCORE Team!

*PCORE Medical Director*
Steve Kairys, MD, MPH, FAAP

*Fran Gallagher, MEd*,
Executive Director of AAP NJ and NJPCORE

*Harriet Lazarus, MBA*
Associate Director of Programs, NJPCORE

*Cynthia Heulitt*
Financial Controller, AAP NJ, Purchasing Alliance and NJPCORE

*Nicole Chabot-Waugh, MSW*
Medical Home and Early Identification of Autism, Program Coordinator, NJPCORE

*Marilyn S. Dunning, M.A.*
Child Abuse and Neglect, Program Director, NPCORE

*Shreya Durvasula*
Child Abuse and Neglect, Program Manager and Breast Feeding Hospital Initiative, NJPCORE

*Mary Jo Garofoli*
Child Abuse and Neglect, Program Manager, NJPCORE

*Judith Grandjean*
Medical Home/NJ Immunization Initiative, Program Director, NJPCORE

*Diane Klemm*
Child Abuse and Neglect, Program Director, NJPCORE

*Lisa A. Makai*
Administrative Assistant/Volunteer Coordinator, NJPCORE

*Jacqueline McFadyen*
Managing Director, Purchasing Alliance , AAP NJ

*Bert Mulder*
Director of Membership and Events, AAP NJ

*Lisa Murison*
Membership and Events Coordinator, AAP NJ

*Pam Olliver*
NJ Immunization Initiative/VFC Program Manager, NJPCORE

*Dorothy Williams McCall*
NJ Immunization Initiative, Program Director, NJPCORE

Consultant:
*Ruth Gubernick, MPH*
Program Development Specialist , AAPNJ & NJPCORE

Volunteers:
*Iris Cooper, Veronica Gragnano, Joseph Lee, Wilma Pierson Kimberly Pinnix, Diane Synhorst*

*Contact information for all staff members can be found on www.njpcore.org. We can also be reached at our office, 609-588-9988.*

## AAP NJ & PCORE Working Together

### Englewood Area Community Foundation to Partner with American Academy of Pediatrics, NJ State Chapter, on Childhood Obesity Prevention Grant

ENGLEWOOD, NJ, April 2010 –

The American Academy of Pediatrics, NJ Chapter (AAP NJ), in collaboration with the Englewood Area Community Foundation (EACF) and the Pediatric Council on Research and Education, has been awarded a $20,000 *Healthy Active Living Grant* from the National American Academy of Pediatrics. The grant, one of only five awarded nationally, will fund "FIT FAMILIES for Child Obesity Prevention", an Englewood-based program that will increase awareness and provide education on healthy beverage consumption in Bergen County.

FIT FAMILIES will be implemented in partnership with the Bergen Family Center, Englewood Hospital and Medical Center, Englewood Health Department, and Healthbarn USA. An educational forum on pediatric obesity and the importance of healthy beverage choices will be held for regional pediatricians, health department officials, school nurses, social service providers, and parents. The forum will be followed by a family workshop component at the Bergen Family Center involving children, infant to five, and their parents/caretakers. Families will participate in a series of fun, interactive workshops on healthy eating and beverage consumption, grocery shopping, cooking, and creating a healthy environment for mealtimes.

"EACF is excited to manage this project locally and is pleased to work with the AAP NJ to fight the epidemic of childhood obesity. These funds will educate and bring resources to families in Northern New Jersey that will help promote healthy nutritional choices", said Michael Shannon, President.

The Foundation's long-range goal is to expand FIT FAMILIES into the "Obesity Prevention Initiative" (OPI), a five-year project to reduce pediatric obesity in the Bergen County communities of Bergenfield, Englewood, Hackensack, New Milford, and Teaneck. OPI is a coordinated community campaign of consistent health messages on nutrition and physical activity, which will be communicated through a partnership of community organizations who work with children at varying levels. OPI's purpose is to reduce the prevalence of obesity among elementary school children and ultimately to develop a community model that could be replicated in other counties in New Jersey and around the country.

*The Englewood Area Community Foundation is a non-profit organization located in Englewood, NJ. Our mission is to improve life in the communities of Northern New Jersey. One way we accomplish this is by convening residents, non-profits, and school and local government representatives to discuss concerns and policies in our three areas of interest: public health, education, and community action. Through open dialogue, the Foundation demonstrates that by working together people can improve services at lower cost, resolve common problems, and help their communities thrive. To contact the Foundation please call 201-568-5608 or e-mail, eacf@eacf-nj.org. For more information visit our website atwww.cfnj.org/eacf.*

**AAP NJ PURCHASING ALLIANCE**

The economy is challenging! Are you interested in saving money on your malpractice insurance? The AAP NJ Purchasing Alliance, a NJ Chapter MEMBERS ONLY benefit, has created an opportunity for you to save at least $1,800 and up to $3,600 per year on malpractice premiums with MDAdvantage. If you are not a Chapter member - join today!

Current MDAdvantage Policy Holders - APPLY for your 20% Discount
Call your broker or MDAdvantage directly to not miss out on your discounted rate. The discount is effective at the renewal date of your policy. Check on your renewal date today, call, and SAVE!

Other Insurance Carrier Policy Holders - Explore Options to SAVE!
Many physicians will save significantly on their current medical malpractice premiums by taking advantage of the AAP NJ Purchasing Alliance discount. How? Call your broker or MD Advantage to obtain a quote. A complete list of MDAdvantage appointed brokers can be found on their website at www.MDAdvantage.com.

Steps to Apply:
(1) AAP NJ Chapter Membership: If you are not an AAP NJ Chapter member, fill out and mail the AAP NJ Chapter application along with a check for $150 membership fee to National. Application can be downloaded at www.aapnjpurchasingalliance.org.

(2) AAP NJ Purchasing Alliance Membership: Please fill out and mail the AAP NJ Purchasing Alliance application along with a check for $125 to: AAP NJ Purchasing Alliance. Application can be downloaded at www.aapnjpurchasingalliance.org.

If you have any questions, please call the AAP NJ Purchasing Alliance office at 609-433-7600 or visit www.aapnjpurchasingalliance.org
PLEASE NOTE THAT MDADVANTAGE'S UNDERWRITING GUIDELINES WILL APPLY TO ALL PROSPECTIVE INSUREDS AND PREMIUMS WILL VARY BASED ON A NUMBER OF UNDERWRITING FACTORS. If MDAdvantage declines to offer you a policy at this time, the Purchasing Alliance membership fee will be refunded.

## National Election - AAP NJ Member Running for AAP President!

The AAP National Nominating Committee has named Wayne A. Yankus, MD, FAAP and Robert W. Block, MD, FAAP as candidates for AAP President-elect. The election will take place from August 1 - September 1, 2010 (please note new dates, this year only) and the winner will take office as President-elect immediately following the annual business meeting at the National Conference and Exhibition (NCE). All vote-eligible members will be notified by e-mail when the on-line ballot is available. In addition, a telephone voting option also will be available for the first time.

The following two pages will introduce the candidates and provide their answers to the first election question: What ideas do you have to implement/foster mentoring in the AAP?

### Wayne Yankus, MD, FAAP—Midland, NJ

Dr. Yankus is a New Jersey native and practicing community based pediatrician who did his pediatric training at New York University Hospital-Bellevue Medical Center and internship at the University of Medicine and Dentistry of New Jersey. He attended medical school at the Autonomous University of Guadalajara in Mexico.

Dr. Yankus serves as chair of the New Jersey Chapter's Committee on School Health and is founder of its "Critical Issues in School Health" program which is in its 19th year. He is the past president of the New Jersey Chapter of the American Academy of Pediatrics, and a current member of its government affairs committee.

He served as chair of the Academy's national section on school health and was awarded the Academy's Milton J. Senn award for contributions to the nation's school health. He was awarded the American Academy of Pediatrics, New Jersey Chapter Recognition award, and is an expert panelist for Education.com, a national education website.

He represented District III on the CATCH committee and was vice president of the Chapter Forum Committee (currently ALF).

Dr. Yankus practices pediatrics in Midland Park, NJ and is the medical liaison to the Ridgewood Board of Education. He is an honorary member of the Board of Children's Aid and Family Services, a former trustee of the Greater Bergen County YWCA, and was honored by the YWCA in 2004 with its Community Role Model Award with his wife Pat. Dr. Yankus is married and the father of three young men.

www.wayneyankusmd.com

### What ideas do you have to implement/foster mentoring in the AAP?

Mentoring is about empowerment. To be a successful mentor, you must have experience in your field and be willing to share your expertise. Training encompasses anything that helps increase the realization of a person's potential. I believe in mentoring members to enable them in their work, and to assist in developing their careers while still meeting personal and family needs.

The work force has changed in pediatrics and many of our new pediatricians are women working part time. To have a successful mentoring program within the AAP, I would encourage chapters to identify willing members who would be available to new members. It would strengthen chapter value. Nationally, it can be done by using social media. Mentoring can happen anywhere and at any time. One person can mentor many people. Mentoring can be as simple as an email, "tweet," or linked-in message.

I would promote use of existing services first and add to the AAP Website a "just ask" column that would be answered by volunteer pediatricians chosen by their councils or sections. Listservs can also be tapped for mentoring. The Section on Practice Management listserv is a classic example of an interactive connection that section members use to exchange ideas and support.

Full mentoring contacts could be developed through the office of membership by request of the individual. Those who request mentors should find chapter administrators and officers also helpful in locating a pediatrician who could serve another pediatrician's need. Participation can be one question or a long term relationship between colleagues, and enrich the lives of both members. Whether you are in direct patient care or academic medicine, members of the Senior Section locally and nationally hold a treasure of information and are often quite willing to mentor new pediatricians. We are teachers by virtue of being students first and always.

Mentoring colleagues follows our physician oath and should be a natural result of membership in our professional organization. It is with our peers we find our practice voice. The AAP is positioned to be influential in the workplace by developing new ways to mentor members.

## National Election - AAP NJ Member Running for AAP President!

### Robert W. Block, MD, FAAP—Tulsa, OK

Robert W. Block, MD, FAAP is Professor and Daniel Plunket Chair, Department of Pediatrics, University of Oklahoma School of Community Medicine, Tulsa.

Dr. Block received his MD from the University of Pennsylvania and completed three years of pediatric residency at the Children's Hospital of Philadelphia. He became board certified and elected as a Fellow in the AAP in 1974. He served three years in the U.S. Army prior to joining the new faculty of the University of Oklahoma - Tulsa in 1975, where he remains.

From 1990 to 1996, Dr. Block served as Vice-President and President of the AAP Oklahoma chapter. Dr. Block worked ten years with the AAP COCAN, four as Chair. He represented the AAP on the U.S. Advisory Commission on Childhood Vaccines for three years, two as Chair. He continues as the AAP liaison to the Family Violence Prevention Fund.

Dr. Block was the founding Chair, and remains a member of the newest American Board of Pediatrics Subboard, Child Abuse Pediatrics. During his 37 years of practice, Dr. Block has followed his interests in adolescent behavioral medicine, especially drug abuse and teen pregnancies; learning disabilities, ADHD and behavior issues; and for the last 25 years, child maltreatment.

Dr. Block is an award winning teacher in general pediatrics; and manages an active pediatric clinic, serving as a medical home for 12,000 children. He has presented over 2,000 community and professional talks, and has served often as a media spokesperson for children's issues locally and nationally for the AAP.

**What ideas do you have to implement/foster mentoring in the AAP?**

My first mentor was my father, a pediatrician in private practice in Iowa. Other mentors were clinicians and advisors, who encouraged me during my residency. My friend and career mentor, Dan Plunket, MD, FAAP, demonstrated teaching, clinical, and relationship building skills that have guided me for years. I try to emulate those qualities while mentoring students, residents, young faculty, and pediatricians new to our Tulsa, OK community.

Mentoring within the AAP should focus on clinical and business needs of private practices, while fostering alignment between members in private practices and in academics, centering on connecting experienced members with newer members looking for ideas and advice. A mentor supports another individual or group of individuals as they pursue common goals. Mentoring often is simply leading by example. Good mentors engage others through active listening, encouraging ideas, and by offering suggestions that are designed to support and energize another person. The AAP is a great resource for finding mentors among its many members, and can serve as an organizational mentor by listening to many opinions while guiding members' best ideas into policies and guidelines.

The AAP should continue to engage our trainees and young physicians, facilitating the acquisition of knowledge in medicine, business, policies, and politics. While advocating for children, AAP supports members in practice settings through email list-servs, task forces, sections and other activities. Providing a way for pediatricians to learn about practice management from experienced and successful practitioners is important. The AAP continues to support senior pediatricians, many of whom can use their practice or academic experiences to mentor a new FAAP entering practice or academics.

The AAP can facilitate the development of mentors through a task force, section or council on mentoring. A task force could design methods for connecting interested members with a mentor in their area of interest. I suggest inviting a young physician to observe committee or section executive committee meetings to connect with leaders who might become mentors. Using new technologies, we can support mentor/mentee pairs across time and space, generating, developing, and reviewing ideas. AAP resources can support mentoring program evaluation and improvement.

## AAP Section on Administration and Practice Management

### Congratulations to the winners of the 2010 SOAPM Election!

Chairperson: Jill Stoller, MD, FAAP
Executive Committee Member: Herschel Lessin, MD, FAAP
Executive Committee Member: Budd Shenkin, MD, FAAP

For more information about SOAPM, visit: http://www.aap.org/sections/soapm

*It is the mission of SOAPM to impart both basic and cutting edge administrative and practice management innovations that will improve the state of pediatric administration and practice management for its membership and members of the AAP. SOAPM will accomplish this mission by dedicating its talent, skills, and resources to educating and serving its membership.*

"Strategies to Prevent a Delayed Diagnosis in Turner Syndrome."

By: Chayim Y. Newmark, MD, FAAP

Turner Syndrome occurs in about 1:2000 live female births.[1] It is characterized by the absence of all or part of the normal second sex chromosome, and presents with a constellation of physical findings that often includes congenital lymphedema (puffy hands and feet), short stature, and gonadal dysgenesis.

## Diagnosis

Puffy hands and feet (congenital lymphedema) can alert one to the diagnosis of Turner Syndrome in about one quarter of affected girls.[2] Some infant girls may have webbed neck.

Occasionally, infants receive the diagnosis because of the presence of coarctation of the aorta. However, many girls with TS do not have any obvious stigmata. One third of girls with Turner Syndrome are diagnosed in midchildhood on investigation of short stature. Most of the remainder of females with Turner Syndrome are diagnosed in adolescence when they fail to have normal pubertal breast development and/or fail to have initiation of menses. Rarely, the diagnosis is not made until adulthood, because of recurrent pregnancy loss.

Typically, the diagnosis is confirmed by standard cytogenetic analysis (karyotype). There are faster and less expensive methods for diagnosing TS, using the detection of single nucleotide polymorphisms (SNPs) on the X chromosome.[3]

Approximately half of the karyotypes in females with TS reveal a single X chromosome (45, X) in all cell lines. Others have mosaicism, meaning that they have an additional cell lineages besides 45, X. It is important to know the exact cell lines present, since girls with mosaicism for a cell population with a Y chromosome are at increased risk for malignancy (gonadoblastoma) in the streak gonads.[4]

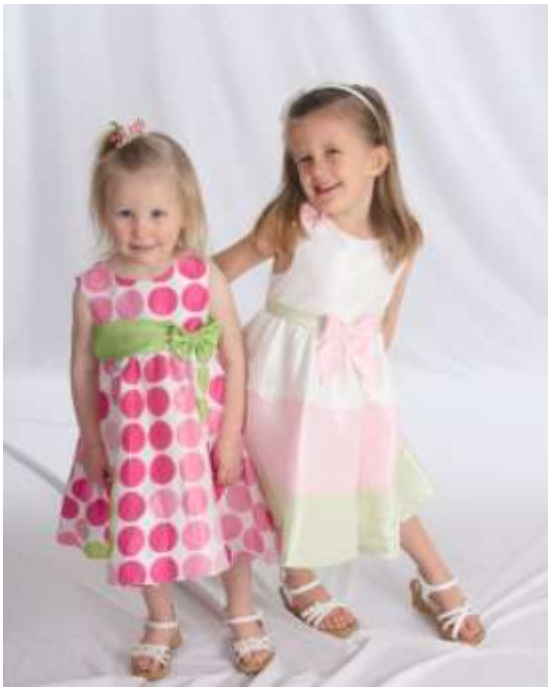
## Manifestations and Management

### *Short Stature*

Women with Turner Syndrome reach an adult height 20 cm below their expected midparental height.[5] The mean final adult height is about 143 cm, which is about 4 feet, 8 inches.[5] At birth, the length tends to be close to the normal range. However, by 18 months of age, many girls with Tuner Syndrome will have a decrease in their growth velocity. Approximately 2% of girls whose height is below the 5th percentile have a diagnosis of Turner Syndrome. It is important to point out that children with Turner Syndrome may not be very short; however, they will be shorter than expected for their midparental target height.

Treatment with recombinant human growth hormone is now the standard of care for girls with Turner Syndrome. Data reported from the National Cooperative Growth Study (NCGS) indicate that from 1995 to 2000, girls with Turner Syndrome were not started on growth hormone until an average age of 9.0 ± 3.8 years. Furthermore, their height at initiation of growth hormone therapy was -2.9 ± 0.9 SDs, which is approximately the 0.1%.[6] This delay in starting growth hormone therapy is likely related to delayed diagnosis of Turner Syndrome in some girls, and in others it is due to delay in referral to a pediatric endocrinologist. The later growth hormone therapy is started, the longer it will take for the girl's height to improve to the normal range, and the less likely they are to reach a final adult height within the normal range.

A recent randomized controlled trial evaluated the effect of early growth hormone therapy in the toddler years in girls with Turner Syndrome. During this two year study, the control group had progressive growth failure, with a decrease in height from -1.8 ± 1.1 SDS (at baseline) to -2.2 ± 1.2 SDS (after 2 years).



*The older sister, right, was diagnosed with Turner syndrome in utero, and failure to thrive at birth. She was later identified as having reflux and frequent ear infections.. Photo credit: Turner Syndrome Foundation, New Jersey Chapter.*

This is in contrast to the growth hormone treated girls, whose mean height score increased from -1.4 ± 1.0 SDS (at baseline) to -0.3 ± 1.1 SDS (after 2 years).[7] This means that after 2 years, the untreated girls were at about the 1% and the growth hormone treated girls were at about the 40%.

### *Gonadal Failure*

The ovarian cells in females with Turner Syndrome undergo premature cell death. By 20 weeks gestation, 70% of ovarian germ cells were apoptotic in those with Turner Syndrome, compared to 3% in age-matched normal XX ovaries.[8] The ovarian failure manifests itself as both estrogen deficiency as well as a lack of fertilizable ovum.

Girls with Turner Syndrome tend to have normal pubic and axillary hair development, as these are due to adrenal androgens, rather than ovarian estrogens. However, most girls with TS will not have full breast development nor menstrual cycles. Occasionally, there is enough residual ovarian function for breast development and/or menstrual periods, either as pills or estrogen patches.

*(Cont. from page 8)*

Studies show that estrogen patches have the advantage of not causing liver enzyme elevations[9] and promote increased growth factor (IGF-1) levels.[10] There are various estrogen replacement regimens that are used, but the common point among of all of them is to start with low dose estrogen, and slowly increase the dose over a couple of years. This allows for normal uterine and breast development.

There is much research looking into various forms of assisted reproductive technologies to help women with TS carry a pregnancy. There have been reports of ovarian tissue wedge freezing as well oocyte cryopreservation in young women with Turner Syndrome, in order to preserve fertility.[11]

## Developmental and Learning Issues

In general, most people with TS have normal intelligence. Some of the deficits that are more common in females with TS include: visuospatial organization, social cognition, and math abilities. Attention deficit disorders are also more common in these individuals.[2] As with anyone with learning disabilities, early diagnosis and interventions are very important.

## Cardiovascular Issues

Approximately 1/4 to 1/2 of all females with TS have congenital heart disease. Therefore, all individuals with TS should at least have an echocardiogram at the time of the diagnosis of TS. Typically the malformations are left-sided defects, with coarctation of the aorta and bicuspid aortic valve being the most common. There seems to be an increased risk of aortic root dilatation and subsequent aortic aneurysms in individuals with TS.[12]

## Endocrine Issues

Acquired hypothyroidism is more common in females with TS. Approximately, 41% of women with TS have anti-thyroid antibodies, with about one-third of these women having hypothyroidism, requiring thyroid replacement. Interestingly, 83% of the women with the particular karyotype, X-isochromosome, have anti-thyroid antibodies. The hypothyroidism tends to occur in the 20s and the 30s, but a few percent of cases present in early childhood.[13] Some studies have found an increased incidence of obesity, insulin resistance, and type 2 diabetes in women with TS.[2]

## Otological Concerns

Recurrent ear infections are quite common in females with TS. By a mean age of 2 years, over 50% of girls already had a history of recurrent otitis media.[14] This increased incidence of infection is due to a shorter, more horizontal eustachian tube, interfering with middle ear drainage and causing nasopharyngeal reflux. Approximately, one-quarter of girls with TS with have hearing loss, typically conductive hearing loss related to the middle ear dysfunction and chronic ear infections. However, sensorinueral hearing loss is also more common in females with TS.[14]

## Renal Concerns

Approximately, one third of females with TS have kidney malformations.[15] These anomalies include: horseshoe kidney, single kidney, duplicated collecting system, and pelvic kidney. Therefore, a renal ultrasound is recommended at the time of diagnosis of TS.[15]

## Musculoskeletal and Orthopedic Concerns

Commonly, increased carrying angle of the arm is found, due to malformation of the ulnar head. Congenital dislocation of the hip and scoliosis tend to be more common in girls with TS. Other malformations that occur in TS are: webbed neck, widely spaced nipples, nail dysplasia, high arched palate, and short forth metacarpal.

## Dermatological Concerns

The congenital edema of the hands and feet tend to resolve on their own within the first couple years of life. Nevi tend to be more common in females with TS. There also seems to be an increased incidence of keloid formation in these individuals.

## Strategies to Prevent Delayed Diagnosis

One study found that girls with TS were not diagnosed until an average of five years from the time that their height fell below the 5th percentile.[16] The authors of that study proposed the following guidelines for screening for TS: Any girl with one or more of the following: Short stature (height <5th percentile), webbed neck, peripheral lymphedema, coarctation of the aorta, or delayed puberty, should be screened for TS. Additionally, any girl who has at least two or more of the following: nail dysplasia, high arched palate, short fourth metacarpal, and strabismus, should be screened for TS.[16]

For more information:
www.TurnerSyndromeFoundation.org Toll Free: 800-594-4585


1. *Nielsen J, Wohlert M. Chromosome abnormalities found among 34,910 newborn children: results from a 13-year incidence study in Arhus, Denmark. Hum Genet. May 1991;87 (1):81-83.*
2. *Sybert VP, McCauley E. Turner's syndrome. N Engl J Med. Sep 16 2004;351(12):1227-1238.*
3. *Meng H, Hager K, Rivkees SA, Gruen JR. Detection of Turner syndrome using high-throughput quantitative genotyping. J Clin Endocrinol Metab. Jun 2005;90(6):3419-3422.*
4. *Gravholt CH, Fedder J, Naeraa RW, Muller J. Occurrence of gonadoblastoma in females with Turner syndrome and Y chromosome material: a population study. J Clin Endocrinol Metab. Sep 2000;85(9):3199-3202.*
5. *Lyon AJ, Preece MA, Grant DB. Growth curve for girls with Turner syndrome. Arch Dis Child. Oct 1985;60(10):932-935.*
6. *Parker KL, Wyatt DT, Blethen SL, Baptista J, Price L. Screening girls with Turner syndrome: the National Cooperative Growth Study experience. J Pediatr. Jul 2003;143(1):133-135.*
7. *Davenport ML, Crowe BJ, Travers SH, et al. Growth hormone treatment of early growth failure in toddlers with Turner syndrome: a randomized, controlled, multicenter trial. J Clin Endocrinol Metab. Sep 2007;92(9):3406-3416.*
8. *Modi DN, Sane S, Bhartiya D. Accelerated germ cell apoptosis in sex chromosome aneuploid fetal human gonads. Mol Hum Reprod. Apr 2003;9(4):219-225.*
9. *Jospe N, Orlowski CC, Furlanetto RW. Comparison of transdermal and oral estrogen therapy in girls with Turner's syndrome. J Pediatr Endocrinol Metab. Apr-Jun 1995;8(2):111-116.*
10. *Janssen YJ, Helmerhorst F, Frolich M, Roelfsema F. A switch from oral (2 mg/day) to transdermal (50 microg/day) 17beta-estradiol therapy increases serum insulin-like growth factor-I levels in recombinant human growth hormone (GH)-substituted women with GH deficiency. J Clin Endocrinol Metab. Jan 2000;85(1):464-467.*
11. *Oktay K, Rodriguez-Wallberg KA, Sahin G. Fertility preservation by ovarian stimulation and oocyte cryopreservation in a 14-year-old adolescent with Turner syndrome mosaicism and impending premature ovarian failure. Fertil Steril. Feb 24.*
12. *Sybert VP. Cardiovascular malformations and complications in Turner syndrome. Pediatrics. Jan 1998;101(1):E11.*
13. *Elsheikh M, Wass JA, Conway GS. Autoimmune thyroid syndrome in women with Turner's syndrome--the association with karyotype. Clin Endocrinol (Oxf). Aug 2001;55(2):223-226.*
14. *Davenport ML, Roush J, Liu C, et al. Growth Hormone Treatment Does Not Affect Incidences of Middle Ear Disease or Hearing Loss in Infants and Toddlers with Turner Syndrome. Horm Res Paediatr. Apr 27.*
15. *Lippe B, Geffner ME, Dietrich RB, Boechat MI, Kangarloo H. Renal malformations in patients with Turner syndrome: imaging in 141 patients. Pediatrics. Dec 1988;82(6):852-856.*
16. *Savendahl L, Davenport ML. Delayed diagnoses of Turner's syndrome: proposed guidelines for change. J Pediatr. Oct 2000;137(4):455-459.*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These health and nutrition organizations support Fuel Up to Play 60, a partnership between the NFL and National Dairy Council impacting an expected 60,000 schools and 36.6 million students.
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NMA
NHMA
SCHOOL NUTRITION ASSOCIATION
This program empowers youth to make changes at school that will help them "fuel up" with nutrient-rich foods missing from their diets, such as low-fat and fat-free milk and milk products, fruits, vegetables and whole grains and to "get active and play" for 60 minutes daily.
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# You Can Bet on Vaccines:
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## 6th Annual Vaccines for Children Conference

November 9 - 10, 2010

Atlantic City Convention Center, Atlantic City, NJ

*NOVEMBER 9TH CONFERENCE (Day 1)*

**CME & CNE Provided!**

| | |
|---|---|
| 12:30 pm | Registration and Exhibitor Showcase |
| 1:25 pm | Welcome and Introduction |
| 1:30 pm | Parents, Peers and the Media: *Margaret Fisher, MD & Paul Offit, MD* |
| 2:45 pm | Break |
| 3:00 pm | **Workshops:**<br>A: Media Training for Pediatric Leaders: *Daniel Levy, MD*<br>B: NJ Immunization Network: *Margaret Fisher, MD & Lawrence Frenkel, MD*<br>C: Communicating Vaccine Safety Data: *Alison Singer, MBA*<br>D: Strategies to Communicate Vaccine Safety to Parents: *Marguerite Leuze, RN, DMH; Patricia Lucarelli, MSN, RN, CPNP; Nancy Gerrity, MSN, RN, HO*<br>E: Social Media Webinar: PKIDs: *Communications Made Easy: Trish Parnell, BS* |
| 4:30 pm | Exhibitor Showcase & Reception |

*NOVEMBER 10TH CONFERENCE (Day 2)*

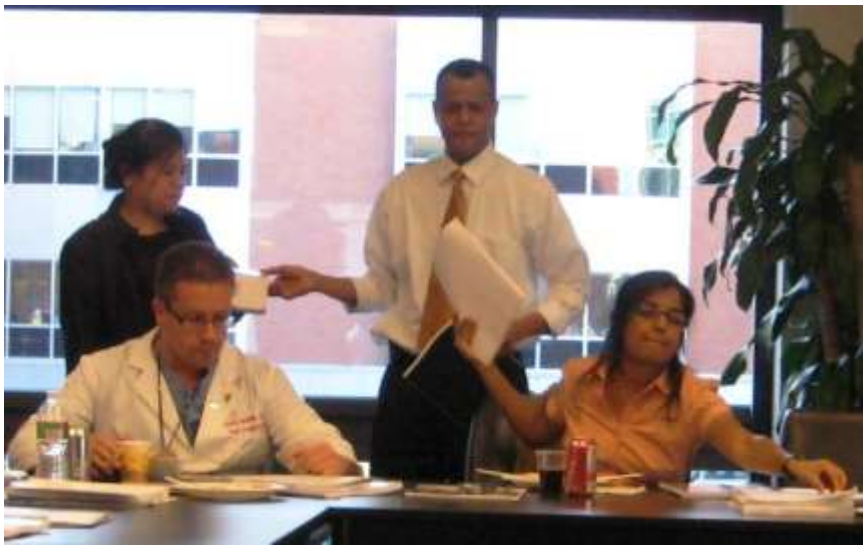
| | |
|---|---|
| 7:00 am | Registration, Continental Breakfast, and Exhibitor Showcase: |
| 8:00 am | Welcome: *Fran Gallagher, MEd,* & State Update: *Christine Armenti, BSN, MS* |
| 8:30 am | **Keynote:** |
| | From Pig Viruses to Insect Vectors and New Adjuvants: *Margaret Fisher, MD & Paul Offit, MD* |
| 9:40 am | Facilitated Networking/Exhibitors |
| 10:10 am | Children with Special Health Care Needs: *Diana MTK Autin, ESQ* |
| 10:40 am | National Perspective: *Iyabode Beysolow, MD* |
| 11:40 am | Exhibitor Showcase |
| 12:10 pm | Lunch, Door Prizes & Award Ceremony; Facilitated Networking Community Resources Exhibit |
| 1:15 pm | **Ask the Experts - Question and Answer Panel:**<br>*Iyabode Beysolow, MD; Jeffrey R. Boscamp, MD; Margaret Fisher, MD*<br>*Lawrence Frenkel, MD; Everett Schlam, MD; Charles A. Scott, MD*<br>*Moderator: Steven Kairys, MD, MPH, FAAP* |
| 2:15 pm | **Workshops Repeat:**<br>A: Media Training for Pediatric Leaders: *Daniel Levy, MD*<br>B: NJ Immunization Network: *Margaret Fisher, MD & Lawrence Frenkel, MD*<br>C: Communicating Vaccine Safety Data: *Alison Singer, MBA*<br>D: Strategies to Communicate Vaccine Safety to Parents: *Marguerite Leuze, RN, DMH; Patricia Lucarelli, MSN, RN, CPNP; Nancy Gerrity, MSN, RN, HO*<br>E: Social Media Webinar: PKIDs: *Communications Made Easy: Trish Parnell, BS* |
| 3:00 pm | **Evaluations/Conference Concludes**<br>*Full disclosure will be provided at the educational activity.* |

## Catch Corner

### New Jersey Residency Advocacy Program (NJ-RAP)

By: Paul Schwartzberg, MD, FAAP AAP NJ CATCH Facilitator

The goal of the New Jersey Residency Advocacy Program (NJ-RAP) is to improve pediatric resident's involvement in community and child advocacy, especially involvement in the legislative process. It is difficult for individual pediatric residency programs to develop their own independent curriculum and this program will be the first attempt to create a joint effort amongst the various programs in New Jersey.



*Attendees at the first meeting of the New Jersey Residency Advocacy Program (NJ-RAP) on April 29, 2010.*

The New Jersey Pediatric Residency Advocacy Program will allow all New Jersey pediatric residents to get a basic understanding of the legislative process and how it can fit within the demands of a busy pediatric resident schedule. It will also increase pediatric residents' confidence with becoming involved in legislative advocacy-related issues and be more aware of opportunities to advocate on child health issues that interest them. Additionally, the program will increase collaboration between our New Jersey pediatric residency programs and the AAP New Jersey chapter through focus groups, workshops and legislative chapter contacts and resources.

Our initial goal of creating a core group of residents and faculty from various pediatric residencies has been established. This group had its first meeting on April 29, 2010 and included representative pediatric residents and faculty from seven different programs (Jersey Shore University Medical Center, UMDNJ-Robert Wood Johnson University Hospital, Morristown Memorial Hospital, Cooper University Hospital, St. Peter's University Hospital, Newark Beth-Israel Medical Center, and Monmouth Medical Center) as well as members from the AAP NJ Chapter.

At this meeting, members were given a standardized advocacy training tool-kit that included modules that can be incorporated into a pediatric residency curriculum. These tool kits will be disseminated to residents and interested faculty members in New Jersey pediatric residency programs.

As an incentive to participate, New Jersey pediatric residents will have the opportunity to participate in site visits to Trenton to utilize the skills they obtained from this tool-kit. These visits will be coordinated by Nancy Pinkin, our AAP New Jersey government affairs experts.

Additionally, we plan to post advocacy activities on the AAP NJ Chapter membership web site so that Program Directors and residents will be able to access advocacy activities that are of interest to their individual residency programs. Further information on this program and the web site will be provided at the AAP New Jersey Chapter CME Conference & Annual Meeting on June 8, 2010.

The 2011 CATCH Planning Funds and Cycle 1 Resident Funds Call for Proposals and online application are both now available. Check out our new look!

Planning Funds - www.aap.org/catch/planninggrants.htm
Resident Funds - www.aap.org/catch/residentgrants.htm

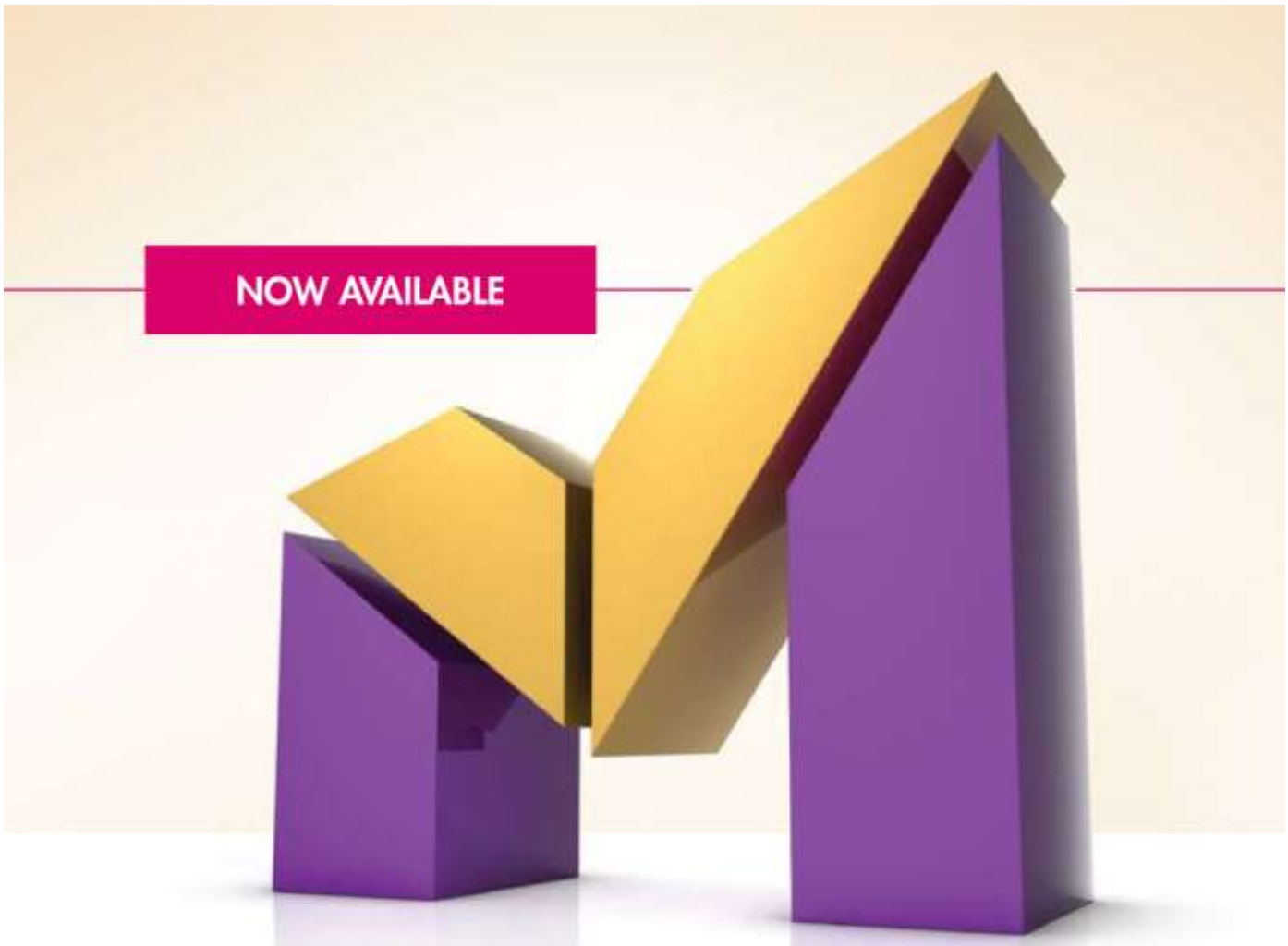
Please feel free to contact Dr. Paul Schwartzberg, your CATCH facilitator, prior to submitting your application at pschwartzberg@meridianhealth.com if you are considering applying for a CATCH grant or if you need more information or technical assistance.

## Discount for Members

### *Vaccine-Preventable Disease: The Forgotten Story* from the Texas Children's Hospital

Behind each person who has contracted a vaccine-preventable disease is the story of a life interrupted, of a family devastated. *Vaccine-Preventable Disease: The Forgotten Story* profiles families who have suffered the true cost of not vaccinating

The AAP NJ Chapter has contacted the Texas Children's Hospital and they have offered a discount so that Chapter members would pay $2.00 each plus shipping and handling. The books are normally priced at $3 .00 each plus shipping and handling. Please contact Lisa Murison at lmurison@aapnj.org if you are interested in ordering copies for your practice.

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## CONFERENCE FACULTY

*"A Tale of Two Cities: Addressing Trauma & Depression in Pregnant Teens"*

**DEREK SUITE, MD, MS,**
PSYCHIATRIST, MEDICAL DIRECTOR & FOUNDER, FULL CIRCLE HEALTH, INC.

**LINDA LAUSELL BRYANT, MSW,**
EXECUTVE DIRECTOR, INWOOD HOUSE
NEW YORK, NEW YORK

*"Non-Suicidal Self-Injury in Adolescents"*

**JANIS WHITLOCK, PHD, MPH**
DIRECTOR,
CORNELL RESEARCH PROGRAM ON SELF-INJURIOUS BEHAVIOR
ITHACA, NEW YORK

*"Warning Signs, Risk & Protective Factors: Sorting Out Adolescent Suicide"*

**PETER GUTIERREZ, PHD**
ASSOCIATE PROFESSOR,
DEPT. OF PSYCHIATRY,
UNIVERSITY OF COLORADO,
DENVER SCHOOL OF MEDICINE
DENVER, COLORADO

*"Identifying Youth at Risk of Committing School Shootings"*

**PETER LANGMAN, PHD**
CLINICAL DIRECTOR,
KIDSPEACE
OREFIELD, PENNSYLVANIA

*"Incorporating Mental Health Checkups into Adolescent Office Visits"*

**JOHN GENRICH, MD**
PEDIATRICIAN,
COLORADO SPRINGS, COLORADO
PHYSICIAN ADVISOR, TEENSCREEN, NATIONAL CENTER FOR MENTAL HEALTH CHECKUPS
COLUMBIA UNIVERSITY
NEW YORK, NEW YORK

*"Adolescent Mental Health Services in New Jersey"*

**NADEZHDA ROBINSON, PHD**
DIRECTOR,
DIVISION OF CHILD BEHAVIORAL HEALTH SERVICES,
DEPT. OF CHILDREN & FAMILIES
TRENTON, NEW JERSEY

IN COLLABORATION WITH:

Holy Name Medical Center & New Jersey Department of Health and Senior Services

# Project Aims to Promote Safe Driving by Teens

RESEARCH UPDATE from the AAP Department of Research

*Reprinted with permission from AAP News Dec 2009*

A new $1.3 million project from the AAP Pediatric Research in Office Settings (PROS) network seeks to test a leading-edge approach in the offices of primary care providers (PCPs) to promote parent-teen-driving agreements and safe driving. The three-year project, funded by the Centers for Disease Control and Prevention, will adapt an evidence-based program called Checkpoints for promotion by PCPs, leading to better parental monitoring of teen driving. Providing anticipatory guidance on teen driving safety is a key recommendation of the AAP policy statement, *The Teen Driver (Pediatrics*. 2006;118:2570-2581).

Under the leadership of Jean T. Shope, M.S.P.H., Ph.D., of the University of Michigan's Transportation Research Institute, and Joseph O'Neil, M.D., M.P.H., of Riley Children's Hospital of Indianapolis, the project will include a brief intervention by PCPs with follow-up over the Internet, including an interactive parent-teen driver agreement.

During the first year of the study, a PCP training program will be developed to fit with the Web-based Checkpoints program. In the second year, a pilot test of the PCP training and the intervention program will be conducted in a small number of physician practices. Changes to the PCP training, intervention and Web site will be made based on test results and feedback. A larger sample of PCPs subsequently will be recruited to participate in the full scale study, with participating PCPs trained to conduct the refined brief in-office intervention, including a streamlined referral of parents to the Checkpoints Web program.

Measures of intervention success with parents will include:

- dissemination: reach (hearing the PCP message), exposure (going to the Web site), exploration (viewing the materials) and access (downloading the materials)
- implementation: initiation (making the agreement), adoption (signing the agreement) and maintenance (using the agreement).

Translation effectiveness will be determined by the PCPs' success in getting parents to visit the Web site, amount and type of Web site usage target behavior involvement and costs.

Practices will be recruited through PROS and the Electronic Primary Care Research Network of family medicine practitioners. Participating practice staff and PCPs will be trained to identify eligible families, deliver the brief intervention, assist families in accessing the Checkpoints Web program, and implement promotional and reminder activities. Variation in adoption, implementation and institutionalization of the PCP/Checkpoints Web program will be measured at three levels (practices, individual PCPs and individual parents) as described above. The economic feasibility of the intervention for all parties will be assessed as well.

Collaboration with the AAP Committee on Injury, Violence and Poison Prevention will facilitate rapid translation of study findings into AAP policy and pediatric practice. "This is not just about promoting teen-driving agreements; this is about saving lives," said PROS Director Richard C. "Mort" Wasserman, M.D., FAAP.

Core funding for PROS is provided by the Academy and the Health Resources and Services Administration Maternal and Child Health Bureau.

PROS seeks practitioners interested in participating in this or any of its other research. For more information, see the coupon below.

**Join AAP practitioners around the country…**

… in generating knowledge about the best ways to care for children. Pediatric Research in Office Settings (PROS) is looking for pediatricians to help develop and carry out primary care research in the practice setting. Any pediatric practice or clinic with at least one AAP member is eligible to join PROS. For information on being part of this innovative AAP research effort, e-mail pros@aap.org, fill out and fax this coupon to (847) 434-8910, or mail to:

PROS, American Academy of Pediatrics
141 Northwest Point Blvd. • Elk Grove Village, IL 60007
Yes! I'd like to be involved with PROS research.

Name _____
Degree _____
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AAP News December 2009

## National AAP Update

### Implementation Guidance - PCV-13 Updated 5/24/10

The American Academy of Pediatrics has developed the following implementation guidance in response to the recent Food and Drug Administration (FDA) licensure. Recommendations for use of PCV - 13 have been published in the Morbidity and Mortality Weekly Report (MMWR) and *Pediatrics*. This document is designed to assist practices in the transition from using PCV 7 to PCV 13 vaccines and it will be updated as new policy and implementation information becomes available.

Policy: On March 12, 2010 the Centers for Disease Control's Advisory Committee on Immunization Practices (ACIP) published recommendations on the use of a 13-valent pneumococcal conjugate vaccine (PCV13 [Prevnar 13, Wyeth Pharmaceuticals Inc., a subsidiary of Pfizer Inc.]). PCV-13 was licensed by the Food and Drug Administration (FDA) for prevention of invasive pneumococcal disease (IPD) caused by the 13 pneumococcal serotypes covered by the vaccine and for prevention of otitis media caused by serotypes in the 7 valent pneumococcal conjugate vaccine formulation (PCV7 [Prevnar, Wyeth]). The ACIP recommendations approved by ACIP on February 24, 2010 address the following: 1.) routine vaccination of all children aged 2- 59 months with PCV-13, 2.) vaccination of children aged 60-71 months with underlying medical conditions that increase their risk for pneumococcal disease or complications, and 3) PCV13 vaccination of children who previously received 1 or more doses of PCV 7. Additionally, the MMWR includes guidance for vaccination providers transitioning from PCV7 to the PCV 13 immunization schedule.

Full Report: Licensure of a 13 – Valent Pneumococcal Conjugate Vaccine (PCV13) and Recommendations for Use Among Children --- Advisory Committee on Immunization Practices (ACIP), March 12, 2010; 59 (09); 258-261 The American Academy of Pediatrics' updated recommendations on PCV 13 published in *Pediatrics* can be found here: http://pediatrics.aappublications.org/cgi/content/abstract/peds.20101280v1. Additional information on pneumococcal disease - clinical manifestations, etiology, epidemiology, diagnostics, treatment, and control measures - can be found in the *Red Book 2009* pgs 524 -535 and on *Red Book Online* (subscription required).

### Supply and Ordering

There are currently 8.3 million US doses available in filled syringes, and Pfizer indicates the product began shipping the week of March 15th. Supply of PCV-13 vaccine is expected to be adequate to cover a 4-dose series for infants and catch-up of 2-5 year olds in the United States. For initial ordering, consider adding an appropriate number of vaccines to cover 1 catch-up dose per 2-5 year old in the practice. For Prevnar 7, Pfizer will amend its return policy and accept partial package returns for credit as well as waive its policy of only accepting returns within 6 months of the lot's expiration date through December 31, 2010. As a result, practices can return private inventory of Prevnar 7. Pfizer will not accept returns of Prevnar supplied through the VFC Program or from any government agency.

*Reprinted with permission of the American Academy of Pediatrics from http://www.aap.org/immunization/illnesses/pneumococcal/pcv13implementationguidance*

## PCORE Recruitment Opportunity

Attention Primary Care Practices in Cumberland, Salem, **Gloucester and Camden Counties… PCORE& SPAN are re**cruiting practices to participate in the Medical Home Program, COST FREE!

You may be saying… we are already a medical home. The Medical Home Program provides an opportunity for pediatric/family practices located in Cumberland, Salem, Gloucester and Camden Counties to gain an understanding of how to strengthen their medical homes. The AAP describes a medical home as primary care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective.

Responsibilities and Benefits for your Practice

- Participation as a practice team in 3 Collaborative Learning Sessions.
- Training/Technical Assistance provided by a Medical Home Resource Team (MD, Statewide Parent Advocacy Network (SPAN), Quality Improvement (QI) Facilitator)
- Networking Opportunities Between Practices
- Team Building within the practice
- Strengthen Family/Provider Communication
- Continuous Technical Assistance (including monthly support calls)
- Hot Topic Conference Calls /Local Meetings based on the Needs Determined by the Practices
- Self Assessments (Medical Home Indices, Pre and Post, Provider & Family Versions)
- Link to Community Resources & Other PCORE onsite Quality Improvement Programs (e.g. Early Identification of Young Children with Autism; Obesity Prevention)

PCORE
Pediatric Council on Research & Education
Foundation of the American Academy of Pediatrics / NJ Chapter

Interested but Not Sure? We can visit your practice at a convenient time (breakfast, lunch, or early evening) and share information and answer questions. Call or email today!

Contact: If you are a community-based primary care provider in Cumberland, Salem, Gloucester and Camden Counties and would like to participate in this program, please contact Judie Grandjean, Program Director (jgrandjean@njpcore.org) or Nicole Chabot-Waugh, Program Coordinator (nchabot-waugh@njpcore.org).

Register Online
www.AAPNJ.org

**2010 American Academy Of Pediatrics New Jersey Chapter – 19th Annual School Health Conference**

## "Issues in Children's Health – What's New & Practical"

Wednesday, October 27, 2010 – The Palace at Somerset Park

| | |
|---|---|
| 7:00 am | Registration, Breakfast, Exhibit Showcase |
| 7:45 am | Welcome<br>*Wayne Yankus, MD, FAAP, School Health Committee Co- Chair; Polly Thomas, MD, FAAP, School Health Committee Co- Chair; Stephen Rice, MD, PhD, MPH, FAAP, AAP NJ President and Marie Peppas, President of the New Jersey State School Nurse Association.* |
| 8:00 am | What's New in Infectious Disease<br>*Margaret "Meg" Fisher, MD, FAAP* |
| 9:15 am | Preparing for a Pandemic, the H1N1 Experience in NJ<br>*Christina Tan, MD, MPH* |
| 10:30 am | Break & Exhibit Showcase |
| 11:00-12:45 pm | Morning Workshop Breakout Session |
| 12:45-1:45 pm | Lunch & Exhibit Showcase |
| 1:45-3:30 pm | Afternoon Workshop Breakout Session |
| 3:30-3:45 pm | Professional Development Certificates Distributed |

6.0 Contact Hours

CMEs - 6.0 AMA PRA Category 1 Credits™

## WORKSHOP BREAKOUT SESSIONS

Please review the workshop selections very carefully. This year, we are offering both long AND short workshop options. If you choose a long workshop, please note it will take the entire length of the breakout session. If you choose to attend a short workshop, TWO will be required to cover the length of the breakout session.

There are **TWO** breakout sessions during the day, once in the morning **(11:00-12:45 pm)** and once in the afternoon **(1:45-3:30 pm)**
You may choose 1 long OR 2 short workshops in the morning breakout session AND you may choose 1 long OR 2 short workshops in the afternoon breakout session.

**Long Workshop Options**
Long Workshops run for 105 minutes. All four are available in the morning and again in the afternoon. You will select your workshops on the registration page.

**1. Pediatric Assessment, Essentials for School Nurses**
Patti 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 the school nurse to include when conducting a focused pediatric assessment, to help ensure appropriate triage and care of their pediatric and adolescent patients.*

**2. School Rules and Regulations for 2010: Issues for School Nurses**
Linda Morse, RN, MA, CHES - *School health services are supported by numerous laws and regulations. How do I know what is required and what is simply "best practice?" Where do I go for guidance about school nursing practice in New Jersey? This session will help school nurses and physicians understand school nursing practice in New Jersey's schools.*

**3. Acute Brain Injury & Sports Related Mild Traumatic Brain Injury**
Joseph Rempson, MD and Arno Fried, MD
*This workshop will discuss the student or patient who experiences a concussion. It will include the mechanics, diagnosis and treatment of concussion from a sports-related mild traumatic brain injury.*

**4. Anxiety and School Phobia**
James Hambrick, PhD and Sandra Pimentel, PhD
*This workshop will discuss an overview of the Cognitive-Behavioral model for anxiety and school phobia in youth, critical strategies for functional assessment and specific applications of Cognitive Behavioral Treatment for anxiety and school phobia in youth.*

**Short Workshop Options**
Short Workshops run for 50 minutes. Some are available only in the morning or only in the afternoon. You will select your workshops on the registration page.

*(Offered Both Morning and Afternoon)*

**A. Pediatric Syncope: The Kid Who Passes Out**
Brian Walsh, MD, FAAP & Fuad Kiblawi, MD, FAAP *This workshop will help participants understand the common causes of pediatric syncope, identify concerning "red flags" in pediatric syncope and indications for emergent evaluation and understand the expected evaluation of children after syncopal episodes.*

**B. Bumps, Lumps & Rashes: What's New in Dermatology & When There is More Than Meets the Eye** – Kimberly Morel, MD, FAAD, FAAP (AM) or Helen Shin, MD (PM)
*This workshop will provide updates on management of dermatologic conditions, recognizing a variety of conditions that present in the skin and those rashes requiring urgent medical attention.*

**C. What's New at DYFS** – Robert Morgan, MD and Margarita Marriaga
*The workshop will present on recent changes in the NJDYFS Program regarding case identification, provision of services and expanded child health units. These are new assets for community providers to be aware of to aid in the management of vulnerable children and families.*

*(Only Available in the Morning)*

**D. Stress Management for Kids: The Third Wave of Cognitive Behavior Therapy**
Steven Gordon, PhD, ABPP *This workshop will teach participants how to identify the three waves of behavior therapy, and the six core processes of the third wave.*

**E. Vitamin D Deficiency in Children - Its Causes, Consequences & Repair**
Robert Heaney, MD, FACP, FASN, FACN *This workshop will characterize vitamin D status of children in America today; define vitamin D inputs needed to achieve specific levels of vitamin D repletion; identify sources of vitamin D available to help satisfy needs of the body, and discuss and evaluate the safety of various vitamin D repletion regimens.*

*(Only available in the Afternoon)*

**F. Healthcare Guidelines for Parenting Tweens** – Evelyn Shalom, MA, AASECT
*This workshop will describe guidelines that healthcare professionals should share with parents of tweens, and will offer tips and practice for talking with tweens about difficult issues.*

**G. X to Gen XXL: Strategies for Preventing Childhood Obesity** – Keith Ayoob, EdD, RD, FADA *At least 1 in 3 children is either overweight or obese and the consequences are devastating for health and the health care system. Nutrition has its greatest impact in the arena of prevention and this workshop focuses on screening tools and strategies for preventing, addressing, and treating childhood weight issues.*

## PROS Update

### PROS Child Abuse Reporting Experience Study (CARES)

From Suspicion of Physical Child Abuse to Reporting: Primary Care Clinician Decision-Making

- CARES was a prospective observational study to determine how frequently primary care clinicians reported suspected physical child abuse, the levels of suspicion associated with reporting, and what factors influenced reporting to child protective services (CPS). Clinicians collected data on child injury visits, including information about the injury, child, family, likelihood that the injury was caused by child abuse (5-point scale), and whether the injury was reported to CPS.
- Of the 1,683 children with suspicious injuries included in this report, 95 (6%) were reported to CPS. The maximum number of children reported by an individual clinician was 3. Clinicians did not report 27% of injuries they considered likely or very likely caused by child abuse and 76% of injuries they considered possibly caused by child abuse.

**Clinicians did not report 27% of injuries they considered likely or very likely caused by child abuse**

- Clinician factors associated with reporting (based on multivariate analysis) indicated that clinicians were more likely to report if they had previously lost a family as patients because the clinician had reported to CPS and if they had not previously reported all suspected child abuse during their career. Practice level factors such as urban vs. rural and the availability of child abuse evaluative resources were not significant.
- The patient level factors that were most highly related to reporting were the injury not being consistent with the history provided and the patient being referred to the clinician because child abuse was suspected. Additional significant factors included race, clinician familiarity with the patient, and injury severity.
- Clinicians had some degree of suspicion that ~10% of the injuries they evaluated were caused by child abuse. It appears that clinicians apply various interpretations to the legal mandate to report when there is reasonable suspicion of child abuse. This will be explored further in the companion manuscript.
- This is one of the first national efforts to systematically and prospectively study the issue. Our prospective findings indicating that physicians do not report all suspected child abuse are consistent with retrospective study findings in which physicians admit they have not reported all suspected child abuse.

These were among the findings from the AAP's practice-based research network - Pediatric Research in Office Settings (PROS) and National Medical Association's pediatric practice-based research network, NMAPEDSNET. Funding for the Child Abuse Reporting Experience Study (CARES) was received from the Agency for Healthcare Research and Quality (grant R01 HS010746), the Maternal and Child Health Bureau (grant R40 MC 00107), and the American Academy of Pediatrics. Overall, 434 clinicians participated in data collection, and collected information about 15,003 child injury visits. The 327 clinicians included in this report represent 141 practices in 41 states.

*This article based on study results appeared in Pediatrics: Flaherty EG, Sege RD, Griffith J, Price LL, Wasserman R, Slora E, Dhepyasuwan N, Harris D, Norton D, Angelilli M, Abney D, Binns HJ. From suspicion of physical child abuse to reporting: Primary care clinician decision-making. The Child Abuse Reporting Experience Study Research Group. Pediatrics. 2008; 122 (3):611-619.*

## Pediatricians and the Law Update

### FTC Extends Enforcement Deadline for Identity Theft Red Flags Rule

From the Federal Trade Commission Web Site www. ftc.gov

May 28, 2010 - At the request of several Members of Congress, the Federal Trade Commission is further delaying enforcement of the "Red Flags" Rule through December 31, 2010, while Congress considers legislation that would affect the scope of entities covered by the Rule. Today's announcement and the release of an Enforcement Policy Statement do not affect other federal agencies' enforcement of the original November 1, 2008 deadline for institutions subject to their oversight to be in compliance.

The Rule was developed under the Fair and Accurate Credit Transactions Act, in which Congress directed the FTC and other agencies to develop regulations requiring "creditors" and "financial institutions" to address the risk of identity theft. The resulting Red Flags Rule requires all such entities that have "covered accounts" to develop and implement written identity theft prevention programs to help identify, detect, and respond to patterns, practices, or specific activities - known as "red flags" - that could indicate identity theft. The Rule became effective on January 1, 2008, with full compliance for all covered entities originally required by November 1, 2008. The Commission has issued several Enforcement Policies delaying enforcement of the Rule. Most recently, the Commission announced in October 2009 that at the request of certain Members of Congress, it was delaying enforcement of the Rule until June 1, 2010, to allow Congress time to finalize legislation that would limit the scope of business covered by the Rule.

The Commission urges Congress to act quickly to pass legislation that will resolve any questions as to which entities are covered by the Rule and obviate the need for further enforcement delays. If Congress passes legislation limiting the scope of the Red Flags Rule with an effective date earlier than December 31, 2010, the Commission will begin enforcement as of that effective date.

For more information and materials, visit www.ftc.gov/redflagsrule. The FTC also published a compliance guide for business, and created a template that enables low risk entities to create an identity theft program with an easy-to-use online form (www.ftc.gov/bcp/edu/microsites/redflagsrule/get-started.shtm

*A template to help practices quickly develop their own program can be found at the Kern Augustine Conroy & Schoppmann, PC website: http://www.drlaw.com/Articles-and-Publications.aspx. When implementing programs to prevent identity theft, practices must also consider individual state regulations which may differ from, or be more burdensome than, the federal regulations. Kern Augustine Conroy & Schoppmann, P.C., provide general counsel to AAP NJ. www.drlaw.com*