Is New Jersey Baby-Friendly?
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Child Sexual Abuse Prevention
Addressing Personal Space and Privacy in the Pediatric Practice
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The Affordable Care Act Survived, But Will Physicians?
Michael J. Schoppmann, Esq.
In Loving Memory of

Patricia P. Van Abs

July 11, 1946 - August 18, 2012

Program Director,
New Jersey Immunization Network

On August 18th, New Jersey lost a very special person. Patricia Van Abs (Patty) spent the majority of her career helping people. During the decades of the 80’s and 90’s, Patty was Program Services Director and then Executive Director of the Central NJ March of Dimes (MOD), followed by almost a decade as State Director of the NJ Chapter of the MOD. In late 2009, Patty retired from the MOD and in early 2010 she came out of retirement and accepted the position as the first Director of the NJ Immunization Network (NJIN), a network co-led by AAP/NJ and NJAFP. Her extraordinary talents as a leader with sensitivity to people and circumstances were uncanny. Patty worked with colleagues to grow NJIN, a statewide coalition committed to advancing immunization rates in NJ. The organization is a network of over 200 organizations and individuals. Patty was an exceptional leader who left her mark in this world and whose work shall continue for many years benefiting some of New Jersey’s most vulnerable citizens.

Patty was not only a special person in the work place but also at home as a daughter, wife, mother, and grandmother. She was always there for her family through illness and good times. While we miss her dearly, we are thankful for the experience and inspiration of having Patty in our lives!
SEASONS CHANGE

Summer is on the move, soon to be replaced by Fall. The eternal demonstration that change is part of life.

Recently AAP NJ Chapter and PCORE team members experienced an unexpected and sudden change … a sad loss.

The inside cover, “In Loving Memory of Patricia P. Van Abs” reminds us how precious and fragile life can be.

Patty Van Abs, served as the Director for the NJ Immunization Network (NJIN, see page 20). Patty will be missed and remembered by all of us. Her contributions and inspiration will live on through her tireless work to educate providers, legislators, and the general public about the safety and importance of vaccines to prevent disease. In her short tenure at AAP NJ / PCORE, Patty accomplished building a strong infrastructure and foundation for NJIN. On behalf of our team, we extend our deepest sympathies to her husband Dan, and other family members.

In celebration of Patty’s life and contributions, we will continue to work to make NJIN’s vision a reality.

I’m thankful for having incredible leadership and a dynamic team at AAP NJ /PCORE. The leadership path in New Jersey’s Chapter involves a commitment designed to ensure smooth transitions as the “presidential” torch is passed. Once again we’ve experienced a seamless transition with dedicated energy to building on the strengths of our Chapter and PCORE.

Dr. Stephen Rice, Dr. Meg Fisher, our Officers, and the entire Executive Council generously share their time, energy, and expertise on behalf of children and their parents, pediatricians, and our many partners – thank you! Likewise, Dr. Steve Kairys, AAP NJ /PCORE Medical Director, has inspired some of the most meaningful support and technical assistance for community pediatricians, such as linking critical areas of health to primary care: mental health, oral health, child abuse and neglect prevention… all within the framework of strengthening and expanding medical homes.

The leadership and our team work together on advocacy and education, member benefits, quality improvement opportunities, and more.

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You may notice the NJ Pediatrician is sporting a new look. Stay tuned for more improvements and additions, including features such as CME activities by 2013. Please share with us the gift of your feedback. Let us know your thoughts, your questions, your concerns or any other input you believe will enable the NJ Pediatrician to provide you with greater service and assistance.

If interested in submitting a new idea or article, please contact Michael Weinstein, Newsletter Editor at 609-588-9988, ext 116 or at mweinstein@aapnj.org

SEASONS CHANGE

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MESSAGE FROM THE PRESIDENT

Margaret (Meg) Fisher, MD, FAAP
American Academy of Pediatrics, NJ Chapter President

Wow, how wonderful it is to assume the Presidency of the New Jersey Chapter! Dr. Rice and Fran Gallagher have provided fantastic leadership, moving our Chapter along in so many ways by continuing to build on our strengths and expanding our circles of influence. We are the go-to people in areas affecting child health... a tremendous responsibility and privilege. We hope to continue our successes as the world changes around us.

In August, the Executive Committee met to discuss a book entitled “The Race for Relevance”; we used the opportunity to explore ways for ensuring our Chapter remains relevant to our current members and to plan for the future. Furthermore, we discussed ways to attract and engage more members so we better represent all pediatricians and pediatric specialists in New Jersey.

We need a multi-pronged approach to accomplish our goals. Our strengths have been in the area of continuing medical education; many options are available to pediatricians. Our goal will be to ensure we offer a variety of venues and topics to help pediatricians and all those who care for and about children. The Pediatric Council on Research and Education (PCORE), under the direction of Steven Kairys, MD, has allowed us to thrive in a multitude of areas including performance improvement, medical home, oral health, child abuse, obesity prevention and care. Through the efforts of PCORE and its dedicated team, we are able to offer maintenance of certification credits to our members. We will strive to continue and expand these programs.

Our partnerships with the state are growing and strengthening. The New Jersey Immunization Network, a collaboration of AAP/NJ, NJAFP, the state, pharmaceutical companies and child advocacy groups is robust. And, we have established regular meetings with the Commissioner of Health and the Assistant Commissioners. We look forward to continuing and expanding all of these relationships.

Our current Government Affairs Committee which is capably run by Jeanne Craft, MD has taken on a meaningful child advocacy role. We are now a proactive organization. Along with the Agenda for Children as a guide, the committee has risen to a new level.

We are now working more effectively with our partners in Trenton to improve children’s health and to support pediatricians in their roles.

Recently our practice management committee met with our leadership in order to strengthen and re-energize efforts in this area. The tremendous energy displayed during this planning meeting gives me great hope that we will continue to move forward. Health care is changing and we will make every effort to ensure that children and pediatricians benefit from these changes.

Bert Mulder, our Director of Membership and Events, has ensured that we have valuable member benefits. Take a look at our web site to appreciate the depth and breadth; go to http://www.aapnj.org, put your cursor on membership and click on member benefits. While you are there, take a look at the rest of the web site to see what your Chapter is doing!

Finally, August was National Immunization Awareness Month. As a pediatric infectious disease specialist I cannot help but remind you of the value of on time vaccination. There are many resources available for you; check out these government web sites: http://healthfinder.gov/nho/PDFs/AugustNHOToolkit.pdf and http://www.cdc.gov/vaccines/events/niam/. Our national Academy is very active in immunization efforts both domestically and internationally. We are participating in the UN Foundation project called a Shot@Life; everyone can be a part of this effort. Go to http://shotatlife.org/ for details. The AAP has received a grant from the Bill and Melinda Gates Foundation to establish a Global Vaccine Advocacy Project; I am the Chair of the project advisory group. Many of the chapters of the Academy have projects related to immunization. In New Jersey we have our NJ Immunization Network; we are also launching a project related to vaccine hesitancy and dealing with vaccine hesitant parents.

These are just a few of the many things going on in our Chapter. My plea to you is to get involved. We need your thoughts, skills, energy and your commitment to help us grow. Please invite a colleague to join AAP/NJ today!

Sincerely,

Margaret C. Fisher, MD
The Essex County Pilot PCP/Child Psychiatry Collaborative Program is a joint venture between AAP/NJ, NJ Pediatric Psychiatry and the Statewide Parent Advocacy Network (SPAN). The project is an important first step in trying to develop for NJ more services for children with mental health issues, more support for pediatricians and family physicians who become involved with children with mental health issues and more capacity for primary care providers to screen for mental health issues.

Up to ½ of all lifetime cases of mental health illness begin by age 14; the median age of onset of anxiety disorder is 6 years, behavioral disorder is 11 years, mood disorder is 13 years and substance abuse is 15 years. Sadly, 70% of children and adolescents who are in need of treatment do not receive the care they need. Almost all of these children have a primary care home that could provide better early identification, care management and care coordination.

One of the solutions in over 20 states currently is a model of child psychiatrists actively mentoring and supporting the pediatrician and family physician to provide some level of care for many of these children.

The model started in Massachusetts 10 years ago is the model that the Essex County Project is exploring.

Utilizing grant support from the Health Care Foundation of New Jersey and the Partners Health Foundation, a child psychiatrist is available every day of the work week to take any call from a primary care physician in Essex County. The call is triaged by a licensed Social Worker and the call is forwarded to the psychiatrist if a consult is needed but the situation is not a crisis situation. The consultation is between the child psychiatrist and the primary care provider; the child or family do not talk with the child psychiatrist. The child psychiatrist listens and coaches the primary care doctor, offering suggestions, next steps, potential medication and/or optimal referral sources. The LSW is also available to the primary care provider and family to provide additional ideas for resources and community support.

The program is still in the start up phase, having kicked off July 3, 2012. We are still accepting applications from any pediatrician in the greater Essex area to join the program and help us begin to start a process that we hope will have state wide acceptance and support.

Sincerely,

E. Kairys, MD

If you haven’t been to one of our events, join us. We feature nationally and internationally known speakers, opportunities for interactive learning, and time for conversations between friends and colleagues.

Take a look at our upcoming community health conference on October 17 (pgs. 22&23). Dr. Michael Rich is an international speaker who was a filmmaker prior to being a pediatrician. His presentation highlighting the science behind the positive and negative effects of media on children is one that you will not want to miss. Hope to see you there.

Think of our team as your team... we are here for you. Please visit the AAP/NJ website to learn more about our staff and consultants and their credentials that include expertise in Social Work, Education, Health Business Administration, Public Health, Communications, Events, Program Evaluation, Nursing, and more. We are strategically working to better align the work of our Practice Management and Government Affairs committees per our AAP NJ Chapter Agenda for Children. Our work in pediatric health care to promote prevention, wellness, and chronic care management requires support such as adequate payment to sustain services and support care coordination. Let us know what you find most valuable and what you would like to see as added value to your membership. Look forward to hearing from you!

Warm Regards,

E. Kairys, MD

The AAP/NJ Team is comprised of 16 highly educated and dedicated individuals who stand ready to respond to Chapter/membership needs and also conduct a wide array of Quality Improvement programs through NJ PCORE.

Visit www.aapnj.org to learn more about the Team, their responsibilities, and the services and programs they provide to members.
CHILD ABUSE AND NEGLIGENCE

Twelve (12) dedicated pediatric health teams from Southern and Central NJ came together in August for the AAP NJ Chapter’s Strengthening Pediatric Partners MOC Part IV quality improvement midway Learning Sessions – 6 teams per session. Practice teams focused on their individual and aggregate progress made as part of the 12 team cohort. Teams shared their accomplishments, challenges and experience using effective resources. Strategies for providing families with enhanced guidance and support in preventing abuse that often is triggered by crying, maternal depression, toileting and discipline were discussed and tools developed by practices shared. Presentations for sustaining project gains beyond the 6-month grant were highlighted by Steven Kairys, MD and Fran Gallagher, MEd.

Opportunities …

We continue to recruit hospitals, primary care practices, early intervention practitioners and EMS providers for the multiple CAN trainings. For additional information on CAN training programs, please visit: bit.ly/Tm1EKE or scan the QR code below.

ASTHMA

New resource on the horizon...

AAP/NJ in partnership with the Pediatric Adult Asthma Coalition of New Jersey (PACNJ), is in the final stages of creating a training video for primary care providers on diagnosing and managing Asthma in accordance to the most recent NIH guidelines.

Titled, Asthma Today: Implementing EPR-3 Guidelines for Managing Asthma in the Primary Care Practice, this one-hour video, which will soon be available at www.PACNJ.org, can assist pediatricians and other primary care providers in: applying the clinical guidelines to assess a patient’s asthma severity; offer detailed methods for monitoring control; and demonstrate best practices for educating patients in asthma self-management.

Asthma Today presents three office-visit scenarios designed to demonstrate practical application of the EPR-3 Guidelines and sensible methods for educating patient.

Two AAP/NJ members, Kimi Alli, MD and Puthenmadam Radhakrishnar, MD are featured in the office visit scenarios.

Watch your ENews each Thursdays, we will notify you as soon as the video is available.
Bringing Baby-Friendly to New Jersey

By Lori Feldman-Winter, MD, MPH
Physician Champion, AAP/NJ BFHI

Change is necessary; change is good. You go first.

This has been the motto of many hospitals attempting to improve maternity care practices related to breastfeeding care. What is known is most mothers want to breastfeed; however, the environment in New Jersey hospitals was not conducive to breastfeeding initiation and ultimately continuation. Immediate separation of mothers and infants after birth, indiscriminate supplementation of infant formula, misinformation or no information to assist and support breastfeeding attempts, competing forces with marketing of infant formula and finally no connection with the community to support continued breastfeeding contribute to the environment that was previously not supportive. These aspects of care serve as the basis for the AAP endorsed Ten Steps to Successful Breastfeeding, a document authored by the World Health Organization in the early 1990’s and is the core of the Baby-Friendly Hospital Initiative (BFHI). Evidence shows that designation as a Baby-Friendly hospital improves overall and exclusive breastfeeding for well and sick NICU newborns alike. The designation also contributes to higher patient satisfaction and a safer environment.

In 2010 New Jersey had no Baby-Friendly hospitals, the rates of exclusive and overall breastfeeding were lagging behind other states and we had one of the highest rates of supplementation of breastfed newborns. Maternity care practices have been monitored by the CDC mPINC survey since 2009, and New Jersey had a mean score below the nation, with a score of 60 out of 100. With funding from the CDC to the NJ Department of Health and in collaboration with AAP/NJ we launched an 18-month project to shepherd ten hospitals through the process of becoming Baby-Friendly designated. All ten hospitals have given up the practice of supplying mothers with infant formula company marketing materials including discharge packs, all have adopted new infant feeding policies consistent with the BFHI, all have moved through at least 2 phases of the 4-D pathway of Baby-Friendly, and hundreds of staff nurses and physicians have been trained.

Proudly, we now have 2 NJ Baby-Friendly hospitals, 2 more have been assessed and are close to designation, and several more of the original mini-granted hospitals have a plan for assessment within 2013. Change is hard, but change is also notable. The CDC just published their report card on breastfeeding in the US http://www.cdc.gov/breastfeeding/pdf/2012BreastfeedingReportCard.pdf NJ now stands out for a positive reason; we are one of the few states that have increased their mPINC score by more than 6 points and we are now at 71! But the work is not nearly done. This process requires pediatrician involvement. Pediatricians need to acquire three hours of education, and also need to demonstrate competencies in care. The United States Breastfeeding Committee has developed a set of Core Competencies in breastfeeding, endorsed by the AAP. http://www.usbreastfeeding.org/Portals/0/Publications/Core-Competencies-2010-rev.pdf. AAP/NJ has developed resources including a toolkit and curriculum to help educate pediatricians to improve care. Now is the time.

...the work is not nearly done.

Change is necessary. Take the opportunity to not only use materials to get educated individually but serve as a champion for your own hospital, work with nursing staff to engage in interdisciplinary teaching models, such as skills fairs. Adopt a family centered care approach and examine newborns in their mothers’ rooms. Ensure appropriate follow up with a scheduled visit within 48 hours of hospital discharge, or at 3-5 days of life, and refer to community support programs that are equipped to provide continued skillful support and management of breastfeeding. The landscape of maternity care has changed for the better and pediatricians are necessary to make it work.

Lori Feldman-Winter, MD, MPH

www.aapnj.org
I write this for my pediatric colleagues.

We have seen the practice of pediatrics shift from a primary focus on the delivery of acute care to one which now focuses increasingly on the provision of anticipatory guidance and preventive care to assure optimal growth and development.

There is not one amongst us who doesn’t routinely address the importance of back-to-sleep, seat belt safety, bicycle safety, water safety and environmental hazards, believing that the time taken to deliver each of these messages helps to reduce risk to children and has proven value. So I ask why it has been so challenging for us to incorporate in our prevention repertoire a message that addresses personal space and privacy, an issue that presents considerable risk to children and has proven value. So I ask why it has been so challenging for us to incorporate in our prevention repertoire a message that addresses personal space and privacy, an issue that presents considerable risk to children and has proven value. So I ask why it has been so challenging for us to incorporate in our prevention repertoire a message that addresses personal space and privacy, an issue that presents considerable risk to children and has proven value. 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So I ask why it has been so challenging for us to incorporate in our prevention repertoire a message that addresses personal space and privacy, an issue that presents considerable risk to children and has proven value.

We know that we can’t just tell kids to wear their seat belts one time and expect that we have successfully addressed car safety.

Since CSA affects approximately 1 in 4 girls and 1 in 7 boys it’s well overdue that we add this issue to our prevention repertoire. Even if we can’t “immunize” every child against the possibility of CSA we can likely help protect some from being abused.

Before we think about prevention, let’s reflect on some basic facts; most children who experience CSA do so at the hands of someone they know and trust. That person is most likely to be a family member or someone who knows and has easy access to the child.

Although it is appropriate to talk about “stranger danger” the reality is that only a relatively few children are molested by strangers or registered sex offenders.

Most perpetrators do not intend to physically harm the child while engaging them in sexually inappropriate activities and thus few children ever present with physical examination findings that confirm sexual contact. Very few children actually experience sexual contact that involves the use of force and restraint that we call rape. About 1/3 of perpetrators are juveniles and 40% of child victims are under 6 years old.

See Personal Space on page 9
her disclosure and protection was further delayed. A 3 year old can say the word vagina or penis as easily as they can say “diamonds” or “ding-a-ling”.

Discourage co-bathing with siblings and adults.

Introduce the concept of “OK and NOT OK” touching and the need to tell if anyone touches their “private” parts in a context other than providing care. A good time to have this discussion is right after completion of the non-genital components of the annual physical while the child is sitting in their underwear or a gown. Discussing OK and NOT OK touching provides an easy transition to the genital examination. In the context of the genital examination the child can learn the distinction between a doctor’s examination and inappropriate touching.

If you have heard about “good touch – bad touch” that is a phrase that was thought to be a way to communicate a prevention message. We have since learned that phrase is problematic because children do not anticipate being touched in a way that is “bad” by someone they know, love and trust. Touching in private parts can feel “good” and be confusing to children. If what the child experienced is perceived by them as being “bad” there is the possibility that may think that they are “bad”. We do not want children to have to make a judgment on the quality of the touch thus the simplified message about what’s OK and what’s NOT OK now is a standard approach to introducing this concept.

Parents should emphasize to their children that it is never OK to have a “secret” and if anyone tells them to keep a secret or they think they need to keep a secret they need to tell two adults. Explain how “surprises” can be fine because we find out but secrets are never okay. All of these messages should be delivered at every annual visit.

Parents should explain (to children) that if anyone ever touches them or makes them touch someone else’s private parts they need to tell two adults right away.

If a child walks into a bedroom or bathroom and the parent needs privacy they should tell the child they need privacy. Wherever the message of privacy can be reinforced it should. Children should be taught to respect siblings need for privacy.

The pediatrician should deliver the above guidance annually at every health maintenance assessment and modify based on developmental age.

If these messages are routinely delivered to young children as they grow older they will not only expect this discussion but will accept it as well.

The parent has an ideal opportunity to reinforce the concept of a right to personal space and privacy starting with preschoolers when supervising their bathing. The parent explains that the parts of their body that are covered by a bathing suit or their underwear are called private parts and the reason they are called that is because they belong to them and they are the only one that can see them or touch them. Reinforce that the only people who are allowed to touch their private parts are:

- The child themselves when washing or wiping themselves;
- Parents or caregivers, if they need help with washing or having a wiping problem;
- Doctors checking to be sure their body is okay during a physical or when there is a problem with their private parts—with Mom/Dad in the room.

Parents should explain that if anyone ever touches them or makes them touch someone else’s private parts they should tell two adults right away. The reason for emphasizing two adults is that you want the child to tell someone who is a family member as well as someone who is not such as a teacher. When young children experience something inappropriate and then think about telling, they might be reluctant or afraid to tell a parent because they have processed the message from Mom/Dad as; Don’t let anyone touch your private parts, I let someone touch my private parts, Mommy/Daddy is going to be mad at me. As a result the child might turn to a teacher or another adult because they think they won’t get into trouble. The important message is not who they tell but that they tell. Parents should emphasize to the child that they will not get into trouble or be punished for telling, in fact they will be brave.

While supervising the bathing the following questions or statements can be made to reinforce the concept. Periodically say: “Don’t forget to wash your vagina/penis and butt and when you’re done let me know and I will help you with your hair, or Don’t forget to wipe your private parts, Who is allowed to touch your private parts? and What do you do if someone touches your private parts?” Over time when these simple messages/questions are asked, the child will respond by saying, “Mommy/Daddy, I know that”.

Just because kids know what is OK and what is not doesn’t
The Crisis of Drug Shortages
By Rachel Meyers, PharmD, BCPS

In June of 2011, the American Hospital Association (AHA) surveyed hospitals and found that 99.5% had experienced a shortage in drugs over the previous six months, with 82% reporting a delay in treatment and more than 50% reporting that they were not able to provide the recommended treatment for a patient due to a shortage. The problem of shortages in the United States has grown dramatically over the past decade, but recent legislation may help alleviate the problem.

Shortages have mainly been concentrated in the area of sterile injectables; 80% of drugs on shortage between January 1, 2010 and August 26, 2011 were injectable medications according to the FDA. Sterile injectables present an array of different challenges for drug manufacturers, all of which contribute to problems in supply. First, most sterile injectables are produced by a limited number of manufacturers, with the top three generic manufacturers producing 71% of the market by volume. Indeed many of these products have one manufacturer who produces at least 90% of the supply volume. If a manufacturer encounters a problem in production such as malfunctioning machinery or if they decide to switch the production line to another product entirely, a shortage can rapidly ensue. The slim profit margins of generic drugs also contribute, with manufacturers often choosing to use a production line for a more profitable drug. In addition, many manufacturers do not produce excess inventory, but rather practice “just in time” inventory. Add to all of this the explosion of new drugs without an equivalent increase in manufacturing capacity, and it is the perfect storm for a crisis in supply.

There are several recent shortages which have had a substantial impact on the care of children.

The shortage of parenteral vitamin K forced many hospitals to switch to oral vitamin K for the prevention of Hemorrhagic Disease of the Newborn. This switch complicated care as the oral formulation requires multiple doses, necessitating that parents fill a prescription for oral vitamin K solution – which needs to be compounded – and administer subsequent doses at home. In addition, the shortage of the infant concentration of sodium bicarbonate may require the use of the more concentrated adult formulation.

Historically, the U.S. Food and Drug Administration (FDA) was limited in what they could do to avert a shortage. Notification of a potential shortages is only required for sole-source manufacturers of certain drugs and the FDA frequently would be alerted of a problem by wholesalers or health care providers once the crisis was well under-way. The FDA then would work with other manufacturers of the product to try and increase supply, though this could take months to take effect on the market. The FDA can also provide an expedited review of an Abbreviated New Drug Application (ANDA) in order to increase the number of manufacturers of a product. Controlled importation of products from overseas is an option that can be taken if necessary, but is only done with extensive FDA oversight. Currently the FDA has allowed importation from India of Lipodox, a liposomal doxorubicin to help meet current patient care needs.

In October of 2011, President Obama signed an executive order which directed the FDA to broaden reporting of shortages, and expedite reviews of new suppliers, manufacturers, and manufacturing changes. The FDA was also instructed to report any stockpiling or price inflation practices promptly to the Department of Justice.

In the six months following the executive order, the FDA saw a six-fold increase in early notifications from manufacturers, and was able to prevent 128 shortages.

More recently, on July 9, 2012, President Obama signed “The Food and Drug Administration Safety and Innovation Act,” which amends the Food, Drug, and Cosmetic Act to authorize “user fees” for brand name drugs and introduces these fees for generic and biosimilar medications. This increase in fees is meant to fund the expedited review of generic medications in order to accelerate their availability on the market.

Of note for pediatricians, “The Food and Drug Administration Safety and Innovation Act” included legislation which will have a substantial effect on the availability of pediatric drug information.

The Act makes permanent the incentives introduced by the Best Pharmaceuticals for Children Act (BPCA) and the Pediatric Research Equity Act (PREA).
Governmental Affairs
Joseph Simonetta, Tracie DeSarno
Public Strategies Impact

Labor Day has come and gone and the summer recess of the legislature is rapidly coming to an end. With that the fall/winter session will have many initiatives that will affect healthcare and healthcare providers. Among those are:

Hospital Disclosure

The Legislature passed Senate bill 782 in June. S782 provides that, as a condition of receiving charity care payment distributions, a hospital would be required to file by November 30 of each year with the Department of Health and Senior Services (DHSS): (1) Internal Revenue Service Form 990 for the prior year and all schedules and supporting documentation required to be submitted to the Internal Revenue Service in conjunction with Form 990; or (2) if the hospital does not file a Form 990 with the Internal Revenue Service, all governance, financial, and operating information that would otherwise be reported on Form 990 for the prior year, including the information that would be included in the schedules and supporting documentation, to the extent that such information exists with respect to a for-profit hospital. DHSS is to post this information on its Internet website. This legislation was opposed by the hospital industry and it was conditionally vetoed by Governor Christie in August. The conditional veto essentially guts the bill by deleting the entire text of the bill and replacing it with language that requires the Commissioner of Health to review existing hospital financial reporting requirements and make recommendations as to how the State can more effectively make the data publicly available. The Commissioner is to report her findings to the Governor directly no later than six months after the effective date of the bill. Senator Weinberg, the bill’s sponsor, has indicated that she plans to seek an override of the conditional veto in the fall.

Out-of-Network Reimbursement and Waiver of Co-Payments

The Assembly Financial Institutions Committee released A2751 on June 18, 2012. This legislation, entitled “Healthcare Disclosure and Transparency Act” places various requirements on healthcare providers regarding the providing of services to patients who are out of network in terms of health insurance. The legislation requires a physician, when scheduling an appointment with a covered person, to disclose whether the health care services are in-network or out-of-network with respect to that person’s health benefits plan and that there may be a financial responsibility of the covered person, including applicable deductibles, copayments and coinsurance. The bill also requires the physician, if providing out-of-network services, to provide to the covered person, in a clear and understandable manner and in the terms the covered person typically understands, a description of the procedure; an estimate of the costs charged by the physician for those services; and a notice to contact their insurance carrier for further consultation on the costs of the procedure. The bill requires a health care facility, at least three days prior to an elective procedure, to provide a written disclosure form to the covered person on which the health care facility shall make certain disclosures regarding whether the physicians providing the services at the facility are in-network or out-of-network with respect to that person’s health benefits plan and concerning the financial responsibility of the covered person with regard to services received at the facility. The health care facility must, prior to the performance of the procedure, ensure that the covered person signs and returns the disclosure form to the health care facility. Finally, the legislation requires providers of health benefits plans to disclose in writing to a covered person, at the time of enrollment in the plan and upon request thereafter, the reimbursement methodology that the carrier or entity uses to determine amounts of reimbursement for out-of-network services and to establish and maintain a website to serve as an information clearinghouse for covered persons to obtain information to assist them in their health care needs. This legislation is onerous in the requirements it places on providers and the provider community is generally opposed to several of its provisions.

Health Benefits Exchange

The Legislature passed legislation creating a state health insurance exchange in March of this year. Creation of the exchange is required under federal Patient Protection and Affordable Care Act. Under the legislation the exchange would be established “in but not of” the Department of Banking and Insurance, and would be governed by an independent eight-member board that is free of business ties to interested stakeholders. The governing board would include as non-voting ex-officio members the commissioners of the Department of Banking and Insurance and Human Services,
This year’s AAP election will be conducted online only, from August 31-October 1.

Watch your e-mail in early September for a message from the AAP Election Coordinator, containing a personalized link that will take voting members directly into the ballot; no other login information will be required. You will be able to access the ballot beginning August 31. In addition, there will be a link to the ballot on AAP website. All that will be required for you to access the ballot is to log on to MyAAP and click on the link.

Visit the AAP election website for information on the President-Elect candidates Michael D. Klein, MD, FAAP, and James M. Perrin, MD, FAAP.

ALL MEMBERS ARE URGED TO VOTE.

DISTRICT III

David I. Bromberg, M.D., FAAP, District Chairperson Candidate

Biography

Dr. Bromberg has been practicing pediatrics in Frederick, MD, for the past 33 years, where he is part of a large general pediatric group. He has a specialty interest in behavioral pediatrics. Additionally for 10 years, he directed the Community Practice Program at the University of Maryland, sending residents to community pediatric sites for their ambulatory experience. This mixture of practice and academics gives him a perspective across several pediatric venues. Dr. Bromberg has been a member of the Academy since 1978 and active in the Maryland Chapter since 1981. He has chaired several committees, including the Continuing Education Committee and the Committee on Emotional Health, and served as chapter vice president and president. He was awarded the Maryland Chapter Leadership Award and the Pediatrician of the Year Award. He also has been recognized for advocacy and teaching with the Academic Pediatric Association Community Teaching Award and the first Frederick IECC Champion of Children.

On the national level, he has been active in District III for the past 13 years, serving on the National Nominating Committee and as District Vice Chair and chair of the District Vice Chair Committee. He currently is the chair of the Richmond Center Professional Advisory Committee and serves on the Mental Health Leadership Work Group.

Dr. Bromberg received his M.D. from Tulane University and completed residency and chief residency at the University of Maryland, followed by a fellowship in behavioral pediatrics. He and his wife, Gayle, have three grown children.

Position Statement

It has been a great honor working for District III as the District Vice Chairperson. In that role, I have seen the mighty strength of the District III chapters in addressing the health care needs of the children of the Mid-Atlantic region.

Significant health issues remain, including accessing pediatric primary and specialty care, helping to meet patients' and families' mental health needs, and incorporating the digital world into pediatric practice. I would like to have the opportunity to strengthen the district's role in coordinating and furthering the chapters' children's agenda in these and other areas.

The national AAP also continues to be confronted with new problems. The District Chair has the very important role of being on the AAP Board of Directors. Just as one health care battle appears to be won, another threatening challenge takes its place. The Academy must stay in the forefront, understanding the implications of legislation and health system change on the health of children and the welfare of pediatricians. As a member of the Board of Directors, I would work diligently to see that this mission is accomplished.

The District Chair serves the important role of acting as a liaison between the chapters and the national AAP. There are many shared issues for both of these groups, including advocacy, membership enhancement and communication with families and with pediatricians. I would work as District Chair to strengthen this relationship. I look forward to your support to help build a stronger District III and AAP.
Did You Say Auditory Processing Disorders?
By Jay Lucker, Ed.D., CCC-A/SLP, FAAA
Trenna Stout, Director of Pathways at Speech Path Services LLC

Auditory Processing Disorders, or APD, affect how your brain processes information received through your auditory system. APD affects the way you interact with your world. For many, differentiating between Autism, ADHD, executive function disorders and APD is problematic.

What is needed is a clear definition of APD. Lucker (2008, 2010, 2011) describes APD as a breakdown in dealing successfully with auditory information. APD does not affect how a person hears, but how effectively a person understands what is heard. Proper identification of APD can identify appropriate treatments leading to overcoming problems faced having APD.

Difficulties one may see in a person with APD can include:
- Listening (noticed for a period of time)
- Mishearing/discrimination problems
- Problems following directions
- Problems attending to oral messages
- Distracted by background noises
- Poor organization of verbal material
- Oral and written expression problems
- Remembering what they hear
- Learning to read

(As described by the National Coalition on Auditory Processing Disorders, NCAPD, www.ncapd.org)

However, these are also behaviors seen in children with other problems. This is why appropriate diagnosis is needed.

Early recognition of APD is crucial for someone’s future success. Social, emotional, and behavioral issues can develop if APD is not detected until late in a child’s life (Edell, Lucker, & Alderman, 2008).

ASHA (The American Speech and Hearing Association, 2005) and Lucker (2009, 2010, 2011) recommend a multidisciplinary team approach to assess APD. After proper assessment by an audiologist, individualized treatment plans can be developed and implemented by a speech-language pathologist and other professionals. People with APD can learn skills to properly deal with and overcome their APD (Edell, Lucker, & Alderman, 2008).

If you think your patient has APD, obtain a comprehensive assessment of auditory processing. Early intervention is the goal. The earlier the identification, the earlier treatments can be provided so that you or your child do not have to live confused, struggling and thinking, “I don’t get it?”

Reference
Pediatric Residents - More Actively Engaged in the Community

By: Shilpa Pai, MD, FAAP

Pediatric residents at Robert Wood Johnson Medical School are now becoming more actively engaged in the New Brunswick community as part of a new community and advocacy-based curriculum.

The American Academy of Pediatrics has been a staunch supporter of the pediatrician becoming an advocate in the community as evidenced by the AAP Policy Statement in 1999 - “the major threats to the health of America’s children - the new morbidity - arise from problems that cannot be adequately addressed by the practice model alone...it is especially important now for pediatricians to reexamine and reaffirm their role as professionals in the community and prepare themselves for it, just as diligently as they prepare for traditional roles.” More recently, the 2007 ACGME competencies states that “all residents must be provided structured educational experiences, with planned didactic and experiential opportunities for learning and methods of evaluation which prepare them for the role of advocate for the health of children within the community.” I had these core concepts in mind as I developed the REACH curriculum, which stands for Resident Education in Advocacy and Community Health, recently launched in July 2012.

Residents have enjoyed the opportunity to learn about the community-based services that they, as health care providers, can better utilize to provide more comprehensive care to their families. Meanwhile, the CBO’s have appreciated the resident-physicians’ role in teaching their clients.

Another component of the REACH curriculum will be the walking tour of New Brunswick, where residents and faculty, will be led on a tour of New Brunswick by Mariam Merced (RWJ Community Health Foundation) and Susan Giordano (Homeless and Indigent Population Health Outreach Project – RWJ Medical School). These two community leaders will teach the residents about the New Brunswick populations while taking them on a tour of the local bodegas and health service agencies frequented by their patients, in order to educate about the impact of poverty and culture on the health of our patients and their families.

This REACH partnership will be an exciting opportunity, not only for resident education, but for improved comprehensive care of our patients and their families within the context of their community.
THE AFFORDABLE CARE ACT SURVIVED, BUT WILL PHYSICIANS?

By: Michael J. Schoppmann, Esq.

The U.S. Supreme Court, in reviewing appeals as to the constitutionality of the Affordable Care Act (ACA), with a 5 to 4 Decision and Chief Justice Roberts breaking with dissenters, has left the ACA intact, for now. The foundational requirement that most citizens buy health insurance or pay a fine was held to be a tax permitted by the Constitution, and not decided under the Commerce Clause. As all provisions hinging upon the mandate remain intact, the focus should now shift to—what will the ACA mean to physicians?

Some key surviving insurance provisions:

- Insurers cannot deny coverage based on pre-existing condition,
- Annual or lifetime coverage limits are barred,
- Dependent coverage is now mandated to age 26,
- Preventive services must be provided without cost-sharing.

In addition, the ACA provides that insurers must also now meet medical loss ratio limits, maintain quality reporting requirements, coordinate with health insurance exchanges, meet employee enrollment/coverage requirements, include prescription drug benefit expansion, provide funds for recruitment/training/retaining of healthcare workforce, and empower Accountable Care Organizations and the Medicare Shared Savings Plan.

However, the ACA’s Medicaid expansion provision was limited by the Supreme Court. Originally, the ACA would have forced states to expand Medicaid or face the loss of all of their Medicaid federal dollars. The ACA is now limited to acting on the potential loss of funds only for the newly eligible poor.

So, what does the ruling mean for physicians? While expanded insurance coverage should equate to additional patients, the “reimbursement” system remains profoundly broken. The ACA did not fix the reimbursement formula and the “hidden” provisions affecting physicians will continue, unless and until Congress acts to repeal.

Some of the ACA’s provisions that the public and the average practicing physician doesn’t hear about:

- Failure to comply could result in severe sanctions,
- Increased funding for health care fraud and abuse enforcement,
- Expansion of civil monetary penalties,
- Claims for services from an Anti-Kickback Statute violation now equate to false claims,
- Lower triggers for application of federal False Claims Act,
- Modified “knowing and willful” requirement under Anti-Kickback Statute,
- No need to prove actual knowledge of Anti-Kickback Statute, nor specific intent,
- CMS can suspend provider pending investigation of “credible allegation of fraud”,
- Increased scrutiny of Medicare enrollment applications
- CMS can exclude for knowing false statement or omission on the application,
- Overpayments must be refunded within 60 days or face False Claims Act liability.

The hard reality of the ACA ruling is that the regulatory burden on physicians will continue to accelerate, building an exponential growth curve of unprecedented scrutiny. To survive, physicians must actively and aggressively embrace a new concept—Prospective Compliance. It is no longer advisable, acceptable or survivable to focus exclusively on patient care. Physicians and medical practices must become multi-dimensional—caring for patients while also remaining compliant with law, regulation and contract.

Post ACA, Prospective Compliance means that physicians and practices must permit (if not dedicate) staff time and focus on issues beginning with proper credentialing, progressing through periodic snapshot audits and risk self-assessments, building toward a compliant medical practice. However, what the ACA foretells is that every physician, every practice must become Prospectively Compliant now, not after an investigation or action commences. Under the ACA, the risks and requirements lie not only with issues of fraud or abuse. The ability of any physician and/or practice to be compensated, compensated on a timely basis and rewarded under a “pay for performance” system will be dictated by the level of compliance held by the physician and the medical practice.

See Affordable Care Act on page 19
The Division of Children and Families funds a statewide network of Family Success Centers that provide wrap-around resources and supports for families before they find themselves in crisis. These Centers can be a valuable resource for assisting pediatricians in identifying child abuse prevention services that can help families overcome problems that threaten their safety and stability.

Core services include: Access to information on child, maternal and family health services, Linkage to publicly-funded health insurance programs and referrals to local health care services, Economic self-sufficiency/employment related services/income security services, Information & Referral Services (connection to off-site public and private resources), Life Skills training (budgeting, nutrition, etc.), Housing related services, and Parent education.

**Atlantic County**
New York Ave School Family Success Center
411 North New York Avenue
Atlantic City, NJ 08401
Phone: 609-441-0102

Dr. Martin Luther King School Family Success Center
1700 Marmora Avenue
Atlantic City, NJ 08401
Phone: 609-345-1994

Hammonton Family Success Center
310 Bellevue Avenue
Hammonton, NJ 08037
Phone: 609-567-2900 ext. 106

Pleasantville Family Success Center
9 South Main Street
Pleasantville, NJ 08232
Phone: 609-272-8800

Egg Harbor Township Family Success Center
3050 Spruce Avenue
Egg Harbor Township, NJ 08234
Phone: 609-569-0376

**Bergen County**
Englewood/Teaneck Family Success Ctr.
44 Armory St.
Englewood, NJ 07631
Phone: 201-568-0817 ext. 32

**Burlington County**
Burlington County Family Success Ctr.
45 High Street
Mount Holly, NJ 08060
Phone: 609-267-4001

**Camden County**
Camden Family Success Center
2850 Federal Street
Camden City, NJ 08105
Phone: 856-963-0270

PARTNERS Family Success Center
180 White Horse Pike
Clementon, NJ 08021

**Cape May County**
Cape May Family Success Center
1046B Route 47
Rio Grande, NJ 08242
Phone: 609-465-4066

**Cumberland County**
Gateway Family Success Center
155 Spruce Street
Bridgeton, NJ 08302
Phone: 856-451-1133

Holly City Help Family Success Center
511 Columbia Avenue
Millville, NJ 08332
Phone: 856-327-1510

IMPACT Family Success Center
1038 E. Chestnut Avenue
Suite 130
Vineland, NJ 08360
Phone: 856-507-7840

**Essex County**
Babyland Family Success Center
755 South Orange Avenue
Newark, NJ 07106
Phone: 973-399-3400

Central and West Ward Family Success Center
982 Broad Street
Newark, NJ 07102
Phone: 973-639-2100

East Orange Family Success Center
60 Evergreen Place, Suite 307
East Orange, NJ 07018
Phone: 973-395-1442

FOCUS Family Success Center
441-443 Broad Street
Newark, NJ 07105
Phone: 973-624-2528 ext. 114

Ironbound Community Corporation
Family Success Center - Cortland Street
29-31 Cortland Street
Newark, NJ 07105

**Gloucester County**
Gloucester Family Success Center
S. Broad Street #202B
Woodbury, NJ 08096
Phone: 856-848-7150

**Hudson County**
West Hudson Family Success Center
655 Kearney Avenue
Kearney, NJ 07032
Phone: 201-998-0803

Horizon Health Center Family Success Center
725 Bergen Avenue
Jersey City, NJ 07306
Phone: 201-451-4767
Specifically, the six-month patent extension afforded manufacturers who conduct research on children is now permanent. In addition, the recent legislation requires the Office of Pediatric Therapeutics to hire a neonatologist who will also serve on the Pediatric Review Committee.

While recent changes will take time to show their effect, it appears that increased transparency and expedited FDA review of new manufacturers will help alleviate this significant challenge to patient care.

For a current shortage list, please visit the following websites:

FDA Drug Shortages:

ASHP Drug Shortages:

References


FAMILY SUCCESS CENTERS

Hunterdon County
Hunterdon County Family Success Ctr.
3 East Main Street
Flemington, NJ 08822
Phone: 908-237-0465

Mercer County
North Ward Parent/Child Family Success Center
1554 Princeton Avenue
Trenton, NJ 08638
Phone: 609-393-2980

South Ward Parent/Child Family Success Center
635 S. Clinton Avenue
Trenton, NJ 08611
Phone: 609-695-6275

Middlesex County
New Brunswick Family Success Center at the Puerto Rican Action Board
90 Jersey Avenue
New Brunswick, NJ 08903
Phone: 732-828-4510

Monmouth County
Long Branch Concordance Family Success Center
279 Broadway, Suite 301
Long Branch, NJ 07740
Phone: 732-571-1670

Morris County
Morris County Family Success Center
73 Basset Highway
Dover, NJ 07801
Phone: 201-843-7400

Ocean County
LCSC Family Success Center
415 Carey Street
Lakewood, NJ 08701
Phone: 732-901-6001

Passaic County
Paterson Family Success Center
79 Ellison Street
Paterson, NJ 07505
Phone: 973-278-0220

Straight & Narrow Family Success Center
101 Cedar St.
Paterson, NJ 07501
Phone: 973-333-6240 x 12

Salem County
Family Success Center of Salem
14 New Market Street
Salem, NJ 08079
Phone: 856-935-0944

Somerset County
EmPower Family Success Center
34 West Main Street, Suite 201
Somerville, NJ 08876
Phone: 908-722-4400

Sussex County
Sussex County Family Success Center at Project Self Sufficiency
127 Mill Street
Newton, NJ 07860
Phone: 973-940-3500

Union County
Jefferson Park Ministries Family Success Center
213 Jefferson Avenue
Elizabeth, NJ 07201
Phone: 908-469-9508

Plainfield Center for Stronger Families
504 Madison Avenue
Plainfield, NJ 07060
Phone: 908-731-4200 Ext. 5235

Warren County
NORWESCAP Family Success Center
459 Center St.
Phillipsburg, NJ 08865
Phone: 908-213-2674
Milk: Nutrient Power House

An 8-ounce serving of milk, flavored or not, gives kids as much...

- **Protein** as 1 1/2 medium eggs
- **Phosphorus** as 1 cup of canned kidney beans
- **Calcium** as 10 cups of raw spinach
- **Riboflavin** as 1/3 cup of whole almonds
- **Vitamin D** as 3/4 ounce of cooked salmon
- **Potassium** as one small banana

USDA National Nutrient Database for Standard Reference, Release 24

Nutrients included are either a good/excellent source in one 8-ounce serving of lowfat milk and lowfat flavored milk, and/or nutrients lacking in America’s diets.

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The mission for senior members at AAP/NJ builds on the national strategic plan as outlined in the AAP Section on Senior Members. Our Chapter remains committed to: fostering the involvement of members over the age of 55 years in various Chapter activities; supporting senior members in life transitions; promoting and sustaining connections between seniors and other Chapter members; and providing seniors with opportunities and avenues for advocacy.

In 2011, AAP/NJ in concert with membership, many of whom were from the senior ranks, developed and printed the Agenda for Children, which lists eight critical areas of focus that endorse comprehensive access to healthcare for all children and depicts pediatricians as the most qualified professionals providing healthcare to children. The booklet provides focus to our Chapter’s legislative activities and serves as a quick-reference guide for educating and advising State and local decision makers.

At this year’s AAP/NJ Annual Meeting, over 30 people attended the Seniors’ breakfast and listened to a presentation by our advocate, Joseph Simonetta, describing how the government works in New Jersey and what our Chapter can do to positively- and proactively – impact the development of policy and regulations. Joe applauded the foresight of the leadership of the Government Affairs committee in developing the Agenda and Meg Fisher noted its positive influence on the development of regulations guiding the use of Pulse Oximetry testing in newborns in New Jersey.

There is more work to be accomplished in areas like immunization and Senior members are encouraged to be active in the process. We can and do make a impact!

Dr. Dan Levy, Vice Chair of District III presented updates on AAP’s Senior Section, emphasizing the organization’s goal to better serve the needs of AAP members over the age of 55. He recommended that seniors read the book, Speaking as a Leader and consider applying its principles. AAP/NJ Executive Director, Fran Gallagher encouraged seniors to engage in mentoring young physicians and PCORE Medical Director, Steve Kairys closed the breakfast highlighting the role PCORE can play in assisting seniors in quality improvement and maintenance activities.

The bottom line? Seniors are important to the Chapter’s goals and accomplishments. Get involved. Stay involved. And let leadership know how we can best serve you. If you are interested in becoming involved in the Senior Section, please contact me at lfrenkel@uic.edu.

The Affordable Care Act continued from page 15

While mandatory compliance plans presently exist only in the arena of Medicaid, they are certain to become an integral part of health care “reform”.

In conclusion, to survive the aftermath of the ACA ruling, physicians must view it as an awakening. While an awakening of the giant known also as government oversight, it must also be an awakening to every physician that the need for Prospective Compliance is no longer a political question, a legal dispute or an option.
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The New Jersey Immunization Network (NJIN) has grown from a handful of AAP/NJ and AFPNJ members concerned about falling immunization rates, the negative impact of anti-vaccine forces, and the mounting financial burdens on pediatricians to a statewide collaborative of more than 200 actively involved individuals and organizations.

Monthly general meetings, which are open to all members and guests, and subcommittee meetings all make it possible for the organization to pursue five significant objectives:

- **Supporting efforts to develop, implement, and improve the New Jersey Immunization Information System (NJIIS)** - We are working in concert with NJIIS toward advancing timely immunization rates and ensuring the effective and efficient use of the system by health care practitioners without onerous, time consuming, and expensive obligations. Several NJIN members are on the NJIIS steering committee as part of these efforts.

- **Professional Education** - The arena of vaccination and immunization science and policy is complicated and ever changing. Providers are finding it increasingly difficult to remain current on recommendations for optimizing up-to-date immunization of infants, children, adolescents, adults, seniors, and special populations including pregnant women and health care workers. The network presents webinars and workshops in collaboration with AAP/NJ and NJ State Department of Health (NJDOH) designed to keep providers current on the latest issues and techniques that hinder improving the State’s immunization rates. Another recent educational and quality improvement series of programs teaches providers how to best deal with vaccine hesitant parents.

- **Subcommittee on Technology and Interfaces** – This committee was formed to achieve two important goals;
  1. To produce a primer for providers regarding Electronic Health Records, Interfaces to NJIIS and Meaningful Use
  2. To explore and negotiate lower technology costs with vendors for hard-pressed providers.

Both efforts are being conducted in collaboration with the federally funded regional HiTec office and the New Jersey Department of Health.

- **Government Relations** – NJIN remains proactive in its efforts to increase awareness and education of the State’s legislative and executive branches on legislative, regulatory and policy related to immunization. Network spokespeople are made available to testify at legislative hearings, meet with individual legislators or their aids, and assist the NJDOH and other state departments in any way possible. We have established a close working relationship with many people at NJDOH to optimize efforts to increase immunization of individuals of all ages in NJ.

- **Media and Consumer Education** - For several years, sensationalized and misleading misinformation has appeared in print and electronic media in absence of true science and medicine. On several occasions, the network has worked to counter this misinformation and the anti-vaccine propaganda by providing letters to the editor, op-ed articles, and radio and TV interviews. In addition, NJIN is speaking with retailers such as drug store chains to help the immunization network bring the importance of protective vaccines to the public.

**SUMMARY**

Over the past 18 months, NJIN has become a “go to” resource for professionals, the media, government representatives and the general public on immunization issues. NJIN continues to facilitate connecting needs to resources; questions to answers; people to people. NJIN proactively disseminates information on a weekly basis that both enables and encourages everyone to make knowledgeable immunization decisions that will positively affect their lives and those of their patients/constituents.

If you are not already a member of the New Jersey Immunization Network, join today. Become part of this growing collaborative committed to protecting the health of all individuals through timely, age-appropriate immunization against vaccine preventable disease.

To learn more about NJIN meetings and activities, please contact Mary Jo Garofoli by calling 609-588-9988 or via email at mgarofoli@aapnj.org
Dr. Rich - The Mediatrician - Headlines Annual School Health Conference

Dr. Michael Rich will deliver one of three plenary sessions on October 17th at the 21st Annual School Health Conference: Clinical Pearls That Make a Difference. Dr. Rich is an internationally known speaker, known as the “Mediatrician” who will offer awareness and advice on how the media affects children and their families in and out of school.

Other plenaries will include Food Allergy and Anaphylaxis by Allergist Dr. Gary Zuckerman and Foodborne Infectious Diseases by Infectious Disease Specialist Dr. Meg Fisher.

Workshops are planned for the conference as well. Topics include: Bullying in School, Diabetes Care and Equipment, Legal Issues Faced by School Nurses and Physicians, Resources for Children with Special Needs, Post-Concussion Management, and Ophthalmologic Screening and Triage.

The Conference will be held at the Palace in Somerset, NJ. Mark the date on your calendars.

Register your school physician and get a 20% discount on your registration. CME and CNE Approved Program.
### Conference Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 - 7:45 AM</td>
<td>Registration / Breakfast / Exhibitor Showcase</td>
<td>Meg Fisher, MD, FAAP, Elliot Rubin, MD, FAAP; Pauline Thomas, MD, FAAP</td>
</tr>
<tr>
<td>7:45 - 8:00 AM</td>
<td>Welcome</td>
<td>Michael Rich, MD, MPH, FAAP, FSAM, an Associate Professor of Pediatrics at Harvard Medical School and Associate Professor of Society, Human Development, and Health at Harvard School of Public Health, came to medicine after a twelve-year career as a filmmaker. His current areas of health research and clinical work bring together his experience and expertise in medicine and media. He uses scientific evidence about the powerful positive and negative effects of media to advise children and those who care for them on how to use media in ways that optimize their development.</td>
</tr>
<tr>
<td>8:00 - 9:00 AM</td>
<td>What You Need to Know About Media &amp; Kids’ Health</td>
<td>Michael Rich, MD, MPH, FAAP, FSAM, a world renowned Pediatric Infectious Disease Specialist and Vice-President of AAP/NJ, is back by popular demand at the AAP/NJ School Health Conference to discuss Foodborne &amp; Other Infectious Illnesses. Dr. Fisher is one of the most engaging speakers in pediatric infectious disease, sharing common sense information on microbes and how we use and combat them. Dr. Fisher will make you laugh, learn and leave with new insights. She has served on the Committee of Infectious Diseases and the Section of Infectious Diseases of the AAP. She is a strong advocate for children and families and thus a proponent of vaccines. Dr. Fisher has published over 30 articles in peer-reviewed journals, numerous invited articles, book chapters, audiocasts and a book.</td>
</tr>
<tr>
<td>9:00 - 10:00 AM</td>
<td>Food Allergy &amp; Anaphylaxis: For Every Reaction an Equal and Opposite Pro-Action</td>
<td>Gary Zuckermark, MD, FAAP, a world renowned Pediatric Infectious Disease Specialist and Vice-President of AAP/NJ, is back by popular demand at the AAP/NJ School Health Conference to discuss Foodborne &amp; Other Infectious Illnesses. Dr. Fisher is one of the most engaging speakers in pediatric infectious disease, sharing common sense information on microbes and how we use and combat them. Dr. Fisher will make you laugh, learn and leave with new insights. She has served on the Committee of Infectious Diseases and the Section of Infectious Diseases of the AAP. She is a strong advocate for children and families and thus a proponent of vaccines. Dr. Fisher has published over 30 articles in peer-reviewed journals, numerous invited articles, book chapters, audiocasts and a book.</td>
</tr>
<tr>
<td>10:00 - 10:20 AM</td>
<td>Break / Exhibitor Showcase</td>
<td>Stephen G. Rice, MD, PhD, MPH, FACSM, FAAP, the Director, Sports Medicine Fellowship, Jersey Shore University Medical Center, Dept. of Pediatrics is returning to discuss the hot topic of post-concussion management. Dr. Rice is an exceptional speaker, well-known expert on sports injuries including concussion. He is a nationally recognized author of several landmark articles and clinical guidelines in sports medicine. Dr. Rice serves as a Clinical Professor of Pediatrics, UMDNJ-Robert Wood Johnson Medical School; AAP/NJ President; Chairman of the Sports Medicine Committee; Liaison to the MSNJ Council on Legislation and the MSNJ Ad-Hoc Scope of Practice Committee.</td>
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<tr>
<td>10:25 - 11:15 AM</td>
<td>Workshop Session 1</td>
<td></td>
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<tr>
<td>11:25 - 12:15 PM</td>
<td>Workshop Session 2</td>
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<tr>
<td>12:20 - 1:30 PM</td>
<td>Lunch / Exhibitor Showcase</td>
<td></td>
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<tr>
<td>1:35 - 2:35 PM</td>
<td>Cafeteria Pandemonium, The Ultimate Food Fight: Foodborne &amp; Other Infectious Illnesses</td>
<td>Meg Fisher, MD, FAAP, a world renowned Pediatric Infectious Disease Specialist and Vice-President of AAP/NJ, is back by popular demand at the AAP/NJ School Health Conference to discuss Foodborne &amp; Other Infectious Illnesses. Dr. Fisher is one of the most engaging speakers in pediatric infectious disease, sharing common sense information on microbes and how we use and combat them. Dr. Fisher will make you laugh, learn and leave with new insights. She has served on the Committee of Infectious Diseases and the Section of Infectious Diseases of the AAP. She is a strong advocate for children and families and thus a proponent of vaccines. Dr. Fisher has published over 30 articles in peer-reviewed journals, numerous invited articles, book chapters, audiocasts and a book.</td>
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<tr>
<td>2:45 - 3:35 PM</td>
<td>Workshop Session 3</td>
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<tr>
<td>3:35 - 3:50 PM</td>
<td>Evaluation / Adjournment</td>
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This activity has been jointly sponsored by Health Research and Educational Trust of New Jersey & American Academy of Pediatrics, New Jersey Chapter.

### Workshop Sessions

- **Combating Bullying at School - Erica Lander, Psy. D**
  Recognize bullying: both the bully and the victim and explain strategies for addressing school based bullying including helping young children to develop resilience before it happens.

- **Concentrating on Post-Concussion Management - Stephen G. Rice, MD, PhD, MPH, FACSM, FAAP**
  Overview of the pathophysiology of concussion; discuss the rationale for why immediate brain rest following a concussion is needed; be able to state the steps of the graduated return to play protocol for returning athletes to full participation following resolution of symptoms; state when to refer to the medical doctor, and how often follow-up is recommended; and distinguish real ongoing symptoms from possible psychological mimics.

- **Pumped Up: What’s New In Diabetes Care and Equipment - Colleen Chou, MA, RN, CDE, CPT & Ian Marshall, MD, FAAP**
  Review appropriate care of patients with type 1 diabetes mellitus; identify techniques and become familiar with equipment used by patients in and out of school; and discuss experience with injections and insulin pumps.

- **Crank Up Your 504 IEP: Interventions to Improve Outcomes - Diana MTK Austin, Esq., Alan Wellers, MD, FAAP, & Marguerite Leuze, RN, CSN, DMH, Fran Gallagher, MD ( moderator)**
  Describe the top 5 special needs diagnoses in elementary, middle and high school; discuss the role of the school nurse in each of these cases; and identify strategies to help the school nurse and doctor coordinate care of the special needs child with private physician and with parents.

- **Cracking the Code for School Nurses and Physicians - Pat Barnett, RN, JD**
  Describe major legal issues facing school nurses and doctors during the 2012/2013 school year; identify the correct approach to at least 3 legal issues in schools; and obtain contact information and web sites to use for future questions on school based legal issues.

- **Seeing Your Way to Optimal Eye Screening and Triage - Monte Mills, MD, FAAP**
  Review vision screening techniques; identify leading causes for screening failure and know how to refer to the medical home; discuss eye pathology including strabismus, amblyopia, the red eye, eye trauma and foreign bodies; and discuss the controversy over vision therapy for non-ophthalmic diagnoses.
mean they aren’t vulnerable and they can stop someone from touching them inappropriately, but they may be more likely to recognize what they’re experiencing is inappropriate and may disclose sooner rather than later.

...children armed with information about personal safety are 6–7 times more likely to develop protective behaviors...

You might be asking, if I am going to add this message to the repertoire of anticipatory guidance, where is the science that it works. Unfortunately the “science” of prevention is still evolving and there is no body of literature that purports a single message/approach that can be used to simply supply the magic bullet of prevention. We know that children armed with information about personal safety are 6-7 times more likely to develop protective behaviors, enhance potential for disclosure and experience less self blame. As in the early development of every area of prevention “common sense” was used to build a foundation that was then tested and led to the science. There isn’t a parent who wouldn’t want to protect his or her child against a sexually abusive experience. When we begin to give the parents the language to communicate these concepts, we educate children about this potential risk and empower them to help protect themselves.

It is the collective responsibility of parents, pediatricians and our institutions to deliver and reinforce children’s right to personal space and privacy.

Now, it’s time for pediatricians to integrate personal space/body safety into every annual health maintenance assessment.
ATTENTION:
Ocean and Burlington County Practices

We are currently recruiting Burlington and Ocean County pediatric practices interested in participating in a FREE immunization quality improvement program focusing on your 24 – 35 month patient population.

Program Benefits:

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For more information, contact Anne Lorenzo, Program Coordinator at (609) 588-9988 or alorenzo@aapnj.org

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On July 27, 2012, I attended the AAP District III Leadership Meeting in Coeur d’Alene, Idaho on July 27th. I was honored to recognize several successful CATCH activities going on in District III, including several from New Jersey:

**Fostering Compliance in Asthma Care**, Howard Britt, MD, Newark, NJ

**Bridging the Gap: South Asian Infant Well-Care**, Monica Mirchandani, DO, West New York, NJ

**A Medical Home for Gay, Lesbian, Bisexual, Transgender (GLBT) Youth**, Barbara Snyder, MD, University of Medicine & Dentistry of New Jersey, Robert Wood Johnson Medical School

**Healthy Tomorrows:**
- **Children’s Health Center**, Paramus, NJ
- **Newark School-Based Health Center Program**, Perth Amboy, NJ

All the District III representatives were very impressed with all the CATCH projects in New Jersey and the rest of the district. Congratulations and keep up the good work.

For more information on CATCH activities, please check the following web sites:

- **CATCH** - [www2.aap.org/catch](http://www2.aap.org/catch)
- **Healthy Tomorrows** - [www2.aap.org/commpeds/htpcp/](http://www2.aap.org/commpeds/htpcp/)
- **Community Pediatrics** - [www2.aap.org/commpeds](http://www2.aap.org/commpeds)

**Grants database** of previous grantees: abstracts, goals, contact information - [www2.aap.org/commpeds/grantsdatabase](http://www2.aap.org/commpeds/grantsdatabase)

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**Governmental Affairs continued from page II**

or their designees, and the chairperson of a 15-member Advisory Committee made up of stakeholders who will provide advice to the board. The final five members of the governing board would be residents of the state appointed by the governor with advice and consent of the Senate as follows: one person who is a member of the American Academy of Actuaries, two persons recommended by the Assembly Speaker and two persons recommended by the Senate President, each with knowledge and expertise in specific areas. The governing board would appoint and set compensation for an executive director; board members would serve terms of four years. The governing board of the exchange would: certify health care plans offered by the Exchange and facilitate the purchase of plans by individuals, establish the State Business Health Options Program (SHOP) to assist participating employers in facilitating the enrollment of their employees in qualified plans; create and offer a Basic Health Plan to enable uninsured persons with incomes of between 133 percent and 200 percent of the federal poverty level (for a family of four, incomes between $30,657 and $46,100 a year) to purchase essential health benefits through the provision of federal funds pursuant to the federal act; develop and implement a plan of operation for the exchange, including the procedures and minimum requirements for the selection, certification and recertification of qualified plans; provide a customer service center and an Internet website that provides standardized comparative information on qualified plans, as well as an online calculator that will allow consumers to determine the cost of a plan after any premium tax credits or subsidies and apply for any available federal fund-

This pilot program seeks to encourage and support Pediatricians and Family Physicians in remaining actively engaged in the prevention, early detection and management of children with mental health issues by enhancing their capacity to link children and their families with essential mental health resources.

The Care-Child Psychiatrist Consultation initiative also supports the significant reasons for augmenting early detection capacity as identified in the Chapter’s Agenda for Children:

- Pediatricians see children up to 14 times in the first five years of life
- Mental health issues arise in up to 30% of pediatric office visits, half of which are serious enough to disrupt functional status
- Rising rates of autism, Attention Deficit Hyperactivity Disorder (ADHD), anxiety disorders, depression and behavioral disorders indicate these numbers will continue increasing;
- Early detection improves health outcomes and lowers the cost of care.

During the pilot program, the Warm line will be available to Pediatric and Family Physician practices throughout Essex County.

**The Number** - The Primary Care Child Psychiatry Consultation Pilot Project Warm line number is: 973-395-1440

**Warm line operation are available** Monday through Friday - 9:00am to 5:00pm

**On-call hours for the child psychiatrists are:**
- Monday - 1:00pm to 5:00pm
- Tuesday – Friday 9:00am to 1:00pm

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"I found this service to be incredibly helpful in the care of my 13 year old patient. The psychiatrist was extremely thorough and her suggestions were promptly put into action. The intake person was friendly and made the process user friendly. Thank you for your contribution to this effort."

Lori Beth Elliot, Psychiatric Nurse Practitioner
Vanguard Medical Group

For additional information on the Care-Child Psychiatrist Consultation Initiative, please contact Juliana David at (609) 588-9988, ext. 103 or via email at jdavid@aapnj.org
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**AAP NJ Chapter Agenda for Children…**

In previous issues you’ve read about the strategic planning process that led to the development of our Chapter’s *Agenda for Children*, a pocket sized publication that has been shared with all NJ legislators, State and community partners, National and Chapter members. The Agenda is designed to clearly articulate - in a proactive way - Chapter priorities on behalf of all of New Jersey’s children. It provides a 30 foot view of 8 priority areas highlighted in the graphic below.

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**Medical Home**

**Oral Health**

**Obesity**

**Access to Care**

**Scope of Practice**

**Payment**

**Mental Health**

**Immunize**

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**So what’s happening with the Agenda now?**

AAP NJ Chapter & PCORE leadership and staff came together this summer to strategically align Practice Management /Pediatric Council priorities with the AAP NJ Chapter *Agenda for Children*. The Practice Management Committee is co-chaired by Drs. Richard Lander and Andrea Katz. We were joined by invited guests Arturo Brita, MD, Deputy Commissioner, Mark Delmonte, Esq., AAP Director of Advocacy; Michael Schoppmann, Esq., Chapter’s General Counsel; and DOH, Chip Hart, a practice management consultant.

**Health care is rapidly changing and we are actively planning.**

Twenty-two pediatricians came together with staff and guests and formed workgroups focused on: Medical Home, Scope of Practice/Access to Care, and Payment.

Drs. Landers and Katz framed the issues, followed by Dr. Jeanne Craft who addressed the value in aligning practice management strategies within the Government Affairs committee, and Dr. Steven Kairys, addressed the important connections between quality improvement as one strategy for meeting the practice management strategies. The planning process serves as a guide to best allocate resources and enable our Chapter to focus on issues most important to children’s health, membership, and future success.

So … a 30 ’ view is important for the vision; however, you may be asking how are we filling in the details—the actual activities and work to promote the *Agenda for Children* priorities. This issue highlights numerous grant and cooperative agreement funded programs. You will see we are working on programs to promote linking mental health, oral health, and other preventative health with pediatric primary care within the context of strengthening medical homes. In each of these areas we are integrating education and advocacy efforts geared to sustain improvements, for example, payment issues, community resources, and having a team able and eager to provide technical assistance. Our *Agenda for Children* offers our partners the much needed pediatric leadership and expertise in children’s health issues. Check out updates on the website ([www.aapnj.org](http://www.aapnj.org)), become engaged, and stay tuned … this is important work in progress!

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**Membership = Benefits**

When was the last time you reviewed all the benefits made available to AAP/NJ members? Members are often surprised at the depth of savings on everything from malpractice insurance and legal council to medical billing and supplies. Visit the *Members Only* section at [www.aapnj.org](http://www.aapnj.org) for a complete listing of benefits and savings.
Invite a Colleague to Join Today!

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN
New Jersey Chapter

For AAP/NJ Use Only
AAPNJ ID # __________________
DISTR# __________________

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□ MD □ DO □ Other (specify) ___________________________________________ □ Male □ Female ___________ ___________ ___________ Date of Birth (MM/DD/YY)

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APPLICANT SIGNATURE

I hereby certify that all information recorded on this application and any attached documents are accurate and support my qualifications for membership in the American Academy of Pediatrics, New Jersey Chapter for which I now apply.

Signature of Applicant ____________________ Date ____________________

PAYMENT To pay your Chapter dues payment of (see rates above) __________ please complete below.

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□ I will pay using the following credit card: □ Visa □ Mastercard □ AMEX Include the 3- or 4-digit CVV located on the signature space of your card.

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□ Your membership will automatically be renewed every year. Please check this box if you wish to decline.

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For Questions, Please contact: Bert Mulder, Director, Membership and Events via email BMulder@aapnj.org

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