Universal Newborn Pulse Oximetry Screening

A Letter from Christina Tan, MD, MPH - Acting Commissioner, NJ Department of Health & Senior Services - Health Care Providers and Administrators:

On June 2, 2011, Governor Chris Christie signed first-in-the-nation legislation to protect the health of newborns from potentially life-threatening congenital heart defects by requiring all birthing facilities licensed by the New Jersey Department of Health and Senior Services to perform pulse oximetry screenings. This law takes effect on August 31, 2011, whereby each birthing facility licensed by the New Jersey Department of Health and Senior Services will be required to perform pulse oximetry screening on every newborn in its care at 24 hours of life or later (NJ.S.A. 26:2-111.3 and 111.4).

With an incidence of approximately nine cases per 1,000 live births, congenital heart defects are one of the most common types of major congenital anomalies and are responsible for more deaths than any other class of malformations. Approximately one-quarter of congenital heart defects are severe and are commonly referred to as critical congenital heart disease or CCHD. Although CCHD lesions are more prevalent than hypothyroidism and phenylketonuria combined, few hospitals screen for these conditions.

Detecting CCHD after discharge from the nursery is associated with significantly higher rates of CCHD-related morbidity and even death. In many instances where CCHD is not diagnosed until after discharge from the hospital, the hypoxemia produced by the heart defect(s) in the newborn period is mild and cyanosis does not occur. In multiple recently published studies involving over 200,000 newborns, pulse oximetry screening in the regular nursery has been shown to reliably detect a significant number of, but not all, babies with CCHD. * Pulse oximetry screening of newborns has been recommended by the United States Health and Human Services Secretary’s Advisory Committee on Heritable Diseases in Newborns and Children (SACHDNC) for inclusion in the Uniform Screening Panel and is currently under consideration by United States Health and Human Services Secretary Kathleen Sebelius.

In order to assist birthing facilities with their mandate to screen newborns with pulse oximetry, the New Jersey Department of Health and Senior Services convened the Working Group on Critical Con...

Cont. on page 10-11

NJ Pediatricians and the Patient/ Family Centered Medical Home (PCMH)

Authored by: Steven Kairys, MD, FAAP and Fran Gallagher, MEd

The PCMH movement continues to grow in the State, regionally, and also at the federal level. Many states and their health insurance companies have developed new reimbursement models that incent the development of the medical home. NJ has yet to develop such models, but AAP/NJ and PCORE are actively engaged with Medicaid and the Department of Banking and Industry to introduce some of the national changes to New Jersey.

AAP/NJ and PCORE continue at many levels to work with community pediatricians to increase their medical home capabilities. In partnership with the Department of Health, Title V, the NJ Statewide Parent Advocacy Network (SPAN) and other key partners, PCORE has developed active Learning Collaborative Sessions with 10 practices in Cumberland and Camden and is expanding now to Middlesex county. Each of these practices has made great strides in involving parents of patients into the processes of care at...

Cont. on page 4
Labor Day marks the unofficial end of summer and the beginning of the next school year. This year, the arrival of September also marks the start of the American Academy of Pediatrics national election. In addition to voting for President of AAP, there is also an important election for the Vice-Chairman of District III (our Mid-Atlantic States of New Jersey, Pennsylvania, Delaware, Maryland, West Virginia as well as the District of Columbia).

Participation in the AAP annual elections in recent years has been disappointing. Last year, New Jersey’s own Wayne Yankus, MD was one of the two candidates competing for AAP President, yet our election turnout among New Jersey pediatricians was no better than other states. In today’s busy world, it is easy to be unable to find the time to learn about the candidates, consider their qualifications and how they would perform as the primary spokesperson for the Academy. The two candidates for AAP President are Dr. Thomas McInerney of Rochester, New York and Dr. Mary Brown of Bend, Oregon. I urge everyone to make the time to become informed and vote; check out this newsletter, AAP News or the AAP website for full details. Show that you care about your professional association and exercise your responsibility to select our next leader.

District III plays an important role for AAP/New Jersey Chapter and its relationship to the National AAP. The leaders of District III participate in a monthly teleconference, meet at the NCE and again at a summertime meeting jointly with another district (we just returned from our meeting with District I [New England] in Annapolis, Maryland that was foreshortened by the impending devastating Hurricane Irene). District III does an excellent job of working together, sharing ideas and functions, and developing a regional cohesiveness that allows us to share our successes and draw on the wisdom and experiences of our neighbors in facing our problems.

The District Chairman is one of the ten members of the AAP Board of Directors and is our direct conduit to the Academy leadership. The District Vice Chairman is involved in various duties regarding chapter grants, chapter recognition and achievements, and helping the District Chairman in formulating, articulating and carrying out District and Academy projects and programs.

The two candidates for District III Vice Chairman are Daniel Levy, MD of Maryland and Nathaniel Beers, MD of the District of Columbia. Both are well qualified and highly talented. His own unique personality, style and vision for the future of the AAP. This is an important election for our District and the functioning of our Chapter. Again, I urge you to make the effort to study the two candidates and vote. The District Vice Chairman should reflect the consensus of the entire membership of our region, not the preference of a small fraction of our membership.

Nationally, the Academy is strongly focused on making each member appreciate its efforts on behalf of all pediatricians - through its advocacy, practice management tools and instruments, educational programs and materials, website support and position papers. Engaging members in an active dialogue is essential to maintaining relevance and meeting the needs of its members; the Academy is committed to proving its value and wants to hear from its members on how well they are being served and what can be done to improve services for pediatricians.
In early September, the White House announced that AAP Immediate Past President, Dr. Judith Palfrey, has been appointed the executive director of Michelle Obama’s Let’s Move campaign to fight obesity. The Academy’s advocacy and close involvement with key health issues for children has literally put the voice of the AAP in a central position to influence policy decisions.

The fall also begins a busy season for our Chapter. Our quarterly Executive Council meeting will be held on Tuesday, September 13th, preceded by an educational session on endocrine growth deficiencies. Dr. Alan Rogol from Cincinnati will be the guest speaker.

Resident Career Day takes place on Tuesday, September 20 in Edison, New Jersey. Dr. Michele Tuck has done another outstanding job in coordinating this annual event, where second year pediatric residents gather to learn about and consider their future careers. Topics focus on pursuing a fellowship, entering private practice, becoming a hospitalist, seeking academic opportunities as well as how to negotiate an initial employment contract. The opportunity for all the pediatric residents in New Jersey to network with one another is another highlight of the day. The program also serves to formally introduce our pediatric residents to our AAP/NJ Chapter and all of the many opportunities and benefits that await them; we hope to spark their interest and inspire their involvement in their local professional association.

The AAP National Convention and Exposition (NCE) takes place in Boston during the middle of October from the 15th to the 18th. As always, there will be lots to learn, see and do in one of America’s great cities.

Our own 20th Annual School and Community Health Conference will take place on Wednesday, October 26th at The Palace in Somerset. Dr. Wayne Yankus and his committee have prepared a superb meeting agenda, covering topics valuable to pediatricians and school nurses. Please make an effort to clear your schedule to attend this great conference.

The 7th Annual Vaccine for Children Conference will be held on Wednesday, November 30th at the Conference Center on the campus of Mercer County Community College in West Windsor. As always, an all-star team of presenters will keep New Jersey health professionals up-to-date on immunizations.

Like the National AAP, our leadership team and Chapter staff in New Jersey are making a vigorous effort to boost our membership by ensuring that we provide value for the dollars you allocate to our organization. The list of membership benefits grows each quarter as AAP/NJ partners with a wider variety of service providers to meet your business and personal needs. In many cases, the savings from a single benefit exceeds the cost of annual membership. More importantly, since our joining together with PCORE and the impending merger of the two entities, AAP/NJ has enhanced its capacity to advocate to the legislature and governor, support governmental agencies through grants and contracts, assist practices with model programs and practice management tools, educate pediatricians and help meet Maintenance of Certification (MOC) requirements, provide technical assistance in incorporating electronic medical records (EMR) while moving toward meaningful use, and provide an opportunity for engagement and leadership by joining a committee.

AAP/NJ Chapter Highlights:
- The Annual meeting in June was well attended with EMR and MOC as the thematic focus along with other interesting topics. Plans are being developed for 2012 conference by Vice President-elect, Dr. Elliot Rubin.
- 57 pediatricians from 17 practices signed on to HITECH opportunity for technical assistance with EMR as they progress toward Maintenance of Certification.
- Membership of pediatricians in AAP/NJ is on the rise. Thanks to the members who are sharing information with their colleagues and helping us to grow.
- The Chapter has created new membership categories, including Affiliate members and Corporate membership. Affiliate membership is open to physicians (non-pediatricians), dentists, advanced nurse practitioners, physician assistants, family practitioners, child and adolescent psychiatrists, child and adolescent psychologists and other allied health professionals (e.g. physical, occupational, speech therapists) practicing and/or residing in the State of New Jersey who are primarily interested in the care and well-being of infants, children, adolescents and young adults. Affiliate members may not vote or hold office. Corporate membership formalizes the working relationships AAP/NJ has had with key business partners for many years.
In January, billing for AAP/NJ Chapter dues will be coming in house rather than from the National AAP. Watch for that correspondence which will offer helpful options. Also look for a Chapter Assessment in the near future... help us know how the Chapter may be most helpful and valuable to you.

AAP/NJ & PCORE have 3 programs with MOC Part 4 credit (EPIC: Medical Home; EPIC BEST [breastfeeding]; EPIC Child Abuse and Neglect Prevention).

New Advocacy Program - a legislative agenda for our Chapter will be published this September and disseminated to all legislators in the Senate and Assembly. In addition, other important advocacy activities include:
- Meetings with NJ DHSS Commissioner, DMAS Commissioner & Medicaid Medical Director and Medicaid Director; our scheduled meeting with DOBI was canceled due to the earthquake that afternoon!
- Pulse Ox Bill passed - 2 pediatricians were on the task force which developed the regulations (1 community based, 1 hospital based) that went into effect on August 31st.
- Immunization education was hand delivered to all Senate and Assembly Health Committee members.
- The Chapter prepared a formal response to Medicaid Waiver Concept Paper produced by the Governor’s office (posted on AAP NJ www.AAP/NJ.org under advocacy tab - NEW TAB!); our response was well-received and highly appreciated by the Commissioner.
- NJIN grows in membership and continues to provide educational outreach. Our last webinar featured Dr. Meg Fisher, with several hundred tuning in from different 26 states!
- An Oral Health Stakeholders meeting held. Our proposal, a “Letter of Intent” was approved for Full Proposal submission (1 of 36 across the nation - 14 will be awarded)—Special thanks to our Oral Health champions, Drs. Cathy Balance, Jeff Bienstock, and David Krol.
- An AAP Fetal Alcohol Syndrome Visiting Fellowship Grant was awarded to NJ; Our champions for this effort are Dr. Uday C Mehta, who oversees the FASD assessment clinic at the Children’s Specialized Hospital at Mountainside, NJ, and Dr. Alla Gordina, a community pediatrician who specializes in Adoption and Foster Care Medicine, with an additional interest in coding for special and time consuming issues. NOTE - there is an article on this in this newsletter - announcing and giving overview of issue and the plans for 2 webinars.
- Several pediatricians continue to work with the Mental Health Taskforce on increasing access and quality of children’s healthcare by linking mental health and primary care - working with state agencies, legislators and an interdisciplinary group (Drs. Steven Kairys, Janice Prontnicki, Wayne Yankus).

During my final year of my two-year presidency, I want to engage and encourage our young pediatricians to join and get involved in Chapter activities. There is enjoyment and personal growth awaiting you - and a chance to truly make a difference - personally, locally, regionally and nationally. Take the leap and become active! Our Chapter will be creating events and activities this winter to facilitate and foster young pediatrician involvement.

AAP NJ & PCORE Working Together

the practice and in improving a number of preventive and chronic disease systems of care. PCORE, in addition, is working with SPAN on a similar project of improving office based care for children with autism

Every program that AAP/NJ and PCORE develop has medical home improvement as a core component. Thus the projects around breastfeeding, obesity prevention, child abuse prevention and early detection, immunizations, and mental health services all focus on that specific content area in the context of an improved medical home.

A recent expansion of the PCMH concept is the Medical Home Neighborhood. This is conceptualized as the PCMH working in concert with the other community health providers, local agencies and services and families to provide wrap around support for children and families. The move toward Accountable Care and Shared Revenues all center on a functional Medical Home Neighborhood. The growth of office based EMR and the linking of office based EMR to an area health information system is yet another piece of the infrastructure needed to support an ACO.
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Breastfeeding as a public health strategy was celebrated around the world during the first week of August, and in New Jersey it is celebrated for the entire month. New Jersey has taken a lead in prioritizing breastfeeding as a public health topic particularly for its role in the prevention of obesity, an epidemic problem for New Jersey citizens. New Jersey children, ages 1-5 years old, have the highest rate of obesity in the nation and reversing this trend takes innovation and collaboration. Under the NJ DHSS’s newly created Office of Fitness and Nutrition (ONF), a public/private partnership entitled ShapingNJ is doing just that. Multiple strategies were developed to target communities, schools, workplaces, and health care settings to promote obesity prevention and encourage healthy lifestyles.

A major boost to the State’s collaborative efforts to promote breastfeeding has been the receipt of a grant from the Centers for Disease Control and Prevention entitled, Communities Putting Prevention to Work-State and Territory Initiative (CPPW-STI). Breastfeeding leaders in collaboration with the American Academy of Pediatrics, NJ Chapter (AAP/NJ) and PCORE and maternal and child health care workers throughout the State are working together to implement new policies and practices that have been shown to help mothers breastfeed. These policies and practices are described in the World Health Organization’s Ten Steps to Successful Breastfeeding and serve as the basis for the NJ Baby-Friendly Hospital Initiative. Through an RFA process, ten NJ hospitals were awarded mini grants to support their implementation efforts. The AAP/NJ Medical Champion for the NJ Baby-Friendly Hospital Initiative, Lori Feldman-Winter, MD, MPH, from Cooper University Hospital, one of the grant funded hospitals, has been leading the learning collaborative and providing monthly technical assistance to help facilities implement these changes. Cooper University Hospital (CUH) was one of the first facilities to stop the practice of giving out formula company sponsored sample packs, a practice shown to undermine breastfeeding. Now, more than a dozen NJ hospitals have stopped distributing sample formula packs.

Through this Initiative, facilities are sharing innovative strategies and working on additional quality improvements, including: having comprehensive infant feeding policies; training all of their staff, including physicians, on the benefits and management of breastfeeding; providing prenatal and post-partum information about breastfeeding, delivery by skin-to-skin, rooming-in, avoidance of unnecessary supplementation, and showing mothers how to maintain lactation should they be separated from their newborns. While NJ currently has no Baby-Friendly USA certified hospitals, project directors expect that with this collaborative not only will more hospitals receive certification, more mothers in NJ will breastfeed exclusively for the first 6 months, continue breastfeeding for at least one year and fewer children in NJ will be victims of the obesity epidemic.

The second major goal of the NJ Baby-Friendly Hospital Initiative is to implement office based trainings for pediatric, family and OB providers and their staff about best breastfeeding practices. Using the EPIC model (Educating Practices In their Communities), these free trainings aim to build partnerships with community based organizations and state and local agencies. The EPIC BEST (Breastfeeding Education, Support and Training) program will empower office staff to initiate sustainable change for their patients and families around best breastfeeding practices. More information on the NJ Baby Friendly Hospital Initiative, including resources for providers and families, can be found on the PCORE website (www.njpcore.org).

For more information, contact Harriet Lazarus (hlazarus@njpcore.org) or Shreya Durvasula (sdurvasula@njpcore.org)
The time is NOW! Come join us at the 20th Annual Educational Conference on Community Medicine and School Health at The Palace in Somerset, NJ on Wednesday October 26, 2011. This year’s conference is full of great speakers who will address timely issues of infectious disease, nutrition, mental health, who can’t play sports and NJ’s new concussion law and how it effects us all in practice.

Featured speakers are Robert Murray, MD, FAAP; Meg Fisher, MD, FAAP; Eric Bartky, MD; and Stephen Rice, MD, PhD, MPH, FAAP. Workshops are part of this AAP/NJ bargain and our largest annual conference. Come join us for the 20th event and celebration.

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As you are aware the AAP, NJ Chapter took a leading role in helping to craft and support the Pulse Oximetry Bill sponsored by Assemblyman Jason O’Donnell. The bill, now law, states:

The law requires birthing facilities in New Jersey, defined as an inpatient or ambulatory health care facility licensed by DHSS that provides birthing and newborn care services, to screen newborns for congenital heart defects (CHDs) prior to discharge. Each birthing facility licensed by the Department of Health and Senior Services must perform a pulse oximetry screening for CHDs, a minimum of 24 hours after birth, on every newborn in its care.

The Chapter through the efforts of Dr. Craft is currently engaged in the drafting of the regulations which will implement the screening process. This is a major thrust of the new legislative and government affairs initiative as outlined by us, namely to have the Chapter engaged in the process prior to the establishment of rules and regulations that effect your practice and patient care. More details included on page 1 cover story: A Letter from Christina Tan, MD.

In addition, the Chapter, with Patricia Van Abs, Director of the NJ Immunization Network, serving as its liaison, participated as a member of a coalition advocating for the passage of Assembly bill 3920. This legislation, sponsored by Assembly Health and Senior Services Chairman Herb Conaway, requires health care facilities to annually offer influenza vaccination to their health care workers. It was released by the Committee in May and awaits a vote by the full Assembly. An identical Senate bill, S2984, was introduced by Senator Joseph Vitale and was referred to the Senate Health, Human Services and Senior Citizens Committee in June. We will continue to work to gain passage of this legislation in the fall.

The Chapter also provided testimony on Senate Resolution 113 which urges the Department of Children and Families, in consultation with the State Department of Human Services, to apply to the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States Department of Health and Human Services for a Planning Grant for Expansion of the Comprehensive Community Mental Health Services for Children and their Families (System of Care Expansion Planning Grant).

The Chapter has also met with members of the Governor’s senior staff and with the Commissioner of Human Services and her staff to discuss the State of New Jersey’s proposed Medicaid waiver. Detailed comments were prepared and submitted to the Commissioner of Human Services outlining the Chapter’s concerns with several areas of the proposed waiver including benefits and provider payments, streamlined and efficient program administration, delivery system innovations and eligibility and enrollment. The Chapter’s comments were well received by the Administration and will provide the groundwork for ongoing dialogue.

Finally, the Chapter recently held a strategic planning session to establish its Legislative Agenda. The purpose of the agenda is to develop a broad based document that defines the major initiatives of the Chapter. The positions as outlined in the Legislative Agenda will be used not only as guidance to the Board in forming its position on individual pieces of legislation and regulation but also as a tool to educate and inform government officials on the Chapter and its activities. The Legislative Agenda is currently in the formatting process and will be available to members soon. We encourage you to read it and get familiar with our major policy positions.

NEW! AAP/NJ Website Advocacy Tab - www.AAP/NJ.org
Screening Algorithm for Critical Congenital Heart Disease
Recommendations from the New Jersey Department of Health and Senior Services

All babies 24-48 hours of age or shortly before discharge if < 24 hours*

Perform and document pulse oximetry in both RIGHT HAND and either FOOT.

Is Pulse Oximetry reading < 90% in either the HAND or FOOT?

- YES
  - Are both HAND and FOOT 95-100% ?
  - If YES, proceed to PASS.
  - If NO, proceed to FAIL.

- NO
  - Is the difference between the two measurements 3 or less?
  - If YES, proceed to PASS.
  - If NO, proceed to FAIL.

FAIL
Do not rescreen.

FAIL
Repeat the above pulse oximetry screening algorithm in one hour by obtaining new measurements from both right hand and either foot. If baby does not pass after a total of three screenings (initial screen and 2 repeat screens), notify responsible medical practitioner and follow recommendations in box below.

- Notify responsible medical practitioner of the failed screen and of need for further evaluation.
- Evaluate for other causes of low oxygen saturation (e.g., persistent pulmonary hypertension, pneumonia, infection, etc.).
- In the absence of a clear cause of hypoxemia, obtain a diagnostic echocardiogram by an expert in the interpretation of infant echocardiograms and review the report prior to discharge home. This may require transfer to another institution or use of telemedicine.
- If saturation is < 90% in either the hand or foot, the baby should have immediate clinical assessment and immediate referral to pediatric cardiology. In this case, do not wait and rescreen.

- A pass on the screen does not exclude the existence of a cardiac disorder.
- If cardiac evaluation is otherwise indicated (e.g., clinical signs, prenatal diagnosis of critical congenital heart disease, dysmorphic features, etc.), proceed with cardiac evaluation even if baby receives a pass on the pulse oximetry screen.

- Optimal results are obtained by using a motion-tolerant pulse oximeter that reports functional oxygen saturation, has been validated in low perfusion conditions, has been cleared by the FDA for use in newborns, and has a 2% root-mean-square accuracy.
- Document results in medical record.
- Screen in the right hand and one foot, either in parallel or direct sequence.
- Apply probe to lateral aspect of right hand and foot in areas that are clean and dry. The two sensors (light emitter and detector) should be placed directly opposite of each other.
- Administration of supplemental oxygen may alter the interpretation of the screening result. For infants requiring supplemental oxygen, delay this screening algorithm until infant is stable in room air. For infants being discharged home on supplemental oxygen, perform screen prior to discharge and review results with responsible medical practitioner.
- Symptomatic babies require clinical evaluation.
- This screening algorithm should not take the place of clinical judgment or customary clinical practice.

* Children in Special Care Nurseries (including Intermediate Care Nurseries, Neonatal Intensive Care Nurseries, etc.) should be screened at 24-48 hours of age or when medically appropriate after 24 hours of age. In all cases, screening should occur prior to discharge from the hospital.

Adapted from the Secretary’s Advisory Committee on Heritable Diseases in Newborns and Children (SACHDNC) Expert Panel Workgroup’s Preliminary Recommendations, Jan. 2011.
Universal Newborn Pulse Oximetry Screening Cont.

genital Heart Disease Screening, a statewide multidisciplinary group of medical experts, including neonatologists, pediatric cardiologists, and pediatricians, parents, and other healthcare providers. The ultimate goal of this Working Group is to develop a comprehensive best practice guidelines document for use by the birthing facilities and others using pulse oximetry to screen for critical congenital heart disease. However, recognizing that birthing facilities need to begin screening on August 31, 2011, and in order to assist you with developing your clinical guidelines. Please visit www.AAP/NJ.org for the screening algorithm developed by the New Jersey Department of Health and Senior Services’ Working Group on Critical Congenital Heart Disease Screening.

This screening algorithm was adapted from that issued by a national expert panel for the SACHDNC. As mentioned previously, a more comprehensive best practice guidelines document is being developed and will be issued in the near-future. Our goal with developing a screening algorithm was to provide a one-page summary of the important components of CCHD screening. It is not meant to be a comprehensive document, as that will follow in the future, nor is it intended to replace clinical judgment.

As you can see (on page 10), the path in the screening algorithm developed by the Working Group is determined by three data points: oxygen saturation in the right hand, oxygen saturation in either the right or left foot, and the difference between the two. If either the right hand or the foot saturation is less than 90%, the result is considered a fail, immediate clinical assessment and referral to pediatric cardiology is strongly recommended, and the protocol should not be repeated. If the right hand and foot are both greater than or equal to 95% AND the difference between the two is less than or equal to 3, then the baby passes the screen and no further screening is indicated. Finally, the remaining babies with oxygen saturations greater than or equal to 90, who also have a pulse oximetry reading of less than 95% in either the right hand or foot OR greater than a 3 percentage point difference between the two limbs, need to have the protocol repeated after one hour. To reduce false positive rates, the protocol (modeled after the national recommendation) calls for those persistently in this latter category to repeat the protocol twice (each an hour apart). After the second repeat, those remaining in this latter category are considered a fail and the responsible medical practitioner should be notified and further evaluation should ensue. If another cause for the hypoxemia is not determined, this evaluation should include an echocardiogram by an individual trained in performing infant echocardiograms. This may require transfer to another institution.

In addition to documenting the screening results in the medical record, although not a mandate, we request that birthing facilities utilize a log to keep track of each baby’s results. A log will be important for data collection, both to evaluate and improve upon the protocol and screening process and also to document that a baby was in fact screened. In the near future, we anticipate sending each birthing facility a sample log sheet with fields that are important for such data collection.

We hope that each birthing facility will utilize a log as well as the attached screening algorithm and incorporate them into clinical protocols. Standardization throughout the State, based on evidence-based recommendations, will better serve the newborns and their families by optimizing sensitivity while reducing the number of false positive results. In addition, utilization of a common protocol will enable evaluation of the process and protocols at a statewide level, thus providing the necessary data to make informed modifications to the protocol with the goal of ultimately simplifying the overall screening process.

We look forward to working with you to ensure that all newborns receive this important and potentially life-saving screening. Should you have any questions or concerns, please contact Dr. Lori Garg, Medical Director of Newborn Screening and Genetic Services via e-mail at lori.garg@doh.state.nj.us or Dr. Marilyn Gorney-Daley, Director of Special Child Health and Early Intervention Services via e-mail at marilyn.gorney-daley@doh.state.nj.us; both can also be reached via phone at 609-984-0755.
Since February 2010, pregnant women and new moms have been receiving information to help them care for their health and give their babies the best possible start in life. This has been made possible by text4baby – a free text messaging service that sends 3 health messages to these women each week from pregnancy until the baby is 12 months old. Women can sign up for the free service by texting BABY to 511411 (or BEBE for Spanish), and it’s even timed to their due date or baby’s date of birth.

The American Academy of Pediatrics was a key content reviewer of the text messages and encourages AAP chapters and their members to promote text4baby in their pediatric practice. These messages focus on a variety of topics critical to maternal and child health: immunizations, nutrition, seasonal flu, mental health, oral health, safe sleep, and more. Text4baby also connects women to health services through the inclusion of national hotline phone numbers within the messages.

Sample text4baby messages include:

- Need free or low-cost health care for you & your baby? Your state has programs to help. Call 877-543-7669 to find out if you qualify.
- Talk to your Dr. about getting a flu shot. Pregnant moms & babies can get very sick from flu. For info call CDC at 800-232-4636.
- Did you get info from your Dr. on newborn screening tests? If not, ask for it. Your baby will have these tests in the first 48 hours after birth.

You are a critical partner in getting families enrolled in text4baby. Given the limited time available for pediatricians to discuss every health promotion topic, text4baby is an important tool to engage and reinforce this critical health information.

Help spread the word about text4baby to the families you see in your practice. Please see below for a script that can be used to describe text4baby.

*If you’re pregnant or a new mom, there is a new free service called text4baby that can help keep you and your baby healthy.*

Text4baby will send 3 text messages each week to your cell phone with expert health tips to help you through your pregnancy and your baby's first year. It’s free to sign up and the messages are free.

To sign up, text BABY to 511411. To sign up for text4baby in Spanish, text BEBE to 511411. You can also sign up and find more at www.text4baby.org. Text4baby is an educational service of the National Healthy Mothers, Healthy Babies Coalition.

Other ways to promote text4baby: for marketing materials, visit www.text4baby.org

For more information, visit the text4baby Web site at www.text4baby.org.
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Licensure & Credentialing Consequences of a State Health Care Fraud Conviction in NJ

Authored By; Daniel G. Giaquinto, Esq. & Matthew R. Streger, Esq.

When a practitioner faces a criminal charge related to health care fraud, it is important to keep in mind not only the potential direct consequences of a conviction - term of imprisonment, fines, restitution, probation, etc., it is also important to be aware of collateral and administrative consequences that will, or may, flow from a criminal conviction. Often times in a criminal case the most important decision any defendant will have to make is whether to accept a plea offer made by the prosecutor, or proceed to defend oneself in trial. Knowing the indirect consequences to a physician - such as impact on licensure and credentialing - that may result from a conviction is imperative in making that decision.

In regard to New Jersey’s Health Care Claims Fraud Statute, found at N.J.S.A. 2C:21-3, there are two degrees of crime listed: the most serious is a second degree crime for violating the statute “knowingly”, and the other is a third degree crime for violating the statute “recklessly”. In conjunction with a separate statute entitled License Suspension or Forfeiture for Health Care Claims Fraud, found at N.J.S.A. 2C:51-5, the second degree crime (knowing violation) would result in a mandatory lifetime forfeiture of a physician’s medical license to be imposed by the court, unless the court finds that such license forfeiture would be a serious injustice which overrides the need to deter such conduct. As one would expect from the wording, this exception (serious injustice) would be difficult to establish. The third degree crime (reckless violation) would result in court-imposed loss of license for “at least one year”. As the language suggests, the loss of license could be more than one year. A second or subsequent conviction of the third degree crime would result in a lifetime ban.

The New Jersey Board of Medical Examiners (the Board) must be notified of any health care claims fraud conviction within 10 days of sentence. N.J.S.A.2C:51-5b. Under the New Jersey Licensed Professionals Uniform Enforcement Act, N.J.S.A. 45:1-1, et seq., administrative action can be taken against a practitioner for a violation of New Jersey statutes pertaining to the practitioner’s licensed profession and also for violations of the regulations of the licensing board or agency. A health care related insurance fraud conviction could constitute summary proof of a violation of several sections of the statute that allows for a suspension or revocation of a physician’s license for proscribed conduct, N.J.S.A. 45:1-21, such as subsections: (b) fraud, (e) professional misconduct, (f) crime of moral turpitude or crime relating adversely to activity regulated by the licensing board, (h) violation of regulation administered by the licensing board, and (k) violation of any insurance fraud prevention law. Any of these violations could not only constitute grounds for the Board to revoke or suspend a practitioner’s license, they could also result in the imposition of alternative administrative penalties found in N.J.S.A. 45:1-22, including but not limited to civil penalties, restitution and payment of the Enforcement Bureau’s costs attributed to the licensing investigation and enforcement procedure. Of course, it bears remembering that even if there is no criminal conviction to form the basis of a Board action, the Board only need prove misconduct by a preponderance of the evidence, thus making it possible to impose professional discipline on a licensee for the same conduct under the same set of circumstances, and using the same evidentiary predicates as a prosecutor would use in a criminal case.

Disciplinary action will almost always be taken against a practitioner once the Board is notified or otherwise learns of a criminal conviction of the practitioner, particularly when the conviction is directly re-
lated to the practitioner’s profession. In this regard it is important to note that licensing authorities such as the Board act independently of the court. Thus the Board is not limited to the statutory period of license suspension imposed by the court for the criminal conviction and may seek a license suspension greater than any suspension imposed by the court, as well as the other administrative penalties it is authorized to impose. There simply is no double jeopardy protection against administrative penalties in addition to penalties imposed by a sentencing court.

Expungements of convictions for health care fraud also receive special treatment in New Jersey. N.J.S.A. 2C:52-27.1 specifically provides that if an order of expungement of a record of conviction is granted to a person convicted of health care claims fraud, that part of the sentence forfeiting the professional license is not rescinded in the expungement unless the court is satisfied the petitioner “is sufficiently rehabilitated.” If the court then rescinded such an order, the physician would still have to apply to the Board for reinstatement of license.

Even if a license suspension imposed by a court and/or the Board is avoided, or the physician’s license is reinstated, program exclusions resulting from a criminal conviction will severely impact a physician’s ability to practice. Under federal law, the U.S. Department of Health and Human Services (hereinafter “HHS”) has the authority to exclude providers from Medicare, 42 U.S.C. 1320a-7. Exclusions are either mandatory or permissive. A conviction of a criminal offense related to Medicare, or related to health care fraud, results in a mandatory exclusion from Medicare of at least five years. 42 U.S.C. 1320a-7(c)(3)(B). The only exception to this mandatory five year exclusion is if the program administrator finds that the exclusion would impose a hardship on beneficiaries of the program, and requests the Secretary of HHS to waive the exclusion. After consulting with the Inspector General of HHS, the Secretary may waive the exclusion, and the Secretary’s decision whether to waive the exclusion is not reviewable.

In regard to the State Medicaid program, a criminal conviction could constitute permissive grounds for debarment or disqualification from the program. The New Jersey Division of Medical Assistance and Health Services, through its Director, “may suspend, debar and disqualify persons from participation in the state program when deemed necessary to protect the interests of the program”. N.J.A.C. 10:49-11. Under this same regulation the commission of a criminal offense as incident to performing a Medicaid contract, or violations of regulations pertaining to the governing of the medical profession, or conviction of any crime involving moral turpitude, are grounds for debarment. N.J.A.C. 10:49-11.1(d). The decision to debar rests within the discretion of the Director, and the length of debarment generally should not be more than five years. N.J.A.C. 10:49-11.1(g). Thus Medicaid debarment could exceed five years if warranted.

In addition, under executive order, the federal government prohibits an individual who is excluded from participation in one federal program from participating in any federal program. Exec. Order No. 12,549 (51 F.R. 6370, February 18, 1986), 5 C.F.R. 919 (1986). Therefore, an exclusion from Medicare and/or New Jersey Medicaid will result in subsequent exclusion from all federal health care programs.

Exclusion from Medicare or debarment from Medicaid will also adversely impact a physician’s ability to obtain or maintain hospital credentials. Under federal regulations, any provider or supplier who employs or works with a physician excluded from Medicare, Medicaid, or any other Federal health care program, cannot bill for Medicare services. 42 C.F.R. § 424.535(a)(2)(i). Furthermore, accreditation by the Joint Com-
mission on Accreditation of Healthcare Organizations (JCAHO) (Standard MS.03.01.01) is another require-
ment of Medicare reimbursement eligibility. 42 C.F.R. § 488.5. Therefore, it is the uniform policy of hospi-
tals to prevent physicians who are excluded from participation in Medicare or Medicaid from practicing on
the medical staff. Further evidence of this limitation is found in most medical staff bylaws, which require
Medicare and Medicaid eligibility as a precondition to being granted and maintaining privileges. Finally, it
also goes without saying that a conviction would result in private insurers taking contractual action to ex-
clude physicians from their programs. Most managed care program contracts contain provisions which au-
 thorize exclusion of providers for criminal convictions, or for professional discipline of any type, including
reprimands.

Thus, when facing state criminal charges for health care related fraud in the state of New Jersey, de-
defendants must be mindful of the statutory requirements of license suspension resulting from a conviction.
Furthermore, a defendant must also keep in mind that the Board can, and most likely will, seek to impose
additional penalties, and may seek a license suspension for a period greater than that imposed by a court.
Finally, program exclusion and loss of credentials, with health care entities and private carriers, is also a
realistic consequence of a criminal conviction.

Although the direct or penal consequences of a conviction must always be the primary consideration, a
physician-defendant cannot afford to lose sight of the indirect or collateral consequences in determining
whether to accept a plea agreement. Defendants and their counsel must consider the total picture, and
the possibility of a “global resolution” when charting a course through the legal minefield inherent in de-
fending against health care fraud criminal charges.

Kern Augustine Conroy & Schoppmann, P.C., Attorneys to Health Professionals, www.drlaw.com has
offices in New York, New Jersey, Pennsylvania and Illinois. The firm’s practice is solely devoted to the
representation of health care professionals and serves as AAP/NJ Chapter General Counsel.

Mr. Giaquinto and Mr. Streger may be contacted at 1-800-445-0954 or via email - dgiaquinto@drlaw.com
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Paid Advertorial
One of the Biggest Risks to Your Financial Well Being that Most Do Not Plan For

Authored By: Paul S. Rothman, President - Financial Management Corp.

You probably don’t need another bill to pay, but skipping this protection could have devastating consequences to your finances or drastically reduce your children’s inheritances before you’ve reached your old age. Not purchasing Long Term Care insurance can be the most expensive mistake you will ever make. I’ll bet you’re not considering the prospect that you may ever need home care or nursing home assistance, right? But the unthinkable can happen. If it can happen to “Superman”—actor Christopher Reeve, it could happen to you! Reeve was paralyzed in a 1995 horse riding accident and joined millions of Americans who require nursing care at home or who now reside in nursing facilities. The risk of needing long term care is real. Did you know that 44% of Americans will need some kind of long term care before age 64?

What is Long Term Care?
Long Term Care is the assistance that is needed when one cannot perform 2 of the 6 “activities of daily living”. These “activities of daily living” are: eating, bathing, dressing, toileting, continence and transferring. These “ADL’S” are usually caused by chronic illness, a disability or injury. Long Term Care is also needed for severe cognitive impairment such as Alzheimer’s, dementia and other brain disorders.

How Does It Help You and Your Family?
1. Protects your assets
2. Protects your independence; live how you want and where you want
3. Protects your family from the potential burden of being your full-time caretaker
4. Protects your savings, college funds, and retirement plans from the high costs of long term care
5. Allows you to be cared for with dignity; you are in control
6. Gives you freedom to choose what makes you comfortable, be it home health aides or any variety of caregivers

When should you purchase Long Term Care Insurance?
Most experts agree that one should start looking into Long Term Care Insurance in their mid 40’s to 50’s. Like most insurance products they are priced by your age and health. The goal is to lock-in your health when you are most likely to qualify for it, because when your health deteriorates the insurance companies will not accept you as a risk, no matter how much more you are willing to pay for it.

Who will pay for Long Term Care?
Your major medical plan? No. At best they’ll cover limited care and only at the skilled level, NOT at the custodial level.

Medicare? This is a traditional medical health plan that pays for “acute” or “skilled” medical services and is NOT designed for long term care. At best, Medicare will pay up to 100 days of skilled rehab services in a nursing home or temporary and limited home care services. This coverage cannot be obtained without prior hospitalization and most importantly, there is no coverage for custodial care.

Medicaid? This is the means tested public assistance program. It is welfare and it has a dis-
Are you struggling to achieve meaningful asthma outcomes?

The **PACNJ Asthma Treatment Plan** can help!

- Easy, effective Checklist of medications, dosage, timing, and asthma triggers
- Can be printed with only the prescribed medications displayed
- Can be saved as a fillable form and attached to a patient's file
- Available in 7 languages
- Available free at [www.pacnj.org](http://www.pacnj.org)
- Nearly 84% of the physicians responding to our survey agreed that the PACNJ Asthma Treatment Plan significantly improved their ability to provide a written asthma action/treatment plan to their patients compared to the one they were using

**6 Key Messages for the Diagnosis and Management of Asthma***

- Assess asthma severity at the initial visit to determine initial treatment
- Use inhaled corticosteroids to control asthma
- Use written asthma action/treatment plans to guide patient self-management and help patients take control
- Identify environmental exposures that worsen the patient's asthma and instruct avoidance
- Schedule follow-up visits at periodic intervals
- Assess and monitor asthma control and adjust treatment if needed

*Based on the National Heart Lung and Blood Institute (NHLBI) National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 3 (EPR-3)
mal reputation for access, quality, discrimination and institutional bias. That’s a nice way of saying you must “spend down” all of your money. There is now a 5-year “look back” period to spend down your assets. You don’t depend on welfare for your needs now for many of the same reasons you wouldn’t want to depend on it later. Recipients face long waiting lists even for inferior facilities.

**Family and friends?** Is that a reality for anyone? Do you really want that for them?

**Your own savings?** This is the point. How long will your savings last if you are spending $300,000 per year in a nursing home? This is called self-insurance. Is this what you want? Do you self insure your home, your office, your life, your health? Of course not! For pennies on the dollar we alleviate these risks in our lives and purchase insurance.

By planning ahead today, and making Long Term Care insurance part of your financial plan, you can help:

1. Protect your assets since LTC insurance acts as a FIREWALL of protection
2. Reduce the burden of care that falls on family members
3. Reduce the emotional and financial burdens that are associated with providing care
4. Maintain control over where you receive care, including in your home.

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**Thursday & Friday**

**OCTOBER 13-14, 2011**

Atlantic City Convention Center

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*Paid Advertorial*
New Eyes for the Needy [a 501(c)(3) non-profit] in Short Hills, New Jersey makes a difference in people’s lives every single day by giving the gift of clear sight to adults and children who cannot afford prescription glasses on their own. New Eyes could be an excellent resource for young patients whose families do not have the resources to get their children the glasses and corrected vision they struggle without.

New Eyes was founded in 1932 by Julia Lawrence Terry, a volunteer for the American Red Cross in New York City during the Depression. As people came to her to fill out forms for food assistance, she realized they could not see to read and complete the forms. Mrs. Terry began collecting old spectacles and brought them into New York to distribute to those in need. She quickly realized, however, that it made more sense to buy people glasses made especially for them. Mrs. Terry obtained a smelter’s license, put out a call for glasses across the country and had the silver and gold frames melted down to raise the money she needed to do just that. New Eyes for the Needy was born. Since that time, New Eyes has helped 7,500,000 people in the United States and 63 countries around the world to see clearly - through a voucher program that buys new glasses in our country and by recycling glasses overseas.

You can imagine the frustration of a child who cannot see what his teacher writes on the blackboard or the sickening feeling that comes over a student when called upon to read when she cannot focus on the text before her. Without corrected vision, children struggle every day to see the blackboard, their textbooks, and maybe even their teacher’s face. When 80 percent of learning occurs through sight during the first 12 years of life, that leaves poor children, whose parents or guardians are unable to provide the eyeglasses they need, at a tremendous disadvantage in the classroom. If a child wears glasses and they break and cannot be replaced because of insurance restrictions, a full year of learning may be lost until he qualifies for a new pair. In his preface to *Eyes for Learning, Preventing and Curing Vision-Related Problems* (2007, Rowman & Littlefield Education), Gary Orfield writes, “Aside from the economic consequences, think of the stress of not seeing clearly, the psychological harm of ongoing underachievement, and the impact on the development of the student’s interest in school and learning through reading…. We have huge numbers of kids we define as poor learners who may not even know they have vision problems, whose parents assume the teachers and school would catch such problems, or who just cannot afford the simplest treatment.”

New Eyes buys new prescription glasses using a voucher program. The children we serve are generally living at poverty level or below and do not have insurance or have insurance plans that do not cover eyeglasses. To qualify for New Eyes’ assistance, a child must have a recent eye prescription (written within the past 12 months). A pediatrician, social worker, case worker or school nurse can refer a child to New Eyes. Applications for vouchers are available on our website at [www.neweyesfortheneedy.org](http://www.neweyesfortheneedy.org). New Eyes processes children’s applications as quickly as possible. We issue a voucher in the child’s name so that a parent or guardian can take the child to a local optical dispenser to get her glasses made.

In New Jersey, New Eyes partners with 600 optical dispensers, including corporate-owned Wal-Mart Vision Centers. Our average cost for children’s glasses is $50/pair.

By giving disadvantaged children the eyeglasses they need, New Eyes equips students with the critical tool - clear sight - that can jumpstart their journey toward self-sufficiency. By being able to see clearly in the classroom, children develop confidence in themselves and their abilities. By getting an education, they may be the one in their family to break free of the cycle of poverty. Armed with an education, young people can open doors to employment opportunities that will allow them to achieve a better quality of life.

For more information about New Eyes for the Needy, please visit our website at [www.neweyesfortheneedy.org](http://www.neweyesfortheneedy.org).
National Election - Your Vote Matters!

The AAP National Nominating Committee has named Mary P. Brown, MD, FAAP, and Thomas K. McInerny, MD, FAAP, as candidates for AAP President-elect. Voters may read about them at the AAP members’ center: www.aap.org/moc

The position of District Vice Chair is also up for grabs this year. The candidates are Nathaniel Beers, of Washington, D.C., and Daniel Levy, of Columbia, Maryland. Bios on both candidates are also available at the AAP website.

On Thursday, September 1, or shortly thereafter, you will receive an e-mail from: AAP Election Coordinator - AAPvote@directvote.net

This e-mail will contain your personalized link to the 2011 National AAP Election Ballot. Please “white list” e-mail from AAPvote@directvote.net so that it does not get caught in your Spam filter preventing you from receiving your election ballot link. The ballot link may also be accessed by logging into the AAP Member Center during the month of September. The election closes at 4:00pm Central Daylight Time on Saturday, October 1.

Please exercise your membership privilege beginning September 1, and vote for your next President-elect and district positions in the 2011 National AAP Election.

The winner will take office immediately following the annual business meeting at the National Conference and Exhibition (NCE). In order to be eligible to vote, as a member you must be a Fellow, Specialty Fellow, Retired Fellow, or Emeritus Fellow in good standing. If your membership dues are scheduled to expire soon, please renew your membership in order to cast your vote in the forthcoming AAP election.

REGISTER TODAY!
7th Annual Vaccines For Children Conference
Pathways to Health: A Booster on Basics

Date - Wednesday November 30, 2011
Location - The Conference Center at Mercer County Community College, 1200 Old Trenton Road, West Windsor, NJ

Topics to Include -
Travelers Bring Back Bugs Which Vaccines Could Prevent | Immunization Techniques: Best Practices for Infants, Children, and Adolescents | The Storytelling Key to Effective Vaccine Communication

Speakers to Include -
Meg Fisher, MD, FAAP | Jeffrey Boscamp, MD, FAAP | Charles Scott, MD, FAAP | Bill Smith, PhD

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The second annual senior section breakfast was held in June at the annual meeting of the AAP/NJ. It was an enjoyable and productive meeting. Three volunteers stepped forward to act as vice-chair and the editor of our periodic report to the chapter, published in our newsletter: Drs. Gilani, Pelliccia, and Radhakrishna!

We have a few action items to accomplish over the next few months. Between now and the end of September, it would be good if each active senior met with their local state legislators to get to know them and discuss the Chapter’s legislative goals for the coming year. We now have a handout and supportive “white papers” about these 8 chapter legislative priorities/issues for your use in these efforts, available through the Chapter office or on our website (www.AAP/NJ.org). If you want me to join you on these visits, let me know.

All pediatricians who are immunizing children less than 7 years of age must become a user of the NJ Immunization Information System (the Registry). It will be important and helpful for each of you to give me feedback regarding your experience with this process and with the Registry itself in order for us to pass this feedback on to the State Health Department Registry Users Committee. These efforts may support the meaningful use requirements of recent high tech activities and qualify for significant financial rebates to your practices. More information regarding this can also be obtained by calling the Chapter office (609-842-0014) or on our web page.

If you have ideas for senior section activities during the next year, please contact me (lfrenkel@uic.edu) or phone (908-616-8650).
Sunday October 16, 2011
THE NEW JERSEY CHRONIC FATIGUE SYNDROME ASSOCIATION & MONMOUTH MEDICAL CENTER Present
New Horizons in Public Health, Treatment & Diagnosis of Chronic Fatigue Syndrome

Malcolm Schwartz, M.D. – Moderator
Susan M. Levine, M.D. – Introduction and Welcome

Elizabeth R. Unger, Ph.D., M.D.
Chief of the Chronic Viral Diseases Branch at CDC

“A Public Health Approach to Chronic Fatigue Syndrome”

Charles W. Lapp, M.D.
Director, Hunter-Hopkins Center, Charlotte, NC
Assistant Consulting Professor, Duke University Medical Center, Durham
Specializes in CFS/ME, FM and related disorders.

“Feeling Better: Clinical Strategies for CFS Management”

Benjamin H. Natelson, M.D.
Director of the Pain & Fatigue Study Center at
Dept. of Pain and Palliative Care, Beth Israel Medical Center, Manhattan
Professor of Neurology at the Albert Einstein College of Medicine.

"CFS Diagnosis: Lumper or Splitter"

Accreditation: "The Monmouth Medical Center is accredited by the Medical Society of New Jersey to provide continuing medical education for physicians."
Designation: "The Monmouth Medical Center designates this activity for a maximum of 5.5 AAMA PRA Category I Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity."
Objectives: At the completion of this conference, the participants should be able to:

- Describe the main activities of the CDC’s CFS program and explain how information from epidemiological studies can be used to reduce CFS morbidity.
- Discuss some effective clinical strategies for the management of Chronic fatigue syndrome and review the most useful therapies.
- Define the clinical and biomedical differences between Chronic Fatigue Syndrome, Fibromyalgia and Post Lyme Syndrome and explain how these differences might lead to diagnostic biomarkers to distinguish each illness.

Certificates of Attendance for other healthcare professionals.

Brochure at www.njcfsa.org or call NJCFSA Helpline 888-835-3677
The American Academy of Pediatrics, New Jersey Chapter is proud to welcome its Corporate Members!

Main Street Vaccines is a nationwide physician group purchasing organization with over 7000 members. Main Street Vaccines features the lowest non-governmental contract prices on a full line of Sanofi Pasteur and Merck vaccines. In addition, Main Street vaccines has returned over nine million dollars to their members in rebates and cash bonuses. Main Street members are eligible for discounts on a complete line of medical/surgical supplies, vaccine refrigerators/freezers, and computer/telephone system design and support, and it is proud to be a leader in bringing green technology to medical offices. Members receive exclusive rates for SMART SINK™, the breakthrough drug recycling system from Cactus, LLC.

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American Dairy Association and Dairy Council

Funded by dairy farmers in New York, Northern New Jersey and Northeastern Pennsylvania, American Dairy Association and Dairy Council Inc works to deliver timely, scientifically-sound nutrition information on the health benefits of milk, cheese and yogurt.

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MDAdvantage Insurance Company of New Jersey, a leading provider of medical professional liability insurance in New Jersey, offers some of the best coverage available in the market, along with unparalleled value and consistently receives high ratings for its claim handling, risk management services, advocacy for physicians and 24/7 accessibility. MDAdvantage also provides complimentary Supreme Advantage coverage to insureds, which consists of employment practices liability, privacy and data security and medical practice administration insurance. MDAdvantage is the only carrier in New Jersey to provide this type of medical practice protection to its physician insureds.

www.mdanj.com
Children’s Specialized Hospital is the preeminent provider of pediatric rehabilitation services and is the largest pediatric rehabilitation system in the United States. Children’s Specialized is dedicated to improving the lives of children and young adults through delivering superior specialized healthcare and medical services, in a safe and caring environment. Our hospital’s core values are excellence, innovation, teamwork, compassion, integrity and fun. Last year, over 18,000 kids, from birth to 21 years of age, came through the doors of our nine New Jersey sites located in Mountainside, Bayonne, Clifton, Fanwood Plaza, Hamilton, New Brunswick, Roselle Park and Toms River (2).

www.childrens-specialized.org

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Join today as a Corporate Member!
The Corporate Membership program is designed to give your organization maximum visibility while helping AAP/NJ expand community outreach programs in vital areas such as obesity, oral health, immunization, mental health, child abuse and neglect prevention, medical home and others. A Corporate Membership offers your organization a wide range of benefits, including:

- Corporate Member Plaque.
- Special created logo "Corporate Member AAP/NJ“.
- Right to promote the organization as "Corporate Member of AAP/NJ“.
- Preferential treatment in exhibit booth selection.
- 15% discount on booths and sponsorships.
- Registration of additional booth personnel at members' rates.
- Featured Corporate Member of the month in E-Newsletter and website.
- Announcement of Corporate Membership in "The New Jersey Pediatrician"
- 25% Discount on Advertisements in “The New Jersey Pediatrician”
- Gain visibility through AAP/NJ web site with a Corporate Member Listing and a link to your home page.
- Copy of Weekly E-News to designated contact person.
- Inclusion on signage at Annual Meeting.
- Complimentary 1/2 Page Ad in Annual Meeting Program Guide.
- Reduced Fee on Mailing Lists.
- Gain recognition and receive a discount as an AAP/NJ Webinar sponsor.
- Visibility to 1,500 members who are pediatricians - and recognize your organization as an AAP/ NJ supporter
- The fee may qualify as an ordinary and necessary business expense, which are generally tax deductible (Please contact your tax advisor for further explanation how the rules apply to your particular business).

Annual Membership Dues: $3,000

Interested in joining? Download a Corporate Member Application Form at www.AAP/NJ.org, or contact Bert Mulder at 609-842-0014, email bmulder@AAP/NJ.org
Adding Chocolate to Milk Doesn’t Take Away Its Nine Essential Nutrients

All milk contains a unique combination of nutrients important for growth and development. Milk is the #1 food source of three of the four nutrients of concern identified by the 2010 Dietary Guidelines for Americans: calcium, vitamin D and potassium. And flavored milk contributes only 3% of added sugars in the diets of children 2-18 years.

5 Reasons Why Flavored Milk Matters

1. KIDS LOVE THE TASTE!
Milk provides nutrients essential for good health and kids drink more when it’s flavored.

2. NINE ESSENTIAL NUTRIENTS!
Flavored milk contains the same nine essential nutrients as white milk - calcium, potassium, phosphorus, protein, vitamins A, D and B12, riboflavin and niacin (niacin equivalents) – and is a healthful alternative to soft drinks.

3. HELPS KIDS ACHIEVE 3 SERVINGS!
Drinking low-fat or fat-free white or flavored milk helps kids get the 3 daily servings* of milk and milk products recommended by the Dietary Guidelines for Americans.

4. BETTER DIET QUALITY!
Children who drink flavored milk meet more of their nutrient needs; do not consume more added sugar or total fat; and are not heavier than non-milk drinkers.

5. TOP CHOICE IN SCHOOLS!
Low-fat chocolate milk is the most popular milk choice in schools and kids drink less milk (and get fewer nutrients) if it’s taken away.

REFERENCES:

* DAILY RECOMMENDATIONS – The 2010 Dietary Guidelines for Americans recommends 3 daily servings of low-fat or fat-free milk and milk products for those 9 years and older, 2.5 for those 4-8 years, and 2 for those 2-3 years.
AAP/NJ Immunization Survey Evaluates NJ VFC

Authored by: Lawrence D. Frankel, MD, FAAP, Co-Chair NJ Immunization Network

A several month long survey targeted at AAP/NJ members and other providers with extensive VFC immunization activities, provided extensive data regarding the experiences of over 100 responders with the program.

- 72% order vaccines for and provide immunizations to children covered under the VFC program
- 51% claim to enter their patients into the NJ immunization registry
- 40% use the registry for ordering and inventory
- 63% report that < 25% of their patients use VFC vaccines
- 17% report that >75% of their patients use VFC vaccines
- 73% order influenza vaccine through the VFC program
- 71% use both the live and killed flu vaccines
- 79% of responders (to this question) believe that the live vaccine is superior to the killed vaccine for healthy children between the ages of 2 and 18
- 55% feel that it is more difficult to order vaccines through the VFC program than other sources
- 32% feel that they are not able to order as much live vaccine as they need and 76% feel that delivery is delayed
- 21% feel that they are not able to order as much killed vaccine as they need and 81% feel that delivery is delayed
- 67% worry that some of their patients are not receiving flu vaccine because of problems with the VFC program
- 98 responders provided specific information regarding their methods of ordering vaccines for their practices and 49 responders provided specific suggestions regarding how to improve the VFC ordering and delivery program

We have shared the results of this survey with the NJ Department of Health and Senior Services and will continue to work with them to optimize the VFC program mechanics in order to increase influenza immunization rates for children in New Jersey.

Are you an NJIN Member?

The NJ Immunization Network is statewide coalition committed to advancing immunization rates throughout the State by providing healthcare providers, the public, and policy makers with the most current scientifically-sound information pertaining to the importance of safely immunizing infants, children, adolescents, and adults throughout New Jersey.

Visit www.AAP/NJ.org to download the membership application!

Feel Free to join us as a guest at our next meeting!
AAP/NJ Fetal Alcohol Spectrum Disorders (FASD) Visiting Professorship

AAP/NJ Chapter is one of 5 states recently awarded a Fetal Alcohol Spectrum Disorders (FASD) Visiting Professorship Program grant from the American Academy of Pediatrics (AAP). The professorship program is designed to increase awareness, early diagnosis and management of FASDs in children within the medical home by identifying experts from the Centers for Disease Control and Prevention FASDs Regional Training Centers (RTCs) to conduct relevant educational opportunities for chapters.

A conservative estimate indicates that in the general population FAS (Fetal Alcohol Syndrome) occurs in 1 to 3 children per 1,000 live births, and FASD occurs in as many as 5 to 10 children per 1,000 live births. In adopted and foster care children FASDs frequency is at least 10-15% higher. FAS occurs twice as often as Spina Bifida and five times more often than Down syndrome. Down syndrome and Spina Bifida, the two most commonly recognized birth defects, can be easily recognized in newborns. In comparison, it can be extremely difficult to diagnose FAS before 8 months of age and in many cases FASDs features are hard to recognize before school entry. NJ has approximately 111,000 live births each year resulting in between 6,438 and 12,210 babies being exposed to dangerous substances in utero which, in many cases, can lead to a range of lifelong disabilities. Early identification and referral to appropriate community resources are critical for optimizing health and education outcomes.

Watch for the SAVE THE DATES for January 2012 for a two part Lunch & Learn Webinar series as it will be posted on the website (www.AAP/NJ.org) and shared in your weekly AAP NJ ENews. Other information will be shared in our communications throughout the year. Please email Fran Gallagher (fgallagher@aap.net) or Irene Muñiz (imuniz@njpcore.org) or call 609.842.0014 for additional information or questions.

MD Champions:
Alla Gordina, MD, FAAP, Community Pediatrician (specializes in Adoption and Foster Care Medicine, with special interest in coding for special and time consuming issues).

Steven Kairys, MD, MPH, FAAP, AAP NJ/PCORE Medical Director (PCORE Medical Director; Chair of Pediatrics at Jersey Shore University Medical Center -- home to one of the 6 NJ Regional FASD Centers)

Uday C Mehta, MD, MPH (Oversees the FASD assessment clinic at the Children’s Specialized Hospital at Mountainside, NJ)

Catch Corner

Authored by: Paul Schwartzberg, MD, FAAP, AAP/NJ CATCH Facilitator

CATCH grants are available for oral health community-based initiatives. Apply now! Grants of up to $12,000 will be awarded to pediatricians to plan innovative community-based child health initiatives. Grants of up to $3,000 are available for pediatric residents.

CATCH is collecting stories from grassroots pediatricians to use to promote CATCH and community pediatrics. We want to illustrate how one pediatrician in partnership with his/her community can solve community problems using community resources. Help us promote the power of communities by sharing your story at http://www.aap.org/catch/form.html.
AAP/NJ Affiliate Membership Now Available!

Affiliate Membership is now available!

Are you a Physician, Dentist, Advanced Nurse Practitioner, Physicians Assistant, Family Practitioner, Practice Manager, or other allied health professional practicing and/or residing in the State of New Jersey who is primarily interested in the care and well-being of infants, children, adolescent, and young adults?

Then show your support of one of the nation’s most active AAP Chapters and become an Affiliate Member today!

Limited Time Offer for Affiliate members!

Help us continue making a difference in the lives of all children in New Jersey by becoming an AAP/NJ Affiliate Member. Join by 12/31/2011 and reap your first benefit of a $30 discount off your $165 yearly membership fee. In addition to the discount, membership avails you to several additional benefits including:

- Expanded discounted service opportunities for web-based screening, diagnostic and management systems, banking, office supplies, home utilities, disability and long term care insurance, medical billing, and practice management solutions.
- Discounts on meetings and events.
- Weekly E-news briefs
- Quarterly Chapter Newsletter, The NJ Pediatrician

Your membership will help AAP/NJ expand community outreach and quality improvement programs in vital areas such as; obesity prevention, oral health, mental health, child abuse and neglect prevention, medical home and others. It will help our Chapter remain a leading voice lobbying on legislative matters vital to your concerns and practice. Through programs like the New Jersey Immunization Network, we will step up initiatives - from local communities to Trenton -to generate greater awareness and understanding of the critical importance of immunization. AAP/NJ continues to be at the forefront of providing leading edge quality improvement projects to health care professionals.

Application forms can be downloaded at www.aAAP/NJ.org, complete and send your $135 Chapter membership fee to: American Academy of Pediatrics 72103 Eagle Way, Chicago, Illinois, 60678. You may also call 800-433-9016, Ext. 5897.

We look forward to welcoming you as a new and valued member

* Please note that although Affiliates Members are not allowed to vote, all other AAP/NJ Membership Benefits apply.
### Who are my AAP/NJ District Councilors?

#### District 1:
(Bergen & Passaic)
- Daniel Schwartz, MD, FAAP  dis@nic.com
- Alex Hyatt, MD, FAAP  hyatta@aol.com

#### District 2:
(Essex, Hudson & Union)
- Daniel Hermann, MD, MPH, FAAP  dhermann@smgnj.com
- Monica Arnold, DO, FAAP  wedge1@pol.net

#### District 3:
(Hunterdon, Morris, Somerset, Sussex, & Warren)
- Alan Meltzer, MD, FAAP  alan.meltzer@atlantichealth.org
- Kristen Walsh, MD, FAAP  walshkristen@yahoo.com

#### District 4:
(Mercer, Middlesex, Monmouth & Ocean)
- Cathleen Ballance, MD, FAAP  ballancecathy@optonline.net
- Indira Amato, MD, FAAP  indyamato@gmail.com

#### District 5:
(Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Salem)
- Kevin King, MD, FAAP  hadpeds@yahoo.com
- Goodman, MD, MMM, FAAP  goodman-michael@cooperhealth.edu

#### District at Large
- Alan Weller, MD, FAAP  asweller@mac.com
- Denise Bell-Koller, MD, FAAP  denise.bell@yahoo.com
- Aimee LaRiviere, MD, FAAP  skabaim@aol.com
- Michele Tuck, MD, FAAP  mptuck@comcast.net

District Councilors represent their districts as voting members of the Executive Council. They guide, coordinate and report on Chapter activities initiated in their districts, maintain effective communication within their respective districts and provide the names of members in their districts interested in serving on committees. Contact your district councilor today if you are interested in becoming more active in the American Academy of Pediatrics, New Jersey Chapter or have a concern or idea to share!

[www.AAP/NJ.org](http://www.AAP/NJ.org) & [www.njpcore.org](http://www.njpcore.org)
The American Academy of Pediatrics has recognized New Jersey Chapter members for their devotion in improving infant, child and adolescent health care as well their services on various committees & program initiatives that promote the health and welfare of children. We applaud and appreciate your efforts and support to the AAP, NJ Chapter and PCORE.

Jeffrey Bienstock, MD, FAAP for his work as chapter treasurer, member of the Pediatric Council on Research and Education Board of Trustees and Government Relations Committee, and for his efforts in integrating and recruiting chapter membership at the regional and state level.

Pierre N. Coant, MD, FAAP for his advocacy efforts as co-chair of the chapter’s Government Relations Committee, member and champion of Medical Home Initiatives.

Jeanne Annette Craft, MD, FAAP for her advocacy efforts as co-chair of the chapter’s Government Relations Committee, Vice Chair of PCORE BOT, and a valuable trainer for the CAN Program.

Wayne Fellmeth, MD, FAAP for his service on the Executive Council and Government Relations Committee.

Margaret ‘Meg’ Fisher, MD, FAAP for her work as chapter vice-president, co-chair of the New Jersey Immunization Network, champion of the Pediatric Council on Research and Education Obesity Prevention Program, and membership on the chapter’s Government Relations Committee and Pediatric Council on Research and Education Board of Trustees.

Lawrence Dean Frenkel, MD, FAAP for his service as the Senior Committee Chairperson, activity on the Government Relations Committee, and leadership on New Jersey Immunization Network.

Joseph Andrew Holahan, MD, FAAP for his leadership in the chairing Children with Disabilities Committee and service on the New Jersey State Interagency Coordinating Council for New Jersey Early Intervention.

Andrea Gail Katz, MD, FAAP for her service as co-chair of the chapter’s Practice Management Committee.

Kevin John King, MD, FAAP for his service as a Chapter District Councilor and work in Pediatric Council on Research and Education program recruitment, helping to make critical linkages for initiatives related to the medical home, electronic medical records, and mental health.

Richard Lander, MD, FAAP for his service as co-chair of the chapter’s Practice Management Committee.

Robert Morgan, MD, FAAP for his work as medical director of the New Jersey Department of Children and Families, Division of Youth and Family Services and service on numerous chapter and Pediatric Council on Research and Education Prevention Programs Advisory Groups.

Stephen Gary Rice, MD, PhD, MPH, FAAP for his service as the chapter president, membership in the Pediatric Council on Research and Education Board of Trustees, advocacy efforts on the Government Relations Committee, and education in supporting primary care physicians in knowing how to treat concussions.

Elliot H. Rubin, MD, FAAP for assisting in the Health Information Technology and Clinical Health launch; membership on the Pediatric Council on Research and Education Board of Trustees, membership of the Government Relations Committee, and for planning the 2011 AAP/NJ Annual Meeting.

Gurmit S. Saluja, MD, FAAP for his membership efforts as a Pediatric Council on Research and Education Board of Trustees member and a trainer on both Child Abuse and Neglect and Obesity Prevention Program.
A revised AAP clinical practice guideline on the diagnosis and management of the initial urinary tract infection (UTI) in febrile infants and young children is markedly different from the previous practice parameter published in 1999.


New data have become available in the past five years, with the findings prompting a reexamination of the older studies. There also is a more transparent process for reporting the strength of recommendations, based on explicit assessments of benefits, harms/risks/ costs, value judgments, role of patient preferences, exclusion and intentional vagueness where it appears.

Recommendations now are called Key Action Statements, and there are seven of them: Three deal with diagnosis, one with treatment, two with imaging and one with follow-up.

The changes from the 1999 recommendations are summarized as follows:

1. **Diagnosis:** The criteria for diagnosis now include an abnormal urinalysis as well as a positive culture containing ≥ 50,000 colony forming units/milliliter of a urinary pathogen. The abnormal urinalysis helps distinguish true UTI from asymptomatic bacteriuria. Guidance also is provided regarding assessment of the likelihood of UTI to help determine which febrile infants clinicians should evaluate for UTI.

2. **Treatment:** Oral therapy is recognized as effective as parenteral therapy.

3. **Imaging:** Renal-bladder ultrasonography (RBUS) should be performed, but voiding cystourethrography (VCUG) no longer is recommended routinely after the first febrile UTI. Indications for VCUG include findings on RBUS that suggest the presence of high grade vesicoureteral reflux or the recurrence of a febrile UTI.

4. **Follow-up:** Emphasis should be on counseling families to seek medical evaluation promptly for UTI during future febrile illnesses.

The rationale for the biggest change — discouraging the routine performance of VCUGs — stems from analysis of the six recent randomized controlled trials of prophylaxis vs. no prophylaxis in young infants following a febrile UTI. The committee that developed the guideline contacted the authors of the six studies, requesting specific data from the studies to enhance comparability and optimal meta-analysis. All six authors contributed their data, resulting in a dataset of 1,091 infants with grades I-IV reflux or no reflux.

Prophylaxis was not demonstrated to be superior to no prophylaxis in preventing recurrence of febrile UTI in infants without reflux or in those with grades I-IV reflux. (In the studies, only five infants with grade V reflux were included, so the effectiveness of prophylaxis for infants with this grade of reflux is not known, but less than 1% of febrile infants with UTI have grade V reflux.)

Recurrent febrile UTI is less common among infants without high grade reflux, so waiting for the second UTI reduces the number of VCUGs performed by 90% and has a higher yield of infants with grades IV and V reflux. Studies of renal scarring suggest that waiting for the second UTI is acceptable and does not offset the benefit of sparing 90% of febrile infants with UTI the radiation, discomfort and cost of VCUG.

The revised guideline also includes a section identifying eight areas for research to inform subsequent revisions. An algorithm based on the guideline is provided along with an extensive technical report.
UTI Clinical Practice Guideline algorithm

1. Infant 2–24 mo with fever >38°C
2. Is patient judged to require immediate antimicrobial therapy?
   Yes
   1. Risk of urinary tract infection (UTI) is ~5%.
   2. A clinician may decide that a febrile infant requires antimicrobial therapy to be administered because of ill appearance or other pressing reason.
   3. A urine sample suitable for culture should be obtained before initiating antimicrobials.
   4. See text and tables below for girls and boys.
   5. A urinalysis helps interpret the results of the urine culture, distinguishing UTI from asymptomatic bacteriuria.
   6. Suprapubic aspiration (SPA) is not recommended unless necessary, because it produces more distress than catheterization.
   7. UA that includes microscopy with a hemocytometer has higher sensitivity and specificity but may not be available.
   8. Urine dipstick is slightly less sensitive, but satisfactory if microscopy not available. Positive leukocyte esterase (L.E) or nitrites or microscopy positive for white blood cells (WBCs) or bacteria is a positive urinalysis.
   9. If urinalysis is negative, UTI is unlikely (~0.3%).
10. A satisfactory culture is necessary to document a true UTI and to guide antimicrobial management. Only urine obtained by catheterization (or SPA) is suitable for culture.
11. Sensitivities vary by region and time. Base route on practical consideration, eg, unable to retain oral fluids.
12. Pure growth of >50,000 CFUs/mL. of a uropathogen and urinalysis demonstrating bacteruria or pyuria.
13. Antimicrobial sensitivities of isolated bacteria should be used to adjust antimicrobial choice.
14. Look for anatomic abnormalities that require further evaluation.
15. Follow-up in 1–2 d is important to ensure risk factors have not emerged that would increase UTI risk.
16. Discontinuation of antimicrobials assumes that urine culture was obtained before any antimicrobials were started.
17. Unnecessary antimicrobials can contribute to antimicrobial resistance and may increase risk of UTI.
18. “Proven UTI” means a positive urine culture obtained by suprapubic tap or catheterization. RBUS indications for voiding cystourethrography (VCUG) should be judged by the clinician.
19. After a second UTI, the risk of grade IV–V vesicoureteral reflux (VUR), i.e., hydronephrosis, is estimated to be 18%.
20. Evaluation ideally within 48 h. Early detection and treatment of febrile UTI may reduce the risk of renal scarring.

3. Obtain urine by catheterization or SPA.
4. Is likelihood of UTI <1%? (See text and Fig 2)
   Yes
   6. Obtain urine for urinalysis only by catheter or SPA or bag.
   7. Conduct enhanced urinalysis with microscope and counting chamber.
      Option
   9. Urinalysis positive?
      Yes
      10. Culture urine obtained by catheterization or SPA.
      12. Urinalysis and culture positive?
         Yes
         13. Adjust antimicrobial therapy according to sensitivities. Treat 7–14 d.
         14. Obtain ultrasonogram of kidneys and bladder (RBUS) any time after UTI is confirmed.
         15. Stop
         No
         17. Second or higher proven UTI or VCUG indicated by RBUS?
            Yes
            18. Obtain VCUG to evaluate for grade IV–V VUR.
            No
            19. Instruct family to seek medical care for future fevers to ensure timely treatment of UTI.
      No
      11. Treat with antimicrobials effective against common pathogens according to local sensitivity patterns; oral or parenteral.
      18. Obtain VCUG to evaluate for grade IV–V VUR.
      19. Instruct family to seek medical care for future fevers to ensure timely treatment of UTI.
      Stop
9. Urinalysis positive?
   Yes
   10. Culture urine obtained by catheterization or SPA.
   12. Urinalysis and culture positive?
      Yes
      13. Adjust antimicrobial therapy according to sensitivities. Treat 7–14 d.
      14. Obtain ultrasonogram of kidneys and bladder (RBUS) any time after UTI is confirmed.
      15. Stop
      No
      17. Second or higher proven UTI or VCUG indicated by RBUS?
         Yes
         18. Obtain VCUG to evaluate for grade IV–V VUR.
         No
         19. Instruct family to seek medical care for future fevers to ensure timely treatment of UTI.
      Stop
7. Conduct enhanced urinalysis with microscope and counting chamber.
   Option
8. Conduct dipstick urinalysis; considered positive if L.E and/or nitrite is positive.

Source: September 2011, Pediatrics
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When you join the AAP NJ and complete ten online encounters with pingmd, you will receive a $100 Visa gift card that covers over half of the AAP NJ membership fee.

Only AAP NJ members in good standing are eligible for this offer and each AAP NJ member may only redeem this offer once. This offer is valid through June 30, 2012. In order to receive the gift card, the AAP NJ member must respond to ten online encounters on the pingmd platform from ten unique users within the first six months following registration on pingmd. The online encounters from these ten unique users must be for patients who are already existing patients of the AAP NJ member’s practice, pingmd is a service mark of Dauphin Health, Inc.

It is important to note that the American Academy of Pediatrics, New Jersey Chapter, does not endorse any vendor, service or product. It is the Chapter's goal to bring discounts to our members. Any vendor providing these discounts, such as listed above, is independent from our Association. Moreover, the discounted rates above may be lower or higher than the rate of your current vendor or other vendors offering similar products and services. We encourage our members to compare rates and choose their vendor, services and products accordingly.