
Linking primary care with children’s mental health…The AAP NJ CME Conference and Annual Meeting ‘The Changing Landscape of Healthcare for Children: Tools for Pediatricians’ held on Tuesday, June 8, 2010 in Princeton, NJ was successful. The day brought greater awareness to the behavioral and mental health needs of the children that pediatricians are seeing more frequently each day and provided strategies and tools that practitioners could use in their practice the next day. The program theme grew out of the work of the AAP NJ Chapter Committee on Youth in Foster Care and Out of Home Placements.

This committee, re-activated 2 years ago via a grant from AAP, is actively working with an interdisciplinary membership of public and private partners to improve the mental, emotional, and behavioral health needs of NJ’s children and adolescents.

The day was filled with events and presentations starting with a senior (55+) breakfast. The breakfast was followed by a warm welcome from Margaret “Meg” Fisher, MD, FAAP, AAP NJ Chapter Vice President and Elisabeth “Sooze” Hodgson, MD, FAAP. Opening remarks were given by Cathleen Ballance, MD, MPH, FAAP and Mary Beirne, MD. ‘Minding Children’s Feelings – Role of Primary Care Providers’ set the stage for the day.

Morning workshops offered knowledge and useful tools for pediatricians and ranged from Mental Health Screening, to CPT coding, to how to advocate for policy and legislative changes that improve the quality of health care for children.

The afternoon presenters focused on health issues for Children in Foster Care. Debra Lancaster of the Department of Children and Families and Nina Colabelli RN, MSN, CPNP, BSN, MS of UMDMJ, shared information on how NJ implemented the Child Health Unit based model. The highlight of the afternoon, and the summation of the day’s presentations, was hearing Sharon and Mia Behrens account of their life together. Sharon, a foster mom, and Mia, the beautiful young woman who came to Sharon as a baby with all odds against her, gave hope to everyone on what can happen if physicians, psychiatrists, and parents work together. Today Mia is a self-assured young woman looking forward to college and a future career helping others, similar to her mom. Mia has recently been nominated for an Emmy Award.

PCORE CORNER

Pediatric Council on Research and Education

Steve Kairys, MD, FAAP, Medical Director/Chair PCORE Board of Trustees and Fran Gallagher, Med Ed, Executive Director, AAP NJ & NJPCORE

Lisa Murison is returning to school to become an elementary school teacher— we will miss her! We would like to thank Lisa for her talents in transforming the NJ Pediatrician newsletter into an informative publication with timely information and resources for pediatricians. She also created the weekly AAP NJ Chapter E-News sent out every Thursday. Both of these communications have been instrumental in communicating to you PCORE updates and opportunities. Thanks, Lisa and best wishes!
President’s Address
Stephen Rice, MD, PhD, MPH, FAAP

Exciting times are ahead for the AAP NJ Chapter as I assume the leadership role of President for the next two years. This past year has been one of transition as the Chapter and PCORE have been re-united through an organizational and administrative restructuring. My thanks and appreciation to Michael Segarra who, as President, navigated the Chapter through this demanding two year process.

We are blessed with a fabulous staff: talented, committed and energetic. Our Executive Director, Fran Gallagher, provides a combination of skill, passion and focus that keeps our operation moving forward every day, making us better today than we were yesterday. She is ably supported by Lisa Murison and Bert Mulder, who are opening new horizons and opportunities in our programming, branding, member benefits and income generation; and a full staff of competent and passionate team members.

The intertwining of the outreach and connectedness of PCORE (with its signature grants and programs within the pediatric community, state government and non-governmental non-profit agencies) with its “parent” organization, the AAP NJ Chapter, has created a powerful synergistic entity that can place our pediatric society in the forefront of the public arena on issues affecting children. The vision of the Chapter is “to be the leading authority, advocate and voice for the health of New Jersey’s children and for the profession of pediatrics”; the vision of PCORE is “Shaping child health in New Jersey for the 21st century.” We are poised to see those visions become reality.

How do we, the pediatricians of New Jersey, nurture this growth phase and bring our ascendancy to fruition? That is my challenge for us in the next two years. There are several key steps for achieving our mission:

1. Improve our “branding” – recognition for AAP NJ and PCORE as the resource for all issues regarding the health and well-being of children, making sure that we are recognized and included whenever a topic in our arena arises. To do that, we must improve our networking with parent groups, other professional organizations and societies; engage with local and state governmental agencies and legislators, and to be a resource to the local media.

2. Enhance member benefits – so that our members get excellent value for their dollars invested in membership. If our benefits are valuable enough, we will retain our member base while bringing in other general pediatricians and pediatric subspecialists as well. In addition to our purchasing alliance for malpractice insurance, other similar types of discounted services and opportunities are being implemented in areas such as office supply purchases and disability insurance. Our E-news and E-blasts bring important relevant information to our members on a weekly basis.

3. Grow membership – engage our pediatricians during their training through our Resident Career Day and advocacy projects; energize our young pediatricians in practice with social and educational programs directed to their needs and interests; provide opportunities and pathways for leadership; keep our senior members involved through an active senior committee; help to advocate with our legislators; provide mentoring to younger pediatricians and offer community service as needed.

4. Educate our members – through a wide variety of educational and special topic conferences and teleconferences, the Chapter is heavily engaged in physician Continuing Medical Education. The fall is filled with programs, including the School Health Conference in October 27 and the Vaccines for Children Conference November 9-10 in Atlantic City. In conjunction with PCORE, we are seeking ABP Maintenance of Certification approval for several quality improvement programs.
President’s Address

(Cont. from p. 1)  

5. **Reinvigorate the committees** – to help our membership advocate, network, serve and educate ourselves and the pediatric community. In addition to the Government Affairs Committee, the Practice Management Committee, the Senior Section Committee and the Young Pediatrician Committee, there are several other opportunities for clusters of interested members to come together in common cause and advance their particular niche in pediatrics.

6. **Provide opportunities for leadership and personal growth** – one of the greatest strengths of the American Academy of Pediatrics is its commitment to providing leadership opportunities for members and for nurturing those who accept the challenge to become leaders. To assure a healthy future for any organization, it must continue to attract young members and encourage them to take advantage of leadership training at the Chapter level, the District level or nationally. District III, which includes New Jersey and the other Mid-Atlantic States, is the national model for outstanding leadership training programs. The next training will be in conjunction with the Vaccine for Children Conference in November. The National Legislative Workshop held in Washington, D.C. is an excellent educational course and has been attended by many of those who currently hold or have held leadership positions in AAP NJ.

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My specialty is sports medicine and there have been a variety of primary care medical conditions in athletes which have been garnering headlines in the news media. I have been closely involved in these areas; one of my goals is to educate our members, especially those in general pediatrics practice, on the key features of these topics.

Between 2003 and 2009, I was privileged to be an executive committee member of the Council on Sports Medicine and Fitness (COSMF) for the AAP nationally. I was given the assignment to be the lead author on the rewrite of the Clinical Report “Medical Conditions Affecting Sports Participation,” published in Pediatrics in 2008. Through this effort, I gained knowledge and expertise in a number of areas, particularly the issues regarding risks for athletes in training with sickle cell trait, whether the pre-participation physical examination process should include screening for cardiac conditions that may cause sudden death (an EKG and/or echocardiogram), and how concussions should be managed. Concussion is an extremely “hot” topic these days. On pages 18-21, I have written an article on concussion management.

The State of New Jersey passed legislation this spring to create a New Jersey Student-Athlete Cardiac Screening Task Force; I serve as chairman of that task force; we are expected to issue a report this fall. The State Legislature also wrote legislation to develop a brochure on sudden cardiac death in athletes, to be written by the American Academy of Pediatrics and the American Heart Association. The brochure has been written by a committee of pediatric cardiologists, one of my sports medicine fellows from last year and myself; it will be published this fall and made available to every student who has to undergo a pre-participation physical examination.

Last December, the CDC held a conference in Atlanta, Georgia on Sickle Cell Trait in athletes to bring together the hematologists and the sports medicine medical community to discuss the issue. I was asked by COSMF to represent the AAP at that meeting. Since that time, the NCAA, as part of a legal settlement over the death of a Rice University athlete with sickle cell trait a few years ago, has decided to mandate that every college athlete be tested for the condition or present evidence of their status. My recommendation is for each pediatrician who has the results of the newborn screening in their charts, give a copy of the results to the parents at the next annual check-up and then flag that chart to indicate that the parents have received the information. This will reduce the number of athletes who will have to be tested in the future.

I hope all of the members of the AAP NJ Chapter share my enthusiasm and will embrace this golden moment to enrich ourselves, our organization and the children of New Jersey by supporting the Chapter and PCORE in its many activities.

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**Concussion is an extremely ‘Hot’ topic these days**

The annual meeting was well attended, with over 150 attendees, and has set the mark very high for future meetings. We hope to see you at next year’s AAP NJ Annual Meeting! Watch your weekly E-News, check out the web site, and stay tuned in our next edition of the NJ Pediatrician for details.

* A few evaluation responses from participants: Based on this CME activity, what, if anything, will you do differently?

- Be better able to access services for my patients who require Mental Health Services and transitioning adult care
- Better attention to coding/ using appropriate icd-9 diagnose, will review behavioral screening in our clinic & mental health
- Look at initiating mental health screening in practice and participate in advocating more!
- Better understanding and follow-up care of children entering foster care
- Increase screening (start earlier and use additional tools), utilize and provide resources to parents
- I hope to become involved in the Government Affairs Committee and will also incorporate a mental health screening tool for all of the patients admitted at our hospital
- Mia’s story gives great hope to care for other foster children
**PCORE on the Move…**

Last month, August, was National Immunization Awareness month. In New Jersey, immunization rates are at an all time low. AAP NJ & PCORE, along with others in the NJ Statewide Immunization Network (NJIN), a coalition co-led by the AAP NJ Chapter and NJ AFP, are working to make every month an opportunity for health providers and the general public to increase their awareness related to vaccine safety and importance. AAP NJ and PCORE’s recent and continuous efforts towards raising immunization rates are highlighted in this issue (Do You Really Know Up-to-Date Immunization Status of Your Patients?; NJ Immunization Congress: Follow Up Activities; AAPI P NJ Leads Formation Of NJ Immunization Network to Battle Anti-Vaccine Forces & Legislation). Many offer important resources for community pediatricians!

The PCORE team has been hard at work with a number of existing quality improvement programs and working with public and private partners to secure funding for additional quality improvement efforts. We would like to share a few highlights:

**The BFHI Forum (Bringing Baby-Friendly™ to New Jersey: A Challenge to Change)** is scheduled for Tuesday, October 12, 2010 at the NJ Hospital Association to serve as program kickoff for NJ Maternity Hospital Leadership. For more information, contact: Harriet Lazarus, MBA at hlazarus@njpcore.org. Lori Feldman-Winter, MD, FAAP is the MD Champion for this program.

PCORE, and Children’s Future, Inc., have been partnering with eleven pediatric/family practices in the Trenton area for the past seven years, providing office based training on various preventive and chronic health topics. A pilot obesity prevention and care coordination/management program, titled “Healthy Habits, Healthy Living” has been implemented at all practices. Partnerships with community based organizations and state and local agencies have been developed so that offices are empowered to initiate sustainable office based change. Program evaluation is being conducted by the Central NJ Maternal and Child Health Consortium. Chart reviews were conducted at the practices during the first quarter of 2010, facilitated by Jessica Stevens, MD, PCORE Consultant. In addition to the office based trainings, Practice Innovator meetings are held on a quarterly basis with representatives from the participating practices. These sessions provide a forum to discuss topics of interest and learn about community resources. (Steve Kairys, MD, FAAP, Medical Director & Meg Fisher, MD Champion for the Obesity Prevention).

AAP NJ in partnership with the Englewood Area Community Foundation, Bergen Family Health Center, and other Bergen County organizations serving children and families at risk, including healthcare professionals, parents and community organizations will promote obesity prevention with a focus on healthy beverage consumption. The program will increase awareness and provide educational outreach to families in northern New Jersey that will help promote healthy nutritional choices. Alex Hyatt, MD, FAAP is the Medical Director for this initiative. Components of the “Healthy Habits, Healthy Living” pilot program will be included in the training program.

The Medical Home Program is currently expanding into the Camden/Cumberland/Gloucester/Salem County area. A Medical Home Day recruitment event was held on June 30, 2010, in 2 locations. Nine practices have signed on to work with the program and will be sending teams to the Medical Home Forum. We are in the process of recruiting an additional 3 practices. Kevin King, MD, FAAP is the MD Champion.

We are preparing applications for 2 of our programs to be reviewed by the American Board of Pediatrics for Maintenance of Certification, Part IV (Quality Improvement). By spring of 2011, we are hoping you will have one more great reason to participate in AAP NJ & PCORE’s Quality Improvement initiatives! Please visit both websites to learn more: www.aapnj.org & www.njpcore.org.

**Integrated Systems Autism Grant Awarded!**

Together with our partners, we are proud to announce that AAP NJ and PCORE have been awarded a State Implementation Grant for Children with Autism and Other Developmental Disabilities!

We partnered with SPAN (lead), NJ DCF, and NJ DHSS in submitting the HRSA Grant and AAP NJ and PCORE will work with all of the SIG Medical Home practices to implement early identification and referrals for Autism and other Developmental Disabilities. The target is central, northern, and southern regions working with the medical home practices participating in SIG Medical Home.
Do You Really Know …

The Up-to-Date Immunization Status of Your 24-35 Month-Olds and Your Adolescent Patients?

Would you like more Information on Vaccine Preventable Diseases and Immunizations?

PCORE’s Immunization Initiative can assist and support practices who are interested in assessing and understanding their 2 year old’s immunization rates, as well as their adolescent (13 year olds) immunization rates. This valuable information can help your practice team evaluate your current well-care policies for this patient population. By following the easy data collection protocol, you will receive FREE site-specific reports, as well as feedback on strategies and opportunities to improve immunization coverage rates.

PCORE’s Immunization Initiative can provide you with the most current vaccine preventable disease information, immunization recommendations, NJ school and childcare requirements and materials and resources to help address concerns about vaccine safety. This is available for interested primary care practices, child care centers, parent groups or parent educators as a FREE 1.0 - 1.5 hour educational session at your location. Please contact Program Co-Director, Judie Grandjean at jgrandjean@njpcore.org for more information.

Interested in Joining Us?
The NJIN meets monthly and has public and private key stakeholders. Meetings are held 12:00 – 2:00 p.m. The next meeting is scheduled for September 28th. If you’re interested in joining in person or by conference call to share your practice’s experience, concerns, and/or successes about issues that impact the immunization rate (need for community outreach/education, vaccine distribution, barriers, immunization registry) please email me (fgallagher@aap.net).

AAP NJ & PCORE Working Together

AAP NJ Leads Formation Of NJ Immunization Network To Battle Anti-Vaccine Forces & Legislation

By: Larry Frenkel, MD, FAAP

The Immunization Action Committee of the NJ Chapter of the American Academy of Pediatrics, representing over 1700 pediatricians, has spearheaded efforts to create a network of committed stakeholders to take on the aggressive and misguided but growing group of anti-vaccine forces in the state trying to pass legislation to expand exemption mandates for infants, children, and adolescents. This has led to the formation of the New Jersey Immunization Network (NJIN) co-led by the AAPNJ and the New Jersey Academy of Family Physicians (NJAFP).

The historic record and first hand experience of pediatricians provides unambiguous evidence that vaccines are the single most important public health intervention of the last 100 years. Routine childhood vaccination has virtually eliminated devastating diseases such as tetanus, diphtheria, polio, smallpox, measles, rubella (including congenital infection), pertussis (whooping cough), bacterial meningitis, and hepatitis B. Even though these problems are not seen as often in the United States today, these organisms still infect unvaccinated people at home and abroad. Modern jet travel makes it possible for them to return to our shores and our state easily and without notice.

Rarely children should not receive certain vaccines. Existing law and regulation already permit this exemption. Allowing additional, scientifically invalid exemptions would leave thousands of innocent children unprotected from deadly vaccine preventable diseases. While parents do have the obligation and right to raise their children in a way that seems to them to be appropriate, this right is not unlimited. For example, existing law and regulation recognize that parents must not neglect their children by failing to provide medically necessary care. Vaccination is medically necessary care.

It is also important to know that failing to provide vaccination to children jeopardizes other adults and children who are exposed to them. It is clear from experience in New Jersey, other states, and around the world that the relaxation of immunization mandates is followed by the return of vaccine preventable disease. Permitting a child not to be vaccinated is to put not only that child at risk, but also those around him or her.

Finally, relaxation of immunization mandates is not only scientifically and morally unjustified but also financially irresponsible. It is generally accepted that each dollar spent on prevention of disease by immunization saves many dollars that must be spent of the care of individuals who contract vaccine preventable diseases. There is little reason in this era of national financial constraints to squander resources that could be put to better use.
On June 14, prompted by serious concerns about the potential impact of pending NJ legislation (Assembly Bill #101 and Senate Bill #1571); which would allow for philosophical exemption for vaccines in schools and child care centers, a diverse group of supporters of the newly formed New Jersey Immunization Network (NJIN) gathered at the State House in Trenton to participate in the NJ Council of Children’s Hospitals’ “Children’s Health Day.” The purpose of NJIN participation was to raise awareness among legislators about the importance of childhood and adolescent immunizations and share concerns about the pending legislation and other barriers to raising immunization rates in NJ. As part of this collaborative effort, representatives from many of NJIN’s partner groups were available to provide educational information and answer questions from legislators, their staff and the public.

The NJ Immunization Network (NJIN) took this opportunity to highlight risks of vaccine-preventable diseases and rationale for improving immunization levels. Lawrence Frenkel, MD, FAAP, a pediatric infectious disease specialist and Co-Chair of NJIN, shared the message as he was interviewed by WZBN TV-25, New Jersey’s Capital News Station, against a backdrop of a “Faces of Disease” exhibit with photos of victims of vaccine-preventable diseases.

Specifically for this exhibit pediatric and family medicine physicians and public health nurses, with input from other NJIN members, developed and shared a power-point presentation, entitled “Immunizations Top Ten Reasons,” addressing vaccine safety arguments and the perils of philosophical exemption from vaccines (available on www.aapnj.org). The science-based responses were written due to serious concerns about vaccine choice in NJ and the resulting increased risk of vaccine-preventable diseases that can impact not only children whose parents choose not to immunize them but also NJ residents who cannot be protected by vaccinations due to age, medical condition or religious beliefs.

Educational packets on New Jersey’s school immunization policies, the impact of vaccine-preventable disease incidence in states having philosophical exemptions, the economic value of vaccine, and vaccine safety were distributed and conversations were held with Governor Christie’s Policy Advisor and 25 Assemblymen and Assemblywomen, including Dr. Herb Conaway, Jr., Chair of the Assembly Health and Senior Services Committee. These focused discussions were held in the halls of the State House, in between Assembly Committee meetings (Note: The Senate was not in session that day).

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**NJ Immunization Congress Follow Up Activities**

By: Ruth Gubernick, MPH

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Don’t Miss the 6th Annual NJ Vaccines for Children Conference, “You Can Bet on Vaccines, Don’t Gamble with Your Children’s Health” on November 9-10, 2010 at the Atlantic City Convention Center, Atlantic City, NJ. This event offers the opportunity to gain knowledge about the latest vaccine information from experts in their respective fields. Come join 1,000 of your colleagues to discuss the important issues surrounding vaccines. Featuring Key Note Speakers, Dr. Margaret “Meg” Fisher and Dr. Paul Offit.

Credits being provided for the 1.5 day conference: 7.75 CME credits, 7.75 CNE credits and up to 7.25 Family Physician CMEs. Visit www.njpcore.org for more information. Questions? Contact Pam Oliver by e-mail at polliver@njpcore.org or by phone at 609-588-9988.

This activity has been jointly sponsored by Health Research and Educational Trust of New Jersey and New Jersey Pediatric Council on Research and Education, the Foundation of the American Academy of Pediatrics, NJ Chapter. This activity is provided by Central New Jersey Maternal and Child Health Consortium. This activity is supported by an educational grant from the New Jersey Department of Health and Senior Services.
Meet Your AAP NJ Executive Council!

Congratulations and Welcome to the new AAP NJ Executive Council Members and District Councilors. Their terms will run from July 1, 2010 – July 1, 2012.

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Grand Rounds

Pediatrician's Roadmap for Meeting the Health Care Needs of NJ Children in Foster and Out of Home Care-The Child Health Unit Based Model - Jersey Shore Univ. Medical Center for Pediatric Grand Rounds

On August 3, 2010, at Jersey Shore University Medical Center for Pediatric Grand Rounds, AAP NJ Committee on Youth in Foster Care and Out of Home Placements presented a program entitled, “Pediatrician’s Roadmap for Meeting the Health Care Needs of NJ Children in Foster and Out of Home Care-The Child Health Unit Based Model”. Cathleen Ballance, MD, MPH – Assistant Clinical Professor of Pediatrics-RWJMS at JSUMC spoke to the special needs of children in Foster Care. Nina B. Colabelli, MSN CPNP-PC, Director Child Health Program UMDNJ/ SN/ FXBC and Debra Lancaster, MLIR-Director of the Office of Children's Health Services (OCHS)/DCF shared information on the Implementation of a Child Health Unit Based Model for Children in Foster Care. The committee is working collaboratively with DCF/ DYFS to help educate community health providers on the new structure of Child Health Units located in each county in New Jersey. The committee hopes to bring this information to more primary care providers caring for children in foster care or other out of home placements. If anyone is interested in presenting this information at your local community hospital at grand rounds or other forum, please contact Dr. Cathleen Ballance at (732) 776-2944 or Fran Gallagher, Executive Director of AAP NJ and PCORE, at (609) 588-9988. We would be happy to arrange this for you.
Meet Your AAP NJ District Councilors!

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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!

HealthyChildren.org launches KidsDoc Symptom Checker

HealthyChildren.org has a new interactive tool to help parents evaluate their child’s symptoms.

Based on Pediatric Telephone Protocols, by Barton D. Schmitt, M.D., FAAP, the "KidsDoc Symptom Checker" allows parents to choose from a wide range of symptoms, and then follow the symptom decision chart to determine the appropriate action to take, whether it be home care or a call to the pediatrician.

The tool is also available as an iPhone application called KidsDoc, providing the same expert advice when parents are on the go. Visit www.healthychildren.org to get started!
AAP NJ, PCORE and Sky Blue FC, jointly promote Children’s Health

AAP NJ, PCORE and Sky Blue FC, the 2009 Women’s Professional Soccer Champions, jointly promoted Children’s Health with fun giveaways and soccer activities at the Yurcak Field at Rutgers University on July 18th. Approximately 2,500 visitors watched Sky Blue FC play the Atlanta Beat. AAP NJ’s guests, families and friends were invited to join the Sky Blue Team Members on the field 2 hours before the game and play soccer with team members.

Stephen Rice, MD, PhD, MPH, FAAP, and Margaret “Meg” Fisher, MD, FAAP were manning the special AAP NJ and PCORE tables promoting healthy eating and movement/activity and parents had the opportunity to “Ask the Pediatrician” about nutrition & physical activity. Bert Mulder, Director of Membership and Events for AAP NJ, participated in the ceremonial first kick. During halftime, families were invited on the field with the players for the Halftime Players’ Parade. The event was a great start for an ongoing partnership and talks with Sky Blue FC are ongoing on how to expand on these future opportunities.

Dr. Fisher and Dr. Rice look on as Seth Hall and John Smith play with AAP NJ/PCORE Frisbees.

Dr. Rice answers parent’s questions at the AAP NJ table

Dr. Rice and Fran Gallagher, Executive Director of AAP NJ distribute Frisbees to attendees to encourage movement and exercise.

Gerry Marone, General Manager of SkyBlue FC, and Dr. Rice on the field before the game.
Help Your Patients Enjoy Dairy Again

Many health authorities agree that low-fat and fat-free milk and milk products are an important and practical source of key nutrients for all people — including those who are lactose intolerant.1, 2, 3, 4, 5, 6

It’s valuable for health and nutrition professionals to encourage and educate individuals with lactose intolerance to consume dairy foods first, before non-dairy options, to help meet key nutrient recommendations.

A Solutions-Focused Approach
People who are lactose intolerant should know that when it comes to dairy foods, practical solutions can help them enjoy the recommended three servings of low-fat and fat-free dairy foods every day,* without experiencing discomfort or embarrassment.

- Gradually reintroducing milk back into the diet by trying small amounts of it with food or cooking with it.
- Try drinking lactose-free milk, which is real milk just without the lactose, tastes great and has all the nutrients you’d expect from milk.
- Eating natural cheeses, which are generally low in lactose and yogurt with live and active cultures, which can help the body digest lactose.

Visit nationaldairyCouncil.org for more information, management strategies and patient education materials.

* These health and nutrition organizations support 3-Every-Day™ of Dairy, a science-based education program encouraging Americans to consume the recommended three daily servings of nutrient-rich low-fat or fat-free milk and milk products, to help improve overall health.


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By: Yasmi O. Crystal, DMD and Milton Houpt, DDS, PhD

A publication from the Centers for Disease Control and Prevention in 2007 reported that although caries rates have been declining in the general population since the 1970s, dental caries rates in children 2 to 5 have actually increased from 24 to 28%, confirming that Early Childhood Caries (ECC) is the most prevalent chronic illness in children in the US; five times more common than asthma. More than 40% of children have tooth decay by the time they reach kindergarten. Most of the caries experience, is concentrated in children ages 2 to 5 from low income and racial/ethnic minority backgrounds, many of whom have limited or no access to dental care.

These statistics are especially staggering because although dental caries is an infectious, transmissible disease, it is largely preventable. It is a complex and multifactorial disease, where several pathogenic microorganisms organized in a biofilm that sticks to tooth surfaces, interact with dietary carbohydrates producing acids that remove minerals from the outer surface of the tooth (enamel) in a process known as demineralization, which can become established as an incipient carious lesion. If this persists over time, it results in cavitation of the enamel surface (carious lesion), known as a cavity, which is at that point, irreversible. The carious process is mediated by saliva, which contains enzymes and minerals that protect the teeth, and when fluoride is present, it can actually strengthen and “heal” the enamel in a process known as remineralization. The critical point is to have fluoride present before cavitation occurs. The main pathogen associated with dental caries, mutans streptococci (MS), is not naturally present on infants at birth, but is mainly acquired from mothers and caregivers through direct contact with saliva (vertical transmission). Infants are especially at risk when their mothers or caregivers have high bacterial counts for MS, which is the case when the adult caregiver has untreated tooth decay, or have had cavities in the last year.

Previously referred to as baby bottle syndrome, or nursing bottle caries, Early Childhood Caries (ECC), is defined as the presence of one or more decayed (cavitated or non-cavitated lesions), missing (due to caries) or filled tooth surfaces in any primary tooth in a child 6 years old or younger. Among children younger than 3 years, any sign of smooth surface caries is indicative of severe childhood caries (S-ECC), and it is not uncommon for children in underserved populations and racial ethnic minorities to have multiple advanced carious lesions before age 2 (picture 1). Children in pain from dental disease eat less, causing impaired growth and increased school absences and inattention and are at greater risk to develop caries in the permanent dentition.

For this reason, the American Dental Association (ADA), the American Academy of Pediatric Dentistry (AAPD), the American Academy of Pediatrics (AAP), the American Association of Public Health Dentistry and the Academy of General Dentistry (AGD) recommend that a child see a dentist to establish a dental home by one year of age or within 6 months from eruption of the first primary tooth. A dental home is defined as the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and family centered way.

Since pediatricians see young infants and children frequently for preventive health care visits, they are in an excellent position to identify children at risk for dental health problems, to coordinate appropriate preventive care and parental education, and to refer affected and high-risk children to pediatric dentists for treatment. The AAP’s Oral Health Initiative and Bright Futures Program, have gathered educational materials and resources for pediatricians to update their training in oral health to be able to incorporate oral health evaluations during well-child examinations. AAP guidelines recommend that an oral health evaluation and caries risk assessment be implemented during well child examinations starting at 6 months of age. A caries risk assessment is based on the caries balance concept, which states that the progression or reversal of dental caries is determined by the balance between pathological factors and caries protective factors.

This information is obtained from an interview with the parent and a clinical assessment of the child. Risk factors include: a mother or caregiver with active dental decay within the last year and/or no access to dental care, continual bottle or sippy cup use with fluids other than water, frequent snacking, special health care needs, and family with low socio-economic status or low health literacy. Additional risk factors found during the clinical examination include visible plaque accumulation, and gingivitis (swollen or bleeding gums). Protective factors are an existing dental home, availability of fluoridated water or consistent intake of fluoride supplements, established brushing habits twice a day with use of fluoridated toothpaste, or exposure to fluoride varnish in the last six months. Disease indicators are found during the clinical examination and include visible decay in the form of white spot lesions (incipient, non-cavitated decay) or frank open cavities, or the presence of restorations placed within the last year.
Clinical Section

(Cont. from p 12) The AAP has a caries risk assessment form that pediatricians and other health care practitioners can use to gather the information required to assess the caries risk of a child from the time of the eruption of the first tooth.9

The AAP’s Bright Futures has also piloted several early intervention programs where children at high risk for dental decay in underserved populations have fluoride varnish treatments applied by the pediatrician at 9 months and 12 months of age, together with a referral to a dental home. These programs and collaborations may very well be the best way to improve the oral health and quality of life of minority children who otherwise get care only when the disease is in its advanced stages, and when the cost of treating it is a definite burden to the health care system.

After determining the risk of the patient, the pediatrician is in a unique position to offer preventive counseling and anticipatory guidance that will prevent these children from developing the later stages of the disease. The most important messages for new parents and caregivers would be to:

∙ have their own teeth checked and treated for caries if necessary
∙ avoid habits and behaviors that spread pathogenic bacteria to their babies, like putting their baby’s pacifiers or spoons in their mouth, blowing on their food to cool it or sharing utensils
∙ limit the child’s exposure to sugar in the form of liquids (juice or sweetened beverages) or snacks
∙ discontinue bottle use at age 1 and to give only water in a sippy cup
∙ brush their baby’s teeth twice a day with a “smear” of fluoride toothpaste from the eruption of the first tooth and switch to a pea size of toothpaste by age 2.10

This last recommendation is of utmost importance, because evidence shows that consistent use of fluoride toothpaste is the most effective way to protect a high risk child from developing cavities. Even though this preventive measure has been adopted in the guidelines of ADA and AAPD, many pediatricians are still unaware of its safety and efficacy.

In New Jersey, we face problems associated with low Medi-

caid reimbursement rates, large areas with restricted access to
dental care, significant numbers of uninsured children and recent immigrants with low health care literacy aggravated by the limited availability of proven public health measures like water fluoridation. Our underserved populations and children across all social strata who suffer from ECC could benefit greatly from collaboration between pediatric medical and dental providers. Increasing awareness among pediatricians and promoting early detection, intervention and referral, the New Jersey Chapter of AAP and the NJ Academy of Pediatric Dentistry can make a difference in improving the overall health of our most vulnerable children.

Dr. Crystal is a Trustee for the American Academy of Pediatric Dentistry, and past president of the New Jersey Academy of Pediatric Dentistry. She maintains a pediatric dental practice in NJ and is an oral health consultant for the AAP (www.comprehensivepediatricdentistry.com.)

Dr. Houpt is professor and chair of the Department of Pediatric Dentistry at the UMDNJ-New Jersey Dental School.

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REFERENCES

At the last Practice Management meeting in July, the committee met with the medical directors of most of the New Jersey managed care companies. The committee discussed the importance of coverage of HPV vaccine in males and reiterated the importance of appropriate payment for vaccines and vaccine reimbursement. We presented the newly revised Business Case for Vaccine Reimbursement.

We are working together with the managed care companies to promote initiatives to combat childhood obesity, including discounts for gym memberships, patient newsletter education on nutrition and the importance of parents partnering with their children to exercise and eat well-balanced meals.

The Practice Management committee stresses that all physicians in NJ that are having any problems with practice management or reimbursement should fill out the on-line hassle factor form and send them to AAP NJ by mail or by fax (see side bar) or fax directly to Dr. Katz at 908-665-8071.

We can only make changes if we have the information we need!

Problems or Issues with Reimbursement?

Download the Hassle Factor Form at www.aapnj.org

Mail to: 3836 Quakerbridge Road, Suite 108, Hamilton NJ 08619

Fax to: 609-842-0015

SAVE THE DATE

Thursday, October 14, 2010

4:30 – 8:45 PM

“CHILDHOOD CANCER: Negotiating the Present...Planning the Future”

Hekemian Conference Center ♦ Hackensack University Medical Center ♦ 30 Prospect Avenue, Hackensack, New Jersey

“Transition Back to Society”
Producers of A Lion in the House and Michael B. Harris, MD, Director, Tomorrows Children’s Institute; and Associate Chair, Joseph M. Sanzari Children’s Hospital at Hackensack University Medical Center

“Supporting Siblings and Their Families”
Melanie Goldish, MA, Founder, SuperSibs!

Generously Supported by:
Hackensack University Medical Center ♦ Horizon Blue Cross Blue Shield ♦ Lance Armstrong Foundation ♦ Leukemia & Lymphoma Society
Office of Cancer Control and Prevention

For more information, contact: B. Lynch Associates, Meeting Administrator (609) 392-7553
MD Advantage is pleased to offer Risk Management Education courses that offer premium discounts. Policyholders will appreciate both the varied selection of programs & the flexibility they offer to meet practice needs.

Two out of the many courses that we offer free to policyholders are:

Podcast: Everything they should Have Taught You in Medical School About the Law: (What Every Healthcare Professional Must Know About the Law)

Online: Nature and Cause of Errors and Injuries In Health Care

Detailed information on Risk Management Education Courses is available on our web site, www.MDAdvantageonline.com or by calling the Risk Management Department at 888-355-5551 ext. 1306.

In Honor & In Loving Memory of Avrum Katcher, MD, FAAP

Dr. Katcher received his M.D. from Johns Hopkins University. After completing his medical training, he served as an Army Captain in the Korean War. He worked at the Hunterdon Medical Center, Raritan Township, NJ from 1959 until his retirement in 1994.

During his tenure he served as the Director of Pediatrics as well as Assistant Medical Director of the hospital. Dr. Katcher was also an Attending Physician at Robert Wood Johnson University Hospital where he taught Developmental Pediatrics to the Resident physicians.

A member of the AAP, Dr. Katcher became chairman of the Seniors section after his retirement. Dr. Katcher was proud of helping to start the Polio Drive in the early 1960s as well as the Educational Services Commission.
WORKSHOP BREAKOUT SESSIONS

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

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

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

1. Pediatric Assessment, Essentials for School Nurses
   Patraskingolli, APN, CENP - When a child needs medical attention in the school setting, school nurses need to be able to perform quick but effective nursing assessments to make accurate treatment decisions. This workshop will review the essential components for the school nurse to include when conducting a focused pediatric assessment, to help ensure appropriate triage and care of their pediatric and adolescent patients.

   Linda Morse, RN, MA, CHES - School health services are supported by numerous laws and regulations. How do I know what is required and what is simply “best practice”? Where do I go for guidance about school nursing practice in New Jersey? This session will help school nurses and physicians understand school nursing practice in New Jersey’s schools.

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

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

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

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

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

C. What’s New at DYFS – Robert Morgan, MD and Margarita Marriaga
   The workshop will present recent changes in the DYFS Program including: identification, provision of services and expanded child health units. These are new assets for community providers to be aware of who deal in the management of vulnerable children and families.

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

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

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

G. X to Gen XXI: Strategies for Preventing Childhood Obesity – Keith Ayoub, EdD, RD, FADA
   At least 1 in 3 children is either overweight or obese and the consequences are devastating for health and the health care system. Nutrition is one of the most potent approaches in the prevention of overweight and obesity. This workshop will focus on screening tools and strategies for preventing, addressing, and treating childhood obesity issues.
Family Meals – More Important Than Ever!
By: Kathleen T. Morgan, Dr. M.H., DTR
Chair, Family and Community Health Sciences, Rutgers Cooperative Extension/ Rutgers University

Nutrition professionals and healthcare providers working with adolescents and their families need to assess family meal patterns and, when indicated, explore realistic ways for increasing the frequency of family meals, taking into account family dynamics and schedules. In addition to discussing family meals within clinic visits, discussions about family meals can be incorporated into talks given within schools and other community based settings. It may be helpful for parents of adolescents to know about ways in which they can positively influence their teenagers’ eating patterns.1 Previous research has demonstrated that eating patterns established during adolescence may often track into adulthood.2

The family meal patterns of adolescents change during the transition from middle school to high school owing to several factors, including scheduling conflicts, dissatisfaction with family relationships, and a desire for greater autonomy.3 These findings showed that dinner meal frequencies were higher than breakfast or lunch frequencies for both adolescent males and females. Regular family meals were defined as five or more meals during the week with all or most of the family living in the house. The evening dinner meal could provide an opportunity for family members to not only share a meal together, but also to establish and maintain open communication that promotes the development of stronger family relationships and enhanced adolescent well-being.4

Encouraging and helping families to learn to cook healthful, quick meals may reduce dependency on less, healthful meal options, reduce the frequency of eating outside of the home, and promote greater nutritional intake. The study showed that families eating meals together “every day” or “almost every day” generally consumed higher amounts of important nutrients such as calcium, fiber, iron, and vitamins B6, B12, C and E and consumed less overall fat, compared to families who “never” or “only sometimes” eat meals together.5–6

Although the responsibility for family meals lies primarily with families, many families will need assistance from the communities where they reside, such as schools, after-school organizations, worksites, and food business.5–6 The ultimate aim is to help families have the time, skills and resources to share more frequent family meals, a variety of healthy food options and positive social interactions among family members.

The strength of parental influence extends beyond childhood; therefore, parents should be encouraged to continue modeling healthful eating behaviors and provide a healthful food environment at home throughout key development milestones of their children’s lives. Furthermore, providing adolescents with the knowledge and skills to develop greater self-efficacy to select healthful food has the potential to positively impact their future health and overall well-being.7

As part of the Get Moving Get Healthy New Jersey Initiative, encouraging “Family Meals” is one of the 6 indicators that we are working on along with 1) increasing consumption of fruits and vegetables, 2) increasing physical activity, 3) reducing portion sizes, 4) reducing screen time, and 5) reducing sugar sweetened beverages. The faculty in the Family and Community Health Sciences Department provide educational outreach in the community in the area of the six indicators above. The department has four new fact sheets for their family meal initiative “Eating Together – Eating Well.”

Eating Together - Eating Well: Healthy Meals for Busy Families
http://www.njaes.rutgers.edu/pubs/publication.asp?pid=FS1092

Eating Together - Eating Well: Making it a Priority
http://www.njaes.rutgers.edu/pubs/publication.asp?pid=FS1104

Eating Together - Eating Well: Nutrient-Rich Family Meals
http://www.njaes.rutgers.edu/pubs/publication.asp?pid=FS1110

Eating Together - Eating Well: Fast Food..Can It Be Healthy In A Pinch
http://www.njaes.rutgers.edu/pubs/publication.asp?pid=FS1091

References
By: Stephen G. Rice, M.D., Ph.D., M.P.H., FAAP, FACSM

The last few years have been ones of remarkable change in regard to concussion. There is much new knowledge to be assimilated by today's practicing physician. There is also a greatly heightened appreciation within the general public for the seriousness of any concussion and the need to manage concussion appropriately. The tipping point for these events is the combination of keen media interest and the NFL finally owning up to cumulative effects of concussion.

In this article I want to emphasize some key points for the general pediatrician and to provide a plethora of excellent resources that are available to you through the Internet. I have been heavily involved in the arena of concussion management for over fifteen years and have seen remarkable changes in our understanding and management of concussion, including circumstances where incorrect information was widely promulgated; many physicians still refer to that discredited source as their primary source of knowledge today!! Grading scales are no longer used to assess the severity of concussions.

In the past decade, three international consensus statements on concussion have been issued. The most recent conference was held in Zurich, Switzerland in November 2008 and provides the best scientific information and consensus of leading minds.

In addition in May 2009, based on an injury to a junior high school football player in which the athlete suffered a concussion and subdural hematoma during the same game, state legislation was passed in Washington State called the “Zachary Lystedt Law”. This law has three components: (1) Educate coaches, athletes and parents about concussion; (2) Any athlete suspected of having a concussion should be removed from play immediately and not return to play that day; (3) Concussed athletes cannot return to activity until cleared by a licensed health care professional knowledgeable in the evaluation and management of concussion. Six other states have passed such a law and similar legislation is pending before the New Jersey Legislature.

Do you meet the criteria of being “a health care professional knowledgeable in the evaluation and management of concussion” in 2010?

That is the purpose of this article, the available accompanying resources/ references and other continuing medical education programs that will be offered during the next two years through AAP/ NJ. In addition, the Council on Sports Medicine and Fitness (COSMF) of the American Academy of Pediatrics has just published a Clinical Report on “Sports Related Concussion in Children and Adolescents” in the September 2010 issue of Pediatrics which is an excellent source of current information.

The NJSIAA (New Jersey State Interscholastic Athletic Association) developed a parent/guardian concussion policy acknowledgment form that must be read and signed by parents and athletes during the pre-participation physical examination process which went into effect in July 2010. The NJSIAA also issued a policy statement in April 2010 on Concussion Identification, Management and Return-to-Play. For the most part, the NJSIAA policy statement follows the Zurich protocol with one key difference; the NJSIAA policy adds a buffer week between the complete resolution of symptoms and the beginning of the graduated return-to-play exercise protocol.

“The definition of concussion is “a complex pathophysiological process affecting the brain, induced by traumatic biomechanical forces.”

Included in the definition are five major features of a concussion.

1. Concussion may be caused either by a direct blow to the head, face, neck or elsewhere on the body with an “impulsive” force transmitted to the head.
2. Concussion typically results in the rapid onset of short-lived impairment of neurologic function that resolves spontaneously.
3. Concussion may result in neuropathological changes, but the acute clinical symptoms largely reflect a functional disturbance rather than a structural injury.
4. Concussion results in a graded set of clinical symptoms that may or may not involve loss of consciousness. Resolution of the clinical and cognitive symptoms typically follows a sequential course; however, it is important to note that, in a small percentage of cases, post-concussive symptoms may be prolonged.
5. No abnormality on standard structural neuroimaging studies is seen in concussion.

Signs and symptoms of concussion can occur in one or more of the following clinical domains (some examples given in parentheses):

a. Symptoms: somatic (headache); cognitive (feeling like in a fog) and/ or emotional (lability)
b. Physical signs (loss of consciousness, amnesia)
c. Behavioral (emotional) changes (irritability)
d. Cognitive impairment (slowed reaction times, slowed speed of processing)
e. Sleep disturbances (drowsiness)

Several tools are available for assessing and managing the concussed athlete through the recovery process. The symptom checklist (22 items with a 7 point grading scale 0 to 6) is helpful; most athletic trainers use this technique to make an immediate assessment. Parents and student-athletes can do likewise at home to chart the progress. **A score sheet is included for your use as an insert in this newsletter.** (Cont. on p 19)
It is not uncommon, however, for children and adolescents to report a symptom score anywhere from 0 to 10 even when they have not experienced a traumatic head injury; keep this in mind when using the post-concussion symptom scale to determine that “all symptoms are fully resolved.” Consider asking all children and adolescents to complete a baseline symptom score during their annual check-ups or pre-participation physical examinations.

Postural stability testing, as measured by the balance assessment test BESS (Balance Error Scoring System), is another reliable and valid tool for objectively measuring the motor domain of neurological functioning.

Athletes are asked to stand with their eyes closed and hands on hips in three positions for 20 seconds: (1) feet together with both ankles touching; (2) standing on their non-dominant leg with the other leg bent at 30 degrees of hip flexion and 45 degrees of knee flexion; (3) feet in tandem position with their non-dominant leg behind the dominant leg.

The NCAA website noted on the resource attachment to this article has a video demonstration of the BESS test. A detailed text description of the BESS test is included as an attachment.

A computer-based neuropsychological testing system (ImPACT) is another helpful tool. About 100 New Jersey high schools have ImPACT testing within their school and have done pre-season baseline testing on their athletes, permitting a direct before and after comparison of the athlete against his or her own baseline test when healthy.

The ImPACT system can also be placed in the pediatrician’s office and this testing carries it own CPT code to enable payment for test administration. Other computer-based neuropsychological test instruments for routine use in basic concussions are also very good, but not as widely used in New Jersey. Neuropsychological testing does not independently determine if an athlete has been concussed nor when they may safely return to play; both of those are clinical decisions.

Management

By now, everyone knows that an individual with a concus-
Graduated Return-to-Play Exercise Protocol:

**Step 1:** No activity, complete physical and cognitive rest. The objective of this step is recovery. (Step 1a. The first day back to school should include no physical activity; no physical education, sports or active recess)

**Step 2:** Light aerobic exercise, which includes walking, swimming or stationary cycling, keeping the intensity < 70% Maximum percentage heart rate; no resistance training. The objective of this step is increased heart rate.

**Step 3:** Sport-specific exercise including skating, and/ or running drills; no head impact activities. The objective of this step is to add movement.

**Step 4:** Non-contact training drills involving progression to more complex training drills (e.g. passing drills). The student athlete may initiate progressive resistance training.

**Step 5:** Following medical clearance, participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by the coaching staff.

**Step 6:** Return to play involving normal exertional game activity.

To reiterate: Children take longer to heal from a concussion than adults. No athlete should return to play while symptomatic at rest or with exertion.

**Post-Concussion Syndrome Versus Prolonged Healing of Initial Concussion:**

Much discussion has taken place regarding post-concussion syndrome. Symptoms that last for more than two weeks in an athlete who has carefully followed all of the recommendations for rest, both physical and cognitive, raise a concern for possible post-concussion syndrome and probably should be referred to a neuropsychologist for a more complete evaluation and management. But in most cases, the prolongation of symptoms is more of a reflection of insufficient rest, not permitting the brain the opportunity to heal, than actual post-concussion syndrome.

This year, I saw a high school senior who was injured in the final game of his high school athletic career in early November. He was evaluated in the emergency room (twice), by his pediatrician and a neurologist. Since he was no longer playing sports, avoiding physical activity was not difficult. But no one mentioned anything about cognitive rest. He continued to try to go about his daily life in the usual fashion, but his symptoms never fully went away. His grades deteriorated as well. He came into my office in late January. He was truly a case of “prolonged initial concussion” rather than post-concussion syndrome. With a week or two of rest, every symptom completely resolved and he felt “like himself” again.

If the brain is given ample opportunity to heal itself before returning the athlete to participation in sports or to the challenging classroom environment, the likelihood of having an increased probability of future concussions with less forceful trauma may not be increased. Much of that phenomenon is probably related to prior insufficient management of initial concussions.

Athletes with a history of headaches, especially migraines, and some learning disabilities may discover that a concussion exacerbates their other underlying conditions. An increase in migraine headache frequency following a concussion, for example, may be an indication of inadequate resolution of brain recovery. These individuals may require additional time for the brain to fully resolve the concussion and regain typical control of the headaches.

I hope that you will explore the wonderful and more complete materials that are attached to this article so that you can answer affirmatively the question raised at the start of the article: Do you meet the criteria of being “a health care professional knowledgeable in the evaluation and management of concussion” in 2010?
Concussion Resources for New Jersey Pediatricians

New Jersey State Interscholastic Activities Association [www.NJSIAA.org](http://www.NJSIAA.org)

- Concussion Identification, Management and Return-To-Play NJSIAA Policy Statement. Developed by The Medical Advisory Board. April, 2010

Centers for Disease Control and Prevention [www.cdc.gov/concussion](http://www.cdc.gov/concussion)

- Information for Physicians – Facts for Physicians Booklet; Acute Concussion (ACE) form
- ACE Care Plan (Work and School Versions)
- Concussion in Sports Palm Card

To order bulk quantities of CDC’s concussion resources free-of-charge and/or to learn how you can get involved to help keep all people safe from concussión, visit [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion) or contact CDC by email (CD C-IN F0 @ cdc.gov) or toll-free at 1-800-CDC-IN F0 (1-800-232-4636).

NCAA Information and Educational Programs [www.NCAA.org/health-safety](http://www.NCAA.org/health-safety)

- New Video released on Concussions in Sport. The video targets student-athletes and is available only on the web at this time. The July 16th Webinar on Concussion Management is now available for viewing. Example Institution-Specific Concussion Management Plans are now posted for reference.

National High School Federation [www.nfhs.org](http://www.nfhs.org)

- Free learning course on concussion designed for coaches, but is very good. A 20 minute Internet program presented by a sports medicine physician who heads the Federation sports Safety Committee. Do not be intimidated by having to register and appear to pay for the course; it is FREE!!


Clinical Journal of Sport Medicine, Volume 19, No. 3 May 2009, pp. 185-200.

ImPACT [www.impact.com](http://www.impact.com)

ImPACT is a computer-based Neuropsychological Testing system for four domains: verbal memory, visual memory, speed of processing and reaction time. For New Jersey, the “gold-standard” of computer-based neuropsychological testing done by high schools – and in primary care offices and concussion centers. A brief 20 to 40 minute testing format; not a substitute for a full neuropsychological testing battery done by neuropsychologists.

Brain Injury Association of New Jersey [www.BIANJ.org](http://www.BIANJ.org)

BIANJ Concussion in Sports Committee a held Concussion Summit in February 2006 at Giants Stadium and has been active in assisting 100 high schools in New Jersey to obtain ImPACT at a reduced rate for a three year period. Producer of concussion poster for your office walls. Resource for information and leadership on concussion. [SportsConcussion.com](http://SportsConcussion.com)

Computerized Neuropsychological Tests

ImPACT -- [http://www.impacttest.com/](http://www.impacttest.com/)
#1 chromosomal anomaly affecting girls
50% => 5% in height will have TS

Early diagnosis is key for short GIRLS

* Average height untreated 4'8"
* Ovarian failure and Infertility
* Heart abnormalities
* Hearing loss and infections
* Kidney issues and Infections
* Type II Diabetes
* Lymphedema
* Hypertension
* Hypothyroidism
* Pigmented moles
* Drooping eyes and cataracts

* Wide short neck
* Low set ears and hairline
* Broad shield chest
* Scoliosis
* Overweight
* Osteoporosis
* High arched palate
* Dental problems
* Upturned fingernails
* Educational difficulties
* Social issues and anxiety

TurnerSyndromeFoundation.org
Toll free: 800-594-4585

Turner Syndrome affects 1 in 2000 females
Save the Date!
Tuesday, October 12, 2010
Bringing Baby-Friendly™ to New Jersey: A Challenge to Change
9 AM - 4 PM
New Jersey Hospital Association
Princeton, NJ

Learn more about New Jersey’s new and exciting program to improve your hospital’s team approach to breastfeeding.

YOUR TEAM IS INVITED...
- Physician Leadership
- Nursing leadership
- Hospital executives
- Lactation leadership

TOPICS WILL INCLUDE:
- New $10,000 grant opportunity for your hospital
- Breastfeeding: Why it matters
- WHO Baby Friendly Hospital Initiative
- Get your Hospital off the ground

FOR RESERVATIONS OR INFORMATION:
Contact Harriet Lazarus or Shreya Durvasula at 609.588.9988 or by email at sdurvasula@njpcore.org.

MARK YOUR CALENDAR TODAY!
Details and Registration Brochure Coming Soon

This event is supported by a cooperative agreement from the Centers for Disease Control and Prevention (CDC) (3U58DP002002-01). Its contents are solely the responsibility of the authors and do not necessarily reflect the official views of the CDC, the Department of Health and Human Services, or the federal government.

This activity has been approved for AMA PRA Category 1 Credits™.
**Member Benefits**

AAP NJ Announces New Exciting Member Benefits!

In addition to substantial savings on your Malpractice Insurance through MD Advantage and the Purchasing Alliance, your AAP NJ membership now allows you to save money on many other personal services through our various affinity programs. To enjoy these savings you must be an AAP NJ member in good standing. Please contact Bert Mulder, Director of Membership and Events, via e-mail at bmulder@aapnj.org or phone 609-842-0014, x112 for more information.

It is important to note that AAP NJ 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.

<table>
<thead>
<tr>
<th><strong>Disability Discounts:</strong></th>
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<tbody>
<tr>
<td>Union Central: 15% to AAP NJ members on sex distinct rates</td>
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<tr>
<td>Principal: 20% to AAP NJ members on sex distinct rates</td>
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<tr>
<td>The Standard: 10% on unisex rates</td>
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<tr>
<td>Discounts on Disability Insurance for AAP NJ Members are available through Callahan Financial Group and Mid-Atlantic Resource Group</td>
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<tr>
<th><strong>Callahan Financial Group</strong></th>
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<tr>
<td><a href="http://www.callahanfinancialgroup.com">www.callahanfinancialgroup.com</a></td>
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<tr>
<th><strong>Mid-Atlantic Resource Group, LLC</strong></th>
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<tr>
<td><a href="http://www.margfinancial.com">www.margfinancial.com</a></td>
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<tr>
<th><strong>Long Term Insurance Discounts:</strong></th>
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<tr>
<td>John Hancock: 5%; MedAmerica: 5%</td>
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<td>United of Omaha: 5% and Transamerica: 10%</td>
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<td>Discount ALSO available to eligible family members.</td>
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<td>Favorable Rates available for other carriers!</td>
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<tr>
<td>Discounts on Long Term Care Insurance for AAP NJ Members is available through Financial Management Corporation.</td>
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<th><strong>Financial Management Corporation</strong></th>
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<td><a href="http://www.thefmc.com">www.thefmc.com</a></td>
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<th><strong>Discounts on Medical Supplies:</strong></th>
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<tr>
<td>Minimum 7% discount for all member purchases ordered from DocSavings.com, an internet based medical supply company run by practicing physicians.</td>
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<td>New Special Offers for AAP NJ members on a wide range of products are announced every quarter.</td>
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<th><strong>DocSavings.com</strong></th>
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<tr>
<td><a href="http://www.doc">www.doc</a> savings.com</td>
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<th><strong>Practice Management Discounts:</strong></th>
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<tr>
<td>AAP NJ Chapter Members now receive a $1,000 discount on MTBC’s comprehensive pediatric billing, practice management and EMR solution!</td>
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<tr>
<td>MTBC’s end-to-end solution—offered at just 5% of monthly collections—presents a service suite that is unmatched in the industry for its scope and value. In addition to full-service medical billing, MTBC clients also receive a number of other practice management services at no additional charge.</td>
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