



PCORE CORNER

*Steven Kairys, MD, FAAP and
E. Sooze Hodgson, MD, FAAP*

PCORE is proud to announce the debut of an obesity prevention pilot program in Asbury Park, New Jersey. The U.S. Department of Health and Human Services, Administration for Children and Families has awarded PCORE a \$50,000 grant to implement this project. Dr. Margaret “Meg” Fisher, MD, FAAP, as Medical Director, will be spearheading this project to address the growing epidemic of childhood obesity in New Jersey.

The purpose of the project is to conduct pediatrician presentations to prevent obesity in low-income children through nutrition awareness. By utilizing an untapped resource (pediatricians in the community), the goal for the project is to help parents and children embrace behaviors that support a healthy and active lifestyle and educate school officials and daycare administrators on strategies that can be adopted to help children and their parents achieve their lifestyle goals.

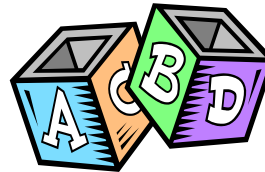
Through the implementation of a speaker’s bureau of community pediatricians from Monmouth County, 24 presentations will take place over the 12 month period in Asbury Park. This methodology is based on the concept that pediatricians are considered by parents as a major source of unbiased information about their child. Therefore, they would be viewed as effective presenters on the topics of nutrition and activity and how if they are improved, the overall health of the family would be enhanced and the long-term goal of preventing obesity can be achieved.

If any member of the Chapter has an interest in addressing obesity in an urban community of need in Monmouth County and would like to

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QUALITY COUNTS! – How to choose child care

Elaine Donoghue, MD, FAAP



As pediatricians, we know that having nurturing and developmentally stimulating environments are critical for early brain development. But quality also costs, and child care is a significant cost for most families. Schools are free for children over the age of five, but under the age of five, parents are responsible for the costs. Did it ever make you wonder why parents pay the most to educate their children when they are at the lowest point of their earning potential? Did you know that the average child care worker wages are on par with parking lot attendants?

With low wages and 30% turnover rates in child care staff, it is difficult to provide quality child care. Research shows that only 8% of infant centers provided high quality care and 14% of all centers provided high quality care and 74% provided mediocre care. With the current budgetary limitations, we are not likely to see dramatic changes in these realities, but until childhood education is seen as a continuum and not something that starts at age five, how can we help parents choose quality child care settings for their infants and children?

The reality is that most parents choose child care based on geography, cost and personal preference. We need to get parents thinking about quality indicators such as staff ratios, care’s licensure and any extra accreditation. They should ask about the center’s policies about medications, illness, and how injuries are handled. Parents can visit to get a sense of the staff’s style of interactions with the children. They can look at playground equipment, food preparation areas and diapering facilities.

Parents can get help from county agencies called Resource and Referral Agency (R&R) or Unified Child Care Agencies (UCCA) in New Jersey. These agencies are charged with helping parents evaluate their options for child care. They provide lists of centers and provide education about quality indicators. Other resources include the AAP brochure, “Child Care: What’s best for Your Family?”. The National Association of Early Childhood Educators (NAEYC) has good information on their website (www.naeyc.org) as does the National Resource Center for Health and Safety in Child Care (nrc.uchsc.edu or 1-800-598-KIDS).

To find out more about these issues, contact the EOIC Child Care program through the AAP/NJ. EPIC Child Care can provide you with a comprehensive resource manual and depending on your location, may even be able to come to your office to provide an educational session.

We have an opportunity to help parents make some difficult decisions that will impact on their children’s development and health. We may not be able to walk the road for them, but we can at least point out the way.

American Academy of Pediatrics



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4th Quarter 2004

*American Academy
of Pediatrics
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President's Message

Bipin N. Patel, M.D., FAAP

"Here we go again." Familiar words I heard from many of you with the news of the Flu vaccine shortage. With recent shortages of Prevnar and other vaccines, the notion of having a reliable oversight for vaccine supply becomes more prudent for public health interest. In the midst of the Flu vaccine shortage, New Jersey went beyond accepting the CDC and AAP guidelines for Flu vaccine use in High Risk groups by enacting a time limited law (till May 2005) mandating such use and penalizing providers \$500.00 who deviate from the regulations. I want to reassure you that even though these regulations were passed at "lightning speed" your AAP/NJ Chapter leadership worked quickly to assess the major concerns and communicated them to the DHSS for clarifications. These responses from the DHSS were emailed to the members within a few days of the law being enacted. It has become important to stay connected by email or web browsing in today's world to remain current in case of emergencies or urgent news. Please give us your email addresses so that we can maintain effective and timely communications with you. It is hard to believe that the vaccine which was routinely refused by the people who needed it most a few years ago is such a hot commodity today. There may be a silver lining to all this, Flu vaccine and vaccines in general will be accepted more readily in the future.



On a high note our School Health Conference was a great success with over 600 attendees. The next planned conference is Resident Career Day in March 2005 and we are already deep into planning for the Annual Meeting in spring of 2005. I am really impressed by the new volunteers who have stepped up for committee work.

AAP's National Conference and Exhibition in San Francisco had many New Jersey members attending. It was great to see so many of you at the District III Breakfast meeting. In addition to the scientific meeting, members shared strategies to combat issues that children and pediatricians are facing today, e.g. the epidemic of Childhood Obesity, inadequate resources for mental health services, reimbursement and rising malpractice costs. These are the very issues we are facing in NJ.

The wheels of change turn slowly but persistent and true to our mission to serve the interests of children and pediatricians of New Jersey, we will succeed. Please join us to achieve these goals.

My best wishes for the coming holidays.



Join the Young Pediatricians Listserv

The Young Pediatricians Committee has a listserv up and running where young pediatricians can discuss relevant issues and receive announcements and news about the Committee.

The Young Pediatricians Committee is open to AAP/NJ members either under 40 years of age or in the first five years of practice.

To join the listserv please email Dennis Kuo, MD, FAAP at status@verizon.net or Henry Shih, MD, FAAP htishih@yahoo.com

The Legislative Scoop

Barbara George Johnson

The 2004-05 legislative session is in full swing and the AAP/NJ is actively tracking legislation and monitoring government actions that will have an impact on the practice of pediatrics in New Jersey.

Changing of the Guards

On November 15, 2004 Governor James E. McGreevey will officially resign as the Governor of New Jersey. Waiting in the wings to take over as the 52nd Governor of the Garden State is Senator and President of the New Jersey Senate, Richard J. Codey. Senator Codey is known for his no nonsense style in Trenton and is no stranger to health care issues. In particular, he has been a champion of mental health initiatives.

Flu Vaccine Shortage

On October 5, 2004, Chiron Corporation notified the Centers for Disease Control and Prevention (CDC) that Fluvirin would not be available for distribution in the United States for the 2004/05 influenza season. Consequently, one half of the expected supply of the inactivated form of vaccine will not be available to the U.S. population. As a result of this notification, the CDC in conjunction with the Advisory Committee for Immunization Practices (ACIP) has issued recommendations for delivery of flu vaccines (see MMWR, October 8, 2004/53(30); 923-924). As a result of this shortage, the New Jersey legislature is introducing legislation that will utilize the CDC's recommendations to set standards for vaccine distribution and delivery during this shortage.

This bill establishes a mechanism to provide for the proper distribution of influenza vaccine to persons most at risk during the current influenza vaccine shortage. Specifically, the bill provides that in order to protect the public health during the 2004-2005 influenza vaccine shortage, the Commissioner of Health and Senior Services shall issue an order to implement an influenza vaccine reallocation plan. The bill provides that a person who willfully or knowingly violates the provisions of the commissioner's order shall be liable for a civil penalty of \$500 for each violation.

Pediatricians will be expected to follow the CDC recommendations which specifies that although certain children aged <9 years require 2 doses of vaccine because they have not previously been vaccinated, physicians will not be allowed to reserve second doses for this group. All children at high risk for complications from influenza, including those aged 6--23 months, who are brought for vaccination, should be vaccinated with a first or second dose, depending on vaccination status. However, doses should not be held in reserve to ensure that 2 doses will be available. Instead, physicians will be expected to use available vaccine to vaccinate persons in priority groups on a first-come, first-serve basis.

The Obesity Factor

The Governor's office is diligently working to complete appointments to the Governor's Task Force on Obesity. This group is slated to meet and begin work on this issue some time in November. The AAP/NJ will have a sitting member on this task force. However, the legislative wheels have already begun to turn on this issue. The Assembly Education Committee heard testimony on several bills related to Obesity earlier this fall. Stephen Rice, MD, FAAP and Margaret "Meg" Fisher, MD, FAAP testified in favor of the legislation; both doctors noted that this is a good start but much more is needed. The bill refers to the CDC's declaration that obesity is an epidemic in the United States. The bill also notes the Surgeon General's call to arms to prevent and decrease obesity in the U.S. This legislation addresses the sale and availability of foods of minimal nutritional value in public elementary and middle schools. It bans the sale or availability of such products until at least one half hour after the close of the school day. In addition, the bill regulates the content of vending machines to include foods high in grains and low in sugars. It also calls for beverages that are 100% juice or vegetables, electrolyte-drinks or water. The bill was favorably released from the Assembly Education Committee but there is still a lot of work to be done before it goes to the General Assembly for a floor vote.



CATCH

Elaine Donoghue, MD, FAAP, CATCH Facilitator

Congratulations to New Jersey on being awarded a CATCH Planning grant in this last cycle. The third cycle for the CATCH Implementation grants is approaching. Implementation grants provide funds in amounts from \$2,500 to \$10,000. This helps pediatricians who work with local communities striving for all children to have medical homes and access to health care services. The program supports pediatricians in the initial implementation of a community-based health initiative. Applications are posted on the AAP website in November and are due in January. Pediatric residents can also apply for CATCH grants in this cycle. Technical assistance is available. If you have questions, please contact the chapter CATCH facilitator, Elaine Donoghue through the AAP/NJ Chapter.

Childhood Obesity Series

The following article is the first in a series developed by the AAP/NJ Task Force on Childhood Obesity. Future articles will be related to issues such as packing a healthy lunch, increasing activity, vending machines, soda and sweetened drinks, and nutrition do's and don'ts for the athlete.

Studies Show That Breastfeeding Protects Against Obesity

Lori Feldman-Winter, MD, FAAP, MPH

Over the past three decades, U.S. rates of childhood and adolescent obesity have tripled. Equally alarming, the rates of obesity in infants and preschool children have doubled. Currently, the prevalence of overweight is 15.5% among 12 to 19-year-olds, 15.3% among 6 to 11-year-olds, 10.4% among 2 to 5-year-olds, and 12% among 6 to 23-month-olds. Recent research has determined that obesity and rapid weight gain in the first 4 months of life are associated with an increased risk of being overweight at 7 years of age, independent of birth weight and weight at 1 year. It is clear that overweight children are at increased risk of becoming obese adults, and as adults, they will experience the most profound effects of the current epidemic of obesity. New findings may lead to new hypotheses about what causes childhood obesity. These in turn may contribute to our understanding of this increasing public health problem in the United States.

One third of the adult population is obese and another third is at risk for being overweight. Paradoxically, this huge problem with obesity comes at a time when our society is preoccupied with weight control, diet, exercise and fitness. What is the explanation? There is unfortunately no simple answer, nor any "magic bullet," to either prevent obesity or treat it. However, among all of the population-based and basic science research looking for ways to halt the epidemic, one relatively simple primary prevention strategy has clearly emerged: breastfeeding.

The evidence that breastfeeding prevents obesity

More than a dozen papers have been published in the medical literature over the last decade documenting the relationship between breastfeeding and prevention of obesity later in life.

Several studies show a "dose-breastfeeding and more exclusive dependent" response to this protective relationship. This means that longer breastfeeding (without introduction of formula) gives greater protection from both childhood and adult obesity. Studies that failed to show this relationship often did not ask about the exclusivity and/or duration of breastfeeding, or were limited by small sample size.

How does breastfeeding protect against obesity?

Several biologically plausible mechanisms can explain how and why breastfeeding protects against obesity. Some show why breastfed infants are leaner than their formula feeding counterparts, and others explain why the effects of breastfeeding continue beyond the period of breastfeeding to offer protection throughout the lifespan. The first is *learned self-regulation of energy intake*. Breastfeeding infants control the amount of milk they take from the breast, but bottle-feeding infants are often urged to finish the milk in the bottle, to ignore their own body signals that they have had enough. One research team asked women to increase milk production by pumping in addition to breastfeeding. Faced with the resulting overabundance, their infants increased their intake temporarily, but in a few days returned to baseline, leaving the extra milk in the breast.

A mother's breasts adapt to her infant's appetite, closely matching milk production to the amount taken by the infant—or infants in the case of multiple births. Furthermore, infants adjust their volume intake according to the calories they consume. If a mother makes higher calorie milk with a higher fat content, her infant takes less volume. Interestingly, one of the most common reasons stated for supplementing with infant formula is a mother worrying about whether she is making enough milk, although supplementation is

seldom really necessary.

The *properties of human milk* may also help explain its protective effect. Levels of the hormones insulin and leptin. High levels of protein in infant formula relative to human milk may cause formula-fed infants to produce higher This early effect may outlast infancy and contribute to an insulin and leptin response later in life, which leads to greater fat deposition, increased appetite, and weight gain. This hormonal imbalance may explain why formula-fed infants consume more calories and are more likely to be obese.

A final explanation may relate to the *characteristics of the mothers* themselves. Breastfeeding is most common among wealthier, more educated, and possibly healthier women. Healthier lifestyles, including increased physical activity, may be responsible at least in part for the reduction in childhood obesity. Nevertheless, after controlling for these factors, studies continue to reveal a link between breastfeeding and protection from obesity.

How much protection does breastfeeding offer?

The degree of protection is not yet clear. In a review of studies looking at the odds of obesity or overweight based on infant feeding, breastfeeding reduced the odds of being overweight by 21% to 34%. This may not seem like much when compared to the immensity of the problem, however, U.S. studies are biased by sample selection. Only 14.2% of U.S. mothers follow the American Academy of Pediatrics recommendation to breastfeed exclusively for about 6 months, according to data just released by the Centers for Disease Control and Prevention. The remainder of mothers either exclusively formula feed or combine breastfeeding with formula feeding. Furthermore, obese mothers are less likely to breastfeed, have difficulty in establishing a milk supply,

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Childhood Obesity Series

Continued from page 4

and have a diminished hormonal response to their infant's suckling. Since childhood obesity predicts adult obesity, and obese mothers are less likely to continue breastfeeding, the cycle of familial obesity may be difficult to break without additional support. This could be one explanation for the finding in a recent study that showed white non-Hispanic children are protected against obesity, yet their non-white or Hispanic counterparts did not have the same effect. The prevalence of obesity is greatest among the Hispanic and African American populations, and exclusive breastfeeding is least common in these groups.

Based on currently available studies, a population-attributable risk of overweight based on formula feeding is 15% to 20%. *This risk may be even

higher if we differentiate the combination of breastfeeding and formula feeding from exclusive breastfeeding.* Another factor to consider is the growing number of women who now provide milk for their infants through pumping, then use a bottle to feed the milk. Since one possible mechanism of obesity prevention involves self-regulation, it is not known to what degree the process of breastfeeding contributes to the effect of obesity prevention.

Recommendations

All mothers with rare exceptions should exclusively breastfeed for the first six months, then continue breastfeeding after starting solid foods until at least one year of age and longer if mother and baby want.

Mothers with risk factors for breastfeeding problems, such as maternal obesity, should seek support early in pregnancy to identify resources that can help them establish full breastfeeding. Mothers who must return to work in the first six months after delivery need support to continue exclusive breastfeeding, such as on-site or nearby childcare to facilitate breastfeeding during breaks, and time and a place to express and store milk at the workplace. The current National Breastfeeding Awareness Campaign of the Ad Council and the US Office on Women's Health is targeting first-time parents and groups that traditionally do not breastfeed. A successful campaign may contribute significantly to halting the current epidemic of obesity in the U.S.

School Health Conference

Wayne Yankus, MD, FAAP, Chairman, School Health Committee

The Thirteenth Annual School Health Conference was held at the Hyatt Regency New Brunswick with a record attendance of 650 people. *School Health: 2004 – Critical Issues in Community Medicine and School Health* garnered many positive comments about the program and workshops. The planning committee wishes to thank those Chapter Members who spoke as experts to the school nurses, physicians, and health care professionals in attendance. Special thanks to Sheila Borgese and the Staff of Association Associates for the tremendous organization required.

Our chapter has scored a real hit with our nurse colleagues and the statewide medical community. Topics include infectious diseases, depression, obesity, female painful abdomen, and many more were discussed. Representatives from the NJ Department of Education and NJ Department of Health and Senior Services were in attendance and were joined by the Association for Children of New Jersey for Governor McGreevey's proclamation of October as Child Health Month. Also in attendance were leaders and members of the New Jersey State School Nurses Association (NJSSNA) who continue their support of the AAP/NJ School Health Conferences.

The School Health Committee is looking for Chapter Members who practice community medicine and/or are involved with local school systems. Contact Sheila Borgese (sborgese@hq4u.com) or Wayne Yankus (yankuswa@yahoo.com).



Mary Suessmann, President, New Jersey State School Nurses Association (NJSSNA)

Bipin N. Patel, MD, FAAP, President, American Academy of Pediatrics/New Jersey Chapter

Wayne A. Yankus, MD, FAAP, American Academy of Pediatrics/New Jersey Chapter School Health Committee

News from National

Committee on Pediatric Workforce Update

Beth A. Pletcher, MD, FAAP – COPW Member

The Committee on Pediatric Workforce (COPW) met in San Francisco at the annual National Conference and Exhibition (NCE) on October 10th and 11th. It was wonderful to see the “standing room only” turn-out for the District III breakfast. I was very glad to have the opportunity to hear about the many initiatives and activities our members are involved in; thank you for allowing me to share some of the work of the COPW at the breakfast.

The COPW also sponsored the Women’s Breakfast Forum on October 11th with more than 300 attendees. During this meeting, Dr. Carol Berkowitz announced the Board’s decision to include women in pediatrics as an Academy mega-issue in the coming year. As the number of women in pediatrics increases, workforce issues continue to be a major theme for the Academy. New data and information can be found on the Academy web page for women in pediatrics at: www.aap.org/womenpedis.

The COPW looks to the membership at-large for suggestions for future initiatives. At the August 2004 Leadership Forum, a number of pressing issues were referred to COPW such as elimination of health disparities for children and educational debt. One of the statements currently under revision is “Prevention of Sexual Harassment in the Workplace and Educational Settings”. At the aforementioned Women in Pediatrics Breakfast Forum, the COPW took the opportunity to share some of the current findings in the areas of sexual harassment and gender discrimination. The Committee was pleased to learn that the landmark statement on culturally effective pediatric care, “Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy” will be published in December. It is worth noting that the COPW has deliberately used the term “culturally effective” rather than the more commonly used term “cultural competence”. The COPW believes that the term “culturally effective” more

appropriately shifts the focus from pure process to outcomes of physician-patient interactions as they relate to the provision of optimal pediatric health care. “Enhancing the Diversity of the Pediatrician Workforce” and “Financing Graduate Medical Education to Meet Pediatric Workforce Needs” are two additional policy statements that the Committee is in the process of revising. Finally, the COPW agreed to petition our Oversight Committee for permission to revise another existing Academy statement “Non-Discrimination in Pediatric Health Care”.

The COPW Subcommittee on Subspecialty Workforce has completed phase one of its exploration of subspecialty pediatric care with the publication of subspecialty specific articles based on data generated by the FOPE II subspecialty surveys. In the next phase, the Subcommittee will continue its work by examining subspecialty provider supply and access to care utilizing currently available data sets. Another potential source of information on pediatric subspecialist supply may be the Academy’s Periodic Survey of Fellows. The Subcommittee hopes to add a question to a future Periodic Survey that asks “Would it be useful for the Academy to survey a sample of pediatric generalists about the availability of specific subspecialists in their area?”. Feedback from this question will help the Academy to determine whether an additional AAP survey on access to subspecialists is needed. The Subcommittee has also planned to examine the workforce implications of resident indebtedness. Because this is a very broad and complex topic, the Subcommittee will focus its study on determining the extent to which resident debt load serves as a barrier or disincentive to pursuing subspecialty careers.

Indeed, indebtedness for graduating medical students and pediatric residents continues to be a key issue for COPW, generating an in-depth discussion during the meeting with

review of relevant data from multiple sources. Early medical school interest in pediatrics continues to be a strong predictor of pursuit of a career in pediatrics, despite increasing levels of debt incurred by students and house officers today.

The COPW also networks with other organizations in order to gain insight into pediatric workforce issues. Both Dr. Richard Behrman, Executive Director of the Federation of Pediatric Organizations’ Pediatric Steering Committee, and Dr. Gail McGuinness, Senior Vice President of the American Board of Pediatrics, shared their perspectives with the COPW in an effort to facilitate our workforce deliberations.

As always I appreciate the opportunity to represent our chapter and district as a member of COPW. Please feel free to get in touch with any and all ideas. You may reach me at pletchba@umdnj.edu or (973) 972-3314

Don’t Miss Important Information

Register your email address on the AAP – Members Only Channel of the AAP web site, www.aap.org, by clicking on “Members Only” on the Home Page, and following the instructions.

STAY CONNECTED – receive updates for flu vaccine supplies; late-breaking news, i.e. bili screening guidelines; developments in communicating with parents via email; and much, much more. Keeping your contact info current in the database will ensure you to receive news alerts, info bulletins, etc.





Questions & Answers Regarding Tuberculin Skin Testing (TST)

Renu Verma, MD, Pediatric Infectious Disease Specialist

- Q. Who should be tested **immediately**?
 - Contacts of a person with confirmed or suspected tuberculosis
 - Children with radiological or clinical finding suggesting tuberculosis disease
 - Children immigrating from endemic countries
 - Children with travel history to endemic countries and/or contact with person from such countries
- Q. Who should be tested **annually**?
 - Children with HIV or living in household with HIV
 - Incarcerated adolescents
- Q. Who should be tested every **2-3 years**?
 - Children exposed to following persons: HIV infected, homeless, resident of nursing homes, institutionalized adolescent or adults, users of illicit drugs, migrant farm workers, foster children
- Q. Children who should be considered for **TST at 4-6 and 11-16 years of age**?
 - Children whose parents emigrated from endemic countries and have continued potential for exposure for tuberculosis by travel to the endemic areas
 - Children without specific risk factors who reside in high prevalence area

Special circumstances

- TST should be performed before initiating immunosuppressive therapy
- Children with medical conditions such as Diabetes mellitus, chronic renal failure, congenital and acquired immune deficiency are at risk for progression to severe disease if acquire infection

TST and BCG vaccine

- Prior BCG vaccination is not contraindication for TST
- Radiographic evaluation of all children with positive TST regardless of BCG immunization, is recommended

Do Not Need TST

- Routine screening of large population
- Children with out risk factors, including infants < 1 year of age



Calendar

Allergies and meningococcal disease are just two topics that will be covered in upcoming teleconferences. To stay current on FREE teleconferences and Chapter activities, visit the AAP/NJ Chapter web site often: www.aapnj.org.

Resident Career Day, March 16, 2004, Victorian Manor, Edison, New Jersey PLEASE ENCOURAGE EVERY RESIDENT YOU MEET TO ATTEND THIS IMPORTANT SEMINAR

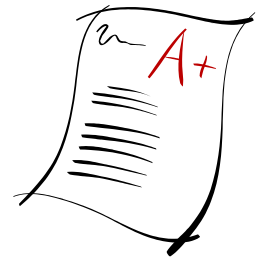
Contact Your AAP/NJ Headquarters



Phone: 609-585-6871; fax: 609-581-8244 – email: hq@aapnj.org www.aapnj.org
AAP National: 800-433-9016 - www.aap.org

HOW NOT TO FLUNK RETIREMENT or WHO AM I IF I AM NOT A PEDIATRICIAN?

Avrum L. Katcher, MD, FAAP, Chairman, Seniors Committee



In our last issue I discussed health maintenance for the Pediatrician. This summary is about changes in career, or navigating transitions, both more appropriate terms for leaving practice. The physician who “retires,” by ceasing to be, and ceases to be active and interested, will not last long. Better to think about alternative ventures, whether for profit or for satisfaction.

Planning, whether to leave practice for other medical work, for non-professional employment, or for leisure, volunteerism or whatever, should begin early. Early means once one is established in the career channel of choice...primary care practice, consulting, research or teaching. It is never too early to commence plans.

Planning includes: Recognition of the impact of loss of identity. If you have worked as a pediatrician all those years, and find you no longer occupies that role, who are you? I faced that at the age of 69 when I left practice, but within weeks discovered I was so occupied with many other ventures that I had less spare time than before. Colleagues have found they cannot give up what they do, but continue as practitioners indefinitely. Some fear the change; others prefer what they have always done. What is important for the person contemplating change is, “What

does it mean for me?”

Consideration of personal financial resources, present and future. What will be needed to maintain lifestyle? What will be the preferred lifestyle? Financial planners today warn, in contrast with a decade or two ago, that almost as much income is needed to maintain that lifestyle as while employed. The savings required deserve careful evaluation, perhaps with the aid of a financial professional.

Selecting activities for the new career. What one is doing should accomplish certain goals, most importantly providing personal satisfaction. In addition, physical, mental and emotional exercise are needed to support health, promote the self-image and the image that others have of you in the world. The cliché “Use it or lose it” is a truth rather than a cliché.

Evaluation of the effect of a change on spouse, other family members and associates. Whether one is leaving medicine altogether, or contemplating other career change, not many of us live in an interpersonal vacuum. We have a spouse, companion, family, colleagues, all of whom may be affected, and all of whom may have something to say. Obviously, planning includes discussion with and consideration of the opinions

of these loved and/or respected persons.

How to plan a life change involves no obscure steps. The first is self-consideration, what am I, where am I, what do I want, and above all, what do those who are very close to me have to say. The second is consideration of choices, whether alternative professional settings or new leisure and non-pediatric activities. Those who prefer to remain in pediatrics may seek administrative work, part-time employment, or a less demanding area. Others may look for volunteer work in pediatrics or out of it, advocacy, a return to learning in partially neglected but desired areas, digging deeper into hobbies in literature, art, music or whatever. Third is examination of personal resources, health, savings, sources of pleasure and what kind of person one wishes to become. When a decision on what to do is made, then comes concrete planning to disengage from current involvement, and create the new environment, the new life.

None of this is surprising. None of these suggestions require a knowledge of rocket science. What is most important is the personal: the self-examination and the interaction with loved ones to achieve the desired goal.

FOOD RULES IN SCHOOLS

STATE OF NEW JERSEY – 211th LEGISLATURE - Assembly, No. 3916

Introduced September 13, 2004 - Sponsored by: Assemblyman CRAIG A. STANLEY – District 28 (Essex)

STATEMENT

This bill establishes statutory minimum nutritional standards for food items sold to pupils at public elementary and middle schools. Specifically, the bill prohibits the sale of foods of minimal nutritional value, as defined by the United States Department of Agriculture, until at least one-half hour after the end of the school day. Additionally, the bill limits food items sold through school vending machines to: whole grain, enriched or fortified grains or grain products; fruits or 100% fruit juices; water; milk or dairy products; soy-based products; vegetables or vegetable juices; electrolyte-replacement beverages; or nuts, nut spreads, seeds, legumes or trail mixes.

The federal Centers for Disease Control and Prevention has declared that obesity, which affects 61% of American adults, and childhood obesity, which affects up to 15% of American children between the ages of six and 17, are epidemics in the United States. The consequences of childhood obesity are grave: obese children have an elevated risk for long-term health problems, including cardiovascular disease, stroke, hypertension, high blood pressure, gallbladder disease, Type 2 diabetes, asthma and certain cancers. In fact, 60% of overweight five-to 10-year-old children already have at least one risk factor for heart disease. Moreover, overweight and obese children are often seriously affected by discrimination, psychological stress, poor body image and low self-esteem.

Health experts agree that one of the most effective ways to prevent the chronic diseases associated with obesity is to establish policies and programs that encourage children and adolescents to develop healthy eating habits that they can maintain throughout their lives. To view the bill: <http://www.njleg.state.nj.us/bills/BillView.asp>

PCORE CORNER

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serve as a pediatrician presenter for a modest honorarium and reimbursable travel expenses, please contact Anne Lorenzo, the Project Assistant at 609-585-6871 or alorenzo@hq4u.com.

This is just one of the new and exciting programs that PCORE is working to develop that serve the children of New Jersey. But PCORE needs your help in order to continue to create programs that are dedicated to improving their health and well-being. As a member of the AAP/NJ chapter, you can help make a difference by supporting the foundation and its mission. Please take a moment to consider making a donation that may be tax deductible to PCORE.

You can make your donation check payable to: Pediatric Council on Research and Education, Inc. (PCORE), 1 AAA Drive, Suite 102, Trenton, NJ 08691 or feel free to contact Lori Donovan if you would like further information at 609-585-6871 or ldonovan@hq4u.com. The chapter leadership of the AAP/NJ appreciates the commitment from those who have supported PCORE in the past and would welcome any new chapter members who would like to support the work that PCORE is doing on behalf of the children in New Jersey.

Know Your District Councilors Get involved in your local activities –

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District 1

- Passaic
- Bergen

District 2

- Essex
- Hudson
- Union

District 3

- Sussex
- Warren
- Morris
- Hunterdon
- Somerset

District 4

- Middlesex
- Mercer
- Monmouth
- Ocean

District 5

- Burlington
- Atlantic
- Camden
- Gloucester
- Salem
- Cumberland
- Cape May

HAVE YOU HEARD?

- **ATTENTION PEDIATRICIANS!** Your patients may be accessing the following reports which can be found on the Internet. You may want to review them so you can answer patient questions and concerns. Be aware that the hospital data is from 2003, the first year in which these indicators were reviewed. It is available online at <http://www.state.nj.us/health/hmo2004/>.
- Report: **PREVENTING CHILDHOOD OBESITY: Health in the Balance** – The report provides a broad-based examination of the nature, extent, and consequences of obesity in US children and youth, including the social, environmental, and dietary factors responsible for its increased prevalence. The report's action plan lays out explicit goals and recommendations for preventing obesity and promoting healthy weight in children and youth in various segments of society. It also explores the actions needed to initiate, support, and sustain the societal and lifestyle changes that can reverse the trend among our children and youth. See report at <http://www.iom.edu>.

PedsPAC is *YOUR* voice!!

Support this activity by sending your contribution to: PedsPAC, 1 AAA Drive, Suite 102, Trenton, NJ 08691

PCORE CORNER

(Re-run from 3rd quarter 2004 in which it appeared abbreviated)
Steven Kairys, MD, FAAP and E. Sooze Hodgson, MD, FAAP

The Pediatric Council on Research and Education (PCORE) was established by the American Academy of Pediatrics/New Jersey Chapter in 2001 as a 501(c)(3) organization. As the AAP/NJ Foundation, it is able to accept state and national grants, gifts, and support from Foundations. From its inception, PCORE has been fortunate to have a committed board of community advocates and pediatricians from around New Jersey and a dedicated and professional staff led by Director of Development Lori Donovan.

PCORE currently operates grants totaling almost \$500,00 a year and has four or five additional projects working their way through the grant process.

What is the value of PCORE to the Pediatricians of New Jersey?

PCORE has five directives that have direct value to Pediatricians and their families. Each depends on a statewide organization like the AAP for its impact and effect and each gives the AAP a presence it would otherwise not have

1. Practice based research and education - the primary focus of PCORE is to improve the capacity and quality of child health care by working directly with the whole office system to generate the changes. Current projects of EPIC SCAN, Children's Futures, NICHQ Immunizations, EPIC Day-Care and potential future projects in lead prevention, medical home for children with special health care needs and child abuse prevention all focus on the office as the focus of change
2. Close collaboration and involvement of State health and welfare in the projects. All of the projects rely on support and resources from such agencies as the Department of Health and Senior Services (DHSS), Department of Human Services (DHS), the Division of Youth and Family Services (DYFS), and Medicaid. In addition, at the local level each site visit to a practice includes a local state health or DYFS representative who provides a personal connection and a chance to develop network ties between the practice and the state systems
3. A statewide vision - Although many of the projects start out as local area pilot projects, all are aimed at having a statewide impact and all are aimed at long term commitment to monitor and work with the practices to ensure that changes are permanent ones.
4. A commitment to the real needs of practicing pediatricians - The projects are all aimed at being individualized to each practice's needs and culture. Each project has a core objective of working within the financial and manpower framework of the practices and also sensitizing state government to the financial realities of pediatric practices.
5. A goal to disseminate the results of the projects - Project measurements will be through strong evaluation, educational formats, and publications. Each project has a well designed evaluation component and each should be publishable in peer reviewed journals.

PCORE is only three years old and has already positioned itself as a leading source of innovative change. What PCORE still lacks is a firm financial foundation. All of the staff of PCORE are supported by the grants but such non grant costs such as office rent, accounting and audit services are not covered by grants. Each year approximately \$30,000 of non-grant dollars are needed to cover PCORE costs.

The AAP/NJ Chapter and the board of PCORE solicits contributions from the membership to help cover these basic ongoing PCORE costs. All such donations are tax deductible and contributions of any amounts are greatly appreciated.

Please help PCORE continues its valuable work by making a donation to PCORE, 1 AAA Drive, Suite 102, Trenton, NJ 08691. If you have any questions, call 609-585-6871.

Chapter Committees & Task Forces

Get the most from your membership...join a committee **today!!!**

- Accident & Poison Prevention
- Adolescent Medicine
- Annual Meeting
- Breastfeeding & Nutrition
- CATCH
- Children With Disabilities
- Computers
- Early Childhood & Depend. Care
- Emergency Medical Service
- Fetus & Newborn
- Firearms Prevention
- Government Affairs
- Infectious Disease
- Medical Liability
- Membership
- Practice Management
- Psychosocial Issues
- School Health
- Seniors
- Sports Medicine
- Young Peds Task Force
- Bioethics/Terrorism
- Critical Care
- International Health
- Pediatric Hospitalist Medicine

Contact the chapter office at 609-585-6871 and we will get you in touch with the committee chair.



Season's Greetings

Advisory Panel Recommends FDA Licensure of Aventis' Menactra™ Vaccine For Protection Against Meningococcal Disease

- First Candidate Quadrivalent Conjugate Meningococcal Vaccine -

Swiftwater, Pa – September 22, 2004 – Aventis (NYSE: AVE), part of the sanofi-aventis Group, announced today that the Vaccines and Related Biological Products Advisory Committee of the U.S. Food and Drug Administration (FDA) voted unanimously to recommend licensure of Menactra™ (Meningococcal [Groups A, C, Y and W-135] Polysaccharide Diphtheria Toxoic Conjugate) Vaccine for protection against invasive meningococcal disease in adolescents and adults aged 11-55 years. Menactra vaccine is the first quadrivalent conjugate meningococcal vaccine for the prevention of meningococcal

disease, a serious bacterial infection that can cause meningitis and sepsis (blood infection). This vaccine is designated to offer protection against four of the most common serogroups (A, C, Y, W-135) that cause meningococcal disease.

Editor's comment: This is great news for pediatricians. The conjugate vaccine will provide more lasting protection and has the potential to create herd immunity. In countries where the vaccine has been used in adolescents and then in younger children, the incident of meningococcal disease has dramatically decreased, as has carriage of these strains. Further, conjugate vaccines are

effective in infants. Thus we should soon have the ability to protect children from almost all the common types of bacteria meningitis. Note that meningococcal serogroup B is not included in the vaccine; this accounts for about 30% of cases of meningococcal infection in the U.S. Unfortunately, this antigen cross reacts with a number of cellular antigens, thus hampering vaccine development. However, there are several candidate serogroup B vaccines being studied. Stay tuned to the national AAP website for educational materials regarding use of this new vaccine.



Spotlight on Committees

Young Pediatrician Committee Report

Initiatives for 2004-2005 year discussed at the September 14, 2004 meeting:

Dennis Kuo, MD, FAAP, Chairman, Young Pediatrician Committee

(1) Welcome packet for chapter was discussed and emails are going out to chapter Committee Chairs asking for "blurbs" about committees to include. Shape of Welcome packet needs to take place and feedback is appreciated; should it be electronic or paper based?

(2) We have identified several young pediatricians who have

started their own practices who are willing to be an informal network for each other and a resource for pediatricians who are thinking of starting their own practices. Under development is an outline for pediatricians to follow and some discussion about approaching Practice Management for collaboration.

(3) The idea of a Journal Club as an

event for Young Pediatricians was discussed and one is tentatively scheduled for the winter to coincide with the next meeting.

(4) Efforts are under way to contact residents who have attended the NCE so we can bring them into the chapter.

(5) Resident Career Day 2005 and the planning of the 2005 CME was briefly mentioned.

This issue of *The New Jersey Pediatrician* is sponsored by **Aventis**.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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December 2004

Dear Friend of New Jersey's Children:

Thanks to the efforts of the AAP/NJ Chapter Members and its community partners, the Pediatric Council on Research and Education (PCORE) has had an active year. We have had measurable progress and success in improving the health care of all children in our state. PCORE is working to:

- improve immunization rates in children in urban areas of need across the state
- increase awareness of lead poisoning prevention
- develop relationships between pediatricians and their communities
- foster awareness of cases of suspected child abuse and neglect in the entire staff of a pediatrician's office
- bring the pediatrician out into the community to attack the epidemic of obesity in minority communities living at poverty level

In addition, PCORE reaches out to pediatric practices and academia to capture their participation in new and innovative training ideas and procedures designed to address preventive health topics.

As you plan for your gifts in the season of giving, we encourage you to remember PCORE – your Foundation. A gift of cash or stock is tax deductible and may be given to celebrate, honor, or remember someone you love, someone who has made a difference, or someone you wish to recognize. Gifts may also be made just because you feel the importance of sharing with others the value of pediatrics to the health of our communities. Thank you for what you do everyday in servicing children and families and for supporting your Foundation in its efforts to enhance our work.

Best wishes for happy and healthy days throughout the Holiday Season and the New Year.

Sincerely,

Handwritten signature of Bipin N. Patel in blue ink.

Bipin N. Patel, MD, FAAP
AAP/NJ President

Handwritten signature of Steven Kairys in blue ink.

Steven Kairys, MD, FAAP
PCORE Chairman

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Chapter President

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