



The New Jersey

# Pediatrician

Volume 33 • 3rd Quarter 2006

Newsletter of the American Academy of Pediatrics/New Jersey Chapter

## PCORE CORNER

*(Pediatric Council on Research and Education)*

Steve Kairys, MD, FAAP  
PCORE Chairman

Lori Donovan, PCORE's Director of Development for the past four years, has resigned from her position effective July 24th. Lori has done a wonderful job and is a major reason behind the current success of PCORE. Lori's ability and energy have resulted in a number of grants and projects from the Department of Health, DYFS, Medicaid, and the Robert Wood Johnson Foundation. She was effective at every level, from networking with State leaders, to supporting her staff, to writing grants and reports, to helping out with the many details and activities necessary to make PCORE go. All of us wish her the best and hope that she remains in contact with us. We will be welcoming Kami Abdale to the Chapter and PCORE on August 29 and will feature Kami in our next issue.

An article was published in the July edition of *Pediatric Annals* about the work of the New Jersey Improving Prevention Services Project. The article is titled, "Using a Registry to Improve Immunization Delivery" and details the value of a state wide immunization registry for primary care and describes the very positive results of our project in New Jersey that raised immunization rates and use of the state wide immunization registry.

The entire July *Pediatric Annals* is devoted to immunizations.

The Robert Wood Johnson grant, Choosing a Healthy Life by Making Healthy Choices is underway in Long

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## Legal Briefs

By Gary Mc Abee, DO, JD, FAAP  
Chair, Committee on Medical Liability and Risk Management

### *Report from the Committee on Medical Liability and Risk Management*

The AAP Committee on Medical Liability and Risk Management (COMLRM) met June 24-25, 2006 at the AAP Headquarters in Elk Grove Village, IL. Our agenda featured an array of medicolegal topics with most of the focus on expert witness issues such as an AAP grievance committee and peer review process to provide oversight of experts; the viability of the concept of specialized health courts to resolve malpractice issues; an expert witness affirmation statement to be signed by experts and to be used in courts; and a discussion about the revision of the AAP statement regarding "Guidelines for Expert Witnesses". The committee also focused on recent events about improper testimony in child abuse cases. Formulation of "The Expert Witness Affirmation Program", which would encompass several of these concepts, was one of the top ten resolutions at the 2005 AAP Annual Leadership Forum. The committee also reviewed vaccine liability including thimerosal and autism as well as recent court cases which have now eased the prior standard of proof in demonstrating proof of causation between vaccine and an illness. Other areas discussed included research on the medical liability experience of pediatricians with recent pediatric malpractice trends, state and federal malpractice reforms, health care fraud and abuse prevention, and pediatric resident education (committee abstract regarding the need for medicolegal education at the resident level was presented at the 2006 Pediatric Academic Society meeting).

COMLRM discussed and responded to resolutions from the Annual Leadership Forum, which have been referred to COMLRM.

• Resolution #53 ALF 2005 "Expert Witness Affirmation Program"

• Resolution #14 ALF 2005 "Automatic Dismissal of a Suit Against a Mandatory Reporter Arising from the Filing of a Child Abuse Report"

The full text of the resolutions can be found on the AAP website under the member center. If you have particular thoughts on how the committee should respond to the resolutions, please let me know.

With 21 states now in malpractice crisis, medical liability reform remains a priority. At this time, the future of federal medical liability reform remains uncertain. There has been talk recently that the Senate will attempt another bill on medical liability reform. A "Q & A" on medical liability is posted on the AAP website on the member center under the medical liability crisis. Our Washington DC staff participates in the medical association coalitions at work on this issue and you will be alerted should there be any important activity in this area.

The name of the committee has been changed. We added "Risk Management" to underscore the committee's commitment to educating pediatricians from residency through retirement on pediatric-specific loss prevention and risk management strategies. To that end, please note that several risk management sessions will be held at the NCE in Atlanta, GA. Finding quality risk management programming specifically focused on pediatric issues can be difficult. Our members should be aware of these educational opportunities to minimize liability risk and loss prevention.

<http://www.aap.org/visit/medliedu.htm>

Finally, COMLRM is always interested in pediatricians' suggestions for future "Pediatricians & the Law" column for the monthly AAP News. Any suggestions can be forwarded to the committee chair at [mcabee-gary@cooperhealth.edu](mailto:mcabee-gary@cooperhealth.edu).

# American Academy of Pediatrics



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## 3rd Quarter 2006

American Academy  
of Pediatrics/  
New Jersey Chapter  
Established 1950

## President's Message Janice Prontnicki, M.D, MPH, FAAP

I am honored to begin my term as president of our New Jersey Chapter of the American Academy of Pediatrics. I look forward to working with all members of our Chapter for the health and well-being of the children of New Jersey as well as our own professional well-being. We have an outstanding committee of officers in Vice President Mike Segarra, VP-Elect Steve Rice, Treasurer Meg Fisher and Secretary Editor Elliot Rubin. Our councilors represent a mix of experienced members and newcomers who bring with them fresh ideas and outlooks. Of course we would have not reached this point without the efforts of past presidents, and I would particularly like to thank Dr. Bipin Patel (immediate Past President) for his leadership these past two years. He is quite a role model and someone to emulate.



Over the next two years, I hope to have the opportunity to meet many of you personally. In order to facilitate this, we will be varying the sites of our Council meetings and scheduling educational opportunities throughout the state. Our first meeting will be September 26<sup>th</sup>, 2006 in Weehawken, NJ and we hope that many of the members from our northern counties will join us. In the spring we plan for a similar event in southern NJ.

For those of you who don't know me, I'm a Neurodevelopmental Pediatrician with a clinical practice at Children's Specialized Hospital in Mountainside and on the faculty of UMDNJ/RWJ. I grew up in Hudson County, went to medical school in NYC, did a residency in Philadelphia while living in Camden County, moved up to Union County to do a fellowship in Middlesex County, joined a practice in Hunterdon County for several years before returning to the medical school faculty. And like any true Jersey girl-my free time is spent in Ocean County whenever possible! So I may not know every county intimately-but I count on our councilors from each district to keep me up-to date on any local issues they are facing.

A major challenge that our Chapter continues to address is the multifaceted issue of immunizations. On a regular basis, advances in medicine give us the opportunity to protect our children from more and more infectious illnesses. Each newly approved vaccine involves a multitude of medical, ethical, legal and financial considerations. We, as pediatricians, are on the front line of providing these medicines-we need to be sure to have some say in these other aspects that effect provision of services. We need to voice our concerns clearly and responsibly when legislation governing such medical care is made. We need to be sure that regulations are not made about required vaccines without also providing for adequate supply and reimbursement/payment. As we often tell our patient's parents-in order to best provide for their children's own health and well-being, they themselves must be healthy, emotionally and physically. If we as pediatricians are putting our practices in jeopardy because we cannot meet the demands imposed upon us, then it's just a matter of time before children's access to a true medical home becomes threatened. We must continue to work with the Legislature on this and other issues. As you know all the pediatrician's with AAP/NJ are volunteers-we all need to keep up our regular practices. While we have a lobbyist to work with us on important issues-testimony in Trenton by a pediatrician is a very powerful tool. Whenever possible, we look to our committee and task force chairs for their expertise. But often we are invited to testify on very short notice. To address this we are working with Av Katcher (Chair of the Senior Committee) to formulate a "Rapid Response Team." Such a team of either part-time or retired pediatricians would be available to represent AAP/NJ in Trenton for critical issues.

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# Resident Rounds

By Nicole Kucine, MD

Residency is one of the most unique experiences of one's career. You are a physician in training, yet are the first line of defense and diagnosis. For many, it is the first experience as both student and teacher. It is where you truly learn both responsibility and accountability, and is the first time where something you do can actually affect a child's outcome. It is where a young physician begins to answer, "What kind of doctor am I going to be?"

Having just completed my three-year pediatric residency, I am beginning to reflect on all that I have seen and learned. The first thing I realize is how much more there is to see and learn. It constantly amazes me how medicine is changing, with new diagnoses, new medications, and new tests. I look at current medical students and realize how much more fluent they are in the language of technology than I was just 3 years earlier.

Some of the most memorable moments of residency were the "When I was young..." stories. Putting aside those about old physicians who "trudged to work barefoot, in a blizzard, uphill both ways", I learned how different residency has been over the years. Hearing tales of residents mixing bags of fluids at the bedside, and making their own blood smears, I realized how much more "hands on" medicine there was in years past (although I can't say I'm sorry that I've never tasted urine to check for glucose.) I sometimes feel that the physical practice of medicine is fading into the background of the new technologies, and for that I feel a loss. Physical diagnosis is the most exciting and educational part of

medicine for me, as I will never forget a patient but can easily lose volumes of memorized text by the hour. It is an interest and a skill that needs constant practice and it is one I try to pass on to my juniors.

After seeing the breadth of patient issues both in and out of the hospital, I have a newfound respect for the general pediatrician. I loved my pediatrician because he was wonderful and seemed to know everything about everything. I never realized how much he actually *had* to know – what to treat, what to refer, what is within normal ranges, and what is beyond. I'm grateful to have found a pediatric sub-specialty that I love, because I don't know if I have enough room in my brain for everything the general pediatrician has to know. To conduct the orchestra of consultants and interpret reams of test results for a complicated patient is no easy task, and I commend all those who do it.

Residency gives you a harsh look at the non-medical hardships of medical practice. When discharges are held up because a patient has no electricity at home, it is frustrating. When a patient comes back to your clinic and tells you they haven't taken their prescribed meds for 3 months because insurance won't cover them, it is disheartening. Despite all of our wonderful new technology and therapeutics, it is next to impossible to provide the necessary care without the proper medical coverage. For most of us, thankfully, these are not issues we have personally dealt with. You learn how to advocate for your patients, and to teach them to do the same for their own health and well being. I am now ex-

tremely proficient in maneuvering the maze of automated phone systems for insurance companies, and know that this skill will unfortunately prove useful time and time again.

For many of us, residency is the first experience we have with a dying patient. Medical students are often sheltered from this difficult yet necessary experience, but not residents. We are often the ones at the bedside holding the hands of our dying patients and comforting their families. While we all love pediatrics for the vibrant nature of children and their amazing ability to rebound after illness, the mortality of our patients is something that we all must learn to face. Residency is a place where this learning can begin.

I cannot say I'm sorry to be done with my residency. I learned a great deal, laughed and cried a lot, and made some lifelong friendships, with both staff and patients. I also worked harder than I ever have before. I am now in the nebulous zone of "Chief Resident" – not a resident, but not an attending. This job will hopefully allow me to work on all the things that I've thought about during residency - reading, teaching, continuing to hone my physical exam skills, and learning from my peers and patients. And I'll have another year to work on being that great doctor I've always hoped I'd be. I'm certainly not there yet, but when I think of all my physician role models, I've got a pretty good idea on how to get there.

***Dr. Kucine is a Pediatric Chief Resident at the Bristol-Myers Squibb Children's Hospital at Robert Wood Johnson University Hospital in New Brunswick.***

## Teenagers, Alcohol and Drugs: Confronting the Issues

The Adolescent/Young Adult Center for Health at the Goryeb Children's Hospital is pleased to announce that Dr. John Knight, Director of the Center for Adolescent Substance Abuse Research at Children's Hospital Boston

and Associate Professor of Pediatrics at Harvard Medical School will be the keynote speaker at the Cummins Endowment for Adolescent Medicine program "Teenagers, Alcohol and Drugs: Confronting the Issues" on Thursday, October 26, 2006 from 7-9 pm at Morris-

town Memorial Hospital.

For more information please contact Maryann Walsh, MPH, CHES at (973) 971-7095 or via email at [Maryann.Walsh@Atlantichealth.org](mailto:Maryann.Walsh@Atlantichealth.org).

## Increasing Immunization Coverage May Reverse Rising Reports of Pertussis

Many people are unaware that reports of pertussis, commonly called *whooping cough*, have been rising in the United States (US)<sup>1</sup> and pose serious consequences for infants who are too young to be fully immunized.<sup>2</sup> Fortunately, in 2005 the Food and Drug Administration licensed 2 combination tetanus/diphtheria/acellular pertussis (Tdap) vaccines, one for adolescents and one for adolescents and adults<sup>3</sup>; until that time, pertussis immunization was limited to infants and young children.

With the availability of Tdap vaccines, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) has voted to recommend that adolescents and adults 11-64 years of age receive a single dose of Tdap in place of a single dose of tetanus/diphtheria (Td) booster vaccine. Tdap vaccine provides adolescents and adults with protection against pertussis, and may help reduce the spread of the disease to vulnerable infants.

ACIP also has voted to recommend that health-care personnel (HCP) who have direct patient contact receive Tdap (if they have not previously done so), especially those who have direct contact with infants less than 12 months of age.

### Reports of pertussis on the rise

The number of reported pertussis cases in the US has steadily increased, reaching 25,827 in 2004, the largest number since 1959.<sup>2</sup> Because of underreporting and misdiagnosis, the true number of pertussis cases is most likely even higher, estimated at 600,000 adults annually.<sup>3</sup>

In recent years, pertussis has had a significant impact on particular age groups. For example, between 2003 and 2004 reported pertussis cases increased 122% overall and 73% in children 4 years of age or younger.<sup>4,5</sup> Adolescents 10-19 years of age and adults over 20 years of age still accounted for a clear majority (approximately 66%) of the reported cases.<sup>5</sup>

The implications of rising numbers of reported pertussis cases are alarming. Most young infants with pertussis still must be hospitalized, and some cases can be fatal.<sup>6</sup> From 2001-2003, 91% of the deaths from pertussis were among infants younger than 6 months of age and 75% were among infants younger than 2 months of age.<sup>2</sup>

### Why are reports of pertussis on the rise?

One reason for the increase in pertussis cases may be that immunity to pertussis "wears off" over time—approximately 5-10 years after completing the childhood vaccination series<sup>1</sup>—which means adolescents and adults who think they have immunity can be susceptible to pertussis and may transmit the disease to infants.

Adolescents and adults also tend to have milder forms of pertussis, or even be asymptomatic; but those who develop even mild pertussis disease may still transmit the organism to unimmunized or underimmunized infants. In families, this is often the case.

In a study to determine the source of infant pertussis, family members, especially new mothers, have been found to be an important source. The study found that, among 264 cases of infant pertussis infection with a known or suspected source, 75% of the sources were family members and 32% were mothers.<sup>6</sup> Tdap immunization for parents and family members may help reduce the spread of pertussis to infants.

### Nearly 50% of Pertussis Sources Are Parents<sup>6</sup>

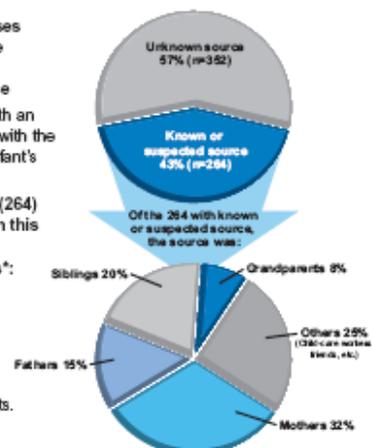
In a CDC study of 774 reported cases of infant pertussis, interviews were conducted in 616 of the families to determine the source of the disease

A source was defined as a person with an acute cough illness who had contact with the case-infant 7 to 20 days before the infant's onset of cough

The source was identified for 43% (264) of the infants with pertussis. Within this subgroup of infants, the known or suspected source of pertussis was\*:

- The mother in 32%
- A parent in nearly 50%
- A family member in 75%

\*It is unknown whether immunizing adolescents and adults against pertussis will reduce the risk of transmission to infants.



### Tdap recommended for adolescents, adults, and HCP

ACIP has voted to recommend Tdap vaccination for new mothers and those adolescents and adults who are in close contact with infants, especially younger than 12 months of age. Specific finalized or provisional recommendations for immunization beyond the completed diphtheria/tetanus/pertussis (DTP) or diphtheria/tetanus/acellular pertussis (DTaP) childhood vaccination series include:

- A single dose of Tdap for adolescents 11-18 years of age instead of Td for those who have yet to receive a Td booster<sup>1</sup>
- A single dose of Tdap for adults 19-64 years of age instead of a Td booster; the Tdap dose is recommended if it has been more than 10 years since the last Td booster, but shorter intervals after Td vaccine are acceptable.<sup>3</sup>

### The role of HCP

With the availability of Tdap vaccine for adolescents and adults, HCP need to redefine the standard of care for infant pertussis by immunizing not only the child but also those who come in close contact with the child. HCP will play a major role in increasing Tdap immunization.

HCP can help reduce the increasing rates of pertussis infection by first making sure that, if they work in hospitals or ambulatory-care settings, they have received Tdap immunization to protect themselves, their patients, and family members. This is especially important for those in direct contact with infants less than 12 months of age.

HCP also need to make sure that family members in contact with infants are up-to-date with their pertussis vaccinations and that infants and young children have completed their DTaP childhood vaccination series.

### Raising awareness among new mothers and their families

To help reduce the spread of pertussis to vulnerable infants, HCP and their organizations should develop campaigns to raise awareness among new mothers and their families about the importance of Tdap immunization. Providers can use existing office visits as an opportunity to increase the use of Tdap immunizations among adolescents and adults. Through the commitment of HCP, plus the availability of Tdap vaccines, the standard of care for providing protection against pertussis in the US is being redefined.

References: 1. Centers for Disease Control and Prevention (CDC). Preventing tetanus, diphtheria, and pertussis among adolescents: use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR*. 2006;55(RR-3):1-44. 2. CDC. Pertussis. In: Atkinson W, Hamborsky J, McIntyre L, Wolfe C, eds. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. The Pink Book. 9th ed. Washington, DC: Public Health Foundation; 2006:79-96. 3. CDC. National Immunization Program. ACIP votes to recommend use of combined tetanus, diphtheria and pertussis (Tdap) vaccine for adults (Advisory Committee on Immunization Practices): March 2, 2006. Available at: [http://www.cdc.gov/nip/vaccine/tdap/tdap\\_adult\\_recs.pdf](http://www.cdc.gov/nip/vaccine/tdap/tdap_adult_recs.pdf). Accessed March 10, 2006. 4. CDC. Summary of notifiable diseases—United States, 2003. *MMWR*. 2003;52:1-85. 5. CDC. Pertussis Surveillance Report—8/12/05. MKT11970. 6. Bisgard KM, Pascual FB, Ehresmann KR, et al. Infant pertussis: who was the source? *Pediatr Infect Dis J*. 2004;23:985-989.

# Message from the Senior Section

Avrum L. Katcher, MD, FAAP

Chairperson, Section on Senior Members

Our section recommends you check out our new website <http://www.aap.org/sections/seniormembers/>. There are many new pages with valuable information for seniors. For those on Medicare, there is a short article on the pros and cons of the new Medicare Part D. There are also links to articles recently appearing in the *New England Journal of Medicine*. If you are age 65 or older, this is worth reviewing.

Our website also contains a summary of activities of other chapter senior committees. The individual chapters have been very energetic. Dr. Patel and now Dr. Pronnicki have been working to get seniors more involved in advocacy at the state level, and soon you should hear more about their plans and objectives. In general, we have two constituencies—ourselves and children/adolescents. On the one hand, we are here to help our members navigate the changes and challenges that occur as we age, to share experiences and opinions, to learn from each other and from many expert

sources outside of pediatrics. We have much to offer the children of the world—many tools we may bring to bear for them—but our most important tool is ourselves. On the other hand, we as pediatricians are here to help children. If you are age 55 or older, do seek this opportunity to join with others for the benefit of children, to be involved, to be active, both while still in practice, and as you are phasing out. Look on the web site to see what the national section for senior members is doing. Your chapter officers have copies of a chapter guide to provide advice for chapter senior committees.

We invite you to the annual National Conference and Exhibition of the Academy, this year in Atlanta, Georgia, from October 6 to 9. At the NCE, the section for senior members will have an outstanding program, organized by Lucy Crain and George Cohen, on Monday afternoon October 9. This program is open to all AAP members and guests, but particularly for our section for senior members. It will be well worth your

while to attend. Afterwards there will be an informal reception to meet faculty and friends. In addition, all chapter officers have been invited.

Recent studies have shown that fewer than 30% of physicians have living wills or advanced directives. Similarly, judicious planning for long term care of family members or ourselves is all too often neglected. Our program will address these concerns and offers 3.5 hours of CME credit. The NCE program is H349 titled “Elephants in the Room” and includes the following lectures: 1-“ABCs of Assisted Living, Long Term Care, & Long Term Care Insurance” by Robyn Stone, Ph.D. of American Association of Homes & Services for the Aging. 2-“All You should Know about Living Wills, Advance Directives, Powers of Attorney, & Health Care Surrogates” by Thomas Finucane, MD, FAAP of Johns Hopkins University School of Medicine. 3-“Palliative Care, Treatment of Pain, and End of Life Care” by Sandra Wishton, RN, MS, PNP from the Hospice of Marin.

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## Center for Pediatric Irritable Bowel & Motility Disorders to Host 1<sup>st</sup> Annual Functional Abdominal Pain Symposium at Goryeb Children’s Hospital

The Center for Pediatric Irritable Bowel & Motility Disorders of Atlantic Health is pleased to host its 1<sup>st</sup> Annual Pediatric Functional Abdominal Pain Symposium. This two-day symposium will be held on September 29-September 30, 2006 at Morristown Memorial Hospital in the Malcolm Forbes Amphitheater. Nationally known speakers will be presenting the latest medical

information on pediatric functional abdominal pain, available treatment options and the role of various mind-body techniques. On Saturday, participants will have the opportunity to participate in an interactive workshop on hypnosis therapy, learning the theory behind hypnosis, as well as engage in hands on training regarding incorporating hypnosis into their practices. Training sessions will be conducted in small groups to ensure indi-

vidualized attention. The symposium is appropriate for general and subspecialty clinicians, trainees, nurses, social workers and mental health professionals. Continuing education credits are approved for physicians, nurses and social workers.

Space is limited, so pre-registration is encouraged. For more information or to receive a program brochure, please contact Charlotte Intile, LCSW at (973) 971-5958 or via email at

[Charlotte.Intile@Atlantichealth.org](mailto:Charlotte.Intile@Atlantichealth.org).

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

## School Health Conference

*"Save the Date"*



Save October 4, 2006 for the Fifteenth Annual School Health Conference entitled "Update on Child Health in the School and Community." The program is sponsored by the AAP/NJ Committee on School Health and designed for any pediatrician and allied health care staff member who is interested in learning about new immunizations, state regulations, emergency medicine, concussions and sports medicine, and much more.

Over 650 people joined the Chapter for last year's event, which consisted of plenary sessions and rotating workshops.

The program starts promptly and ends promptly to ensure a smooth transition for those returning to work or hospital. Added features this year will be a session by the incoming Chapter President Janice Pronnicki on Attention Deficit Disorder (ADD) and Related Syndromes, and another by Viola Lordi, Esq. of a large law office in Trenton on issues of lawsuits, health care, and schools.

Be sure to check [www.aapnj.org](http://www.aapnj.org) for event registration. And don't forget to mark your calendars for October 4, 2006 at The Palace at Somerset Park, NJ!

## Mark Your Calendars!!!

These are some of the AAP/NJ Chapter meetings that are planned for 2006. Please plan on attending and encourage your colleagues to attend as well.

**For details on any of the events:**

**609-585-6871 or [alehman@hq4u.com](mailto:alehman@hq4u.com) or visit [www.aapnj.org](http://www.aapnj.org)**



### **September 26, 2006**

**RSV and HPV** - Chart House, Weehawken, NJ.

Cocktail reception (cash bar) starts at 5:30 pm followed by a complimentary dinner. Supported by an unrestricted educational grant from MedImmune.

**Free to AAP/NJ Members in the Northern Districts.**

*This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Medical Society of New Jersey (MSNJ) through the joint sponsorship of Saint Peter's University Hospital and the American Academy of Pediatrics/New Jersey Chapter. Saint Peter's University Hospital is accredited by MSNJ to provide*

*continuing medical education for physicians.*

*Saint Peter's University Hospital designates this educational activity for a maximum of 2 AMA PRA Category 1 Credit(s). Each physician should claim only those credits that he/she actually spent in the activity. All are welcome including Nurses, Pharmacists and Physicians in Practice.*

### **October 4, 2006**

**15th Annual School Health Conference** - The Palace in Somerset Park, NJ. 5 Category #1 CME Credits to be awarded. More details to come!

## New Jersey Prompt Payment Law

*By Michael Segarra, MD, FAAP*

NJ Prompt payment law states that any claim must be paid within 30 days of receipt if sent electronically and 40 days of receipt if sent by non-electronic means. If a claim is denied or contested, the insurer within 30 days must notify the claimant by writing or electronic means the reason for denial and if

the claim lacks required substantiating documentation, notify the claimant what information is required to complete adjudication of the claim. Claims paid after the required time frame should incur a 10% per annum interest. A critical component of the effectiveness of state prompt pay laws is the definition of a

clean claim, which NJ is lacking. A summary compiled by the American Medical Association comparing all the states is available on the AAP Member Center, private payer advocacy page under the category "prompt payment".

# President's Message

*Continued from page 2*

Our very active and effective Practice Management Committee, under the direction of Co-chairs Rich Lander, Andrea Katz and Jill Stoller, - continually looks for ways to assist members in providing the best services for children while navigating the often confusing maze of payers. They are very involved with the issues surrounding vaccines.

Through the establishment of the Dept. of Families and Children, the State of New Jersey will have a cabinet level commissioner whose main concern is children's issues. This is certainly a positive step for all of us.

We are very fortunate to have in New Jersey dedicated advocates for children and those who care for them. You are part of

that team-as a member of AAP/NJ. Feel free to speak up with suggestions on how to best achieve our goals or volunteer some time for an area that you feel especially concerned about.

Thanks for the opportunity to work together.

## CHILD CARE UPDATE

*Elaine Donoghue, MD, FAAP*

With the rapid increase in the number of infants who are in child care, great attention has been focused on safety for those infants including protection from SIDS risk factors. The overall incidence of SIDS deaths has decreased but it was recognized that the proportion of those deaths that occurred in the child care setting remained steady at about 20%. This led to the AAP Back-to-Sleep campaign which started in 2003. An article in the July issue of Pediatrics reviews the success of the campaign to date. The results showed that 60 of the 101 state regulations

about infant crib safety have been revised since the onset of the campaign and that more than half require nonprone sleeping and limited soft bedding. While that is good news, much work remains to be done. An observational research study to see how the practices are implemented is underway and results are being compiled. Look for results of that study in the next year.

We are happy to report that New Jersey is one of the states with appropriate regulation, but centers do not always follow regulations. Remember to ask parents of infants about who cares for their baby when

they are not there, and remind them to insist on back sleeping and appropriate bedding. Give parents extra copies of any educational materials for their child care providers. If the infant is in a center, write the instructions on the Universal Child Health Record that the infant must be placed to sleep on the back on appropriate bedding.

For more information about the Back-to-Sleep campaign, check out [www.healthychildcare.org](http://www.healthychildcare.org) for further details.

## COMMUNITY ACCESS TO CHILD HEALTH (CATCH) PROGRAM

*Elaine Donoghue, MD, FAAP, CATCH Facilitator*

The next CATCH cycle will be in January 2007 and will include Resident grants and Implementation grants. Check [www.aap.org](http://www.aap.org) for details.

Healthy Tomorrows is a grant program funded by a partnership between the AAP and the Maternal Child Health Bureau. Healthy Tomorrows seeks to provide support to innovative community-based efforts to improve children's health and is similar to CATCH in many ways. A recent evaluation of the Healthy Tomorrows program had a summary of "lessons learned" that may be helpful to pediatricians who are active in the community and who may be considering applying for a CATCH grant. The following is an excerpt from that report.

- Don't start from scratch. Review the relevant literature and learn from the wisdom and experience of others.
- Know your target population. Families served by community-based projects often are isolated by poverty, immigration status, culture and language. Programs must be culturally competent to work with their target populations. Projects may need to budget for transportation or other needs that get in the way of full participation.
- Engage your target population. Successful projects invest time in getting community buy-in, sometimes involving clients in program planning and service delivery from the start. Provide frequent opportunities for feedback from program participants and ensure that they are active on your advisory board.
- Choose leaders who are strong, community-minded, knowledgeable about resources and supports and effective communicators.
- Involve pediatricians. A pediatrician offers credibility and expertise, as well as access to the target population and to other health care providers.
- Develop partnerships with other organizations and individuals interested in the same issue or population that you are addressing. An effective community collaboration is as inclusive as possible. True collaborations require good and consistent communication among partners.
- Stay flexible. Things may not go as planned; a program needs to be allowed to evolve.

Keep these thoughts in mind if you are developing a community-based program or are thinking about applying for a CATCH grant.

Remember that you can get technical assistance on applying for a CATCH grant. Contact Elaine Donoghue at [edonoghue@meridianhealth.com](mailto:edonoghue@meridianhealth.com) if you would like to see the full copy of the Healthy Tomorrows evaluation.

# PCORE Corner

*Continued from page 1*

Branch. This three-year project is utilizing the preschool program and aims to increase physical activity and eating choices as measured by no change in BMI over the three years of the project. There is tremendous support in the community for the project and we hope to use the model in other communities. Dr. Meg Fisher directs this project.

PCORE continues to need more pediatricians interested in engaging in our projects, either as a participant, a worker, or as a leader. Our current range of projects includes immunization, lead, child abuse, prevention of abuse, obesity prevention, mental health, post partum depression, developmental assessment, asthma care and chronic disease manage-

ment, adolescent immunizations, and medical home.

For more information about PCORE and its efforts to improve the health and well-being of children in New Jersey, please e-mail Harriet Lazarus ([hlazarus@hq4u.com](mailto:hlazarus@hq4u.com)) or Anne Lorenzo ([alorenzo@hq4u.com](mailto:alorenzo@hq4u.com)) or call them at 609-585-6871.

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## The Department of Pediatric Neurology at Goryeb Children's Hospital to Host a Conference on Attention Deficit Disorders

The Department of Pediatric Neurology at Goryeb Children's Hospital of Atlantic Health is pleased to announce that on Wednesday, November 29, 2006 it is hosting a conference entitled "Attention Deficit Disorders ~ 2006 Update".

This innovative program will pro-

vide pediatricians, primary care physicians, advanced practice nurses, school nurses, psychologists and Child Study Team members with new information about the pathophysiology and management of Attention Deficit Hyperactivity Disorder. By combining nationally recognized speakers with Goryeb Children's Hospital faculty, the attendee will gain

both scientific knowledge and clinical skills to manage both children and adolescents with ADHD in a variety of settings. Physician and nurse's continuing education credits are being applied for.

For more information or to receive a program brochure, please contact Patricia Ruiz, APRN at (973) 971-5700 or [Patricia.Ruiz@Atlantichealth.org](mailto:Patricia.Ruiz@Atlantichealth.org).

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## AAP/NJ Fellows in the News

*This article was published in the Herald News on June 11, 2006*

Pitchers often ice their shoulders after a baseball game. Track stars frequently limp through a late-season practice. Signs of hard work? Possibly. But just as likely, it is evidence of an overuse injury.

According to a 2005 Yale–New Haven Children's Hospital newsletter, 30 to 50 percent of pediatric sports injuries are caused by overuse. And the number of overuse injuries increases as the athlete gets older.

Stephen Rice, a pediatric sports medicine doctor at the Jersey Shore University Medical Center in Neptune, says all sports injuries fall into one of two categories: traumatic (an explosive force the body can't absorb, which causes a break or a tear) or overuse (a repetitive

action that creates trauma in a certain area of the body). It is the overuse injuries, he said that have been on the rise for the past 10 to 20 years because athletes are specializing in sports at younger ages.

"Children seem to be coming in at earlier and earlier ages with overuse injuries because they're really pushing and pushing endless hours of activity," Rice said. "We tend to be hurrying childhood and pushing children to be more like adults at an earlier age, and really not understanding what the body can handle at such a young age."

In 2000, the American Academy of Pediatrics established a policy statement on intensive training and sports specialization in young athletes, and the statement was reaffirmed in 2006.

The statement recommended that young athletes participate in a wide array of physical activities and wait as long as possible to specialize.

The academy's reasoning?

"It's a simple notion: Variety is good for your body, specific repetition is risky," said Rice, who sits on the American Academy of Pediatrics Council on Sports Medicine and Fitness. "If you do the same thing over and over again, and you see this in running especially, distance running and swimming require perfect form. It's wearing your body down sooner because there is no variety."

Rice likened the repetitive trauma to walking through your lawn for a month—if you walk in a random path each day, the wear on the lawn is

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# AAP/NJ Fellows in the News

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minimal. If you walk the same path each day, the grass on that path will die.

“One of the considerations for diversity is that when you’re doing more than one sport, it gives more variety,” Rice said. “And it makes it more fun.”

Because few studies have been conducted on specific effects that come from specializing in sports at a young age, the Academy makes broad statements about the dangers. But the policy statement suggest that early specialization and intensive training may lead to everything from cardiac problems to long-term growth disturbances as well as diet deficiencies.

Other effects that don’t get much attention are referred to by the Academy as the psychosocial development problems that can come from early specializations.

“Anecdotal reports suggest risks of ‘burnout’ from physical and emotional stress, missed social and educational stress, missed social and educational opportunities, and disruptions in family life,” reads the policy statement. It goes on to state that most athletes find high competition levels to be a satisfying experience.

But Rice referenced a European study that followed tennis players through their high school years. Those who played

only tennis were more likely to quit the sport, while those who participated in a variety of sports continued to participate long afterward.

In the end, while science and medicine work to reach conclusions about the dangers associated with intense training and specialization in young athletes, the proof of overuse is not in doubt.

“At some point you have to make a selection if you think you have potential.” Rice said. “I don’t know what the right answer is, but I’d probably like to encourage kids to be broad for as long as they can.”

## AAP National Committee Activities

Steering Committee on Quality Improvement and Management (SCOQIM). For more information on this committee activity, please go to the AAP/NJ website: [aapnj.org](http://aapnj.org) and click on reports and publications. If you would like to have further information, please contact Dr. Elizabeth Susan Hodgson at (732) 448-1000 x 21 or email: [eshodgson@saintpetersuh.com](mailto:eshodgson@saintpetersuh.com).

## Annual Meeting 2007

We are pleased to announce that we have already received our first sponsorship for the 2007 Annual Meeting! Wyeth will be supporting the event as a major sponsor. We thank them for their generosity. It’s never too early to show your support for the Chapter by signing up as a sponsor for next year’s Annual meeting.

## Legislative Highlights - AAP/NJ 2006 Legislative Report, Spring 2006

*Nancy Pinkin, AAP/NJ Lobbyist*

The legislative process for review and advocacy actions for the State Budget achieved an all time record for New Jersey. We worked day and night through July 10<sup>th</sup> in an effort to protect healthcare services for children. With a \$5 billion dollar deficit looming, legislators and the Governor fought over funding mechanisms to support the FY 2007 State Budget. In the end, Governor Corzine prevailed and the state sales tax increased from 6 to 7 %. Although taxes increased, **financial support for the following programs** was maintained (In comparison –

colleges were cut by \$100 million dollars.):

- NJ FamilyCare
  - Charity care funding for hospitals including inpatient and outpatient services for pregnant women and children;
  - Minority and Multicultural Health funding;
  - Identification System for Children’s Health and Disabilities
  - Public awareness program for black infant mortality
  - Newborn screening program funding;
  - Birth Defects Registry
  - Statewide Birth Defects Registry (CRF)
  - Anti-smoking programs for school based, youth and general populations
  - Maternal child programs
  - Lead Poisoning Program
  - Infant Mortality Reduction Program
  - FQHC’s
- In addition, the Legislature created the new department of Children and Families and appointed Kevin Ryan as its Commissioner.

# Infectious Diseases Corner: Immunization Update

By Margaret Fisher, MD, FAAP

As expected, a human papillomavirus vaccine was licensed in June. The product, Gardasil, is a quadrivalent vaccine with types 6, 11, 16, and 18. It is licensed for use in females age 9 through 26 years. It will be given routinely at the 11-12 year visit. Remember that 40% of adolescents are sexually active; we want to protect them before exposure since the vaccine is not effective after infection. This vaccine is active against the most common serotypes causing cervical dysplasia and cervical cancer (16, 18) and ano-genital warts (6, 11). Studies in boys are in progress. The vaccine is immunogenic and safe in boys; we are awaiting information regarding efficacy. The vaccine is a three-shot series. This is our second anti-cancer vaccine; hepatitis B vaccine which prevents hepatocellular carcinoma due to chronic hepatitis B infection was the first.

The recommendations for use of Rotateq, the newly licensed pentavalent bovine reassortant rotavirus vaccine, are written but are not yet published. Universal immunization is recommended with 3 doses given at 2, 4 and 6 months of age. The first dose can be given as

early as 6 weeks but not later than 12 weeks of age. The first dose must be given in this time span or the child is not eligible for vaccine. The second and third doses are given at 4 week or so intervals; the final dose must be given by 32 weeks of age. The timing is to ensure that the first dose is given before the age at which intussusception begins to increase in frequency. Trials with the vaccine included over 70,000 children and showed no increased incidence of intussusception following vaccine. Note that because of the timing, catch up vaccination will not be an issue. The vaccine can be used in prematurely born babies as long as they have been discharged from the hospital and their postpartum age is within the above limits.

A second dose of varicella vaccine is now recommended for all children; MMRV can be used for both the initial and the second dose. For children who have already received two doses of MMR, the single component vaccine is appropriate. Remember that children over 13 years of age should have received 2 doses already.

Tdap, the adolescent and adult booster, is recommended for all adults. There is a focus on healthcare providers and on parents of young infants. You and your office staff should all be immunized (note the vaccine is licensed for ages 11 to 64 years). Pregnant women can be immunized and women in the post-partum period should be immunized if they have not yet received Tdap and have not received tetanus or Td within 5 years. A Canadian study showed that a 2 year interval is safe. Currently our only way to protect infants under 6 months is to immunize all those around them! There is plenty of pertussis in New Jersey so please get yourself protected today!

Finally, as noted in the last issue of the Newsletter, the new influenza recommendations include all children 6 months to 5 years of age and their family members. So, most of your patients will qualify for vaccine. Go ahead and start vaccinating as soon as you get your supplies. Hopefully there will not be a shortage this year!

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## Conference on Human Papillomavirus (HPV)

The New Jersey Obstetrical & Gynecological Society will hold its semi-annual meeting on September 29, 2006 at the PNC Arts Center, Robert B. Meyner Reception Center, Holmdel, NJ (exit 116, Garden State Parkway). This year's meeting is co-sponsored by Saint Barnabas Medical Center, Department of Medical Education and Clinical Research and will focus on the human papilloma virus (HPV) and the new HPV vaccine. The symposium will feature local and nationally recognized speakers in Ob-Gyn, Pediatrics, Family Medicine and Pathology giving their perspective on HPV. An overview of the conference includes:

- The spectrum and history of human papilloma virus (HPV)

- Identification of the signs & symptoms of HPV
- The etiology, pathology and modes of transmission of HPV
- Review and update of available medical data pertaining to the subject of HPV
- Appropriate treatment measures and preventive strategies
- Appropriate indications and usage of the prophylactic quadravalent HPV vaccine
- Differences between the quadravalent HPV vaccine and the bivalent HPV vaccine (pending approval)
- Methods used to diagnose HPV infections
- Latest recommendations for cervical cancer screening (cervical cytology with HPV testing)

- Challenges presented by HPV and HPV vaccines for pediatric, family medicine, pathology and Ob-Gyn practices

The registration fee for pediatricians is the same as members of the NJ OB/GYN Society - \$75.00.

For more information, contact:

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