Committee Studies Pediatrics:
The Next Generation
Beth A. Pletcher, MD, FAAP

The Committee on Pediatric Workforce (COPW) met September 30th and October 1st, 2006 in Arlington Heights, IL. During the meeting a number of emerging topics were discussed as well as possible collaborative efforts with others to address pressing workforce issues. The COPW’s statement on ensuring culturally effective care has stimulated discussion about ways to measure outcomes (effectiveness) instead of evaluating process (competence), as we move forward. Both trainees and practicing pediatricians may benefit from educational programs on cultural effectiveness, and the COPW will be partnering with the Committee on Pediatric Education to address this need.

There was much discussion about the recent Association of American Medical Colleges’ (AAMC’s) call for a 30% increase in US medical school enrollment over the next ten years, accompanied by a proportionate increase in residency training positions. This recommendation is based on the AAMC’s prediction of a serious physician shortage by 2020. The COPW anticipates that there will be a number of factors that may adversely impact this plan including: likely additional future reductions in GME funding as well as inability to resolve existing physician maldistribution problems simply by increasing physician supply. How training more physicians will influence the pediatrician workforce is quite uncertain at this point in time.

At the meeting there was also a discussion about optimal ways to collect workforce data and, in light of significant geographic and state to state variability, the COPW believes that local data will be most helpful in shedding light on the issue of pediatrician and pediatric subspecialist distribution. The challenge now is to determine what are sufficient numbers of pediatricians and pediatric subspecialists in different geographic regions, how far is a reasonable distance for families to travel for such services, and how does insurance coverage impact pediatric care. To begin to look at some of these issues, the Academy will be conducting a periodic survey of primary care pediatricians to explore referral patterns to, and barriers to care by, pediatric medical and surgical subspecialists.

The COPW continues to examine physician re-entry into the workforce, which appears to be a burgeoning practice issue that impacts male as well as female physicians. At the present time there is very little data on the numbers of physicians re-entering the workforce, nor do we know much about the various paths they take to refresh, relearn, and/or retrain. In an effort to look at these issues on a national basis, about 30 individuals from 20 organizations will be “meeting” via conference calls. If you would like to hear more about this endeavor, feel free to check out the COPW website.

As always it is an honor to serve on the COPW and I am available to bring your ideas, concerns, and suggestions to the Committee. Feel free to give me a call at (973) 972-3314 or email me at pletcherba@umdnj.edu.
President’s Message  Janice Prontnicki, M.D, MPH, FAAP

Sometimes we just need some good news and a reminder of why we went into medicine in the first place! While I’ve never regretted my decision to go into the specialty of pediatrics, there have been times I’ve wondered why go into medicine at all. I’ve certainly heard similar concerns expressed by other pediatricians in our state. It just seems that we spend more and more time battling insurers or wrangling for that elusive shipment of flu vaccine, that we have less and less quality time with the children we’ve dedicated ourselves to.

Well, if you were able to attend the AAP’s National Conference and Exhibition (NCE) in Atlanta this October, hopefully you experienced some of these much needed “feel good” moments. Just being surrounded by thousands of other pediatricians to learn, to share experiences and to enjoy the family centered social activities was important.

There were poignant moments as well. The keynote speaker John O. Agwunobi, MD, MBA, MPH, after an introduction noting countless outstanding achievements and titles including Assistant Secretary of Health (U.S. Dept of Health and Human Services) and Admiral in the United States Public Health Service, took the podium and announced he could sum all those achievements into the one he was most proud of—“I am a pediatrician”. A loud round of applause followed. The speaker went on to tell a story of his most memorable and brave patient whom he met during residency. The doctor keeps that patient’s Teddy Bear with him as a reminder of what’s really important. (New Jersey’s own Dr. James Oleske has a similar keepsake tucked in his pocket from one of his earliest pediatric AIDS patients.)

Other very real issues were discussed at NCE also. At our District 3 breakfast, NJ Chapter member John I. Sutter, MD, MS, FAAP presented his resolution regarding the call for national AAP to take an active position in advocating for fair payment for immunizations. (New Jersey is a member of District 3 as are Pennsylvania, Maryland, D.C., Delaware and West Virginia Chapters.) AAP President Elect Renee Jenkins, who hails from DC, was in attendance, so we know this concern was heard.

NCE was not the only important meeting this October. October was also the month when our Chapter’s School Health Committee held its very successful Annual School Health conference. Thank you to all committee members and long-time Committee Chair Dr. Wayne Yankus for their work in providing this educational and networking meeting for over 500 school physicians and school nurses.

More great news: Soozie Hodgson, MD, FAAP was named our state’s Child Advocate. Congratulations, Soozie! She joins Dr. Robert Morgan in the recently created Department of Children and Families as pediatricians taking leadership roles in Trenton.

Congratulations also to Elaine Donoghue, MD, FAAP who was named Chair of the Provisional Section on Early Education and Child Care. Elaine also provides leadership at the national level in the Section on Telephone Care and CATCH.

In September, we held our Executive Council meeting in Hudson County followed by an excellent CME program open to our members in the northern Counties. In March 2007 we will hold a similar event in southern New Jersey. Our annual meeting will be held in the spring in a central location. We hope this rotation of sites makes it more convenient for all members to access these events throughout the year. We also hope such meetings can provide a chance to learn, to share experiences, to socialize and to remember why it feels so great to say, “I am a pediatrician”.

Wishing you and your family a happy and healthy holiday season!
Governor Corzine Appoints
Dr. E. Susan Hodgson as Child Advocate

This announcement was released by Governor Corzine's office on September 12, 2006.

TRENTON - Governor Jon S. Corzine recently announced the appointment of Dr. E. Susan Hodgson as New Jersey's Child Advocate.

"New Jersey's Child Advocate must be someone who can speak to the complex issues involved in child welfare on behalf of those who are too young or vulnerable to speak for themselves," said Governor Corzine. "Dr. Hodgson's extensive experience as a board-certified pediatrician and demonstrated commitment to child safety will ensure that the state meets the high standards that the children of New Jersey deserve."

Dr. Hodgson has been a practicing pediatrician since 1981 and has devoted her entire medical career to pediatric medicine and working with abused and neglected children. Since 1997, she has been the Co-Medical Director of the Dorothy B. Hersh Regional Child Protection Center in New Brunswick, where she works extensively with children under the supervision of the Division of Youth and Family Services (DYFS). She also practices general pediatrics and is on the teaching faculty at Saint Peter's University Hospital and at the Drexel School of Medicine. Dr. Hodgson was instrumental in the development and implementation of a training program with physicians and DYFS workers for improving recognition of and response to suspected child abuse and neglect. Since 1998, she has co-chaired the state's Central Regional Diagnostic Fatality Review Team.

"I am honored to be chosen as the Child Advocate," said Dr. Hodgson. "It has been my life's work to look out for the health and welfare of children. New Jersey has taken great steps this year to strengthen its commitment to children. I can think of no more rewarding challenge than to join this effort to ensure the safety and well being of New Jersey children."

Dr. Hodgson began her medical career as a resident liaison to Yale-New Haven Hospital Diagnosis Assessment Referral and Treatment (DART) Team for Child Abuse. She went on to work from 1982-1994 as a pediatrician in North Carolina, Georgia, and New Hampshire where she participated extensively in organizations to improve the welfare of children in those states.

As Co-Medical Director of the Dorothy B. Hersh Regional Child Protection Center, she built the center into a comprehensive medical service provider for abused and neglected children. Each year the center handles hundreds of medical and mental health exams for foster care children and psychological evaluations for abused children and their families. She is a fellow of the American Academy of Pediatrics and a member of the state's Central Regional Diagnostic Fatality Review Team.

Continued on page 11

Practice Management Committee Strives to Ease Vaccine Pain

The Practice Management Committee has been concentrating on advocating for proper vaccine and vaccine administration code reimbursements. We have been addressing this on two fronts: through individual discussions with the managed care companies via our Pediatric Council and by working with the Government Affairs Committee to draft a model bill that we hope will be sponsored by a consortium of legislators that have shown they understand the scope of the vaccine finance issue.

The PM committee has been having monthly meetings with Horizon BC/BS. Horizon has shown a willingness to make pediatrician-friendly changes. We are hoping that pediatricians will be seeing a change in Horizon's vaccine reimbursement methodology soon. They seem to have understood our explanations about the overhead associated with all of the current vaccines children require. The Private Payer Advocacy Committee of AAP-national has had meetings with several of the national payers, and we are hoping these meetings will speed changes at the local level.

We are seeing some other positive changes with respect to managed care behavior. Aetna, Horizon, Healthnet, and Qualicare are now recognizing modifier –25 and will pay sick and well-visits on the same date of service. UnitedHealthcare will institute this in early 2007, though they will only pay the sick visit at 50% of the contracted rate. Dr. John Sutter, an AAP/NJ member, has successfully settled a class-action lawsuit with Horizon BCBS. This should effect positive changes going forward.

Despite this we all deal with problems in our offices on a daily basis.

PLEASE inform us of any difficulties you are having! We need to track trends to bring to our quarterly Pediatric Council meetings. We can also help you cut through the mco red tape through the contacts we have made. Email any questions or problems to practice.management@aapnj.org - please include specifics and the eob, if applicable.

Make sure to visit the new practice management website of AAP: http://practice.aap.org/ You will find a wealth of information there!

Practice Management Committee Co-chairs
Jill Stoller, MD, FAAP
Andrea Katz, MD, FAAP
Richard Lander, MD, FAAP
CALLING ALL ADOLESCENTS AND ADULTS

Pertussis protection for adolescents and adults 11 through 64 years of age

Adacel™
Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine Adsorbed
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ADACEL vaccine is indicated for active booster immunization for the prevention of tetanus, diphtheria, and pertussis as a single dose in persons 11 through 64 years of age.
As with any vaccine, ADACEL vaccine may not protect 100% of vaccinated individuals. There are risks associated with all vaccines. The most common local adverse events include injection site pain, erythema, and injection site swelling. The most common systemic adverse events include headache, body ache, tiredness, and fever. ADACEL vaccine is contraindicated in persons with known systemic hypersensitivity to any component of the vaccine or a life-threatening reaction after previous administration of the vaccine or a vaccine containing the same substances. Because of uncertainty as to which component of the vaccine may be responsible, no further vaccination with the diphtheria, tetanus, or pertussis components found in ADACEL vaccine should be carried out. Because intramuscular injection can cause injection site hematoma, ADACEL vaccine should not be given to persons with any bleeding disorder, such as hemophilia or thrombocytopenia, or to persons on anticoagulant therapy unless the potential benefits clearly outweigh the risk of administration.

Before administering ADACEL vaccine, please see brief summary of full prescribing Information on next page.

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Seniors Poised for Action
Avrum L. Katcher, MD, FAAP
Chairperson, Section on Senior Members

The National Section for Senior Members and the American Academy of Pediatrics has awarded the New Jersey Chapter a grant to conduct a training program for seniors on advocacy.

The original idea came from Drs. Bipin Patel and Janice Prontnicki. Chapter leadership has been concerned for some time that legislators, administrators and other government representatives have a tendency to seek expert opinion on child affairs from pediatricians, but want a response yesterday, or, with luck, today or tomorrow. As you all well know cancelling a day or half day of appointments in order to sit in a committee room for some hours, and provide a 15-minute statement, is not enticing.

Our leadership has suggested that it might be possible to recruit senior Fellows from the Chapter, who have retired from active practice, to respond on short notice.

They would be members of a Rapid Reaction Team (RRT). The Chapter members who have been most involved in the particular topic would brief and provide documents for a team member, who would then appear where needed.

The concept seemed very worthwhile to me. I managed to convince the national AAP leaders that this might be a very workable project. Perhaps it could serve as a model, an example, to build comparable groups in every chapter. Therefore it was agreed that a grant would be provided for a training session.

Senior Fellows in New Jersey, (definition is age 55 or above) who would enjoy responding in this fashion, will be invited to a training session tentatively scheduled on Friday, April 20th, 2007, to be held in the Trenton area. At that time state legislators, and perhaps administrators, will be present to discuss how to approach both elected and appointed officials. We hope that as many as possible will attend. It is not necessary to be a member of the Section for Senior Members of the Academy, but we hope that many of you will join.

This will be the first organized project of the New Jersey Chapter Senior Committee. It is a pleasure to inform you that Dr. Lawrence Frenkel has agreed to serve as Chapter Senior Committee Chairperson. Many of you know him; he has recently come back to the Garden State from a position as Department Chairperson at the Medical School in Illinois.

Another project I would like to mention for your interest is our new and expanded web site. Do check in, at www.aap.org/seniors where you will find many new items about your own welfare, health, activities, navigating changes that occur with aging, and interesting projects for children. You will also find records about our annual National Conference and Exhibition (NCE) in Atlanta Georgia. Information is also included on how to contact members of the Executive Committee and staff if you have questions, ideas about new things to do, criticism, or anything else.

COMMUNITY ACCESS TO CHILD HEALTH (CATCH)
GRANTS AWARDED
Elaine Donoghue, MD, FAAP, CATCH Facilitator

New Jersey had two CATCH grants awarded in the summer cycle of 2006. The first was a CATCH Planning grant awarded to Dr. Michael Lamacchia in Paterson, NJ to reverse the growth trend of pediatric obesity and its co-morbidities through a mobile health unit which will visit area schools.

The second was a Resident CATCH grant awarded to Dr. Rebecca Perril in Neptune, NJ which will also address pediatric obesity by developing a Toolkit of activities centered around nutrition and physical activity. She will be examining the psychosocial impact of obesity as well.

Congratulations to both of these NJ CATCH grant recipients!

Don’t forget that the next CATCH grant cycle has begun and the announcements are included in this newsletter. Contact the NJ CATCH facilitator, Dr. Elaine Donoghue at edonoghue@meridianhealth.com if you plan to submit an application. Technical assistance prior to application is encouraged.

This issue of The New Jersey Pediatrician is sponsored by Sanofi Pasteur.
In October 4, the AAP/NJ held its fifteen annual Community Medicine and School Health conference for an audience of over 500 nurses, physicians and allied health professionals.

The conference continued its focus on community medicine with AAP/NJ president Janice Prontnicki, MD, FAAP delivering the keynote address on Attention Deficit Disorder and its most recent treatments. Viola Lordi, Esq. from Trenton discussed issues of personal and corporate liability for physicians and nurses caring for children. Her lecture sparked much interest; she fielded over 50 questions from the audience. Margaret Fisher, MD, FAAP held the audience’s attention with her timely and thorough pediatric infectious diseases lecture. She spoke on new immunizations and public health issues.

This is the largest meeting annually of the state Chapter. The School Health Committee is responsible for its content and speakers. The Committee invites members to participate.
Focus on Influenza
Margaret Fisher, MD, FAAP
National Committee on Infectious Diseases

There is still time and reason to vaccinate against influenza virus. This year the distribution of vaccine has been very problematic for pediatricians. Many, if not most, pediatricians did not receive the vaccine they ordered in a timely manner. The late arrival of vaccine wreaks havoc on offices; vaccine days that were scheduled had to be cancelled. It is extremely difficult to get two doses of vaccine into those who need it.

If you still have vaccine, use it. Encourage your patients to get the vaccine, especially the youngest ones. Remember that vaccine is recommended for anyone who wants to decrease their risk of getting influenza so that could be anyone you see! The targeted patients are those at high risk and their family members and caretakers. At risk patients include the following: all children 6 months to 5 years of age; any child with asthma or other chronic lung diseases including cystic fibrosis, significant cardiovascular disease, immunocompromised state including infection with human immunodeficiency virus, or immunosuppressive therapy, hemoglobinopathies, such as sickle cell anemia, chronic metabolic disease, such as diabetes mellitus; recipients of long-term aspirin therapy, chronic renal disease, neuromuscular disease; or any condition which compromises respiratory function or increases risk for aspiration. Contraindications to vaccine are serious allergic reaction to a prior dose, serious allergic reaction to eggs, and Guillain-Barre syndrome following a prior dose.

Influenza vaccine can be given as soon as you receive your supply; usually this is September or October. Previously unvaccinated children under 9 years of age require two doses of vaccine. In children who were scheduled for 2 doses, received only one dose in the prior year, protection may not be adequate after a single dose this year. Thus the Committee on Infectious Diseases of the American Academy of Pediatrics recommends 2 doses this year for these children (those under 9 years of age who received only one dose last year despite the fact that they should have gotten 2 doses). Note that is different than the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention – they recommend a single dose if the child received any dose in the past.

As of late November 2006, New Jersey had no reported cases of influenza, despite the beginning of influenza cases in all surrounding states. By the time you read this, it is likely that the season will be in full swing.

Remember to continue vaccinating even after the season begins since you may alter or prevent the illness in many.

Mark Your Calendars!!!

These are some of the AAP/NJ Chapter meetings that are planned for 2007. 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 or visit www.aapnj.org

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<tr>
<th>Date</th>
<th>Event details</th>
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<tr>
<td>March 13, 2007</td>
<td>Executive Council Meeting &amp; Dinner/CME - CHOP House, Gibbsboro, NJ. Dinner starts at 6:30 p.m. (this event is open to members in the So. Jersey Counties)</td>
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<tr>
<td>March 27, 2007</td>
<td>Resident Career Day - Victorian Manor, Edison, NJ. 7:45 am to 1:30 pm</td>
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<td>April 20, 2007</td>
<td>Senior Rapid Response Meeting - AAA Travel Building, 2 South Gate Drive, Hamilton, NJ. Morning session. More details to follow.</td>
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<tr>
<td>June 13, 2007</td>
<td>2007 CME Conference, Annual Meeting and Dinner 2:00 pm to 8:30 pm. More details to follow.</td>
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New Recommendations Anticipated from the Committee on Infectious Diseases

Margaret Fisher, MD, FAAP
National Committee on Infectious Diseases

The Committee on Infectious Diseases met in Atlanta on October 7-8, 2006. Statements and reports in progress were reviewed: Chemical and Biological Terrorism has been approved and will be in print soon; Infection Control in Physicians’ Office is still undergoing revisions but is nearing completion; Considerations Related to Exotic Pets is getting very involved and several groups, including veterinarians will be participating; Community Associated-MRSA Infection in Children is still in the process of initial writing; Influenza Anti-virals in Children – was approved and is in press and is probably already out of date; Acute Otitis Media and Meningitis in Children with Cochlear Implants – the proposal for a statement has been approved; Head Lice Revision – in progress with the school health people; Individual Wells for Home Water Supply: Information for Families with Children – the writing process is just starting; Hepatitis A – going to the Board for approval; Use of Systemic Fluoroquinolones – published in September and by publication it was definitely out of date. This lead to a long discussion about how to get policies and statements from committee to members more expeditiously. The possibility of posting proposed recommendations was discussed and has been suggested to the Board.

Influenza vaccine was discussed by Dr. Hank Bernstein. He presented data regarding the response to vaccination in young children. It appears that if a child received a single dose in the first year, that child may not be protected by one dose the following year, especially if the strains are not closely matched. After discussion of the data, the committee voted to recommend 2 doses of vaccine for children under 9 years who are in their second year of receiving vaccine and who received a single dose in the prior year. This recommendation is different from that of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Other items discussed included new diagnostics for tuberculo-
sis, American Heart Association proposed recommendations for prophylaxis against endocarditis, a support group for immunization, Washington activities, state government affairs, pandemic influenza, Red Book updates, Japanese encephalitis virus vaccine, meningococcal conjugate vaccine shortage and thimerosal issues.

A new varicella vaccine statement is in progress to reflect the recommendation for a second dose for all vaccine recipients. In order to confirm natural varicella, the illness must be physician diagnosed. A statement for use of human papillomavirus vaccine is almost finished; the recommendations for use will mirror those of the Advisory Committee on Immunization Practice: all girls at age 11-12 years with permissive vaccination of girls age 9, 10, and adolescents and young adult women up to age 26 years. This is a three dose series.

The committee heard information from GlaxoSmithKline on their human papillomavirus vaccine. The vaccine appears immunogenic and safe in girls and young women. They are using a new adjuvant which is boosting titers. As with the licensed vaccine, titers are highest in the youngest age vaccinated.

The committee heard the latest information regarding Guillain-Barre syndrome following Menactra vaccine. There were 9 additional cases reported this summer in older adolescents. It is not clear whether the vaccine is causative or the data is confounded by known increase in illness in the summer. The risk is at most a bit over 1 per million; this is not high enough to change the recommendations for routine immunization.

Dr. Conner of Medimmune, Inc. presented data regarding the live cold-adapted influenza vaccine. The vaccine was found to be safe and effective in young children and the company will ask for licensure of the vaccine down to the age of 1 year. Side effects of wheezing and hospitalization were presented and discussed.

The mumps outbreak in the Midwest is continuing but to a lesser degree. Vaccine is protective but it is difficult to show this. Studies of roommates show that the vaccine is efficacious.
2007 CATCH
Resident Funds (Cycle II)

Call for Proposals
November 1, 2006—January 31, 2007

CATCH Vision
The vision of CATCH is that every child in every community has a medical home and other needed services to reach optimal health and well-being.

Resident CATCH Liaisons
Tara Lemoine, DO National Liaison
Open District I
Open District II
Dorothy Chen, MD District III
Thomas Baktett, MD District IV
Beth Nagy, MD District V
Open District VI
Carl Tapia, MD District VII
Catherine Ferguson, MD District VIII
Heidi Kloster, MD District IX
Shekou Sesay, MD District X

CATCH Program
Division of Community-based Initiatives
Department of Community, Chapter, and State Affairs
American Academy of Pediatrics
141 Northwest Point Blvd
Elk Grove Village, IL 60007
Telephone: 847/434-7085
E-mail: catch@aap.org

The American Academy of Pediatrics is pleased to announce a new cycle of the CATCH Resident Grant program. The program supports pediatric residents in the planning of community-based child health initiatives. Grants of up to $3,000 are awarded twice each year on a competitive basis for pediatric residents to address the needs of children in their communities. CATCH Resident Funds grant projects may include planning and implementation activities. Priority will be given to projects serving communities with the greatest demonstrated health care access needs and health disparities. Strong collaborative community partnerships and future sustainability of the project are encouraged.

The grant cycle starts November 1, 2006, with an application deadline of January 31, 2007. Please visit http://www.aap.org/catch/residentgrants.htm for more information on the current cycle or visit the Grants/Project Database at http://www.aap.org/commpepds/grantsdatabase/grantsdb.cfm for information on past CATCH resident funded projects.

Apply Now!
To begin an application go to http://www.aap.org/catch/funds/ and enter your AAP ID number and password. Only applications submitted online will be considered for funding.

For additional information and technical assistance, contact your District Resident Liaison, AAP Chapter CATCH Facilitator or the CATCH Program by e-mail at catch@aap.org, or phone at 800/433-9016, ext 4916.
Emergency preparedness seems to be a hot topic these days. One topic that strikes a chord with most parents is the thought of their child being caught in child care or school during an emergency.

What exactly is an emergency though? Emergency situations can include:

- Individual child emergency such as anaphylaxis, seizure or serious injury
- Lost or missing child
- Natural disaster such as flood, fire, storm or earthquake
- Human threats such as a bomb threat or hostage situation
- Power or water failure
- Serious infectious disease outbreak such as pandemic flu

Obviously, each of these situations requires a different response.

So what does this mean to pediatricians?

The most obvious way that pediatricians can intervene is in the individual child emergency. If a child has a medical situation that might present in an emergent manner, it should be addressed in the child’s health form such as the Universal Child Health Record or Care Plan. These forms can be obtained at http://web.doh.state.nj.us/forms. Children with severe asthma, anaphylaxis, type 1 diabetes, seizures or other potentially life-threatening conditions should have an emergency plan in place. Outline the signs of impending emergency and what measures should be taken. Caregivers should know when to call EMS/911 and when just calling the parent is sufficient. They should know what medications or first aid to administer while waiting for first responders.

Security issues or natural disasters are more difficult to address but could still benefit from our input. For example, peanut butter is a common food that is packed for emergency food supplies, but it could be life-threatening to a child with serious peanut allergy. Other non-perishable food sources could easily be included. Child care sites and schools may need to add special equipment or supplies to their first aid kit if they have a child with a special medical problem. Medications such as beta agonist MDIs with spacers, insulin, or injectable epinephrine could be added to emergency supplies if the people doing the planning were made aware of the need.

Serious outbreaks of infectious disease present a different set of challenges such as quarantine and triage. Questions such as who will care for the health care providers children during an epidemic hit close to home and have no easy answers.

Preparing for emergencies can be difficult when just getting through the day is hard enough, but as medical professionals, we should be aware of the implications and help our parents and community partners as we all prepare.

Dr. Donoghue was recently named Chair of the Provisional Section on Early Education and Child Care.

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CME Committee Outlines Innovative Syllabus

The Committee on Continuing Medical Education met in Chicago in November. The strategic plan of the American Academy of Pediatrics was reviewed: priorities for 2006 and 2007 include special health care needs of children in foster care, oral health, disaster preparedness (new items), mental health, obesity, immunizations (added in the prior year and being implemented), access, quality and finance (pillars on which the 6 priorities stand), and the universal principles of health care equity, medical home and profession of pediatrics. Minutes from a variety of committees and planning groups were reviewed. The committee was made aware of the Residency Review and Redesign in Pediatrics Project; for more information go to http://innovationlabs.com/r3p_public/.

This will be a major undertaking with many groups involved.

The following requests were reviewed: Section on Administration and Practice Management Proposal for Future Workshops – a separate course was discouraged but the idea of working with local chapters was supported; request for revised content category for PediaLink was approved; the committee reaffirmed the policy to prohibit planning group members from serving as faculty; HIPAA requirements regarding pictures in handout materials were discussed and term limits for committee members were clarified.

The following courses were approved: 2008 Workshop on Perinatal Practice Strategies, 2008 DB:PREP, 2008 PREP:EM, 2009 Uniformed Services Pediatric Seminar and the Pediatric Leadership Alliance CME Course.

The ACCME accreditation process was reviewed. There are a variety of new initiatives that will be challenging. Interestingly, the AAP is already using many of these methods including innovative needs assessment such as PediaLink self learning plans, follow up to determine whether practices have changed, independence from commercial interests and bias, and collaborative learning methods.

The Committee spent the second day auditing the files for several AAP programs. This exercise helps members understand the complexities of the programs and the things that the reviewers look for when accrediting CME providers.

Finally there was discussion of quality improvement and how to link this with continuing medical education. Several groups are already actively working on this: Partnership for Policy Development, Innovation Network, Bright Futures Small Change Network and Quality Improvement Innovation Network.
Dr. E. Susan Hodgson as Child Advocate

Continued from page 3

member of the American Professional Society on the Abuse of Children. Since 2000, she has served as vice-president of the American Academy of Pediatrics New Jersey Pediatric Council on Research and Education and she currently chairs the American Academy of Pediatrics National Steering Committee on Quality Improvement and Management.

Dr. Hodgson is licensed to practice medicine in New Jersey and New Hampshire and holds a Bachelors degree in biology from Mount Holyoke College, a masters in biochemistry from Mount Holyoke College and a medical degree from Yale University School of Medicine. She lives with her husband in Princeton and they have two grown children.

Concussion in Sports Summit

Stephen G. Rice, MD, PhD, MPH, FAAP
National Committee Council on Sports Medicine and Fitness

The Brain Injury Association of New Jersey’s (BIANJ) Concussion Summit was held at Giant Stadium on February 24, 2006. The AAP/NJ Chapter was one of the endorsers of the Concussion in Sports Consensus Statement. Check the AAP/NJ website http://aapnj.org for a copy of the statement.

The day-long summit featured speakers from the Centers for Disease Control and Prevention in Atlanta, Georgia and one of the leading experts on concussions, neurosurgeon Robert C. Cantu, MD from Boston. The remainder of the speakers were Concussion in Sports Steering Committee members, including sports medicine specialist Stephen G. Rice, MD, PhD, MPH, FAAP, neuro-psychologist Jill Brooks, PhD, athletic trainer Phil Hossler, and education specialist Ron Savage, EdD. The session was facilitated by Steve Adubato, PhD. The summit engendered lively discussion and focused on plans to disseminate this important information throughout various constituencies in New Jersey.

One of the goals of the post-summit game plan is to include the topic of concussions on the agenda of annual and local meetings of as many statewide organizations as possible. The topic of concussion management will be on the agenda of the AAP/NJ annual meeting next June.

The CDC has produced a concussion tool kit for coaches, called “Heads Up”, which contains key information for recognizing and dealing with concussions. It is available through the CDC website: http://www.cdc.gov/tbi/Coaches_Tool_Kit.htm. The CDC is now working on producing a concussion tool kit for physicians which should be available within the year.

A computer-based neuropsychological testing program, ImPACT, developed at the University of Pittsburgh, is in wide use among professional and college athletics. ImPACT is now making a major thrust into the high school market. The BIANJ and ImPACT have jointly announced a grant program in New Jersey, whereby 100 high schools will be able to participate in ImPACT for three years at 50% of the usual cost, $650 for three years instead of $1300. Athletes are pre-tested during preseason to establish a normal baseline in the four general domains of verbal memory, visual memory, reaction time and speed of processing. When an athlete is concussed, these tests are repeated serially and compared to the baseline. Since athletes can become asymptomatic clinically but show significant deficits on the ImPACT testing, these neuropsychological test results can play an important role in assisting the pediatrician and athletic trainer in the management of return to play decisions. Encourage your local high school to apply for one of these grants.

Dr. Rice, the Vice-President Elect of AAP/NJ, has lectured recently at the AAP/NJ School Health Conference in October, the New Jersey State First Aid Council convention, and at the NJEA Convention in Atlantic City in November.

AAP/NJ Councilor to Join AAP Grand Rounds Editorial Board

Patty Vitale, MD, MPH, FAAP has been selected to serve on the editorial board of the AAP Grand Rounds. Dr. Vitale is a councilor in AAP/NJ District 5 and will begin her two-year editorial appointment in January, 2007. Dr. Lewis First, Co-Editor-In-Chief of the AAP Grand Rounds writes: “Dr. Vitale brings a wonderful perspective to AAP Grand Rounds. Her background and expertise in Public Health, Epidemiology, and Community Pediatrics give her a wonderful skill set that makes her a perfect fit for our Editorial Board. Our newsletter prides itself on identifying, summarizing, and commenting on articles that are methodologically sound and of clinical relevance to the practicing pediatrician, and Dr. Vitale will help insure that we continue to do that as a new member of our Editorial Board. We are delighted that she will be joining our team to make AAP Grand Rounds even better than it currently is—and it’s pretty terrific right now.”
Breastfeeding Medicine: An Up and Coming Specialty
Amy Kotler, MD, F-AAP
National Committee on Breastfeeding

Have you ever heard of a breastfeeding medicine specialist? While there is no fellowship or specialty board exam, yet, there is the Academy of Breastfeeding Medicine (ABM), of which one can become a Fellow (FABM). While members of ABM hail from various specialties such as family medicine, internal medicine and obstetrics and gynecology, the vast majority are pediatricians and neonatologists. In a survey I conducted among members of ABM and members of the AAP Section on Breastfeeding, the most common situation were physicians in primary care who also do breastfeeding consults. However, there are a growing number of pediatricians who opened private practices solely dedicated to breastfeeding consults, while others function in academic settings and or are researched oriented.

When I started residency, I was sure that I was going to continue into a subspecialty fellowship since I enjoy teaching and lecturing as well as being an “expert” in a specialty. This idea, however gave way to the desire to have a family sooner rather than later and to be able to work part time. My first position was in a private practice, but because I missed the academic setting and relished the few opportunities I had to teach residents, I contemplated going for a fellowship. However, I had my first child that year, and as I learned more about the science of lactation, through both the personal experience and reading, I decided that this was my calling. Three years out of residency I opened my own general pediatric practice with what I called a “Breastfeeding Resource Center.” I also got involved with La Leche League and the NY Breastfeeding Task force. After many conferences, networking, email lists and independent studies, I realized how much more there was to learn. Most notably, I’ve had to learn more about adult women’s health and get used to examining breasts.

I find breastfeeding medicine exciting because it involves knowledge of endocrinology, infectious disease, pharmacology, pathology, nutrition, gastroenterology, anatomy, gynecology, women’s health, neonatology, and finally development and behavior. Thus, the field encompasses a whole-body approach. Breastfeeding problems can also be evaluated as “pre-breast, breast, or post-breast (the infant),” similar to the approach of other organ systems such as liver or cardiac.

One misconception is that breastfeeding medicine is not an “evidence based” practice. Since I get an OVID alert on breastfeeding and lactation bimonthly, I can assure you there is a huge base of research in the field. This year two new peer-reviewed journals devoted just to breastfeeding medicine were launched. While the vast majority of the research is focused on the properties or benefits of human breast milk, the ABM has on its website (www.bfmed.org) thirteen evidence based protocols for clinical practice with more in development.

The practice of breastfeeding medicine is unique in several ways. First, you have potentially two patients. This makes family medicine practitioners so well suited for the job, but how often are we as pediatricians asked if a mother’s medication or condition will have an impact on her ability to breastfeed? In a breastfeeding consult, it is crucial to get a detailed maternal as well as neonatal history in addition to examination both of mother and baby. Furthermore, it may be necessary to observe a full feeding. This leads to a second unique aspect of a breastfeeding consult: the sheer length of time involved. A typical consult can last anywhere from one to three hours. Some require the mother and baby to be seen prior to the consult by a lactation consultant, thus enabling the basics of latch and milk supply to be addressed and the physician can focus on more complicated medical problems. This highlights how a physician specializing in breastfeeding medicine can work in conjunction with a lactation consultant. The physician plays a different role with the ability to order diagnostic tests, prescribe medicines, and perform procedures.

A third unique aspect of practicing breastfeeding medicine is the need (when appropriate) for medical devices, such as hospital grade breast pumps, nipple shields, nipple shells, at-breast supplementers, and other specialty feeding devices to assist in breastfeeding, transitioning the baby to the breast, and increasing milk supply. These things are not readily available in retail stores. This often lends to the physician office selling and or renting these items. Some find this practice a possible conflict of interest and instead refer out. Although, I have had to put up more capital in starting my practice, I am hoping that offering these items will, one increase my revenue and two provide me with a source of referrals.

Finally, reimbursement for a breastfeeding consult can be challenging. While there are plenty of ICD 9 codes to be used to describe breastfeeding problems for both mother and baby, the specialty is not yet recognized by some health insurers. Some practitioners prefer not to deal with insurance companies, and ask patients to pay out of pocket. For those billing third party payors, The AAP Section on Breastfeeding has a coding pamphlet which describes how to get appropriate reimbursement (http://www.aap.org/breastfeeding/PDF/coding.pdf).

This field is still developing and there are many opportunities; clinically, via research, and via community activism. My interest and enthusiasm soon lead to my being named chair of the AAP/NJ Chapter on Breastfeeding and Nutrition and the state Chapter Breastfeeding Coordinator a liaison to the AAP Section on Breastfeeding. If you are interested in getting involved, want more information, or want to ask about a patient, please contact me, amkotler@aap.net.
Class-Action Compliance

Jill Stoller, MD, FAAP

After several years of watching our revenue per visit in the Aetna capitated plans decrease, my six-physician pediatric practice in northern New Jersey made the decision to drop participation with Aetna HMO and Aetna QPOS, the two capitated Aetna plans. We elected to continue our participation in Aetna fee-for-service plans. We gave our patients nine-months advance notice. In response, many affected patients switched to other insurance companies or to fee-for-service plans within Aetna.

Several weeks before our termination date, we learned, through a patient, that Aetna would not allow us to continue participation in several of their products that they consider part of their "managed care" platform. Aetna links participation in these plans with the capitated products, even though these plans pay physicians on a fee-for-service basis (e.g., Aetna Choice POS, Aetna Select Choice). Not surprisingly, calls to our provider representative were of no help. It was then that I went to the hmosettlements.com website and read through the Aetna settlement. In very clear, plain English, article 7 (b) stated that Aetna could not require physicians to participate in capitated plans, if they chose to participate in only the fee-for-service plans.

I decided to pursue this issue independently and directly with Aetna under the class-action settlement compliance process, since it was clear to me that Aetna was violating its agreement.

I filed a formal compliance dispute. It was simple to download the one-page form, fill it out, and fax it to the Aetna settlement facilitator, Deborah Winegard. I also e-mailed Deborah who told me she would try to get this rectified informally, since it was such a clear-cut issue in my favor. During the interim and assuming that the facilitator would decide in our favor, I allowed the patients in those plans to continue coming for visits, even though those visits were being denied as non-par.

Six weeks later Deborah notified me that Aetna had agreed to allow our practice to stay par with all fee-for-service plans and that Aetna would re-process the previously denied fee-for-service claims.

This may seem like a small issue, but many of our patients switched to those Aetna “Choice” plans so they could continue coming to our practice. The moral of the story is: FIGHT BACK! Don’t allow the MCOs to bully you, and remember that one must be forever vigilant when dealing with them.

The healthcare insurers that settled the class-action lawsuits are non-compliant in many aspects of the agreements, and it is well worth your while to become educated on the terms of the class-action settlement agreements with Aetna, Cigna, and HealthNet.

I am currently working with The Medical Society of New Jersey on a compliance dispute against Aetna for inadequate vaccine reimbursement. Inadequate reimbursement is having a negative impact on the quality of care for Aetna patients, as physicians realize they can’t afford to provide vaccines. Practically speaking, physicians are digging into their own pockets to pay for the vaccines of their patients when the reimbursement schedules are inadequate to cover costs. We must be willing to stand up for the quality of care for our patients.

Dr. Stoller is a member of the AAP Executive Committee, Section on Administration and Practice Management (SOAPM) and an AAP/NJ Councilor At Large.

AAP/NJ CME Dinner

From left to right: Michael Segarra, MD, FAAP, (Vice-President); Jeffrey Boscaamp, MD, FAAP; Meg Fisher, MD, FAAP; Bipin Patel, MD, FAAP (Immediate Past President); and Janice Prontnicki, MD, FAAP (President) enjoying a NYC skyline view at the September 26th AAP/NJ CME dinner meeting jointly sponsored with MedImmune. Drs. Boscaamp and Fisher spoke on HPV, RSV and Influenza.
Recently published guidelines from the Children’s Oncology Group will aid pediatricians in providing appropriate follow-up care for survivors of childhood cancer. Easily accessible and published online, the Long-Term Follow-Up Guidelines for Survivors of Childhood, Adolescent, and Young Adult Cancers represent “risk-based, exposure-related clinical practice guidelines for screening and management of late effects in survivors of pediatric malignancy.”

Ever seen a teenager who completed chemotherapy five years ago now in the office for a complete physical? Have you wondered what complications might arise from her cancer or its treatment, and what testing you should perform to screen for these conditions?

The new guidelines will answer your questions. Simply look up the specific therapies she received, and the guidelines will tell you exactly what testing to order, and at which intervals. They are free, comprehensive, and easily accessible to any practitioner with an internet connection.

Use of the guidelines requires a “Summary of Cancer Treatment” specific for your patient. The summary details type of cancer, specific therapies received including total cumulative doses, and any surgeries or other therapeutic modalities employed. Because the new guidelines are exposure-related, this information is necessary to tailor follow-up testing to the individual needs of each cancer survivor.

In order to make the new guidelines even more useful to pediatricians in practice, two initiatives are underway. The AAP-New Jersey Chapter will be contacting all pediatric oncologists in the state, emphasizing the importance of ongoing communication with primary care pediatricians and particularly the importance of creating a Summary of Cancer Treatment upon completion of cancer therapy and sending it to the child’s primary care provider.

Also, the Children’s Oncology Group Late Effects Committee will be creating an interactive interface on its website. Entitled “Passport for Care”, this new tool will enable clinicians to enter information specific to a patient from the “Summary of Cancer Treatment,” and the interface will generate a follow-up plan individualized for that patient. Plans are for this segment of the project to be completed within the next two years.

As more and more children survive the ravages of childhood cancer, general pediatricians will need to be knowledgeable in the care of these patients and in appropriate follow-up screening. The survivorship guidelines are an exciting and invaluable new resource that will benefit pediatricians and children alike. They can be accessed online at www.survivorshipguidelines.org.

### Highlights of AAP Private Payer Advocacy Update November 2006

**Physician successfully fights Aetna all-products requirement**

Jill Stoller, MD, FAAP and co-chair of the New Jersey pediatric council reports that Aetna was imposing on her practice an all-products requirement that was in violation of the settlement agreement. Per article 7 (b) of the Aetna settlement, the carrier could not require physicians to participate in capitated plans if they chose to participate only in fee-for-service plans. After filing the compliance dispute, Aetna agreed to allow Dr. Stoller’s practice to participate only in the fee-for-service plans. Dr. Stoller advises pediatricians to become aware of the settlement terms with the major carriers (Aetna, CIGNA, HealthNet, Humana, and Wellpoint/Anthem) and monitor and report carrier non-compliance.

Information on the carrier settlements and compliance dispute process can be found at [www.hmosettlements.com](http://www.hmosettlements.com).

**Payment Tip: Identify source of average wholesale price (AWP) used by carriers to determine vaccine payment**

Most carriers base vaccine payments on AWP, which generally is the manufacturer’s list price plus a percentage markup. Since there are several sources of AWP such as Thomson Red Book, Mediscan, First Data Bank, and even carrier’s own data, make sure payers identify the source of AWP and that it is current. The variation in AWP is due to what the current average list price is at the time and the percentage markup applied by the vendor. Since AWP is considered proprietary due to vendor licensing agreements, there are restrictions on how the AWP data can be exchanged (such as posting lists of AWP on websites and listserves). Vaccine manufacturers have established reimbursement support programs that physician practices can call to obtain AWP information on the manufacturers own vaccines:

- **sanofi pasteur**
  - Reimbursement Support Service 800/822-2463
- **GlaxoSmithKline**
  - Reimbursement Hotline 888/822-2749
- **Merck**
  - 800/734-6282
- **MedImmune**
  - 800/949-3789
- **Wyeth**
  - 800/666-7248

In addition to identifying all vaccine related expenses, knowing the AWP is helpful in determining a pediatric practice’s acceptable payment for vaccines.

*Continued on page 15*
The AAP/NJ Government Relations Committee, chaired by Jeff Bienstock, M.D., met to review advocacy positions for key issues of interest to AAP/NJ members and reviewed over 400 bills currently in the legislature. The committee endorsed continued support of legislation to address gun violence, maintain healthy diets in schools, address obesity and numerous other issues. The committee reaffirmed its support of the delegation of epi-pen administration from school nurses to other trained individuals in schools, and pending regulations that would allow EMT’s to administer an epi-pen for anaphylaxis.

Other crucial issues addressed were:

- **Immunization Reimbursement**
  
  AAP/NJ members have been working with Senator Joseph F. Vitale (D-19) to draft legislation that requires health insurers to cover all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health and Senior Services, to ensure appropriate reimbursement to health care providers that adequately covers their costs incurred in providing immunizations. We are utilizing two AAP tools to make our case: The first is the Business Case for Pricing New Vaccines, which explains the numerous components that should go into the pricing of a vaccine. Second, we are using the document Vaccine Addendum to Payer Contracts which has examples of formulas for determining a vaccine price. Both tools are available from the national AAP office. The draft bill is undergoing review by Senator Vitale in preparation for introduction to the Senate. The Practice Management Committee has been working closely with the Government Relations Committee on this high priority issue.

- **Safe Haven Legislation**
  
  Assemblyman Steve Corodeumus (R11) and Senator Anthony R. Bucco (R25) have introduced A2689 and S1328 which expands the list of sites at which newborn infants may be left safely and anonymously by a parent, or another person acting on the parent’s behalf, as outlined in the “New Jersey Safe Haven Infant Protection Act,” to include fire stations and first aid and rescue squads that are staffed 24 hours a day, seven days a week. The bill increases the number of “safe havens” available under the current law, which are now limited to emergency departments of licensed general hospitals and State, county and municipal police stations. According to the sponsors, during the period from August 2000, when the “New Jersey Safe Haven Infant Protection Act” took effect, until November, 2006, 28 newborn infants were turned in safely in accordance with the provisions of the law; however, during the same period, 22 newborn infants were unlawfully abandoned in the State instead of being dropped off safely. AAP/NJ has expressed numerous concerns about the bill. While it is everyone’s concern to reduce such infant deaths, AAP/NJ members wanted to make certain that every effort was being made to ensure that the “safe haven” option is available.

For additional information on AAP private sector advocacy, go to the Private Payer Advocacy link at the AAP Members Only Center or contact Lou Terranova, Senior Health Policy Analyst at ltterrano@hq4u.com or 609-585-6871 ext 7633.

**Reports from Committee Chairman**

- SCQUIM committee minutes from May 2006
- Partnership for Quality (PFQ) meeting from August 2006
AAP National Committee Opportunities Available

To date there are vacancies on several AAP National Committees for the next term (2007-2008). They are:

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Any Fellow of the AAP may nominate a Fellow, or themselves, for a committee position. All nominees must submit a letter of nomination, a completed Fact Sheet, and a current Curriculum Vitae. Letters of support are optional.

The American Academy of Pediatrics Board of Directors policy requires that a Fellow may be nominated for only one committee at a time and may not serve on more than one committee concurrently.

If you are interested in nominating yourself or another Fellow, please contact Annette Lehman at alehman@hq4u.com or 609-585-6871.

Legislative Highlights

Continued from page 15

made to ensure infants were not abandoned at an unstaffed facility and that consideration be given to determine that the child had not been a victim of harm or abuse. Interested parties met with the sponsors, and representatives of the Office of Children and Families. Senator Diane Allen, who also participated in the meeting, expressed concerns similar to those of AAP/NJ. The issue was referred to the Safe Haven Task Force who will now meet in the near future to review the existing program and consider the safest, most effective way to expand the legislation in an effort to reduce infant deaths from abandonment. AAP/NJ also requested that the new Child Advocate be included in the process.

Scope of Practice Legislation

Stephen Rice, MD, PhD, MPH, FAAP is the AAP/NJ representative to the MSNJ Scope of Practice Committee which monitors all scope of practice legislation. They are currently reviewing A3259, sponsored by Assemblyman Wilfredo Caraballo (D-29) and Assemblyman Peter J. Biondi (R-16) which would expand the definition of athletic trainer. The bill revises the "Athletic Training Licensure Act," by expanding the definition of "athletic training" to include the practice of prevention, evaluation, treatment, management and rehabilitation of athletic related injuries or conditions resulting from physical activity, or any comparable injury preventing an individual from participating in physical activities. The bill also expands the membership of the Athletic Training Advisory Committee from six to seven members to include a representative of the general public. The bill repeals section 13 of P.L.1984, c.203 (C.45:9-37.47), which currently permits the State Board of Medical Examiners to issue a temporary athletic training license to licensure applicants. The bill continues to require that the trainer has met the athletic training curriculum requirements of a college or university approved by the board. The MSNJ Scope of Practice Committee did not oppose the legislation. However, AAP/NJ has determined that they will review the legislation further and compare its language to other scope of practice language for physician assistants, nurse practitioners, and physical therapists.

Senior Rapid Response Team

The AAP/NJ Government Relations Committee is working with the Senior Rapid Response Committee to work toward the assembly of a team of experienced pediatricians who would be available to attend legislative hearings and meetings on behalf of the AAP/NJ. A training session will be held on April 20th, 2007 at a conference center next to AAP/NJ headquarters. The Committee welcomes interested pediatricians to participate in the committee or interface with legislators.

Contact Government Affairs Committee Chair Jeff Bienstock to let him know of your interest.
Guidelines for RSV Prophylaxis
(extracted from the 2006 Red Book Online)

Palivizumab, a humanized mouse monoclonal antibody that is administered intramuscularly, is available to reduce the risk of RSV hospitalization in high-risk children. Respiratory Syncytial Virus Immune Globulin Intravenous (RSV-IGIV), a hyperimmune, polyclonal globulin prepared from donors selected for high serum titers of RSV neutralizing antibody, no longer is available. Palivizumab is licensed for prevention of RSV lower respiratory tract disease in selected infants and children with chronic lung disease of prematurity (CLD [formerly called bronchopulmonary dysplasia]) or with a history of preterm birth (<35 weeks' gestation) or with congenital heart disease. Palivizumab is administered every 30 days, beginning in early November, with 4 subsequent monthly doses (total of 5 doses). The dose of palivizumab is 15 mg/kg, administered intramuscularly. Palivizumab is not effective in the treatment of RSV disease, and it is not approved for this indication.

Recommendations by the American Academy of Pediatrics for the use of palivizumab are as follows:*

- Palivizumab prophylaxis should be considered for infants and children younger than 24 months of age with chronic lung disease of prematurity who have required medical therapy (supplemental oxygen, bronchodilator or diuretic or corticosteroid therapy) for CLD within 6 months before the start of the RSV season.
- Infants born at 28 weeks of gestation or earlier may benefit from prophylaxis during their first RSV season, whenever that occurs during the first 12 months of life.
- Infants born at 29 to 32 weeks of gestation may benefit most from prophylaxis up to 6 months of age. Once a child qualifies for initiation of prophylaxis at the start of the RSV season, administration should continue throughout the season and not stop at the point an infant reaches either 6 months or 12 months of age.
- Infants born at 32-35 weeks gestation:
  - younger than 6 months of age at the start of the RSV season
  - when 2 or more risk factors are present: child care attendance, school-aged siblings, exposure to environmental air pollutants (not including passive tobacco exposure which can be controlled by the family), congenital abnormalities of the airways, or severe neuromuscular disease.
- Children who are 24 months of age or younger with hemodynamically significant cyanotic and acyanotic congenital heart disease will benefit from palivizumab prophylaxis. Children younger than 24 months of age with congenital heart disease who are most likely to benefit from immunoprophylaxis include:
  - Infants who are receiving medication to control congestive heart failure
  - Infants with moderate to severe pulmonary hypertension
  - Infants with cyanotic heart disease
- If the first dose is administered in November, 5 monthly doses of palivizumab will provide substantially more than 20 weeks of protective serum antibody concentrations for most of the RSV season, even with variation in season onset and end.

*Please refer to the 2006 Red Book (27th Edition, pages 562-565) or the 2006 Red Book Online for a full discussion of RSV prophylaxis including indications for 2nd season, indications for at risk and not at risk infants, and dosing considerations. Individual patients may benefit from decisions made in consultation with neonatologists, pediatric intensivists, pulmonologists, or infectious disease specialists.

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3rd Annual Golf Outing
To support the Pediatric Council on Research and Education

May 9, 2007
Neshanic Valley Golf Course
Neshanic Station, NJ

More details to follow in the next issue of “The New Jersey Pediatrician”.

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Save the Date

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