The New Jersey
Pediatrician
Volume 32 • 4th Quarter 2007
Newsletter of the American Academy of Pediatrics/New Jersey Chapter

PCORE CORNER

(Pediatric Council on Research and Education)

Steve Kairys, MD, Medical Director/Chair, PCORE Board of Trustees
Fran Gallagher, MEd, Executive Director

As your AAP NJ Foundation, the 'Quality Improvement arm', PCORE has been working with community, state, and national partners to help keep children in New Jersey safe and healthy! Programs are being taught within the framework of the Medical Home and all have medical champions who bring pediatric leadership and expertise. PCORE medical champions and resource teams are:

- ⇒ working with community-based pediatric practice teams to incorporate research based developmental screening tools for infants and toddlers as part of well health supervision,
- ⇒ working to increase adolescent immunization rates as part of adolescent well health supervision;
- ⇒ working with community-based pediatric practice teams and emergency department personnel to help prevent child abuse and neglect
- ⇒ improving chronic care management – a focus on asthma
- ⇒ post partum depression screening for moms of newborns
- ⇒ Reaching out to nearly 700 preschoolers through the *Choosing a Healthy Life by Making Healthy Choices, An Obesity Prevention Program*

This months PCORE Program Spotlight

is *Educating Physicians in Their Communities, Child Abuse and Neglect Prevention* (EPIC CAN, previously known as EPIC SCAN). PCORE, in collaboration with ***ArtsYOUniversity*** presented a powerfully intense and compelling musical, ***Runaways,*** that put faces with our EPIC CAN program.

Continued on page 4

Keep it confidential: A Review of New Jersey State Guidelines for Adolescent Health Care

Susan R. Brill, MD

It's 4:30 in the afternoon and you are seeing Jenny, a long time patient who is now 16 years old. Jenny complains of burning on urination and some 'weird' vaginal discharge. Her mom is in the exam room with her and says, "I'm sure it's just a bladder infection, or maybe a yeast infection." You are aware that Jenny's symptoms may mean something else, such as a sexually transmitted infection (STI). When mom steps out, you ask Jenny if she's ever been sexually active; she says "Yeah, just one time about a month ago, but we broke up now—please don't tell my mom about it!"

Practitioners who care for adolescents will recognize this scenario. It is important for any clinician caring for adolescents to be aware of the laws and limits of confidentiality in the state they practice. Minor consent laws allow the practitioner to provide teenagers with appropriate, confidential health care. Some of these laws are based on the emancipated status of the adolescent, such as a patient under age 18 who lives apart from family, is self supporting, or married. However, many states give decision making authority to a 'mature minor'; a patient under 18 who can understand the risks and benefits of treatment vs. no treatment. Most instances involve diagnosis and treatment of STIs, access of family planning services, substance abuse treatment and mental health services. Many states provide specific statutes elucidating scenarios where teens may seek services without parental knowledge or consent.

Professional organizations have published statements and practice guidelines that support a minor's right to consent for treatment. The Society for Adolescent Medicine supports confidentiality protection as an "essential component of health care for adolescents because it is consistent with their development of maturity and autonomy". Protecting the confidentiality of a teen's health information is an important ethical duty that respects their autonomy, protects them from harmful outcomes and gives a "fair and reasonable opportunity to receive appropriate health care".[i] The American Medical Association also encourages physicians to allow mature minors to give informed consent for medical, psychiatric and surgical care without parental consent and notification in conformity with state and federal law.[ii]

In New Jersey a minor may give consent, without parental involvement, for testing and medical, surgical or hospital treatment of a 'venereal disease'. In addition, physicians may inform a minor's parents that he or she is seeking such services if they deem it in the minor's best interests. Also, a minor over 13 years of age is allowed to consent to HIV testing.[iii] Clinicians need to be very clear with their patients that they will protect this sensitive health information to the best of their ability. However a major roadblock for providing confidential treatment for STIs occurs around billing for testing and treatment. If a parent receives an Explanation of Benefits (EOB) or bill regarding gonorrhea and chlamydia testing for example, this could lead to a serious breach of trust on the part of the patient, and reduce the effectiveness of diagnosis and screening programs. In our state clinicians are working with insurance companies to protect such sensitive health information. Until this is assured, practitioners need to explain the limits of confidentiality they may provide in their office. A referral to a confidential clinic in your community may be warranted.

Continued on page 3

American Academy of Pediatrics

New Jersey Chapter
1 AAA Drive, Suite 102
Trenton, New Jersey 08691
Phone: 609-585-6871
Fax: 609-581-8244
Email: hq@aapnj.org
Web Site: www.aapnj.org
AAP National: 800-433-9016

2006-2008 OFFICERS

President
Janice Prontnicki, MD, MPH, FAAP

Vice President
Michael Segarra, MD, FAAP

Vice President-Elect
Stephen Rice, MD, PhD, MPH, FAAP

Treasurer
Margaret (Meg) Fisher, MD, FAAP

Secretary/Editor
Elliot Rubin, MD, FAAP

Immediate Past President
Bipin N. Patel, MD, FAAP

Executive Director
Debbie Hart, CAE, APR

Layout/Design
Marina Atkinson

4th Quarter 2007

American Academy of Pediatrics/ New Jersey Chapter Established 1950

President's Message

Janice Prontnicki, MD, MPH, FAAP

Your AAP- NJ Chapter remains very busy advocating on behalf of children and the pediatricians who care for them.

New Jersey has the dubious distinction of being at the bottom of the list when it comes to paying pediatricians who care for children on Medicaid. Although this is a long-term problem, over the past year we have been especially interested in correcting this. Over the summer, representatives from the AAP/ NJ met with Commissioner of Human Services Jennifer Velez and her staff to seek corrective action. I'm happy to report that Governor Corzine has written into the state budget an amount that when annualized and with federal matching funds will lead to an increase of $20 million/year in Medicaid payments for providers of services to children. We met again last month. These funds and the rate increases become available January 2008. It is definitely a step in the right direction although it does not guarantee fee increases for those Medicaid recipients in managed care plans. However, the Medicaid authorities expect that this move will prompt those payers to follow suit.

I have been working closely with National AAP on the issue of SCHIP (State Children's Health Insurance Plan). This is the Medicaid expansion program that in our state is known as Family Care. Often this plan covers children whose parents work but whose employer does not offer health care coverage and the family cannot afford to purchase such coverage elsewhere. As you know, President Bush vetoed this despite strong bipartisan support in Congress. I have attended rallies sponsored by Senators Lautenberg and Menendez as well as testified at a hearing chaired by State Senator Vitale. After Congress failed to override the President's veto, our Governor has initiated a lawsuit against the President on behalf of our State's children. We will continue working on this important issue.

Despite adequate supplies of flu vaccine this year, NJ pediatricians have again failed to receive timely distribution through the VFC (Vaccines for Children) program. We met with Commissioner of Health Fred Jacobs to discuss this and other topics. We were discouraged to hear that the state seems to have no control over this distribution issue. Other surrounding states are not facing similar problems. We will continue to work on this inequality.

Wishing you and your family a
Happy and Healthy Holiday Season!

Instructions for authors: Authors are to attempt to follow the ***MSTAUATNOCROALDTO*** policy of the New Jersey Pediatrician (Make Sure To Avoid Using Acronyms That No One Can Remember Or At Least Define Them Often).

Keep it Confidential

Continued from page 1

Other NJ statutes have addressed sensitive adolescent health issues such as drug and alcohol abuse and family planning. Practitioners should be aware that in New Jersey a minor may consent for treatment of the use or abuse of drugs or alcohol. A minor may also receive family planning care and counseling without parental involvement as well. An experienced clinician will need to determine an ethical and legal limit to such confidentiality. For example, if a minor requires intensive inpatient detoxification and rehabilitation, most clinicians would feel obligated to involve a parent in treatment decisions.

Minor consent laws do differ from state to state; if questions arise, it is appropriate to seek more information from respected internet sites, or consider querying an attorney for more information. Suggested web resources include monographs from the Center for Adolescent Health and the Law, www.cahl.org, and from the Guttmacher Institute, www.guttmacher.org

[i] SAM Position Statement: Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine, Journal of Adolescent Health, Vol. 35, No 1

[ii] AMA Statement H-60.965: Confidential Health Services for Adolescents, www.ama-assn.org, accessed 10/31/07

[iii] State Policies in Brief: An Overview of Minor Consent Laws, www.guttmacher.org, accessed 11/6/07

Susan Brill, MD is Director of Adolescent Medicine, The Children's Hospital at Saint Peter's University Hospital and Clinical Associate Professor of Pediatrics, Drexel University College of Medicine

Annual Meeting 2007: A Pediatrician Goes to War

Pierre Coant, MD, FAAP

Dr. Charles Garbarino presented to the Pediatricians of New Jersey his experiences from the Iraq War during the keynote address at the Annual Meeting on June 13, 2007. Colonel Garbarino was the first physician from the New Jersey National Guard to be deployed for Operation Iraqi Freedom where he has served two tours of duty.

The first visit, January to April 2004, was served at Camp Spearhead in Shu-Aibah Port, Kuwait. His second deployment, August to December 2005, was at Forward Operating Base Warrior (Kirkuk, Iraq) assigned to the 3-116th Cavalry Battalion. Kirkuk became a hotspot in the conflict, with hostile actions occurring against U.S. Forces. Colonel Garbarino, with the Cavalry Medics, cared for the injuries and medical problems of the 500 soldiers assigned to the Battalion.

AAP/NJ invited Dr. Garbarino to speak on his experiences as a physician in the Iraq War. Dr. Garbarino is a pediatrician in private practice who also works with a neonatal group; while he was away he appreciated the coverage his partner, Dr. Deborah Coy, and other associates provided. He also valued the immense support from his wife, Lydia. Dr. Garbarino said, "When a soldier is deployed, the family and relatives of the soldier need a lot of support. The family unit is stressed as the soldier performs his duty."

Dr. Charles Garbarino offered with slides, pictures, and words a mesmerizing view of his experiences in the Iraq conflict. The presentation transported the AAP/NJ audience to the ongoing conflict and the far away world of death, disease, and sacrifice. He relied on his pediatric and military training to care for the soldiers and their wounds. Dr. Garbarino is a BLS, ACLS, ABLS and Advanced Trauma Instructor with the military and he used his pediatric diagnostic skills to care for the soldiers who he respectfully calls, "Big Kids".

Dr. Garbarino recounted his exploits

and incidents to the pediatricians gathered in the auditorium. The mortar fire, the wounded soldiers, and the different medical roles he had to perform were recalled from treating chest pain to repairing a rotator cuff injury. The audience was impressed with Dr. Garbarino's skills, care and compassion for the soldiers.

Afterwards, the audience had time for questions for this unique Pediatrician and Soldier. When asked why he left the safety of New Jersey to go to Iraq, one of the reasons he gave was because of his Uncle Louie. Dr. Garbarino said, "Uncle Louie served in World War II and I was close to him. Every time I look into a soldier's eyes I see my Uncle Louie."

Dr. Garbarino told about the suffering and problems soldiers returning from war face. Soldiers are coming home both physically and psychologically traumatized. Post Traumatic Stress Disorder affects many returning soldiers and all soldiers should be supported through their ordeal. "Remember the soldiers and their families -- Uncle Sam owes it to the soldiers to give them the best medical and mental health care possible," says Garbarino.

Colonel Garbarino has recently received the NJ Distinguished Service Award from the Garden State for his military service in Iraq. Dr. Garbarino was so moved from his experiences that he is writing a book called "Pediatrician Soldier (A Kids' Doc Goes to War)." He is donating all proceeds of his book to the children of soldiers not returning from the war.

The Pediatrician and Army Officer is devoted to his patients both children and soldiers. He is trying to make a difference by having the word spread for civilian communities to open their arms in support of the deployed soldier and their loved ones. Dr. Garbarino says, "No matter what you think about the war, always remember the soldier and do what you can to help the soldiers and their families."

Dr. Garbarino is available to discuss his experiences in Iraq at other medical or hospital events. He hopes to help fellow physicians as they in turn help in treating and caring for the returning soldiers as well as their families. He can be reached at chaslyd@aol.com or (973) 736-4442.

PCORE CORNER

Continued from page 1

In addition to being a fundraiser, the evening received rave reviews from the audience and raised awareness about the effects of child abuse and neglect later in life. The evening was opened up with an introduction from E. Susan "Sooze" Hodgson, MD, Child Advocate for the State of New Jersey.

Special Thanks…. Debbie Nuzzo, PCORE Board of Trustee, Chair, Fundraising Committee & to ***ArtsYOUniversity*** who generously donated the use of their beautiful theatre, the energy of owners Michael McClure and Susanne Trani-McClure, and the artistic talents of the senior dance company of girls ranging from 13 years to 18 years old.

ArtsYOUniversity Artistic Director & Cast: *Michael McClure (Artistic Director), Rachel Rocco, Danielle Hernandez, Cara Mitchell, Kimmi Teller, Jenny Delgado, Kristen Majoros, Angelique Sherman, Lauren Monteleone, Samantha Alfonse, Aliyah Nemser, Olivia Russell, Kellie Palermo, Brittany Bow, Siobhan Campbell, Ashley Mil, Joanna Caruso*

PCORE Board of Trustee Members: *Steve Kairys, MD, Debbie Nuzzo, Elaine Donoghue, MD, Michael Segarra, MD, Jeanne Craft, MD*

PCORE Staff: *Fran Gallagher, Cynthia Heulitt, Mary Jo Garofoli, Anne Lorenzo, Lisa Makai, Annette Lehman*

NJ EPIC Child Abuse and Neglect Prevention Program (CAN)

Is your pediatric or family practice in Cumberland County? Are you a health provider in an emergency room anywhere in New Jersey? If you are either, we invite you to participate in PCORE's NJ EPIC CAN pilot program. This educational program is designed to work with your office team to develop a protocol for handling child abuse and neglect cases in the healthcare setting. Additional information about EPIC CAN pilot is featured later in this issue of the PCORE Corner Spotlight, page 8.

There are many benefits to participating practices, in addition to being cost free… a few include:

- Onsite CME and nursing credits pending application approval, and visits are scheduled at a convenient time for you.
- Curriculum is provided as an office resource
- Health Care Provider Toolkit with extensive resources for family
- Ongoing consultations with professionals in the field of child abuse and neglect prevention
- Enhanced partnerships with community resources in protecting children and strengthening families
- Increased family/parent involvement in prevention and intervention efforts.

Interested?

Contact Kate Putnam, MEd, Program Co-Director: 609-588-9988 or kputnam@njpcore.org
Program Medical Director, Steven Kairys, MD
Funding Source: NJ Department of Children and Families

NJ Senior Section Update

Lawrence D. Frenkel, MD, FAAP, Chairperson of the NJ Senior Section

The Senior Section surveyed its membership during the late summer with regard to topics for our meetings during the next year or so. The selection for the next meeting was: "Medicare Made Easy: Parts A to Z" or "Everything That You Wanted to Know About How This Government Monolith Affects Your Life But Were Afraid to Ask". This program is scheduled for the end of April and will probably include supper and be held at St. Peters University Hospital. Choices for future meetings included "Preparing Your Will" and "Until You Retire." Section members who missed the survey should contact the NJ/AAP for a form or call Larry at 908-616-8650.

With regard to legislative activities, I represented the Section at a meeting with Dr. Fred Jacobs, the outgoing Commissioner of Health and Senior Services. There was a candid and far reaching discussion of issues of importance to pediatricians and to the children that we serve. Dr. Jacobs shared information and suggestions regarding how we could move toward resolution of some of these issues but none of them are automatic. One goal for the next year for the Section is to formalize mechanisms for its members to be able to rapidly provide needed testimony and advocacy in an expedited and effective manner. This will also be discussed during the April meeting.

Resident Rounds:
A 13-Day-Old Baby Girl with a Vesicular Rash

Charles Flores, MD, Dr. Flores is a 3rd Year Pediatric Resident at The Bristol-Myers Squibb Children's Hospital at UMDNJ-Robert Wood Johnson University Hospital

Fig 3. Scalp involvement showing vesicles and crusting.

A 13-day-old baby girl presented to the emergency department after being sent in by her PMD for a persistent vesicular rash since birth that is worsening. The infant was a full term baby girl, born via spontaneous vaginal delivery without complications. Baby's Apgars were 9 and 10 at 1 and 5 minutes, and she weighed 9 pounds 1/2 ounce at birth (90th percentile). The pediatrician noted the baby to have a vesicular rash with underlying erythema on both arms and legs, and on the lower abdomen upon delivery. Placental bacterial and viral cultures were sent which were negative. Mother's prenatal labs were significant for her being varicella non-immune. There was no history of any maternal intrapartum infection and at the time of delivery there were no signs of any active infection. The mother had no history of HSV infection.

The child was seen by her PMD at 5 days of age who noted that aside from the vesicular rash, the child was well appearing, afebrile, and gaining weight. The family history was unremarkable with no history of any skin or nervous system disorders. The PMD sent the child to see a dermatologist where a skin biopsy was taken from the leg and the child prescribed Locoid (hydrocortisone butyrate 0.1%) cream without much improvement. The child was seen again at 13 days of age by her PMD, who sent her in to the ED after noting worsening progression of the rash to confluent vesicular lesions most notably on the legs.

In the ED the baby was well appearing, comfortable, and afebrile, weighing 4.24kg (90th percentile). Skin examination reveals linearly arranged erythematous vesicular lesions distributed mostly over bilateral legs and arms (see fig1). The vesicles were mostly confluent on the left leg with some crusting (see fig 2). Scalp examination revealed vesicles with crusting, similar to the lesions on the left leg (see fig 3). The baby was active, with good muscle tone and strength. The baby did not exhibit any increased irritability when the lesions were palpated. The remaining physical findings were normal. Dermatology and infectious disease consults were obtained.

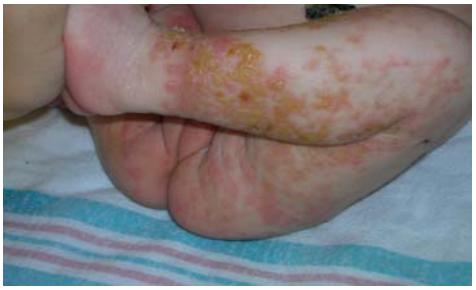


Fig 2. Vesicles with crusting on lower left leg.

A complete blood count demonstrated a hemoglobin of 15.8 g/dL; white blood cell count of 20.4x10^3/mcL with 17% neutrophils, 1% bands, 46% lymphocytes, 11% monocytes, 24% eosinophils; and platelet count 828 x10^3/mcL. Peripheral blood smear revealed normal RBC morphology. Gram stain of the lesions revealed rare WBCs and no organisms. Bacterial and viral cultures of blood and skin were obtained. Urinalysis was normal. Cerebral spinal fluid analysis was not obtained due to lesions noted over the infant's back in the L3-L5 distribution and the fear of introducing infection. HSV 1/2 combined Ab and HIV testing was done on the mother. The baby was treated empirically with intravenous nafcillin and acyclovir.

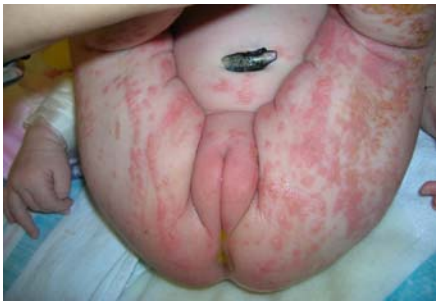


Fig 1. Erythema and inflammatory vesicles in a linear distribution on bilateral lower extremities.

A clinical diagnosis is made.

QUESTION: What do you think the diagnosis is?

a)Langerhans' cell histiocystosis
b)Herpes simplex virus infection
c)Varicella zoster virus infection
d)Transient neonatal pustular melanosis
e)Bullous impetigo
f)Erythema toxicum neonatorum
g)None of the above

Denouement is on page 7.

CATCH Corner

CATCH (Community Access to Child Health) continues to grow. There were several applications for CATCH grants in the last cycle and the results will be announced soon. Good luck to the applicants! We hope to continue to support New Jersey applications with technical assistance and grant development guidance.

Don't forget that the application for the 2008 CATCH Implementation & Resident Cycle grants are now available online on the AAP Web site. CATCH is also pleased to announce that a new funding opportunity will begin this cycle. CATCH and the AAP Julius B. Richmond Center of Excellence will partner to offer grants for projects focused on reducing second hand tobacco smoke (SHS) exposure for children and youth. The grants will be part of the general call for proposals and therefore must follow the same application and reporting procedures and meet the same eligibility and selection criteria as those under the CATCH Implementation Funds program. The grant cycle starts November 1, 2007, with an application deadline of January 31, 2008.

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.*

It helps to touch base with your CATCH facilitator prior to submitting your application, so please feel free to contact Dr. Paul Schwartzberg at pschwartzberg@meridianhealth.com if you are considering applying for a CATCH grant or if you need more information or technical assistance.

Annual School Health Conference

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

The School Health Committee of the AAP/NJ held its 16th annual meeting on Community Medicine: School Children and Your Practice. There was a record attendance for the event (534 people) and the committee welcomed many new physicians to the sessions.

Legal issues and behavioral health topped the list of interests with sessions on infectious disease, bullying, dermatology, and drug testing in schools.

Governor Corzine sent a declaration honoring the AAP/NJ for its work in child advocacy. He declared October Child Health Month.

Dr. Mark Faber, MD spoke on Behavior Crisis: What Every Health Professional Should Know.

Dr. Wayne Yankus, MD, FAAP - Chair of the School Health Committee addresses the attendees.

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 visit www.aapnj.org

March 18, 2008
Resident Career Day - Hilton Garden Inn, Edison, NJ. 7:45 a.m. till 1:30 p.m. Look for more information coming in January.

April, 2008
Senior Section Meeting - Topic: Medicare Made Easy. St. Peter's Hospital. More details to follow.

June 4, 2008
AAP/NJ Annual Meeting - More details to follow.

September 9, 2008
Resident Career Day - More details to follow.

Resident Rounds Case Conference: Denouement

Continued from page 5

DENOUEMENT

The answer is: **g) None of the above**

The presence of multiple linearly arranged erythematous vesicles since birth in a 13 day old newborn in the face of a laboratory finding of eosinophilia point to the clinical diagnosis of incontinentia pigmenti. All the child's cultures are negative and the mother's HSV and HIV tests are negative.

Skin biopsy from the leg sent by the outpatient dermatologist shows spongiotic microvesicles containing numerous eosinophils which confirms the diagnosis of incontinentia pigmenti.

***Differential Diagnosis*:** The differential diagnosis of vesicular eruptions in a neonate is best approached when systematically approached by dividing it into 3 broad categories, which includes 1. Infectious conditions (most important to consider), 2. Noninfectious transient vesicular conditions, and 3. Nontransient vesicular conditions.

Infectious conditions are most important to consider first, as they can be life threatening; thus, the threshold for providing antibiotic coverage should be low. Infectious conditions to consider include: HSV, group B *streptococcus*, *staphylococcus aureus*, and varicella zoster virus. Noninfectious transient vesicular conditions that should be considered include: Erythema toxicum neonatorum, transient neonatal pustular melanosis, miliaria, neonatal acne, trauma (including child abuse). Nontransient vesicular-bullous conditions to consider include: epidermolyis bullosa, Langerhans'-cell histiocytosis, pemphigus vulgaris, and bullous mastocytosis.

Given the well clinical appearance of the child an infectious cause was unlikely, but still needed to be safely excluded. Though this mother was varicella non-immune, she had no recent evidence of illness, making this diagnosis unlikely, and testing for this virus in the infant was negative. Furthermore, the bacterial and viral cultures sent from the blood and wound were negative. Maternal blood tests for HSV 1/2 and HIV were also negative.

The other transient and nontranient vesiculobullous conditions did not resemble the presentation of this newborn. Langerhans cell histiocytosis may present as papules or vesicles during the neonatal period but the pathologic Langerhans cells are typically visualized during microscopic examination. Transient neonatal pustular melanosis is notable for superficial pustules without erythema, along with hyerpigmented macules with or without scale. The pustules and macules can manifest anywhere on the skin, including the palms and soles. Erythema toxicum neonatorum is common in healthy infants during the first week of life and is characterized by erythematous macules, wheals, papules, and pustules that wax and wane, with new lesions that last for several days. It usually begins on the face and spreads to the trunk without involving the palms or soles.

***The Condition*:** Incontinentia pigmenti (IP) is an uncommon X-linked dominant disorder that is usually lethal in affected males in utero, and variably expressed in females. It is a disorder that affects skin, hair teeth, nails, eyes, and central nervous system. The disease is transmitted female to female in general. The gene for IP has been mapped to chromosomal locus Xq28. The diagnosis of IP is established by clinical findings along with corroborative skin biopsy.

Skin manifestations are subdivided into 4 stages: erythematous vesicles in linear distribution (usual onset around birth to 2 weeks of age and resolves by 4 months old), verrucous papules and plaques (onset at age 2 to 6 weeks and resolves by 6 months), hyperpigmented streaks and whorls following lines of Blaschko (onset at 12 to 26 weeks of age and resolves by puberty), and pale atrophic patches and/or hypopigmentation (onset at early teens to adulthood and can last throughout adulthood).

Alopecia, hypodontia, abnormal tooth shape, and dystrophic nails can be observed. Dental abnormalities are the most common non-cutaneous manisfestation of IP, occurring in more than 80% of all patients with nearly 65% of presenting with major anomalies. The most common abnormality is partial absence of teeth (anodontia) which is noted in 43% of patients.

Ophthalmic anomalies are among the most severe manifestations of the disease and are often found in conjunction with neurologic deficits. Ocular abnormalities are divided into retinal and nonretinal manifestations. Nonretinal manifestations include strabismus, optic nerve atrophy, nystagmus, and uveitis. Retinal lesions affect the peripheral retina or macula and can lead to retinal detachment. Retinal lesions may become evident between the neonatal period and 1 year of age, necessitating the need for frequent ophthalmologic evaluation during this time period. The prognosis for normal vision in a child without demonstrable findings within the first year of life is generally considered to be good.

CNS clinical manifestations include infantile spasms, seizure disorder, spastic paralysis, motor retardation, and microcephalus. Early seizures may signify abnormal neuronal and neural crest cell migration, leading to gross cerebral malformations. Patients found to have early seizures are frequently are developmentally delayed.

The prognosis for IP is generally good, with poorer outcomes related to patients with underlying neurologic, ophthalmologic, or dental abnormalities. The skin manifestations do not require specific treatment except when superinfection is suspected. Spontaneous improvement of the skin and resolution of skin lesions is common, so parental reassurance must be provided. It is important to rule out any visual, motor, or cognitive disorders. Regularly scheduled eye and dental exams is a necessity. Neurologic symptoms warrant imaging of the brain to look for cerebral malformations and warrant consultation with a neurologist.

***Patient Course*:** Once the diagnosis of IP was confirmed, antibiotics were discontinued. Opthalmology, genetics, and neurology consults were obtained. Routine electroencephalogram was done to look for seizure activity and was normal. Ophthalmology exam revealed normal retina bilaterally. The patient was discharged home with follow up with her primary care doctor, a neurologist, an ophthalmologist, and a geneticist.

The patient's skin lesions have only mildly improved, but she has not exhibited any other complications of IP to date. She continues to feed well and lack any signs of neurologic impairment. Genetic counseling will be provided to the family and she will continue to be under the care of her primary care doctor and aforementioned sub-specialists.

PCORE Program Spotlight:
EPIC CAN (Educating Physicians in Their Communities on Child Abuse and Neglect)

Steven Kairys, MD, Medical Director
Kate Putnam, MEd & Ruth Gubernick, MPH, Program Co-Directors

EPIC CAN 'KICK OFF'

Cumberland County primary care practices and community stakeholders gave the EPIC CAN (Educating Physicians In their Communities on Child Abuse and Neglect) program an enthusiastic welcome at the project Kick-off on Oct. 23 in Vineland. The meeting brought representative physicians, nurses, and other office staff from pediatric and family practices across the county. Steve Kairys , MD, MPH, Medical Director of NJ PCORE and Chair of the Pediatric Department at Jersey Shore Medical Center, served as host for the morning event held at a South Jersey Healthcare Regional Medical Center site. The group was welcomed by Douglas Rainear, Director of the Cumberland County Freeholders and the prime mover in establishing a county-wide effort to improve the quality of children's lives in the area through the Children's First Initiative.

Dr. E. Susan "Sooze" Hodgson. New Jersey Child Advocate and a pediatrician, spoke eloquently about the history and importance of EPIC CAN. As a former physician trainer, she has seen firsthand the impact the site-based training has had on empowering practice staff to recognize, appropriately address, and prevent child abuse and neglect that they encounter. Dr. Hodgson encouraged the attending physicians to enroll in the CAN training and to believe in the message of CAN: "People who care CAN make a difference in preventing child abuse and neglect." Dr. about the Department's prioritization of the well-being of children being the reason that the funding of CAN was increased this year. Her hopes are that EPIC CAN will continue to be a program serving the needs of the healthcare community, along with partnering organizations/agencies and families, in their mission of keeping children safe and healthy. A DYFS Foster Parent, Joann Murphy, spoke eloquently of the need for preventive, proactive medical care for the most vulnerable children and for the kind of training offered by EPIC CAN.

E. Susan "Sooze" Hodgson, MD, Child Advocate for the State of New Jersey, 10/23/07 EPIC CAN Cumberland County "Kick Off"

Kairys reminded the group that though currently EPIC CAN will focus its office and health center-based trainings in Cumberland County, it will be offered across the state to hospital emergency department (ED) staffs, as well.

Karen Baldoni, Assistant Director of Policy and Planning from the New Jersey Department of Children and Families, spoke

The response that morning from the attending primary care providers was very enthusiastic, with over half the practices in Cumberland County enrolling on the spot. Interested practices who have not yet signed up to participate in this free program are welcome to enroll during the next month. Emergency departments from hospitals throughout NJ Jersey have begun to express interest in EPIC CAN. If your office, health center or ED has questions or is interested you can call the NJ PCORE Office and speak with the Co-Director, Kate Putnam at 609-588-9988.

New Jersey VACCINE VOICE

To view the Fall 2007 edition of the
New Jersey Vaccine Voice,
please visit:
http://www.gatewaymch.org/NJ_Vaccine_Voice%20Fall%202007.pdf

AAP National Meeting Calendar

To view upcoming AAP meetings and CME courses, visit the calendar via the CME finder at **www.pedialink.org**

Report from the National Senior Section

Avrum L. Katcher, MD, FAAP, Chairperson of the AAP National Senior Section

Welcome to all members of the New Jersey Chapter, Section for Senior Members. I would like to bring you some of the activities of the National Section for Senior Members.

Well, thus far we have had only positive consequences from all the hard work our members have contributed. Joan Hodgman and Arthur Maron continue their wonderful work on the *Bulletin,* whose latest issue we hope you are reading. Jerry Aronson has even further expanded our Web page, where as you probably know there is an enormous amount of information for seniors, related to many aspects of aging and life, as well as opportunities to work with the AAP. Do go to the AAP web page, at www.aap.org/sections/seniormembers. There you will find an enormous amount of information about many topics—too many to list here—which may well be relevant for you.

We have been very pleased with the responses of the AAP Chapters to our encouragement to form Chapter Senior Committees. Dr. Annunziato and Jackie Burke have completed a total revision of the splendid Chapter Guide, to aid Chapters who desire to create or expand such Committees. Your Chapter Officers and Executive Directors should by now have copies of the Chapter Guide. If not, please contact Jackie Burke at the AAP office in Elk Grove Village, IL, by mail or at jburke@aap.org. If you have any questions or desire further advice, contact one or more of the Chapters who have very positive programs. These include: Arizona, California I , Delaware, Florida, Iowa, Louisiana, Maryland, Missouri, New Mexico, New York II, South Carolina, Texas, Virginia, and Wisconsin. Other Chapters are considering establishment of Senior Committees or programs as well. Larry Frenkel and his group are working hard to develop a Senior Committee for New Jersey.

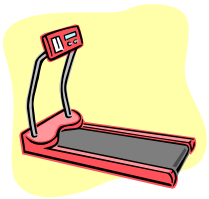
An even larger group of Chapters are calling on senior members to work in the area of advocacy, often in dealing with legislators and administrators. Wisconsin has formed a joint venture with the state AARP Chapter, to work with grandparents who find themselves parenting again, teaching healthy diets, and offering screening tests. The two groups have also support the SCHIP venture.

Our Executive Committee, led by Lucy Crain, Michael O'Halloran and Jerry Aronson, is working closely with Jackie Burke and Ken Slaw and his staff at the national AAP headquarters on a strategic planning initiative. What goals should we pursue? What may we realistically be able to accomplish? What will most benefit children, and simultaneously meet the needs and wishes of our membership? Data is being gathered, and the spring meeting of the Executive Committee will devote a large proportion of time to this topic. We had a similar venture a number of years ago and we hope to progress even further now.

It was noted by the executive committee that AAP membership categories and options for seniors do not appear to be widely advertised. The feeling is that many seniors are not aware of money-saving emeritus and retired membership categories. If you are unsure on this point, suggest you communicate with Jackie Burke or the membership division at AAP.

The Executive Committee also believes that a major goal for the Section for Senior Members is to aid our members to "develop" and "grow" well. The comparability with the role of the pediatrician in child development is not entirely facetious. The life cycle changes through which we all must progress are similar in principle to those of any other age. We have the advantage of our training as pediatricians in this area, and of our life experience. Look on our web page for more information on this topic.

Edward R. Murrow, the broadcaster who brought such vivid images to us via his nightly radio comments from Britain, would sign off with "Good night and good luck." I'd close with "Good health and good luck!"



Get Moving, Get Healthy – NJ Website: Tips for Family Meals and More

The holidays are a great time for families to share meals and conversation. But why stop there? The new *Get Moving - Get Healthy – NJ* website, http://getmovinggethealthynj.rutgers.edu , offers tips for improving and enjoying family meals. Recent research shows eating family meals has many benefits.

"Not only do family members tend to eat more nutritional foods when they eat together," said Kathleen Morgan, Chair of the Department of Family and Community Health Sciences, Rutgers Cooperative Extension, "but increasing evidence shows that teens that regularly eat meals with their family are much less likely to engage in addictive behaviors, such as smoking, drinking alcohol or taking drugs." Research also shows that families that eat together take in more nutrients, eat more vegetables and consume less fat and soda. When families share a meal, they share conversation, too.

The *Get Moving - Get Healthy - NJ* website has information and resources on healthy eating, physical activity, the health benefits of a healthy lifestyle, and more. These are some ideas found on the website for family meals:

- Aim for eating at least one meal together each day. Today's busy families find it hard to take time to eat together. However, the family meal does not have to be a dinner; it can be breakfast or another meal that fits best in your family schedule. It could also be a healthy meal on the road or picnic at the soccer field.
- Establish a regular meal schedule, including time for breakfast.
- Provide healthful foods and beverages at each meal, including vegetables, fruits, dairy and whole grains. When introducing new foods, try one at a time and serve it with other well-liked foods.

Continued on page 11

Announcing PCORE's 4th Annual Golf Outing

Mark Your Calendars!

May 14, 2008
Neshanic Valley Golf Course

There are many opportunities to get involved and to support our work in shaping children's health for the 21st Century… for ALL children. One is sure to be a good match for you, please consider:

- **Joining our Golf Committee – We Need Volunteers Statewide (meetings are held via conference call at 9:00 p.m., just one a month)**
- **Register to Enjoy a Day of Golf and/or a Lovely Evening Cocktail Hour and Gourmet Dinner**
- **Consider Purchasing A Sponsorship**
- **Help to Recruit Other Sponsors**
- **Making a Tax Deductible Donation (no amount is too small!)**
- **Donate Gifts for Door Prizes (e.g. gift basket, gift certificates for dinner or theatre, complimentary green fees or a round of golf)**

For more information, please contact:

Harriet Lazarus at hlazarus@njpcore.org
609-588-9988
or
Jim Watkins at watkinj2@wyeth.com
973-660-5027

Sports Medicine:
Update on Pre-participation Physical Examinations (PPE)

Stephen G. Rice, MD, PhD, MPH, FAAP, *Vice President-elect and Chairman, Sports Medicine Committee, AAP/NJ and lead author on the Conditions Affecting Sports Participation Report.*

New Jersey – New Annual Athletic PPE form

The New Jersey Department of Education has produced a new Annual Athletic Pre-Participation Physical Examination Form which goes into effect on January 1, 2008. You can access and download the form from the following link: http://www.state.nj.us/education/districts/forms.htm

LaCoyya Weathington of the Office of Program Support Services headed the project with significant input from school nurses and sports medicine physicians. The form was presented to the Executive Committee of AAP/NJ at our September meeting just before its publication; some minor adjustments and corrections from our members were incorporated into the form before it went to press. The form is truly "a work in progress" and can be amended annually if necessary.

The new form is more focused and more detailed. The most significant changes include an improved medical history section with expanded questions on head injuries and heart-related conditions. More attention is also given to asthma and allergies.

The physician will now be required to sign off that the history was reviewed.

When you schedule athletes for the physical examination, insist that the history section be completed prior to the physical examination portion (in the waiting room if necessary). Since you will be very familiar with most of your patients and their past medical histories, this review will probably be very brief.

The physical examination portion has an expanded section on the cardiac exam. If a murmur is detected, evaluate the murmur while the athlete is standing, squatting and while breath holding (Valsalva maneuver). Determine if the murmur changes in any of these positions. There is an attached sheet the form that explains possible pathologic conditions associated with such changes in murmurs.

To avoid the prior confusions over evaluation for scoliosis and hernias, the form now places absent in the "normal" column – making it simpler to fill out the form for the completely normal athlete.

The musculoskeletal portion of the form has been enhanced by explaining that the range of motion, strength and joint stability are the key areas of focus. The neurological section has been reduced to focus attention to balance and coordination without listing specific required tests.

Physicians will now be asked to estimate physical maturation as normal or abnormal without a specific requirement to state a Tanner Scale number.

Make sure that all of the measurements and vital signs are entered onto the form before signing and stamping the form (to avoid having the forms bounced back to your office). This includes height, weight, blood pressure, pulse and vision.

Remember that normal values for blood pressure are based on the new tables that take into account age, gender and height percentile. Those with hypertension greater than the 99th percentile plus 5mm Hg should be restricted from activities that would raise their blood pressure further. Those with blood pressure above the 90th percentile should have their blood pressure repeated and followed. Those with blood pressure above the 95th percentile consistently should be fully evaluated.

Vision worse that 20/40 requires correction (more for school performance than athletic performance).

AAP Clinical Report: Medical Conditions Affecting Sports Participation

The Council on Sports Medicine and Fitness (COSMF) Clinical Report: Medical Conditions Affecting Sports Participation (last published in 2001) is in its final stages before publication in the next few months in *Pediatrics*. As has been the case in the past re-writes of this report, the new version is significantly more comprehensive than the prior statement, citing 68 references to help pediatricians locate the source of its recommendations. Many new sections were added (GI diseases, rheumatological diseases, pregnancy) and most other sections were expanded or explained more clearly.

Get Moving, Get Healthy

Continued from page 9

- Mealtime is a good time to teach civilized behaviors, so try to follow rules about staying seated, passing items instead of grabbing at them, putting napkins on laps, and not chewing with your mouth full. Use only gently reminders. Mealtime should be a time to feel nurtured, together, connected and part of the family.
- Be a good role model. Many families have a "one bite" rule, meaning everyone has to take one bite of the food to see if they like it.

The *Get Moving, Get Healthy - NJ* (GMGH) website is part of a larger GMGH initiative to improve the health of NJ families and individuals. Rutgers Cooperative Extension, part of the New Jersey Agricultural Experiment Station, along with numerous partners developed this website. The entire GMGH project includes educational programs in schools and in the community, training for professionals, a walking challenge to launch in January and a public marketing campaign.

For more information, visit the website, http://getmovinggethealthynj.rutgers.edu or contact your local Rutgers Cooperative Extension office listed under County Government in the phone book.

Committee on Pediatric Workforce (COPW)

Beth A. Pletcher, MD, FAAP, Chair of National AAP's Committee on Pediatric Workforce

The COPW met in late September in Elk Grove Village, IL to address ongoing policy statement development and to consider areas of greatest need in the workforce arena. In order to "jump start" discussions, a number of presentations were made by both committee members and individuals from outside the Academy. The Committee has been discussing for some time current and future roles that pediatricians may play, with changing patient demographics as well as shifts in workforce numbers and structure. Among the many roles that pediatricians and pediatric subspecialists have taken on, the one we first decided to focus on is the role of the pediatrician as a caretaker for the underserved.

The Committee is looking at a number of initiatives to help members learn more about this important topic, including possibly writing an article or two for members on practical issues such as use of an interpreter in pediatric practice, or overcoming barriers to care for underserved patients. The COPW heard a wonderful presentation by Wilda Knox and Dr. Ada Stewart from the Minority Affairs Consortium of the AMA regarding their Doctors Back to School Program. This initiative brings practicing physicians into middle schools in underserved communities to provide information to children on careers in medicine. It is the goal of this program to "sew some seeds of interest" in a medical career during this formative time, which may someday translate into training more physicians from underserved areas. To this end, the COPW hopes at the time of their spring meeting to participate in a Chicago area Doctors Back to School day. Who knows how many future pediatricians we might inspire - leading to an increase the diversity of the pediatrician workforce!

Our newest committee member, Dr. Luisa Alvarado-Domenech presented some extremely interesting data on the state of pediatric care in Puerto Rico, where she lives and practices. Dr. Mary Rimsza summarized for our group three recent state level workforce studies from Colorado, Massachusetts, and Pennsylvania and also provided a foundation for us to begin serious discussions about physician reentry into the workforce. Until very recently, little was known and few studies were done on this group of physicians who have a potentially important role to play in the physician workforce. How and why physicians who have left practice decide to return to the workforce, and what retraining pathways are available, are important factors to consider as we look at overall supply and distribution of physicians. Quality of care for patients, affordability and location of programs for retraining practitioners, as well as evaluative tools for assessing when a physician is fully ready to reenter practice, are all aspects of this subject under consideration by various stakeholders. Clearly more studies need to be done and data collected to shine a light on this critical segment of the physician workforce.

The COPW statement on "Financing GME to Meet Pediatric Workforce Needs" is currently under revision. A subcommittee of the COPW consisting of Dr. Andrew Hotaling, Dr. Mary Rimsza and Dr. Rachel Tellez are working on strategies to implement the recommendations outlined in our statement on "Culturally Effective Pediatric Care". Dr. Basco has taken on a project to look at pediatrician demographics and practice characteristics of pediatricians who identify themselves as underrepresented minorities. Preliminary data from the most recent Periodic Survey of Pediatricians on pediatric subspecialty care was discussed. Committee members will be looking at this data in conjunction with members of the Division of Health Services Research to see what we may learn about patterns of referral for subspecialty care, access to and barriers to subspecialty care, pediatrician satisfaction with pediatric subspecialty services and perceived need for specific kinds of pediatric subspecialists in a variety of practice settings. Stay tuned for some insights on this topic in the coming months.

As always it is a pleasure to have the chance to share what the COPW is doing and I look forward to hearing any thoughts or concerns you have about workforce issues. Feel free to call me at (973) 972-3314 or you can email me at pletchba@umdnj.edu.

Are you a community-based primary care provider in Newark, Irvington, Orange or East Orange?

Want to know what's up with Adolescent Immunizations and Well-Care? Interested in improving the quality of adolescent health care? Wondering what the NJ mandate for using the NJ Immunization Registry is all about?

If so, call us now to learn how to participate in the PCORE Adolescent Immunizations Community Partnership (AICP) Program – COST FREE (grant funded by the Vaccine Preventable Disease Program, NJ Department of Health and Senior Services). This program is working in partnership with the Essex-Metro Immunization Coalition and other key stakeholders and focuses on increasing the awareness of families, teens, and providers about adolescent immunizations and vaccine preventable diseases. Using an EPIC (Education Physicians in Their Communities) approach for continuing education, the curriculum, the adolescent and improvement specialists, and the resources come onsite to your practice and work with your team. **Scheduling onsite visits will begin January 2008. Interested? Contact Diane Synhorst, PNP, Program Co-Director at 609-588-9988 or dsynhorst@njpcore.org.**

Special Thanks to the AICP Curriculum Committee:

Susan Brill, MD - Saint Peter's University Hospital
Montrae Calhoun-Thomas, MD - Park Ave. Pediatrics
Fran Gallagher, MEd - PCORE
Ruth S. Gubernick, MPH - AICP Program Co-Director
Steven Kairys, MD - Jersey Shore Medical Center; PCORE Medical Director
Elizabeth Marino, MD - UMDNJ, Newark
Wendy Neal, MD - Newark Beth Israel Medical Center
Elizabeth Rose, MD - Newark Beth Israel Medical Center
Dileep Sarecha, MBBS, MPH - Vaccine Preventable Disease Program, NJDSS
Paulette Stanford, MD - UMDNJ, Newark

Pediatric Palliative Care:
Enhancing Support for Complex Patients and Their Families

Mary Ann West R.N., M.S.N. & Ellen Coughlin

The needs of chronically ill children with a life threatening condition are complex and challenging. From the moment a diagnosis is made the family is sent on a journey that is frightening, confusing and emotionally devastating. Physicians and other health care workers often find themselves at a loss to cope with the "unnatural" nature of a child having a life altering illness and the powerful reactions that are evoked from parents, siblings, and the community. The goal of pediatric medicine is to treat aggressively to achieve a cure and prolong life. With the hope of a cure fading, families are faced with many difficult decisions. The quality of life for both the patient and the family become paramount. This focus on quality of life is what pediatric palliative care is all about.

Pediatricians and pediatric specialists are the family's life line for information, support and guidance about their ill child, but it is impossible for the physician to meet all of their needs. For children with complex health issues possibly related to prematurity, neurological conditions or developmental delays, not only are the patient and family struggling with medical concerns but the emotional, spiritual and sometimes financial impact on their lives is also enormous.

Throughout the child's illness families need time to process their child's changing needs and evolving treatment plan, ask multiple questions and be offered options that make sense for their individual family situation. This is where the introduction of a pediatric palliative care program can be invaluable. Palliative care places emphasis on the quality of the child's life and views the patient and family as the unit of care. Palliative care can, and should be, provided along with appropriate medical treatment of a child's condition and not be implemented only as a last resort when a child is in a terminal stage of illness. The unpredictable nature of a child's disease trajectory makes planning particularly difficult for these families. An interdisciplinary palliative care team can work with the patient's pediatrician to deliver medical, psychosocial and spiritual support to the young patient and their family.

With the support of their physician and a palliative care team, babies and children with chronic life threatening illnesses can be cared for at home with excellent pain and symptom management. Terminally ill children, such as children with cancer for whom treatment options have been exhausted, are able to receive aggressive comfort care at home once it is determined that comfort and quality of life are the main goals of care. Pediatric palliative care can be the supportive care needed by these special children and the people who love them so very much.

Pediatric Palliative Care Services do exist and are available for your patients. The New Jersey Hospice and Palliative Care Organization has established a pediatric committee to address and improve interventions to meet the palliative care needs of children in New Jersey and can be contacted for help or for referrals to agencies providing pediatric palliative care services.
Contact NJHPCO by web http://www.njhospice.org/ or Tel #.908-233-0060.

Ms. West is the Chairperson of the Pediatric Committee of The New Jersey Hospice and Palliative Care Organization & Coordinator of The Butterflies Program Valley Home Care / Valley Hospice in Paramus, New Jersey

Ellen Coughlin is Vice-president of Patient and Family Services, The Saint Barnabas Hospice and Palliative Care Center

NJ Pediatric Council on Research & Education (PCORE)

Vision
Shaping child health in New Jersey for the 21st century

Mission
The mission of PCORE, the Foundation of the American Academy of Pediatrics/ NJ Chapter is to:

- Promote the medical home through public and private partnerships
- Catalyze linkages between healthcare providers, families, public partners and communities
- Improve systems of care in communities and healthcare practices
- Educate both pediatricians and families
- Promote comprehensive pediatric healthcare through public and private partnerships
- Translated research into models of care and translate outcomes into improvements to those models of care
- Orchestrate improvement in health and social policies that affect all children especially those who are most vulnerable
- Provide pediatric expertise for systems of quality care for all children

Questions / Comments? Please contact us at:
3836 Quakerbridge Rd., Suite 108, Hamilton, NJ 08619. Phone 609.588.9988
Fax: 609.588.9901 www.njpcore.org

Get in touch soon! The PCORE team looks forward to working together with you on behalf of New Jersey's children and their families...as we work to shape child health in New Jersey for the 21st Century!

Legislative Report

Nancy Pinkin, MPA, CHE

SCHIP REAUTHORIZATION VETOED BY PRESIDENT BUSH AGAIN

AAP-NJ has been working with Governor Corzine and members of the legislature to advocate for continuation of federal funding of SCHIP, the State Children's Health Insurance Program. Dr. Janice Prontnicki and Nancy Pinkin traveled across the state to participate in press conferences to call attention to the issue. Congressmen Saxton, Garrett and Frelinghuysen voted against funding the expanded program and President Bush vetoed the bill, opposing inclusion of children and families over 200% of the federal poverty limit (FPL). New Jersey covers children up to 350% of the FPL. For the second time, President Bush has vetoed the program. New Jersey families were previously allowed to enroll in New Jersey Family Care under a federal waiver, but enrollment is now closed.

Governor Corzine and Senator Vitale will hold a press conference on Wednesday December 19th to announce a new program, Healthy New Jersey. Current information indicated it will create a program to allow families to buy-in to NJ FamilyCare.

Dr. Janice Prontnicki and Nancy Pinkin have been working with the Governor's staff and the Attorney General's office on preparation for filing an Amicus Brief in support of Governor Corzine's lawsuit against the federal government regarding the SCHIP program. National AAP has been working closely with us throughout the SCHIP reauthorization process.

AT LONG LAST THE STATE HAS HEARD YOUR CRIES FOR HIGHER MEDICAID RATES

The Department of Human Services has announced that as of January 1st, 2008, it will raise Medicaid fee-for-service reimbursement **up to 80% of Medicare rates** for children up to age 21 years of age. New Jersey currently has the lowest Medicaid reimbursement rates in the nation. To become a Medicaid provider under the new reimbursement rates, please contact Joseph Cicatiello, Director of Provider Enrollment, at the Department of Human Services or download an application from the DHS website fee-for-service application, including a background check.

There will be no limit or cap to the number of Medicaid fee-for-service patient you need to accept.

Providers within the SAME Medical Group can get paid for the same day of in-patient care if they use a -77 modifier code. For second physician visits in a NICU, call Medicaid for permission for an override to approve your in-patient visits.

LEGISLATIVE ACTION

ATHLETIC TRAINER SCOPE OF PRACTICE LEGISLATION

A 3259 Caraballo / **S2678** Lesniak / Carinale revises the "Athletic Training Licensure Act," by amending the definition of "athlete" to include an individual who participates in strenuous physical exercise, physical conditioning, or a sport. The bill also sets parameters on when a licensed athletic trainer may provide athletic training. The bill provides that a licensed athletic trainer may provide athletic training only: 1) to athletes engaged in interscholastic, intercollegiate, or intramural athletic activities which are being conducted by an educational institution licensed in this State; or to professional athletes; or 2) to athletes in any setting when the athletic trainer is under the supervision of a physician licensed in this State. In addition, the bill adds a definition of "supervision," relative to this setting, which means that a physician licensed in this State must be accessible to an athletic trainer, either on-site or through voice communication during athletic training.

While AAP-NJ is supportive of the work of athletic trainers, we have some concerns about the legislation related to the supervisory aspects of the relationship between the physician and the athletic trainer and have requested clarification of the supervisory role of the physician. Dr. Stephen Rice and Nancy Pinkin have been testifying on the bill, requesting amendments to clarify the direction under which the athletic trainer must practice. Numerous amendments to the bill have already been incorporated. We have also been reviewing the issue with the Board of Medical Examiners and bill sponsors. We continue to communicate with bill sponsors to seek amendments in the bills or through the regulatory process.

CHIROPRACTIC SCOPE OF PRACTICE LEGISLATION

S2636 Sweeney (D3) / **A3122** Caraballo (D29); Wisniewski (D19); Albano (D1); Prieto (D32); Van Drew (D1) +10 permits revised methods of treatment for chiropractors and establishes continuing education requirements. The bill provides that a chiropractor may use any method of treatment of a patient, except the use of surgical cutting, so long as the methods of treatment or diagnoses or analysis were taught in any chiropractic college or post graduate course or approved by the chiropractic board. The bill further provides that a chiropractor may order, request, or prescribe generally recognized medical tests or provide dietary or nutritional counseling, and perform physical examinations including school physicals. **AAP has strongly opposed allowing chiropractors to perform school physicals since they are trained to maintain wellness, not diagnose disease and since they oppose immunizations.**

A4416 Caraballo / S2871 Karcher (D12); Lesniak (D20) provides that practice of chiropractic includes diagnosis and adjustment of articulations of spinal column and other joints. Chiropractors seek to amend their current scope under this bill to state: "the practice of chiropractic is defined as follows: "A system of adjusting the articulations of the spinal column by manipulation thereof." It is within the lawful scope of the practice of chiropractic to diagnose, adjust, and treat the articulations of the spinal column and other joints, articulations, and soft tissue structures [1]clinically related to the spinal column[1] and to order and administer physical modalities and therapeutic, rehabilitative and strengthening exercises."

The Scope Of Practice Coalition, comprised of AAP, MSNJ and other specialty groups, continues to oppose the legislation and has been working on language changes, should either or both of the bills pass.

Continued on page 15

Legislative Report

Continued from page 14

BLACK BOX WARNING BILL SEEKS TO MANDATE PARENTAL CONSENT FOR PSYCHOTROPHIC DRUGS PRESCRIBED TO MINORS

AAP-NJ continues to work closely with Assemblyman Herb Conaway, M.D. and his staff, including Dr. Ken Ganti, and Chief of Staff Kevin DiSimone to address "Black Box" legislation that would have required written consent for any prescription written for medication that has a **"Black Box Warning**" associated with it. To date none of the following bills have moved further in the legislative session.

A3566 Diegnan (D18) / **S2364** Lance (R23) / Codey (D-27), requires physicians and other prescribers to obtain informed consent from parents or guardians of minors for medications with "black box warnings." The United States Food and Drug Administration (FDA) requires pharmaceutical companies to place a "black box warning" on a drug label if medical studies indicate that the drug carries a significant risk of serious or life-threatening adverse effects. Under the bill, a physician, advanced practice nurse, or other authorized prescriber in violation of the bill is to be subject to disciplinary action by the applicable State professional licensing board.

A4147 Conaway (D7) requires DHSS to make list of drugs with "black box" warnings accessible through its website; and **AR251** Conaway (D7) — Memorializes Congress and President to enact legislation to require FDA to post list of drugs with "black box" warnings on its website. Both bills were heard and reported of the Assembly Health Committee.

A4245, (DIEGNAN), requires physicians and other prescribers to obtain informed consent from parents or guardians of minors for certain medications with "black box warning." The bill was heard in the Assembly Consumer Affairs Committee and released. AAP testified on the legislation throughout the legislative process that the correct process to address mediation issues was within the processes of the scientific community and professional organizations such as the FDA and the CDC rather than via the legislative arena. Parent advocates testified that their children had been given prescriptions for Paxil but were not aware that the drug had side effects including violence and increased depression. They stated that manufacturers of the drug had not made public know side effects of such drugs.

AAP continues to monitor these bills and address legislative and parental concerns as they arise. Please let us know your thoughts on these bills.

STANDARDS FOR CHILDREN'S HOSPITALS

AAP pediatricians and Nancy Pinkin met with representatives of Govenor Codey's office to discuss **S2703** (Codey) which requires State designated children's hospitals to have a Pediatric Emergency Physician on duty at all times in the emergency department. Participants continue to meet on the issue.

S2728 SCS "HEALTH INFORMATION TECHNOLOGY DEVELOPMENT, IMPLEMENTATION AND DEPLOYMENT ACT." (VITALE, BUONO, WEINBERG) /A404 CONAWAY)

S2728, the "HEALTH INFORMATION TECHNOLOGY DEVELOPMENT, IMPLEMENTATION AND DEPLOYMENT ACT," (VITALE, BUONO, WEINBERG) /A404 CONAWAY) was heard in Senate Health, Human Services and Senior Services Committee and released. Assemblyman Conaway, MD, the lead bill sponsor, testified that he has been serving on a National Governor's Association group on health information technology, which is considering how to implement health technology programs in states throughout the country. He noted that New York has committed $100 million to get information exchanges moving in that state. He stated the benefits of the technology are prevention of unnecessary testing; improved patient health outcomes, and improved response to community threats from terrorism and disease. He noted that he wants to ensure the plan is developed in public, with citizen input. The Commission will be located in the Department of Health and Senior Services, with input from the Department of Banking and Insurance.

While not originally funded, the bill now includes funding from insurance fines, with a cap of $1 million. This is a change from a recommendation to secure funding from an assessment on the HMO's. The Association of Health Plans (AHP) requested that the HMO assessment should have included all attorneys, health providers and others but the final source of funding was changed to funding from the collection of fines in the DOBI. AHP had requested greater representation since they were required to pay for the program.

Added to the Committee, at the request of Senator Weinberg, was a member of the Division of Children and Families and an IT expert. She had stated that the Division had just implanted a new technology program for tracking children and their families and this must be considered in the Commission.

Press Release From The Assembly Democrats

HEALTH INFORMATION TECHNOLOGY BILL CLEARS SENATE PANEL
Measure Would Improve Quality of Health Care, Access to Patient Information

(TRENTON) -- A Senate panel today released legislation Assemblymen Herb Conaway, Jr., M.D., Upendra Chivukula and Vincent Prieto sponsored to enhance the quality of health care delivered to New Jersey residents through a health information technology (HIT) system.

"Improving access to health records for patients and medical practitioners would ensure that every patient receives the best care each and every time they seek medical attention," said Conaway (D-Burlington / Camden), a practicing physician. "Our paramount goal should be to do all that we can to reduce medical errors that can threaten the health and safety of New Jersey medical patients. This health information sharing network will better coordinate the care of a patient among hospitals, emergency rooms, clinics, nursing homes, pharmacies, and health care professionals."

The "New Jersey Health Information Technology Promotion Act" (A4044) would establish the state's first electronic medical records infrastructure and create a Health Information Technology Commission to oversee the development, implementation and oversight of the program.

Continued on page 16

Legislative Report

Continued from page 15

"This will go a long way in continuing to advance the quality of health care for all New Jersey residents through a secure and integrated medical records system," said Chivukula (D-Middlesex). "We need a comprehensive network to improve patient care, health policies and efficiency in research while cutting administrative costs and increasing our state's emergency preparedness.

"It's time that New Jersey takes the first step into the future of medical care by replacing paper records with the efficiency of electronic medical records," said Prieto (D-Hudson).

"Health Information Technology can save New Jersey over three-quarters of a billion dollars," said Conaway. "Electronic medical records also have the potential to cut-down on fraud and the misuse of New Jersey's health care resources."

Thomas Edison State College released a 1994 healthcare information networks and technology study that showed that New Jersey could save as much as $760 million by migrating from paper-based systems to an electronic network.

The 19-member Health Information Technology Commission would be established within the Department of Health and Senior Services to oversee the creation and functions of a state-wide health information technology plan, with the assistance of the Department of Banking and Insurance, which will institute an Office for the Development, Implementation and Deployment of Electronic Health Information Technology, which shall be known as the "Office for e-HIT". The commission would be charged with promoting the use of national standards for the state's HIT system including security, privacy, data content, format, vocabulary and information transfer standards.

The commission would include:

The commissioner or a representative from the state departments of Health and Senior Services, Banking and Insurance, Human Services and Treasury;

19 members of the public, including representatives from professional health care organizations from across the state including, one general practitioner physician, one physician who represents an acute care teaching hospital, and one physician from a non-teaching acute care hospital.

The commission also would have access to assistance and services from any state agency as needed.

The "New Jersey Health Information Technology Promotion Act" cleared the Senate Health Human Services and Senior Citizens Committee by a 6-0-1 vote. It now heads to the Senate President, who decides if and when to post the bill for a vote.