# New Jersey Pediatrics

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**NEW JERSEY PEDIATRICS**

www.aapnj.org | Winter 2013

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As the weather turns cold, we begin to think of the holidays and the challenges of winter weather. In October, we passed the one year mark following superstorm Sandy. While many of our communities have recovered, far too many families remain displaced. Anniversaries are very difficult for families who have suffered loss. This is a time when behavioral problems and depression can lead to self harm. It is critical for those who practice in the Sandy-affected counties to ask how children and their parents are doing. There are many resources available including New Jersey Hope and Healing. Services can be accessed by calling 877-294-4357. Visit their website for more information: http://www.mhanj.org/new-jersey-hope-and-healing/.

I am sure all of us watched with horror as the Typhoon Haiyan swept over the Philippines. Please consider donating to your preferred charity or the national AAP; these families need our help.

Thanksgiving has come and gone; likely most of us ate too much but enjoyed the opportunity to gather with family and friends. For those of you interested in the obesity epidemic, the news is good, the epidemic is slowing, but we still have far too many children and adults who are overweight. Shaping New Jersey is a project of the state, which involves multiple partners including NJAAP. Visit their website for an abundance of good information and toolkits regarding schools, child care, healthcare and communities: http://www.state.nj.us/health/fhs/shapingnj

There are more holidays in sight; try to find ways to eat healthy and stay active - even in the cold. Cold weather sports include skiing, snowboarding and sledding. Each comes with wonderful benefits but also injuries. Be sure your families are aware of the risks involved in these activities and recommend appropriate gear to minimize injury. Frostbite and cold injury can occur right here in New Jersey so dress in layers and come inside. Be able to recognize hypothermia and frost bite and be ready to intervene. The Centers for Disease Control and Prevention has information at http://emergency.cdc.gov/disasters/winter/staysafe/frostbite.asp. The American Academy of Pediatrics provides advice for parents on the HealthyChildren.org website.

Winter brings an end to football season and the beginning of basketball, swimming and ice hockey. Sports are wonderful for children but again, injuries occur in all these sports.

The Athletic Trainers’ Society of New Jersey has released new recommendations on concussion prevention. As pediatricians we must be aware of concussion diagnosis and management as well as return to play issues. Go to their website for more information: http://www.atsnj.org/.

Finally, winter is flu season so get immunized and ensure that all of your patients are immunized. This is the best tool we have to prevent influenza. As we have noted in two webinars, this year there are lots of choices of vaccines, but not all are approved for children. The recommendations regarding egg allergy have changed. Children with minor egg allergies can be safely immunized with the inactivated influenza vaccines. There is now an egg free recombinant vaccine, FluBlok, which is licensed for use in people 18 to 64 years of age. I suspect we will have a pediatric vaccine by next year.

Other infections are more common in the winter. Currently there is an outbreak of meningococcal infection at Princeton University; the outbreak began in March 2013 and as of November has affected 8 people. The strain is serogroup B which is not included in the quadrivalent vaccine. The NJ Department of Health and the Centers for Disease Control and Prevention will be launching an immunization campaign using a serogroup B vaccine which has been approved in Europe and Australia but not yet in the United States. For details go to the CDC website and see the NJ Department of Health frequently asked questions document: http://www.cdc.gov/meningitis/index.html. Since students will be coming home for the holidays, be aware of this outbreak and a similar one in California. Review the signs and symptoms of meningococcemia and read about this outbreak so you are prepared to educate your patients and staff.

As always, it is my pleasure to serve as your president. Please let me or Fran Gallagher, our Executive Director, know if you are willing to participate in our committees. We would love your input! Sincerely,
Wow, 2013 flew by and it was quite a year! Thanks to our Chapter’s vision and leadership from the NJAAP Executive Council, the PCORE Executive Advisory Council, Councils and Committees, engaged members, and a committed and dynamic staff, our Agenda for Children made substantial progress. And while much work remains to ensure the safety and optimal health of all children in New Jersey, I felt it would be apropos to reflect back on the some of the 2013 accomplishments that earned NJAAP – and our members - an AAP Chapter of Excellence Award.

The merger of AAPNJ and Pediatric Council on Research & Education (PCORE) is complete. And now, NJ Chapter, AAP (501c3) is one strong voice more dedicated than ever to fostering healthy children and supporting pediatricians. In 2013, NJAAP assembled a diverse interdisciplinary team comprised of a pediatrician, pediatric nurse practitioner, individuals credentialed in public health, social work, education, health and business administration, finance, marketing, communication, and more. The collaborative talent and passion of this group continues to strengthen our infrastructure, partnerships, resources, and facilitates educational outreach to pediatricians, parents, community providers, legislators and the general public. Meet the staff at www.aapnj.org.

In 2013, NJAAP introduced its first Editorial Board, with an eye on transforming Chapter Communications. The Editorial Board has helped to usher in a new look and fresh content for the quarterly journal, New Jersey Pediatrics, our weekly ENews, the Facebook page (please visit and “like” us), and WellView, our new digital broadcast system. Looking forward, WellView’s cutting-edge technology will help pediatricians; extend health and wellness messaging to parents in their waiting rooms, emphasize the importance of pediatric medical home, and create a new source of revenue for the Chapter.

Advocacy efforts in 2013 succeeded in ensuring NJ pediatricians are now at the table on behalf of children in decisions related to pediatric health care laws, regulations, and concerns. The Chapter secured an AAP Friends of Children grant to help pediatricians address trauma recovery and rebuilding. We have partnered with the NJ Department of Children & Families to secure nearly 1.5 million to work in 10 counties most affected by Super Storm Sandy. We worked with Horizon to design a pediatric medical home project slated to kick off in January 2014. The pilot will include payment for care coordination (written plans) within the medical homes, payments for other aspects of medical home care provided, resources and support. Additionally, we launched two preventative oral health initiatives and continued Child Abuse and Neglect Prevention and Intervention Education to: primary care practices, emergency departments, EMTs, early intervention professionals and school nurses to 16 of New Jersey’s 21 counties. (CAN EXTENSION MENTION?) The NJAAP co-led NJ Immunization Network is thriving, having hosted ten educational outreach events and our efforts to help increase the number of newborns identified with Critical Congenital Heart Disease, contributing to saving lives through CCHD Program training and technical assistance.

Our Chapter has created a strong program for residents to become engaged in NJ AAP & PCORE programs and advocacy efforts through a White Coat Day at the NJ State House and Resident Career Day. In 2013, we hosted some exceptional events including the 3rd Annual Children’s Ball, an Annual Meeting and Conference for Physicians, a Vaccines for Children Conference and the Community /School Health Conference. And last but certainly not least, we expanded membership benefits – including equipment, installation and content feed for the WellView system completely FREE of CHARGE. Check out all the benefits at the NJAAP members only site at www.aapnj.org. So, together, let us toast and celebrate our collective achievements in 2013 before moving on to the challenges of 2014 and the rapidly changing health care universe.

A final note - After reading the Winter issue of New Jersey Pediatrics, please share it with a colleague who is not yet a member. Our mission is more important today than ever before – children and their families are more at risk of fragmented care than ever before. A vaccine in one location, a sports physical in another, who is screening for social emotional or other delays or diagnosis if there is not continuous care within a pediatric medical home? Help us to keep care comprehensive and coordinated by working to attain the NJAAP Mission: the attainment of optimal health, safety and well-being of New Jersey’s children and promotion of pediatricians (pediatric primary care, pediatric sub specialists and pediatric surgical specialists) as the best qualified of all health professionals to provide child healthcare. Join us today and work to achieve health equity, strong pediatric medical homes and support the profession of pediatricians!

Wishing You a Happy & Healthy Holiday Season!

Fran Gallagher, MEd Executive Director, NJAAP
Dear Editor, New Jersey Pediatrics:
As a practicing pediatrician in New Jersey for almost 3 decades, I have found the management of abdominal pain and possible appendicitis in young people to be one of the most challenging clinical situations that we can face. I therefore read Dr. Saad Saad’s article on the timing of appendectomy in children from New Jersey Pediatrician, Fall 2013 edition, with great interest. Demonstrating the safety and efficacy of delayed intervention is a great revelation and a useful contribution in this fraught situation. Dr. Saad’s mention of the limits of resources and staffing, especially at community hospitals where most of us work, is directly on point. Things that allow these decisions to be made in a more deliberate manner, therefore, are typically to the good.

That difficulty extends to imaging personnel and ability. We have all observed over the years the increasing use of CT in this process. Like any useful tool when utilized properly, abdominal CT enhances the clinician’s ability to get it right; but over time we can all note too many instances where it has been used to little real clinical benefit to the child but nevertheless subjects him or her to considerable radiation.

Dr. Saad shows that we can and often should take necessary time to observe these patients’ clinical progression and that it is generally safe to do so. I would hope that that might also enable us to modify some of our evaluation protocols to utilize ultrasound over CT whenever clinically appropriate. Certainly there is already considerable evidence in the literature that supports the accuracy of ultrasound compared to CT without the concern of ionizing radiation. Given the greater availability of ultrasound technology during day shifts, I am very hopeful that we can endeavor to emphasize that addition to the excellent advance in management of possible acute appendicitis that Dr. Saad’s erudite study demonstrates here.

Respectfully submitted,
Charles Geneslaw MD FAAP
Toms River, NJ

Editor Note: Dr. Geneslaw is an Editorial Board member for New Jersey Pediatrics
Non-alcoholic Fatty Liver Disease (NAFLD) has recently emerged as the most common cause of liver disease in children, and its rise has been related to the increasing prevalence of obesity in the United States (1) as well as worldwide. NAFLD is defined as hepatic fat infiltration involving greater than 5% of hepatocytes in the absence of significant alcohol consumption, medication use, or other disorders that may lead to fat deposition in the liver. Non-alcoholic Steatohepatitis (NASH) forms part of a histological spectrum of NAFLD and involves hepatic inflammation and hepatocellular damage (2,3). The natural history and prognosis of NAFLD in children is still uncertain, since published data with long-term follow up is limited. While hepatic steatosis is regarded as a relatively benign entity, NASH can progress to liver cirrhosis and the development of hepatocellular carcinoma. The rise of the prevalence of NAFLD in children worldwide is a valid public health concern as this disease is closely linked with the development of liver dysfunction and co-morbid diseases.

Clinical Presentation

As most children with this disease are asymptomatic, NAFLD is often suspected incidentally on physical examination or on laboratory studies revealing elevated serum aminotransferase levels. Right upper quadrant pain is occasionally a presenting symptom. On physical examination, most children with NAFLD are overweight or obese. Components of the metabolic syndrome (central obesity, dyslipidemia, hypertension) as well as acanthosis nigricans are strongly associated with NAFLD, and five-fold increased risk of NAFLD had been observed in children with the metabolic syndrome (4). Mild to moderate hepatomegaly with right upper quadrant tenderness may be present on exam, although liver palpation may be challenging due to adiposity. Splenomegaly as well as stigmata of chronic liver disease are seen only when severe fibrosis/cirrhosis is present. The most common laboratory finding is mild to moderate elevation of serum alanine aminotransferase (ALT). NAFLD may also be incidentally discovered while undergoing imaging. NAFLD in children may be under-diagnosed by healthcare providers due to lack of screening guidelines and appreciation of potential complications of this disease.

Histopathology

Liver biopsy remains the only accepted technique to diagnose NASH, establish the presence of fibrosis, and exclude other chronic liver diseases. Characterization of the histological features in children is central both for diagnosis and management of NAFLD (5). Simple steatosis refers to the accumulation of liver fat without evidence of inflammation and may have a benign prognosis compared with NASH. However, recent adult data suggest that a proportion of patients with simple steatosis may progress to NASH (6). Whereas adult (type 1) NASH is characterized by steatosis, hepatocyte ballooning, Mallory hyaline, and pericellular/sinusoidal fibrosis, most of which with a distinct centrilobular distribution, pediatric (type II) NASH is characterized by portal-based fibrosis and inflammation, without the characteristic centrilobular findings seen in adult cases. NASH pattern may be heterogeneous, and children may alternatively exhibit features of type I, type II, or overlapping NASH (2,7). Interestingly, the several discrepancies which have been found in the distribution of different types of NASH in children are strongly correlated to sex and ethnicity (8).
Epidemiology and Natural History

The prevalence of NAFLD in children is difficult to estimate as liver biopsy is essential for definitive diagnosis. ALT is a nonspecific marker of liver injury and may be a screening tool to evaluate for NAFLD. But, a considerable subset of children with normal ALT levels can have NAFLD with significant liver fibrosis (9,10,11). One of the few population-based studies reports data collected from the National Health and Nutrition Examination Survey (NHANES) on 5586 children from 12 to 19 years of age found elevated ALT in 8% of this adolescent population. Elevated ALT correlated with male sex, Mexican American ethnicity, waist circumference and fasting insulin levels (12). In a European cohort of 16,390 overweight children and adolescents, 11% of the study population were found to have abnormal aminotransferases and presumed to have NAFLD, although other etiologies of liver disease were not excluded (13).

As liver tissue is the cornerstone for making a definitive diagnosis of NAFLD, a landmark study of NAFLD prevalence examined liver histology from 742 children (age 2–19) who died from unnatural causes (14). The estimated NAFLD prevalence was 9.6% when adjusted for age, gender, race and ethnicity. Multivariate analyses showed that obesity, older age (15–19 years), male gender, and Hispanic ethnicity were independent predictors of NAFLD prevalence.

Data on the prognosis and clinical complications of NAFLD in children remain scarce due to lack of prospective studies evaluating children over time (15,16). A retrospective single center report has been published on the natural history of NAFLD in 66 children (17). Over a period of 20 years, 4 patients in this cohort developed type II diabetes, 2 patients underwent liver transplantation and 2 died of cirrhosis. Cardiovascular disease is the leading cause of death in adults with NASH (18,19,20,21,22). NAFLD in children is associated with multiple cardiovascular risk factors, including abnormal waist circumference, dyslipidemia, hypertension, and insulin resistance (4). Increased carotid intima media thickness (cIMT) has been demonstrated in children with NAFLD (23-25). A recent study similarly found significantly lower flow-mediated dilation of the brachial artery (FMD) response and increased cIMT in 150 obese children with NAFLD when compared to 100 obese controls, demonstrating that NAFLD is a risk factor independent of obesity in the development of cardiovascular disease (26). Longitudinal studies are necessary to elucidate the role of pediatric NAFLD and its severity on long-term cardiovascular outcomes in the general population.

Overall, the risk of death among patients with NAFLD is higher compared to that of the general population. The primary cause of death in adults with NAFLD is cardiovascular disease, followed by extra-hepatic malignancy, and liver disease (27).

Imaging

Due to the increasing prevalence of NAFLD and the invasiveness of the liver biopsy, much attention has been focused on imaging studies that help detect clinically significant steatosis in children. Ultrasound demonstrates echogenicity and frequently enlargement of the liver and is amply used in clinical practice. Although readily available and comparatively inexpensive, ultrasound shows typical echogenicity only when 30% or more of liver is steatotic (28). Computerized tomography (CT) is not used because of radiation considerations. Magnetic resonance imaging (MRI) accurately quantifies fat content in the liver in limited pediatric studies (29,30) but is an expensive modality that is used primarily as a research tool in pediatric NAFLD.

Novel imaging techniques have been studied in determination of liver fibrosis. Transient elastography (TE) (31,32,33,34) and Magnetic resonance elastography (MRE) (35,36) can measure liver stiffness by using a probe that emits a low-frequency vibration and calculates the speed of the propagating mechanical wave. Further studies with increased availability of these technologies will determine the clinical utility of these imaging techniques.

Noninvasive biomarkers

As histo-pathological investigation has limitations in children including its invasiveness and high cost, the need for better noninvasive biomarkers to diagnose and follow liver injury is critical. Noninvasive biomarkers of chronic liver diseases encompass those that measure liver fibrosis, inflammation and hepatocyte apoptosis.

Various scoring systems have been developed for predicting and staging fibrosis in chronic liver disease. “Fibrotest,” which combines alpha-2 macroglobulin, haptoglobin, gamma-glutamyl transpeptidase (GGT), apolipoprotein A1, and total bilirubin (37) has been validated in several (including limited pediatric) cohorts (33,38,39). Another marker, the enhanced liver fibrosis test (ELF) includes a panel of hyaluronic acid, amino terminal propeptide of collagen type III (PIIINP), and tissue inhibitor of metalloproteinase (TIMP-1) combined in an algorithm to predict liver fibrosis (40).
Fulfilling the Promise: Promoting Children’s Healthy Development

(Adapted from a presentation at TEDxBushnell Park, Hartford, CT, June 22, 2013)

by Paul H. Dworkin, MD, FAAP

What if our goals for child health services did not merely include diagnosis and treatment of a wide array of childhood diseases and disorders? What if our goals also included the promotion of children’s healthy, optimal development? I submit to you that this would have profound implications for the way in which we deliver our services, build our programs, and evolve our systems. And why am I so confident in this premise? I am confident because of our experience with Help Me Grow. Help Me Grow is an initiative that promotes children’s optimal, healthy development that began in Hartford in 1997, was disseminated across Connecticut in 2002, and currently, as we speak, is being replicated in 20 states around the country, including New Jersey.

Help Me Grow focuses on the early detection of young children at risk for developmental and behavioral problems and the linkage of these children and their families to community-based programs and services. Our early thoughts about Help Me Grow evolved in the 1990’s, the so-called “Decade of the Brain,” during which the explosion in our knowledge and information about early brain development and early child development was widely disseminated in the popular media and in professional publications. Within this context, we engaged in a series of remarkable conversations exploring how we might best strengthen child health services to promote children’s optimal healthy development. We engaged our colleagues in child health, early care and educational professionals, family support providers, leaders of community-based organizations, our public officials, and, most importantly, we engaged parents and families. Through these conversations, we came remarkably quickly to a series of common assumptions:

• We assumed that, in Hartford, children who are at risk for poor developmental and behavioral outcomes were escaping early detection. Unfortunately, we were not “out on a limb” with this assumption, as any visit to a Hartford kindergarten, 1st or 2nd grade classroom would attest.

• Secondly, we assumed that even in relatively resource poor Hartford, there existed a wide array of programs and services—e.g., Head Start, family resource centers, parent support groups—that were available to address children’s developmental needs and support families in promoting their children’s optimal healthy development.

• Third, we assumed that Hartford, its children and families would benefit from a comprehensive, coordinated, region-wide approach that focused on the early detection of young children at risk for developmental and behavioral problems and the linkage of these children and their families to community based programs and services.

Armed with these assumptions and a grant from the Hartford Foundation for Public Giving, we undertook a pilot project in Hartford in 1997 that ultimately evolved into Help Me Grow. Help Me Grow focuses on the early detection of vulnerable young children who are at risk for developmental and behavioral problems through the process of developmental surveillance and screening and links these children and their families to community-based, development-enhancing programs and services through a single central porthole of entry, Child Development Infoline, a specialized call center of our United Way statewide 2-1-1 system.

The success of Help Me Grow in Hartford from 1997 to 2002 encouraged us to advocate for statewide dissemination and, in 2002, Help Me Grow became a program of the Connecticut Children’s Trust Fund, now a unit within our Department of Social Services. This advocacy in support of state-wide dissemination yielded extraordinary lessons. I wish to share 3:

• The first is the importance of our language. In Connecticut, as in New Jersey, we are fortunate to have a wide range of very effective developmental programs: our Part C of the Individuals with Disabilities Education Act (IDEA) early intervention program, Birth to 3; our Part B of IDEA, pre-school special education; and our Title V Children with Special Health Care Needs programs are all excellent, but, only accessible to those children who meet their relatively restrictive eligibility criteria. In Connecticut, the “land of steady habits,” we knew that advocacy in support of expanding eligibility criteria for these programs was “dead at the legislative doorstep.” However, when we spoke with legislators about enhancing access to community-based programs and services that already exist and that were typically of no cost to the state, a managed care plan, or a family, they expressed receptivity and encouragement.

Continued on page 9
Speaking of enhancing access rather than expanding eligibility criteria made all the difference—i.e., the importance of the language we use.

• A second lesson learned is the value of so-called “strategic reframing.” We regarded and spoke of Help Me Grow as a developmental program, given its focus on identifying young children at risk for poor developmental outcomes and linking these children and their families to developmentally-enhancing programs and services. In fact, developmental concerns were very common reasons for children and families to access Child Development Infoline and Help Me Grow, but they were the second and third most common reasons. The most common reason was concern about their child’s behavior, specifically, a behavioral concern that had not yet escalated into emotional disorder or psychiatric diagnosis. So, in 2002, at the time of our advocacy, then Governor John Rowland was championing an initiative called Connecticut Community Kid Care, whose focus was to expand community resources to address the needs of children with serious emotional disturbance. We went to Governor Rowland and, just as importantly, his chief budget officer, Mark Ryan, and said we support Connecticut Community Kid Care, but emphasized the need for a prevention component and, knowing the frequency with which Help Me Grow addressed behavioral concerns, advocated for its support. Reframing Help Me Grow as a behavioral program led to its incorporation within the Governor’s budget, support from the legislature, and its placement in every biannual State budget since 2002.

• A third lesson is the importance of data collection. Critics of Help Me Grow said we would do more harm than good because, while they believed we would be successful at identifying young children at risk, they did not believe that the resources existed to create a successful linkage. We said, “We think you are incorrect, but just in case you are not, we will collect data on the capacity issues and the gaps in services and we will use that data to inform our advocacy. The critics were satisfied and their opposition waned, enabling statewide dissemination.

In 2007, I received a phone call from a pediatric neurologist, Dr. Joseph Donnelly in Orange County, California, whom I knew from his previous time spent at Baystate Medical Center in Springfield, Massachusetts. Dr. Donnelly was aware of our work in Connecticut and asked the question, “Can you provide technical assistance in enabling us to replicate Help Me Grow in Orange County?” I acknowledged that I did not know, but we were pleased to try. In fact, Help Me Grow Orange County has been spectacularly successful! That experience imbued us with the confidence to go to The Commonwealth Fund in New York City in 2008 and receive a grant to support the replication of Help Me Grow in 5 states. In 2010, we received a major grant from the W.K. Kellogg Foundation in Battle Creek, Michigan to establish the Help Me Grow National Center at Connecticut Children’s Medical Center to continue working in those 5 states, and to bring Help Me Grow to an additional 10 states by the end of a recently concluded, 3-year grant period. At present, Help Me Grow is being replicated in more than 20 states, including New Jersey, exceeding our expectations.

Why has this happened? Why the receptivity to Help Me Grow? We believe there are at least 3 reasons:

• Most importantly, Help Me Grow does what it sets out to do. That is, it successfully links children and families to programs and services. Evaluation consistently demonstrates that 85% of children and families are successfully linked to a developmentally-enhancing program or service.

• Second, Help Me Grow does promote children’s optimal healthy development. Research shows that linkage to these community-based programs and services strengthens those protective factors that correlate with the best developmental outcomes for children: parents’ resiliency; social connections; concrete support in times of need; knowledge of parenting and child development; and children’s social and emotional competence.

• Third, Help Me Grow has cost benefits. We know of the continuous fiscal exigencies at the federal and state levels. When Help Me Grow is in place, child health providers are more likely to link children and families to community-based programs and services, rather than exclusively rely on referral for the next in a series of medical and laboratory evaluations that likely add very little support and value.

Ultimately, this dramatic spread of Help Me Grow is encouraged and inspired by the testimonials on the part of parents and providers. I invite you to go to HelpMeGrowNational.org, our website, and view the video of the very first call to the Washington State Help Me Grow program and listen to the stories of the parent and the care coordinator. From my perspective, being involved with Help Me Grow since its humble origins on the streets of Hartford, to see the current impact of this initiative on a family across the country in Snohomish County, Washington is overwhelming.
Where do we go from here? We will not be satisfied until every state has the opportunity to replicate Help Me Grow. In fact, requests and new affiliates are coming in at least monthly, if not weekly. In addition, we must always be mindful of new information to enable us to be even more successful in promoting children’s optimal healthy development. We know so much about the impact of social determinants on children’s developmental outcomes. We understand so much better the influence of early experiences and how they can either facilitate or hinder children’s optimal development. We know so much about the pernicious impact of toxic stressors on young children’s healthy development. These demand our effective community engagement to strengthen those protective factors and overcome these toxic stressors. I have no doubt that we have the skills and the knowledge to do this work. I also am very confident that we are evolving the structures to do this work. For example, at Connecticut Children’s Medical Center, we now have an Office for Community Child Health that supports programs focused on the promotion of children’s optimal, healthy development. What I do not know is whether or not we have the public and the political will to do this work. Only you know the answer to that question—and I hope it is in the affirmative.

Paul Dworkin is Executive Vice President for Community Health at Connecticut Children’s Medical Center and professor of pediatrics at the University of Connecticut School of Medicine. For the past 15 years, he served as physician-in-chief at Connecticut Children’s and chair of the Department of Pediatrics of the UConn School of Medicine.

NJAAP is a key partner in NJ Help Me Grow (HMG)
To learn more about Help Me Grow, please visit: www.helpmegrownational.org.
For information on HMG in New Jersey contact:
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In The News

Stephen G. Rice, MD, PhD, MPH, FACSM, FAAP recognized for lifelong contribution to the field of sports medicine awarded the Thomas E. Shaffer Award

Dr. Stephen Rice is director of the Jersey Shore Sports Medicine Center and program director for the pediatric sports medicine fellowship at Jersey Shore University Medical Center. He is clinical professor of pediatrics at Rutgers-Robert Wood Johnson Medical School. An M.D.-Ph.D. graduate of New York University. He did his pediatric residency at Seattle Children’s and was a University of Wisconsin faculty member. Dr. Rice, a high school and university team physician, is medical director for the NJ Youth Soccer Olympic Development Program. A former member of the AAP Council on Sports Medicine and Fitness Executive Committee, he also is the immediate past president of NJAAP.
1. Help Me Grow focuses on:
   a. Early detection of young children at risk for developmental and behavioral problems.
   b. Linkage of young children at risk for developmental and behavioral problems and their families to community based programs and services.
   c. Promotion of children’s healthy development
   d. All of the above

2. The “Decade of the Brain” was the period of time in the 1990’s in which there was an explosion of information about early brain development.
   a. True
   b. False

3. The assumptions that guided the origin of Help Me Grow included:
   a. Children at risk for poor developmental or behavioral outcomes were escaping early detection.
   b. There were a wide array of programs and services (Head Start, family resource centers, parent support groups) available to address children’s developmental needs.
   c. Children and families would benefit from a comprehensive, coordinated, region-wide approach to early detection and of young children at risk and linkage to community based programs and services.
   d. All of the above

4. The “Child Development Infoline” is a specialized call center of the United Way statewide 2-1-1 system.
   a. True
   b. False

5. Expanding eligibility criteria for developmental programs was the target of Help Me Grow, rather than enhancing access to community-based programs and services that already existed.
   a. True
   b. False

6. Currently, Help Me Grow is being replicated in more than 20 states, including New Jersey.
   a. True
   b. False

7. Evaluation of Help Me Grow has shown that 85% of children and families are successfully linked to a development enhancing program or service.
   a. True
   b. False

8. The protective factors that correlate with the best developmental outcomes for children include all of the following except:
   a. Parents’ resiliency
   b. Social isolation
   c. Knowledge of parenting and child development
   d. Children’s social and emotional competence

9. The strongest objection to Help Me Grow is its lack of cost-effectiveness.
   a. True
   b. False

10. Children’s healthy development may be affected by:
    a. The impact of social determinants
    b. The influence of early experiences
    c. The impact of toxic stressors
    d. All of the above
Adolescent Obesity Surgery: Where Do We Stand?

By S. Burjonrappa MD, FRCS (Ed), FACS
Pediatric Surgeon and
Clinical Assistant Professor of Surgery

Introduction: Morbid obesity is becoming a modern day epidemic with changing lifestyle and eating habits. Morbid obesity is defined as a body weight 100 pounds (200%) above ideal weight or a body mass index (BMI) greater than 35 with comorbidities or 40 without. The incidence of obesity in the United States has nearly doubled in most states over the past two decades and tripled in some southern states as compared to incidences in the early 1980’s. This health care problem has also effected the pediatric population and at least one-third of children in the country are overweight with a 5% incidence of morbid obesity. Adolescents with a single overweight parent have a 50-75% incidence of obesity into adulthood and this risk increases to nearly 80% when both parents are obese. This is reflected in a shortening of life expectancy by about 10-15 years and an increase in healthcare costs through the life of the individual that is proportional to the extent the individual is overweight. Obesity in adolescents thus has its implications at both the personal and societal levels.

Pathophysiology: The adipose tissue secretes the hormone Lectin that is an anorexigenic hormone (suppresses appetite). Lectin exerts its appetite suppressant effect by acting on the central nervous system and also by inhibiting Gherlin secretion by the stomach. The latter being an oroxigenic hormone secreted from the greater curvature of the stomach. In morbid obesity there is an elevation in serum Lectin levels as well as a resistance to the effects of the hormone thus negating its anorexigenic effects. Hormonal effects in morbid obesity affect multiple systems. Plaminogen Activation Inhibitor (PAI) levels are elevated increasing the risk for development of systemic clots. Renin-Angiotensin system activation causes elevation of blood pressure and cardiac effects include an increased stroke volume, increased stroke work and a predisposition to the development of arrhythmias that may partially be related to activation of the sympathetic nervous system. Erythropoietin levels may also be elevated. Obesity hypoventilation syndrome and obstructive sleep apnea are two common effects of morbid obesity on the respiratory system. They are characterized by decreased compliance and an increased work of breathing.

Altered sensitivity to cerebrospinal fluid pH changes is thought to partially mediate some of the observed effects. Endocrine and metabolic effects include dyslipidemia, insulin resistance, hypercortisolism, and carbohydrate intolerance. The metabolic syndrome is defined as a combination of dyslipidemia, glucose intolerance, and hypertension in the setting of morbid obesity. Obesity impacts almost all body systems however predominant effects are on the cardiovascular system and all cause mortality in obesity is essentially parallel to cardiovascular mortality.

Surgical Indications: Surgery is considered only after exhausting all non surgical therapeutic options including psychological behavioral modification, exercise programs and pharmacological treatment strategies aimed at identifying and treating potentially reversible endocrine or metabolic causes. Surgery is generally considered after 13 years of age in girls and after 14 years of age in boys. Strict selection criteria are used while choosing surgical options in this age group as compared to the adult population. Adolescents do not always excel at losing weight, but are generally more successful than adults. Comorbidities among children are not as severe as in grown-ups, and because they are growing, adolescents have different nutritional requirements. Lastly, adolescents are usually not psychologically prepared and demonstrate poor compliance with health care recommendations. Adolescents have not often put their best effort into weightloss and are generally more successful than adults in loosing extra weight, do not have comorbidities that are as severe, are growing and have different nutritional requirements and are usually not psychologically prepared and have poor compliance with health care recommendations. Obesity surgery in any adolescent is considered only after a psychological evaluation and at least 6 months of dietary modification and exercise therapy.

Absolute surgical indications include: BMI greater than 40 with any of the following obesity complications including 1) Obstructive sleep apnea 2) Pseudotumor cerebri 3) Diabetes Mellitus and 4) Metabolic syndrome. Surgery is also indicated in the absence of any complications in adolescents with a BMI greater than 50. Relative indications are numerous and include: panniculitis, venous stasis disease, arthropathies, stress incontinence, impairment of activities of daily living.
significant psychosis, and Gastro-esophageal reflux Disease (GERD).

**Contraindications:** Success in bariatric surgery involves significant dietary and behavioral modification to ensure that weight loss is maintained and nutritional complications are avoided. Absolute contraindications to surgery include substance abuse problems, psychiatric diagnosis that would impair adherence to post-operative medication/dietary regime, medically correctable causes, inability or unwillingness of patient/parent to comprehend surgical procedure and consequences, and lastly inability or refusal to participate in a lifelong medical surveillance.

**Surgical Therapy:** Surgical options include restrictive procedures (adjustable gastric banding, vertical sleeve gastrectomy (VSG)); Malabsorptive procedures (Jejuno ileal Bypass (JIB)); and combination procedures (Gastric Bypass (GBYPS), Duodenal Switch procedure (DS)). Restrictive procedures limit the amount of food that can be ingested and induce early satiety. Malabsorptive procedures decrease the length of the intestine where mixing of digestive juices and food occurs thereby limiting nutrient absorption. Pure malabsorptive procedures are no longer performed because of the significant morbidity associated with such operations. Combination procedures as the name indicates combine the advantages of restrictive and malabsorptive procedures. Combination procedures such as GBYPS have the best results with nearly 100% excess weight loss at 5 years. Adjustable gastric banding usually results in excess weight loss of around 56% at 5 years. Five-year results are still not available for VSG although average weight loss (% of total) is superior to adjustable gastric banding at around 58%.

VSG is fast becoming the most popular morbid obesity procedure in the USA for both the adult and adolescent populations. It is technically an easier operation with a better safety profile as compared to other procedures. This is the procedure we plan to offer the adolescent population at our comprehensive adolescent obesity center. The only absolute contraindication to performing the VSG is the presence of Barrett’s esophagus. Primary care pediatricians can facilitate referral by maintaining documentation of weight loss counseling and early referral to a dietician and exercise physiologist. Lag time from surgical consultation to procedure is around 8-9 months. Usually a sleep study and electrocardiogram are obtained as baseline. Specialist consultations (endocrine, pulmonology, gastroenterology, cardiology, etc) are obtained as needed. Laboratory testing includes routine hematology and biochemistry, thyroid function tests, and lipid profiles. Hospital stay for the procedure is usually 48 hours and in the pediatric intensive care unit. Complications are rare and include exacerbation of reflux, leakage from the staple line, stretching of the pouch, and narrowing of the stomach outlet. Patients are discharged on a liquid diet and slowly resume a regular diet over 6-8 weeks. Vitamin (including B12 and D), and mineral supplements (including Calcium and Iron) are important. It is important to maintain a protein intake of 60-70g/day.

**Setting Expectations:** Surgery is one of the therapeutic options that is now available to manage morbid obesity in the adolescent population. It should be used in a highly selected population after appropriate screening and after deliberation in a multidisciplinary setting. This team concept to management of adolescent obesity will hopefully reduce the financial burden of obesity on the society and improve the quality of life at the individual level. Resolution or improvement of diabetes, hypercholesterolemia, hypertension, and sleep apnea is seen in 75-90% of the patients.

**References:**


Nonalcoholic Fatty Liver Disease, cont.

When evaluated in a study of 112 pediatric patients with biopsy proven NAFLD, ELF was found to be predictive of fibrosis (41).

Cytokeratin-18 (CK-18) is a major intermediate filament protein in hepatocytes that is cleaved during apoptosis and has been extensively evaluated as a biomarker. CK18 has been found to both predict the presence of NASH and its severity (42, 43). A recent pediatric study demonstrated that plasma CK18 levels were significantly higher in children with NASH compared with those with hepatic steatosis and correlated with the main histological features of NASH and fibrosis stage (44).

Although currently biomarkers are utilized for research purposes in the diagnoses of NAFLD, recent developments in the field show great potential that noninvasive biomarkers will be used in the future for staging and monitoring the disease.

Multiple factors are probably involved in the pathogenetic mechanisms of NAFLD. Over nutrition and development of obesity have a central role in the accumulation of hepatic fat stores. The role of oxidative stress has received considerable interest and may occur as a result of mitochondrial dysfunction, hypoxia, glutathione depletion, or dietary deficiency of antioxidants.

Recent research has suggested a role for increased fructose consumption as a risk factor for NAFLD (45, 46) and complications of metabolic syndrome (49, 50). Strong evidence exists that fructose consumption may promote hepatic de novo lipogenesis and intrahepatic lipids, inhibition of mitochondrial β-oxidation of long-chain fatty acids, triglyceride formation and steatosis (48).

Visceral adipose tissue (VAT) is believed to play a pivotal role in the pathogenesis of NAFLD, since it participates in producing most adipokines, such as Tumor Necrosis Factor alpha (TNF-α), leptin, adiponectin and resistin which are involved in inducing insulin resistance and low-grade inflammation (51-53). Leptin is a satiety adipokine that regulates appetite and metabolism at the level of the hypothalamus (54). Most obese humans have high circulating levels of leptin, as a result of what has been characterized as leptin resistance (55-57). In this resistant state, some of the protective effects of leptin are lost, such as the promotion of fatty oxidation and the prevention of hepatic lipogenesis (58). There is also evidence that leptin directly promotes hepatic stellate cells, leading to fibrogenesis, and may play a role in the development of HCC (59-61). Adiponectin has been shown to improve insulin sensitivity as well as have an anti-inflammatory effect (62). Both increased leptin and decreased adiponectin have been associated with increased steatosis in NAFLD (63,64). Data continue to accumulate regarding the role of intestinal microflora in the development of NAFLD. Obesity and fructose consumption are associated with gut-derived endotoxin transmission in humans (66). Recently, it had also been proposed that vitamin D deficiency, a common finding in NAFLD patients, may predispose individuals to increased endotoxin exposure (67).

Genetics

Evidence that only a minority of patients with NAFLD progress to NASH suggests that disease progression may be dependent on complex interplay between environmental factors and genetic predisposition. Genetic contribution to NAFLD is suggested by increased prevalence in boys, as well as certain ethnicities and races. Family clustering of NAFLD has been seen in siblings (59%) and parents (78%) of children with NAFLD when compared to age and BMI-matched children without NAFLD, likewise implying a genetic component to NAFLD (72).

Several recent genetic studies in NAFLD have focused on variants of the adiponutrin gene, otherwise known as patatin-like phospholipase 3 (PNPLA3). A meta-analysis that reviewed 11 studies, including 2651 patients with biopsy-proven NAFLD confirmed that PNPLA3 polymorphisms could be correlated with increased steatosis and worse histologic injury (76).

More recently, a major advance has come from the recognition first obtained by genome-wide association studies (GWAS) conducted in a population-based cohort of 928 adolescents assessed for NAFLD showed that single-nucleotide polymorphisms in two genes are expressed in liver associated with NAFLD in adolescents (77). Although the findings of these studies need to be validated prospectively, integration GWAS-derived genetic scores carry the promise of genetic risk stratification and may offer opportunities for distinct therapeutic targets.

Treatment Options

The identification of appropriate treatments for children with NAFLD is a significant priority worldwide given the epidemic environment of this disease.

First line of treatment in adult and pediatric NAFLD is lifestyle changes inducing weight loss—including caloric restriction, improved diet composition and exercise (78-81). Exercise alone, even without weight loss may have histological benefits as well (82,83). Limited pediatric studies support these findings (84,85).
Although lifestyle modifications seem to be beneficial in the treatment of NAFLD in children, they are difficult to achieve and maintain in daily practice and long-term efficacy of diet and exercise in the treatment of NAFLD has not been established.

Over the past decade, bariatric surgery has become a widely accepted option for patients who suffer from extreme obesity and its co-morbidities and have failed lifestyle intervention. Given the role of obesity in the pathogenesis of NAFLD, bariatric surgery has been proposed as a potential treatment strategy and has been successful in adults (86-88). There are only few studies that report resolution or improvement of co-morbidities after bariatric surgery in adolescents (89,90); however, liver outcome data is limited.

Recently, interesting dietary supplementation such as probiotics and N-3 long-chain polyunsaturated fatty acids (LCPUFA) has been investigated in pediatric NAFLD (91-96). The preliminary results of dietary supplements such as LCPUFA and probiotics are encouraging and further studies of such supplementation for children with NAFLD are needed.

Owing to the likely role of insulin resistance and oxidative stress in the development and progression of NAFLD, most studies on pharmacological treatment have focused on two categories: those that improve insulin resistance and those that have a hepato-protective response, such as antioxidants. Both PIVENS (Pioglitazone or Vitamin E for NASH Study) (97) and TONIC (Treatment of NAFLD in Children) (98) trials, support the use of vitamin E in addition to lifestyle interventions for the treatment of NASH. However, long-term effect of vitamin E on NASH has not been established.

Cysteamine bitartrate is Food and Drug Administration approved for the treatment of cystinosis (99). In a pilot study of children with NAFLD, treatment with 24 weeks of EC-cysteamine resulted in significantly improved ALT, AST, total adiponectin, leptin, and cytokeratin-18 fragment levels in the absence of change in BMI (101). Currently, a multicenter randomized placebo-controlled study investigating the treatment of pediatric NASH with delayed release cysteamine (Cysteamine Bitartrate Delayed-Release for the Treatment of Non-alcoholic Fatty Liver Disease in Children (CyNCh) trial NCT01529268) is underway (103).

**Summary**

NAFLD has been recognized as the most common cause of chronic liver disease in children and adolescents. Pediatric NAFLD prevalence tends to increase with the epidemic of obesity. Most children are asymptomatic at the time of presentation. NAFLD in children may be under diagnosed by healthcare providers due to lack of screening guideline recommendations and appreciation of potential complications of this disease which include liver dysfunction, cirrhosis, and cardiovascular disease. Although liver biopsy remains the gold standard for diagnosis and monitoring disease activity, novel imaging studies and biomarkers are being rigorously evaluated for clinical use in children. The etiology of NAFLD is multifactorial with both environmental and genetic components playing a role. Lifestyle modifications that result in weight loss remain the first line treatment of NAFLD in children but are difficult to achieve and maintain in daily practice. Dietary supplementation such as LCPUFA and probiotics may prove to be favorable. Beneficial effect of Vitamin E on hepatic injury has been demonstrated in well-designed adult and pediatric studies, and other multicenter randomized placebo-controlled trials in pediatric NASH are underway. Further research efforts are required to characterize the pathophysiology of the disease, recognize genetic risk factors, and identify effective and sustainable treatment options.

**Editor Note:** See References at www.aapnj.org

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**Over 50 Pediatricians Have Earn 25 QI Maintenance of Certification Points in NJAAP Project**

Over the past three years, more than 50 physicians have successfully completed the NJAAP Maintenance of Certification (MOC) part four quality improvement project, Strengthening Pediatric Partners (SPP). The data and feedback collected attests to the program’s success in reducing the occurrence of child abuse and neglect.

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**Learning Session to begin in April 2014. Registration Limited**
First Annual Flu Carnival Draws Crowds, Smiles And Rave Reviews
by Jeff Bienstock, MD

On September 22, 2013, PediatriCare Associates held its first annual Flu Carnival, vaccinating over 600 children for the upcoming 2013-2014 Influenza season. The Carnival began as a practice dream that emerged during our annual practice retreat, where the managing partners and managers from our three offices gathered to identifying strategic short and long term practice goals.

Creating a unique way to vaccinate a large number of children en masse for the upcoming flu seasonal while simultaneously easing the burden at our flu clinics and office visits emerged as a top priority. Further, two key criteria were identified as being essential to making the event a success; it must increase awareness of the upcoming flu season among our families, and it must be both fun and educational.

Thanks to the diligent work of a dedicated planning committee working collaboratively with our staff and physicians and local resources, the vision began to take shape. The committee consulted with our local police department on issues related to traffic management and also to enlist their support in presenting families with car seat checks and other safety topics. They also arranged for various classes with two of our consulting psychologists, each lasting 5-10 minutes and connected with a physical therapists, a speech therapist and an occupational therapist to provide information to our families. Lastly, they engaged a DJ who provided music throughout the day.

Leaving no detail unaddressed, the committee planned for a variety of age-appropriate arcade style games, sand art activities, face painters and snow cones as a refreshment.

There were some concerns over crowd control during patient registration, even though patients had been provided with a two hour window for arrival and chart preparation (we “went paper for the day” and then scanned in notes during the week after), so we hired a strolling magician for the day, which worked well as he was quite handy with balloon art.

The planning committee assigned roles to each member of the PediatriCare Associates team, including physicians, nurses and clerical. Team members were placed at key points though out the office to assist with sign in, vaccine administration, copies of immunization records as well as outdoor support with helium balloons, arcade games, face painting and security to provide for the safety of our families. Coffee and bagels were provided for the morning shift and pizza for the afternoon shift and every team member was paid for their time.

The event was a huge success and the feedback from participating families was amazing.

Planning for next years’ Flu Carnival is underway - and we are brainstorming other novel ways to engage our family of patients.

It was an amazing event! My boys forgot the “pain” of their shots very quickly once they were outside having fun at the carnival! Look forward to next year’s event!”

THANK YOU for making flu shots more pleasing to kids to keep them healthy! You made the “going for a shot” so memorable in a good way! Your entire staff ROCKS all of the time! Thanks for all you do!

It was a great event, I’m so glad we were able to go. Thank you and our family hopes that you’ll be able to do it again next year.

All Photos by Robin Gottesman
Each year in the US, millions of individuals are sickened and tens of thousands die. Although there are high risk groups such as pregnant women, the elderly, and those with co-morbid conditions, the current CDC recommendation is that every individual over 6 months of age should be immunized annually, especially the aforementioned high risk individuals and health care personnel. The requirement for annual immunization results from the almost unique propensity for the influenza virus to undergo genetic drift and shift resulting in immunologically different strains of influenza viruses type A and B. When the strains differ from the previous year’s influenza vaccine strains, they are called mismatched or heterologous strains. Thus new and different vaccines are required almost each year containing the strains predicted for the coming influenza season to insure optimal clinical protection. For the 2013/2014 influenza season, the CDC and WHO have recommended either the trivalent (two A and one B strain) or a quadrivalent flu vaccine containing two A and two B strains.

A second important and recent issue with regard to contraindications to influenza immunization is the issue of egg allergy. True anaphylaxis (severe bronchospasm, cardiac dysfunction, hypotension, etc) to eggs is rare. An allergy/immunology specialist can evaluate an individual for egg allergy with skin tests and a blood test for egg specific IgE, specifically ovalbumin. True egg anaphylaxis remains a contraindication for vaccine administration with most current preparations. This year there is a new recombinant vaccine, FluBlok, which has no egg protein; the vaccine is approved for use in patients 18 to 49 years of age. For patients with other manifestations of egg allergy (rhinitis, coughing, rash, urticaria, diarrhea, etc.), the usual vaccines are no longer contraindicated but there are precautions. For anyone with a documented egg allergy, flu vaccine should be administered in a setting where anaphylaxis can be recognized and appropriately treated. Patients should be kept under observation for 30 minutes after immunization. Regardless, the safety profile of influenza vaccine, even in egg allergic individuals, is excellent and the significant benefit of immunization almost always exceeds the minimal risk.

A third issue is the recognition of the value of the live viral influenza vaccine, approved for generally healthy individuals between the ages of 2 and 49 years of age. The effectiveness of 2 currently available influenza vaccines LAIV and TIV in preventing influenza-like illness (ILI) was compared in a well conducted study among 41,670 US military members (aged 18-49 years) during 3 consecutive influenza seasons (2006-2009). ILI, influenza, and pneumonia events post-vaccination were compared. The conclusion of the study was that between 2006 and 2009, live (LAIV) and killed (TIV) influenza vaccines had similar effectiveness in preventing ILI and influenza or pneumonia events among healthy adults. [Clinical Infectious Diseases 2013;56:11-17 56(1):11] Previous data suggested that LAIV was more effective in children and more protective during seasons with mismatched viruses. [Belshe RB et al. Vaccine 2009;28:2149-56. Belshe, R. Vaccine 28S (2010) D45-D53]. Note that this year, the live viral influenza vaccine is quadrivalent.

The fourth issue concerns mandates for flu immunization in New Jersey. As previously noted the recommendation is to immunize almost every individual annually. However, there is legislation that mandates immunization for children 6 to 59 months of age: N.J.A.C. 8:57-4 was passed into law in 2008; it required proof of annual immunization administered to all children 6 to 59 months of age between September 1st and December 31st, prior to child care or preschool attendance. In addition, it would seem that a similar mandate might well be required to successfully immunize health care personnel with patient contact against several appropriate vaccines. [Calderon, M, KN Feja, P Ford, LD Frenkel, A Gram, D Spector, RW Tolan. American Journal of Infection Control 33 (6): 392-398, 2008.]

There is some good news for us here in NJ: by the end of October, over a quarter of a million doses of influenza vaccine had been distributed by the NJ Department of Health. In addition, the medical, religious, and philosophical exemptions to vaccines by citizens were much lower than the US average. The vaccines available in the US for this flu season are described and listed in the table below.
22nd Annual NJAAP

Barbara Snyder, MD, FAAP and Gail Burack, PhD
Why "GLEE is Important: LGBTQ Medical Homes

Colleen Kraft, MD, FAAP
Toxic Stress and Resiliency in Early Childhood

Oren Koslowe, MD - Cutting Through the C.R.A.P.

Barbara Snyder, MD, FAAP and Gail Burack, PhD
Why "GLEE is Important: LGBTQ Medical Homes

Attendees listening to a featured presenter

Hoover Adger, Jr., MD, MPH, MBA
Not Your Father’s Weed: What Kids are Doing to Get High

Cathleen Ballance, MD FAAP
Brush Up on Oral Health School

Yasmi Crystal, DMD
Brush Up on Oral Health School
School Health Conference

Attendees visiting exhibit hall

Magaret “Meg” Fisher, MD, FAAP
When “Routine” Infections Go Bad

Elliot Rubin, MD, FAAP
Conference Chair, NJAAP VP.

NJAAP staff member Amanda Whelan with Government Affairs Co-Chair, Alan Weller, MD, FAAP

Director of Membership, Burt Mulder meeting with exhibitors

NJAAP Executive Director, Fran Gallagher

Mark Reiger, MD, FAAP
Scoliosis, Pain Syndromes and Beyond

NJAAP staff (left to right) Mary Jo Garofoli, Judie Grandjean, Cortney Mott, Amanda Whelan, Fran Gallagher, Cynthia Heulitt, Dana Carlini, Michael Weinstein and Burt Mulder
A NEW KEY TO SUCCESS (AND SURVIVAL)  
By: Michael J. Schoppmann, Esq.

Throughout the medical field in the United States, a new set of questions has arisen which physicians and medical practices should be asking themselves. These questions, and their potentially surprising answers, can determine whether or not a practice retains its participating status by a health plan (private and/or public); whether the reimbursement rates a practice is receiving are increasing (or dwindling); whether the practice is at an increased risk of an adverse investigation or action; and/or whether or not the practice is experiencing the loss of a significant portion of patient flow.

What places medical practices and physicians at an even higher risk of encountering problems in any or all of these areas is that physicians and practices are completely unaware of their ranking in these areas or they do not recognize the need to address this new set of questions. What a physician and/or a medical practice does not know may actually pose a greater risk than what is known. As but one example, there is no method or resource available for purchase which can tell physicians or medical practices what patients choose not to utilize their services. However, by addressing (and continuing to readdress) a basic set of questions, physicians and medical practices can become aware of what may be threatening their very survival, take measures to counteract any negative ranking and/or rating and turn these ranking and/or rating systems into positive assets for their future success.

This new set of questions, in primary terms, is as follows:

☐ Where are we ranked and/or rated?
☐ Who is ranking and/or rating us?
☐ How are we ranked and/or rated?
☐ What is the potential and/or present impact of the rankings and ratings?

In breaking down the analysis of these questions into the sub-categories of (1) payors and (2) patients, the payor analysis bears the higher priority.

As medicine continues to spinoff into countless new pilot projects of differing and untested “payment models,” there is one constant found in each construction – that physicians and medical practices will be examined, evaluated, measured and judged. Terms such as “pay for performance,” “physician performance,” “practice benchmarking” and “value based purchasing” are all now cornerstones of every healthcare reform initiative. However, what most practices and/or physicians do not grasp is the fact that the information gathered through these initiatives is not being compiled for academic or research analysis. Each and every aspect of “physician performance measurements” carries the added elements of “measurement and reporting.” In today’s medicine, data is compiled to be used actively and aggressively – in ways every physician must be aware of and act upon.

In the payor realm, these terms have been in development for years and are already being acted upon and imposed onto physicians and practices by both private and public payors. Some health plans, such as Aetna and United Healthcare, have developed “tiered” physician networks based on their own definitions of quality and efficiency – derived from their own “performance data.” Health plans then use this information to “rank” or “grade” a physician/medical practice and encourage patients to seek care from these “high-performing” practices (at the expense of other practices which the health plan has determined not to be “high-performing”). Failing to meet these new performance standards may also result in a termination or non-renewal of the practice/physician’s participating agreements – which, in certain market-share settings, can be a death blow to the practice.

Risk managing the payor equation, every physician and/or medical practice should immediately contact each of their payors and obtain any and all “performance,” “quality” and/or other policies, protocols or set of standards which exist and/or have been imposed upon the practice by the payor. The practice should then review, closely, each of these performance evaluation measurements and either make changes to meet the imposed requirements or evaluate the financial viability of having the practice terminate its participation with the payor. If the payor is utilizing a “ranking” system, the practice must immediately verify its ranking and challenge any ranking that does not place it at the highest level.

In the public realm, practices and physicians can no longer ignore or discount the ever expanding number of “ratings” sites under which they appear - and are judged.

continued on next page
While practices and physicians may have never enrolled in such sites, or even be aware of the fact that they appear on these sites, their presence exists and, in many cases, reveal how they may be adversely attacked by members of the public.

Risk managing the public equation, every practice and physician should set a routine and unswayable schedule of online credentialing - the act of taking the name of the practice, the names of each of the physicians employed by the practice and seeking out their rating on each of the commonly utilized rating sites (i.e., Vitals, Healthgrades, Ratemds, etc.) and (1) verifying the data included is correct, up to date and accurate and (2) challenging any adverse ratings – within the methods for doing so set by the ratings site.

In conclusion, ratings and rankings are broad titles for foundational changes to the standards every physician/medical practice must meet. Acting in defiance of these standards, or continuing to practice in ignorance of them, will only result in the imposition of devastating consequences – some of which will only be manifested in a manner from which the practice cannot recover. To survive, and to succeed, aggressive and preemptive risk management must be adopted, implemented and adhered to by every physician and medical practice.
At a recent Medical Home celebration dinner, I just happened to mention that while our family resides in one state, our daughter’s Children’s Hospital is in another state. I also have an advocacy perspective as NJ Coordinator of Family Voices, the national network for families of children with special healthcare needs. So at the request of one of the physicians, I will relay the experiences not only of my family but of other parents in this situation.

Insurance Coverage

One of the key issues is ensuring comprehensive coverage as well as coordination of benefits. Children with special needs may be covered not only by their parents’ plans but also could be eligible for Medicaid and/or Medicare.

One complicating factor is what it means to be in a plan’s network. The best coverage occurs when all plans, public and private, consider providers “in network.” However, although a hospital may be in a plan network, each provider must be also be in that network, so families need to check this before signing up with a plan. Further, although Medicaid is a federal program, benefits are state-specific. Families need to get an “out-of-state” authorization for Medicaid coverage for health services provided in another state. And even then, it may not cover prescription medications.

Medication Access

It’s a challenge when a current medication isn’t in a hospital formulary. Families can bring these when their child is in-patient and the hospital pharmacy can approve use of medications from home. At times, parents could also be given prescriptions in-patient that are non-formulary and can go to a local drugstore, again getting the hospital pharmacy approval for use while hospitalized. However even where there are pharmacies on site at the hospital, they may not accept Medicaid (even with an out of state authorization for medical care) across state lines. Possible solutions for medication formulary/billing issues would be for the hospital or drugstore to provide an emergency supply upon discharge until the family will be able to get the rest at their local pharmacy. This is particularly true of medications which may need to be special ordered.

Another solution for medications from compounding facilities would be for the hospital pharmacy to give the actual formula to the home pharmacy if they agree to mix the medication. The compounding facility had actually told our family that otherwise we would be charged $100/bottle despite having private, Medicare, and Medicaid coverage. Lastly, for any medication that Medicaid won’t cover out of state, if it is in their formulary, families can get reimbursed by contacting the Medicaid pharmacy department in their state.

Care vs. Case Management

Care management helps at risk patients with particular conditions (e.g. asthma, sickle cell, etc.) whereas case management is specific to the child. The medical home model is key to best outcomes (see www.medicalhomeinfo.org) particularly across state lines. Families typically only have “in-network” providers in the state in which they reside but as mentioned above they can ask for “out of state authorization.” Families may even be able to get authorizations out of state for out-of-network doctors but these exceptions are more difficult to obtain and result in more out of pocket costs.

One possible solution is for the family to use the pediatrician as the PCP (primary care provider.) The PCP can get copies of all clinic visits and hospitalizations, including out of state. Typically, families will receive hard copies of visit summaries or hospital discharge plans, and they can ask the provider to copy their child’s pediatrician on all correspondence. In this way, there is one provider with all of the information from various specialists, which facilitates coordination of care and avoids unnecessary duplication.

Families will strive to get the best care for their child with special needs, regardless of where it is located. Pediatricians can help facilitate this, even across state lines.
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As the world’s population continues to increase, it’s critical to not only provide nutrient-dense foods for the health of our people, but also to do so in a way that addresses the health of our communities and the planet. Through ongoing research and education efforts, National Dairy Council and its partner, the Innovation Center for U.S. Dairy, promotes sustainable practices and strives to make positive contributions to the economic, environmental and social good.

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And this would deliver:
- 90% DV for calcium
- 90% DV for vitamin D
- 30% DV for potassium
- 48% DV for protein
- + additional nutrients essential for health

DV: Daily Value

Milk is ~17¢ per serving

NUTRIENT MANAGEMENT

Rich in nutrients, cow manure fertilizes the land for growing more crops for people and animals.

1 cow produces 17 gallons of manure per day.

That’s enough fertilizer to grow 56 pounds of corn or 84 pounds of tomatoes.

VALUE FROM REUSE

Having four stomachs means cows can recycle food that people can’t eat.

75% of a cow’s diet is not consumable by humans.

By-products from the human food and fiber industries (e.g., citrus pulp and cottonseed) are converted to milk rather than sent to landfills.

TAKING IT FURTHER

Manure is also becoming a source of additional value. Anaerobic digester systems convert manure and commercial food waste into:
- Electricity
- Fuel for cars and trucks
- Fertilizer and fiber

$200 per cow per year in combined revenues and cost savings

Governor Christie won re-election, capturing 60.5% of the vote. The Governor carried 19 of New Jersey’s 21 counties, only losing the Democratic strongholds of Essex and Hudson.

Despite the Governor’s overwhelming victory, Democrats maintained control of the Legislature. In the Senate, the Democrats did not lose a single seat and their majority stands at 24-16. Every incumbent Senator, except Senator Barbara Buono ran for re-election. Assemblyman Peter Barnes will replace Senator Buono.

In the Assembly, Democrats will likely maintain a majority of 46-34. In the 1st Legislative District, Cumberland County Freeholder Sam Fiocchi defeated Democratic Assemblyman Nelson Albano. In the 2nd District, Democrat Vincent Mazzeo has been declared the winner over incumbent Republican Assemblyman John Amodeo (although a recount is scheduled.) In the 38th, Democratic Assemblyman Timothy Eustace was certified as the winner, defeating Rochelle Park Committeeman Joseph Scarpa by 49 votes. A recount is also expected in the 38th.

In the Assembly, two Democratic members, Assemblyman Albert Coutinho and Assemblywoman Connie Wagner resigned their seats and did not seek re-election. In the 29th Assemblyman Coutinho will be succeeded by Democrat Eliana Pinto Marin in the 29th District and Assemblywoman Wagner will be succeeded by Democrat Joseph Lagana in the 38th District.

Several other Assembly incumbents did not seek re-election – in the 8th District, Republican Assemblyman Scott Rudder will be replaced by Republican Maria Rodriguez Gregg; in the 18th District, Democratic Assemblyman Peter Barnes will be replaced by Democrat Nancy Pinkin; in the 33rd District, Democratic Assemblymen Sean Connors and Ruben Ramos will be replaced by Democrats Carmelo Garcia and Raj Mukherji; and in the 39th District, Republican Assemblyman Robert Schroeder will be replaced by Republican Robert Auth.

Two days after the election, both parties chose their leaders for the next session. Senate President Steve Sweeney, Senate Majority Leader Loretta Weinberg, Deputy Majority Leader Paul Sarlo and Senate President Pro Temp Nia Gill were all unanimously re-elected by members of the Democratic Majority. Senator Tom Kean was re-elected Senate Republican Leader in a 10-6 vote. Assemblyman Vincent Prieto was unanimously elected Speaker and Assemblyman Louis Greenwald was unanimously elected Majority Leader. Assemblyman Jon Bramnick was unanimously re-elected Assembly Republican Leader and Assemblymen Dave Rible and Scott Rumana were unanimously elected for second terms as conference leader and whip.

Lame Duck Session Begins

The Senate returned on November 7 and the Assembly returned on November 18 for the lame duck session which runs until noon on January 14 when the new Legislature is sworn in.

There are “scope of practice” issues that have been of concern. The Assembly passed, by the barest majority, 41-27, A2419, which permits certain licensed psychologists to prescribe medications. NJAAP, and provider groups, argued strongly against this measure.

The Government Affairs committee has continued meeting with legislators to share concerns in opposition to S2354/A3512, legislation, which eliminates requirement of joint protocol with physicians for advanced practice nurses to prescribe medication and S2678/A2026, which revises requirements and the scope of practice for physician assistants. We have been advised that neither of these bills will move forward in the lame duck session.

We do, however, expect legislation to move forward on the issue of pharmacists administering vaccines to children, A3251/S2567. We are hopeful that the sponsors of the legislation will agree with NJAAP that any such legislation limits pharmacist to administering vaccines for influenza only to children 12 years of age and older.

Finally, we expect final legislative approval of S2367/A4415 prior to the end of this session. The “Sudden Cardiac Arrest Prevention Act,” imposes various requirements designed to provide student-athletes, their parents or guardians, coaches and other school officials with information concerning the nature and symptoms of sudden cardiac arrest and establish protocols for the removal-from-play of student-athletes who experience symptoms of sudden cardiac arrest while participating in athletic activities or prior to or after such participation. These requirements are applicable to athletic activities that are sponsored by or associated with a school district or nonpublic school, including interscholastic athletics.

Under current law, the Commissioner of Education is required to develop a pamphlet that provides the parents and guardians of student-athletes continued on page 31
What is it like being the spouse of a physician during his/her residency?

By Paul Czar

Remember the scene in ‘National Lampoon’s Vacation’ where Clark Griswold finds himself pulled over by a police officer on the highway, only to learn that he left Aunt Edna’s dog tied to the bumper of his car? He pleads with the officer, “I’m very sorry, I feel terrible.” The officer, while holding the now-empty leash, replies, “How do you think that little dog feels? Poor little guy. Probably kept up with you for a mile or so.”

We’re the dog.

That’s just a joke, of course. But I believe it helps to illustrate and reflect upon some important thoughts regarding marriage and family life during the course of one partner’s medical education.

As all of the doctors reading this know first-hand, the road through medical school, residency, and beyond can seem endless. Your journey has been more difficult than you could have possibly imagined when you started, but bettering the lives of others is well worth the cost. Helping guide you along your road is a unique and incredible dedication to improving the health or saving the life of every patient you meet. And we have been by your side every step of the way. Not because we are chasing our dreams necessarily, but because we have chosen to support you through yours.

My wife Elizabeth and I have been happily married for over six years now. Our wedding took place a month after we graduated from college, and just two weeks later, we had to pack up and move from Washington, D.C. to Blacksburg, Virginia, for her studies at the Edward Via College of Osteopathic Medicine. Elizabeth is now in her third year of pediatric residency at the Jersey Shore University Medical Center in Neptune, New Jersey. We have somehow managed not only to survive the whirlwind thus far but also have three wonderful children along the way.

It is frightening as a future physician embarking on your journey into medical school or residency. I will never forget the first time Elizabeth explained the residency match process to me. “Make a list? Wait for months? Be told that we’ve been assigned a hospital? Our entire family has to pack up and move in a matter of weeks? Somebody has got to be joking!” I remember thinking to myself in disbelief.

Once matched, you would be assured of continuing your career towards becoming a physician. For your spouses, the match process felt more like a hostage situation. What about our careers? The process of finding gainful employment in our own fields of work is difficult enough when we have sufficient time to search and can decide where we go next. The station wagon we were tied to was rapidly approaching another exit ramp to a new interstate. Yet again we had no real say in the direction of travel or any choice but to keep running as fast as we could to keep up.

Settling down into a residency program finally brings an end to some of the unknown, but it doesn’t make marriage or family life easier. After a while, I gave up on even trying to keep track of Elizabeth’s call schedules, night floats, and moonlighting hours. She typically leaves for the hospital before the kids wake up, and we are lucky if she gets home in time for a family dinner together. I have lost count of the numbers of lunch boxes I’ve packed, the days of work I’ve missed for sick kids and doctor’s visits, the loads of laundry I’ve folded, the dinners I’ve cooked. I’ve gotten to the point that I am no longer embarrassed to overhear someone call me “Mr. Mom.”

Through it all, I have come to realize there are two words that describe a marriage during residency. I’m confident that most of you would choose the same two words to describe your education, residency, fellowship, and practice of medicine as a whole:

**We only ask you to give us whatever time and energy you do have at the end of the day to let us know that we are still a priority in your life, and that you remain devoted to us.**

**devotion** (noun) – an ardent and selfless affection and dedication to a person or principle

**sacrifice** (verb) – the act of giving up something that you want to keep, especially in order to help someone else

continued on page 27
Resident Voice, continued

Being a physician takes devotion and sacrifice. You are committed to medicine, to your education, and most importantly to your patients. With twenty-four hour calls and late nights in the hospital, on weekends and holidays, you spend so much of your time improving the health and lives of all those around you. Most will never fully comprehend the knowledge and skills you have spent so many years acquiring, nor appreciate the gifts you have given time and time again.

Marriage takes devotion and sacrifice. We have all promised to be true to one another, in good times and in bad, in sickness and in health, as long as we both shall live. The best advice I ever received before my wedding was simple, yet perfect – spend every day striving to make your spouse’s life better before your own. Without hesitation, we must constantly and selflessly put the needs of our partner first.

Both medicine and marriage require truly selfless devotion. From the outside looking in, it may seem that having a spouse while in residency could weaken the marriage at home. Marriage takes hard work and time to nurture. When one partner has so little time to give the other, how could it not be difficult to keep the marriage together?

In fact, the opposite is true. Journeying through residency together serves to strengthen the bonds of our marriages. We are unique couples facing unique challenges. I firmly believe that the true measure of a person’s character is what he or she does for others. Our marriages must go far beyond just a commitment to each other. Despite this, understanding the depths of these commitments and learning to embrace them truly brings us closer together than other married couples could possibly imagine.

To all the doctors and residents, we understand that you do not always have time to give us at home. We only ask you to give us whatever time and energy you do have at the end of the day to let us know that we are still a priority in your life, and that you remain devoted to us.

To your spouses, whenever we feel as though we’re being dragged behind the car, remember that we are in fact sitting in the passenger seat. We have chosen to go along for the drive, each and every day, striving to make our partner’s life better before our own.

With the end of her residency quickly approaching, Elizabeth and I once again turn our eyes to the future, unsure where the next road will take us. But we look forward eagerly, knowing that our devotion to each other will take us there together. I am excited for the next leg of our journey, for no matter how bumpy the journey can be at times, I’d much rather spend it with my love than being left on the side of the road.

Turn to page 30 for details on the Leonard P. Rome CATCH Visiting Professorship Program to promote advocacy for children and advance the field of community pediatrics through supporting educational programs at Jersey Shore University Medical Center and Rutgers RWJMS.

NJAAP/PCORE @ Work

NJAAP Conducts Focus Group Session to Determine practices’ experiences with implementing the medical home component of the ISG Project

This past November, Hunterdon Family Practice and Obstetrics, led by MD champion, Dr. Kendra Lewis – MD met with NJAAP Medical Home team member, Judie Grandjean to share information on their offices’ success with implementing strategies to improve their Medical Home. The Hunterdon Family Practice Medical Home Team addressed implementation of developmental and depression screening tools into their practice utilizing the Model for Quality Improvement that was taught during earlier Medical Home Learning Session. Office Manager, Lynn Thompson summed up the experience saying, “What I enjoyed most about NJAAP Medical Home Initiative was working consistently with a small group of dedicated staff who really got to know us, helped us identify areas where we could make improvements in the quality of our patient care, and cheered us on as we progressed” For additional information on the project, please contact Judie Grandjean at jgrandjean@aapnj.org.
Online screening

- Access more than 100 questionnaires from home or in the waiting room on a tablet or smart phone.
- Questionnaires include: ASQ-3®, M-CHAT™ and Follow-Up, PSC, CRAFFT, PHQ-9, Edinburgh, Vanderbilt Parent and Teacher, and more.
- Screenings billable under 96110

QI and Decision Support

- Results table and details instantly available for care
- Results linked to decision support & resources
- Documents and collects data for MU, P4P, ACO, MOC-4, Medical Home
- Interoperable with EHRs

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- MemoryBook populated by milestones and information from patient questionnaires
- Families add photos and comments
- Alerts & resources based on results or by clinician

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January 8th, 2009 a beautiful baby boy named Joey entered this world in a hospital in NJ. His family was overjoyed with his arrival and their new addition to their family. His grandmother, I’ll refer to her as Amy, was thrilled to have a grandson she could dote on.

Two months later, Joey was taken to the emergency room with bleeding on his brain and behind his eyes. His head was swollen and they weren’t sure if Joey could see or hear. He was a victim of Shaken Baby Syndrome (SBS) at the hands of his father; his father whom had also been abused as a child until adopted by Amy when he was 6 years old. Amy is the proud grandmother of Joey, yet also the mother of the abuser. This incident forever changed their lives as Amy now works each day to protect Joey, who is now a SBS survivor and just turned 4 years old this January.

In 2012, Prevent Child Abuse NJ (PCANJ) launched a shaken baby syndrome/physical infant abuse prevention program called the Period of PURPLE Crying® program (PURPLE program). Studies show that infant crying is the most common precipitant of abuse. This program is effective at helping parents understand newborn crying and also teaching them about how to cope with the stress of a crying baby. Anyone who has ever been around a crying baby (add in no sleep for weeks with seemingly no end in sight!) can relate to the frustration of not being able to calm the baby down.

Fortunately, the PURPLE program teaches parents there IS an end in sight and that this is a period that all babies go through in their development. It teaches parents about the normal crying that is marked by these properties that are often the most frustrating for parents:

- Peaks of Crying: starts at 2 weeks and increases around 6-8 weeks sometimes continuing to 3-5 months
- Unexpected: there seems to be no reason for it (diapers are dry, no fever, not tired, etc)
- Resists soothing: no matter what the caregiver does the baby still cries
- Pain-like face: as if something is wrong, even though the baby is healthy
- Long-lasting: babies can cry up to 5 hours a day
- Evening: is the most common time the crying happens

The Period of PURPLE Crying educates parents about this normal pattern of crying and also helps them learn ways to safely deal with the crying without shaking their infant. It has been shown in several randomized control trials to increase parent knowledge and change behaviors related to shaking.

To date, seven New Jersey birthing hospitals are implementing PURPLE program: Saint Barnabas Medical Center, Newark Beth Israel Medical Center, University Hospital, Trinitas Medical Center, Robert Wood Johnson Medical Center, Community Medical Center and AtlanticCare Medical Center. When a baby is delivered at a PURPLE program hospital, the staff teaches the parents about the program, shows them a DVD and provides the DVD/booklet kit to the family to take home and share with anyone who will be caring for their baby. This in hospital intervention is called Dose One.

Dose Two happens within the community at facilities where the baby may go such as the pediatrician’s office or community agencies. This is an opportunity for health care providers (like you!) and community members to reinforce the PURPLE message about the properties of crying and safe ways to cope.

Another great way for the community to increase awareness about the PURPLE program is through the Click for Babies campaign. Volunteer knitters across New Jersey are making thousands of purple newborn baby caps that will be given to PURPLE hospitals in November and December. Babies will get the caps as a reminder to their caregivers to keep them safe! (www.preventchildabusenj.org/purple/clickforbabies.shtml)

Lastly, Dose Three is a universal, public education campaign to reinforcing the message through social media, billboard advertisements, etc.

PCANJ wants to bring this effort to more hospitals in New Jersey because prevention is key to keeping our babies safe.

If you or someone you knows works in a NJ hospital that may be interested in bringing the Period of PURPLE Crying to families who deliver there, please contact Gina Hernandez at: ghernandez@preventchildabusenj.org

Gina Hernandez, MA
The Leonard P. Rome CATCH Visiting Professorship Program
Tuesday, March 11th, Jersey Shore University Medical Center (JSUMC), Neptune, New Jersey
Wednesday, March 12th, Rutgers Robert Wood Johnson Medical School (RWJMS), New Brunswick, New Jersey

We are proud to announce that the Community Pediatrics Training Initiative (CPTI) and The Community Access to Child Health (CATCH) Program have selected Jersey Shore University Medical Center and Rutgers RWJMS for the 2013-2014 Leonard P Rome CATCH Visiting Professorship Program. The purpose of the Program is to promote advocacy for children and advance the field of community pediatrics through supporting educational programs at pediatric residency sites across the country.
We are thrilled to have both of our sites chosen and have selected Dr. Ben Hoffman as our Visiting Professor for this program. Dr. Hoffman currently serves as Associate Director of the CPTI, has led a workgroup with the CPTI to develop competency based objectives for community health and advocacy training, and has served as a site coach for the Macy Foundation-funded CPTI Transforming Pediatric Residency Training program. He is a dynamic speaker who will be visiting both our programs to provide ways to engage our pediatric resident physicians in community partnerships, as well as enhance their experiences in child health advocacy. This program will also provide an outstanding opportunity for community leaders in our area to network with one another and learn more about child health services offered in the greater New Brunswick area, Ocean and Monmouth county as well as all of New Jersey.

We invite you all to attend and participate in this exciting and informative 2 day program, bringing together pediatric faculty members, community pediatricians, community leaders, pediatric residents and medical students from throughout New Jersey.

Some highlights of the program include:

1. Tuesday, March 11th, JSUMC, Neptune, NJ
   a. Community Partners Panel Discussion - One of the New Morbidities: Mental Health
   c. Faculty Development - Key faculty members are invited to this session. Dr. Hoffman will help faculty members better understand the needs of residency training, faculty development, and community partnerships for a curriculum in community pediatrics and advocacy.

2. Wednesday, March 12th, Rutgers-RWJMS, New Brunswick, NJ
   a. Community Partners Panel Discussion - New Brunswick Fight Against Obesity
   b. Keynote Lecture - How Advocacy Can Fit with the Demands of a Pediatric Resident’s and Pediatrician’s Busy Schedule/Legislative Advocacy and the State of Child Health in New Jersey, Ben Hoffman, MD
   c. Faculty Development - Key faculty members are invited to this session. Dr. Hoffman will help faculty members better understand the needs of residency training, faculty development, and community partnerships for a curriculum in community pediatrics and advocacy.
   d. Lunch/Round Table Discussion with New Brunswick Community Partners - Early Childhood Development, Nutrition, Child Safety, Maternal Child Health and Children with Special Health Care Needs
   e. Community Access to Child Health (CATCH) Dinner presentation, Paul Schwartzberg, DO, NJ CATCH Facilitator – Pediatricians and pediatric residents throughout New Jersey are invited to learn more about all current and future CATCH community projects in New Jersey. An update on the CATCH program will also be provided including opportunities for residents and community pediatricians to apply for these grants.

We hope that you will be able to participate in this exciting conference! If you are interested, please contact either Dr. Shilpa Pai at Rutgers RWJMS paiss@rwjms.rutgers.edu or Dr. Paul Schwartzberg at JSUMC pschwartzberg@meridianhealth.com for more details.
Legislative Update from page 25

with information about sudden cardiac death. The pamphlet is distributed to each school district in the State. This bill makes various changes to that law, including requiring that the pamphlet: includes certain specific symptoms of sudden cardiac arrest; is also distributed to nonpublic schools; and includes a form to be signed by the student-athlete and his parent or guardian acknowledging receipt and review of the pamphlet. Under the bill, in order to be eligible to participate in an athletic activity, each student-athlete and his parent or guardian must sign the form and return it to his school.

The bill also establishes protocols for the removal-from-play of student-athletes exhibiting symptoms of sudden cardiac arrest. A student-athlete who exhibits symptoms of sudden cardiac arrest while participating in an athletic activity must be immediately removed from the activity by the team coach. A student who exhibits symptoms of sudden cardiac arrest prior to or after an athletic activity is also prohibited from participating in an athletic activity. The student will not be eligible to return to athletic activity until he is evaluated and receives written clearance from a licensed physician. The bill specifies that the board of education or the governing body or chief school administrator of a nonpublic school, as appropriate, must impose certain penalties on a coach who violates the removal-from-play protocols.

NJAAP/PCORE@Work

New Jersey Immunization Network (NJIN) in the Community

• Grant submission to Horizon Foundation grant for an immunization quality improvement (QI) initiative
  • Partnership with AARP to provide information on adult and childhood vaccines
• Participation as preceptorship for an MPH student who will be working on a survey on barriers to adult immunizations
  • Partnering with school nurses in the Trenton School system to address immunization issues and questions
• Working in concert with the NJ Department of Health to improve immunization rates for Vaccine For Children Providers
  • Planning, organizing, and implementation of the Annual Vaccines for Children (VFC) Conference
• Providing immunization education sessions for interested parents, physician offices, parenting teens, daycare centers, and schools
• Collaboration with the NJ Department of Health on initiatives such as the hepatitis B birth dose, National Infant Immunization Week, National Influenza Vaccination Week, and educational webinars

CME ANSWER KEY

1. d     2. a     3. d     4. a     5. b     6. a     7. a     8. b     9. b     10. d
CHILD CARE UPDATE: Collaborating with Child Care to Reduce Obesity

By Kristen Walsh, MD, FAAP

There are exciting new efforts underway to address childhood obesity prevention in New Jersey. This is sorely needed because New Jersey continues to rate in the top three states for obesity (0 - 5 year olds) for the entire nation. This statistic cannot be allowed to persist. The new efforts aim to improve the quality of both policies and practices in child care centers. New Jersey is one of six states involved in this far reaching effort this year. The New Jersey Department of Health, with five year funding and technical support from Nemours and the Centers for Disease Control and Prevention, is in the process of implementing evidence-based learning collaboratives. These collaboratives have the goal of working with large child care centers (with children ages 0 - 5), impacting 15,000 low-income children and families in five targeted regions:

1. Essex Collaborative
2. Camden Collaborative
3. Southern Collaborative (Cumberland/Gloucester/Salem counties)
4. Northern Collaborative (Hudson/Passaic counties)
5. Central Collaborative (Mercer/Union/Middlesex counties)

WE NEED YOUR SUPPORT! Let your parents know about these collaborative efforts. The children attending these centers will benefit from best practices that focus on access to healthy foods and beverages (including water) and routine physical activity, screen time limitations and breast feeding friendly environments. Participating centers receive a number of benefits, including:

- Assistance to meet and exceed the new Office of Licensing Requirements (implemented September 2013) regarding food, beverages, breastfeeding support, physical activity and screen time limitations
- Training hours and on-site technical assistance at no cost by an expert Early Care and Education team, including an Early Care and Education Specialist and Registered Dietitian/Nutritionist
- Statewide and local recognition
- Comprehensive training materials
- Incentives for the center worth $500
- Collaborative learning among participating centers

The collaborative format is based on continuous quality improvement. A leadership team of three staff from each participating center (with decision making authority) attend and participate in five full-day training sessions over the course of a year that focus on best practices for child care that will help prevent obesity in our young children. The leadership team then becomes the trainer and returns to their center to instruct the rest of the staff using videos, scenarios, curriculum materials and center assessments. The entire center staff work together to develop evidence based plans for center improvement.

For more information, centers can contact:

- Juliet Jones, State Early Care and Education Coordinator at Juliet.Jones@doh.state.nj.us (609 - 605 - 0609) or
- Karin Mille at Karin.Mille@doh.state.nj.us (609 - 777 - 9045)

As pediatricians, we have a vested interest in improving child care, and you can make a difference in your area. Consider stopping by nearby centers, introduce yourself and offer to be a resource to the center. You can be willing to answer questions via phone and/or email, pass along health information relevant to child care settings, or even offer to speak to staff/parents about infectious diseases, nutrition, or other health topics.

There are many ways to get involved, and there are often very tangible benefits to doing so. For example, when new families move to the area, they often focus on finding child care before looking for a pediatrician; as a result, they will often ask child care directors for referrals. If the director knows you and you have made an effort to be helpful, your name will get mentioned; I have noticed that multiple families have been sent to my practice in this way. Early childhood is the focal point for most of our prevention efforts regarding childhood obesity and other chronic health conditions: this is where we will get the biggest bang for our buck. Be the change you wish to see in the world, and get involved locally!
Asthma Today: Guidelines for the Diagnosis and Management of Asthma in the Primary Care Practice

The Pediatric/Adult Asthma Coalition of New Jersey (PACNJ), sponsored by the American Lung Association in New Jersey (ALANJ), has launched a new asthma education program for primary care providers, Asthma Today, based on National Asthma Education and Prevention Program (NAEPP) EPR-3 Guidelines. This free one-hour online CME program includes free tools to support the provider in the classification of asthma severity, assessment of asthma control and the stepwise approach in the treatment of asthma. Dr. Arthur Torre, Chair of PACNJ says, “This program offers practical advice to become proficient in following the NAEPP evidence-based guidelines for treating asthma.”

The focus of the program is to provide instruction on the application of the NAEPP Guidelines and to demonstrate methods for patient education in asthma self-management, a critical key to asthma control. But, can a provider successfully educate patients in a 10 minute visit? Three case presentations are introduced as vignettes by our talented volunteers, Kemi Alli, MD, FAAP, Chief Medical Officer at the Henry J. Austin Health Center, Puthenmadam Radhakrishnan, MD, Bellevue Pediatrics in Trenton, and John Winant, MD, FAAAI, Allergy and Immunology in Mercerville.

In the first two case studies the physicians are classifying the patient’s asthma, prescribing treatment, and providing education. In the third case the physician is conducting a follow-up visit. In each of the cases the provider demonstrates the use of the tools recommended in the NAEPP Guidelines for the diagnosis and management of asthma such as: the Classification of Asthma Severity chart, the Stepwise Approach for Managing Asthma chart, and the Asthma Control Test™.

This one-hour program is organized around three segments, the first is introducing the guidelines and the burden of asthma in New Jersey. The second segment is the presentation of the three case studies. And the third segment is focused on establishing office polices for implementing the asthma guidelines in the primary care practice. Charles Dadzie, MD, FAAP, FCCP, Director of Pediatric Pulmonology and Critical Care Medicine at the Jersey Shore University Medical Center and Patti Lucarelli, RN-BC, MSN, CPNP, APN, PMHS at the Jane H. Booker Family Health Center discuss their success in implementing six policies that dramatically improved asthma control for their patients.

PACNJ has also developed an Asthma Tool Kit for Primary Care Providers to support physicians in implementing the guidelines. These tools are available in English and Spanish, color or black and white and can be downloaded free from the website following the completion of the Asthma Today program. New Jersey Providers can sign up to get a free boxed set of the tools that contains posters, charts, assessment tools and patient handouts. This is a limited offer to the first 85 NJ providers who complete the training and agree to participate in a brief 5-question multiple choice survey evaluating the materials in this kit. This is a grant funded project and we want to learn if these tools are useful in the primary care practice.

This program was developed by the Curriculum Committee organized through the New Jersey Chapter, American Academy of Pediatrics. The project built on the success of the NJPCORE Asthma program piloted in Trenton in 2007.

The New Jersey Academy of Family Physicians is sponsoring the CME activity. It has been reviewed and is acceptable for 1.00 Prescribed credit by the American Academy of Family Physicians. AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMA PRA Category 1 Credit toward the AMA Physician’s Recognition Award.

To learn more about the free CME program, go to www.pacnj.org.

NJAAP/PCORE@Work

CCHD Working Group Met at the NJAAP offices on December 2nd to address NICU Issues. Members included (from left to right): Kim Van Naarden-Braun, PhD, Diane McClure, DNP, RN, Mary Knapp, MSN, RN, Shyan Sun, MD, DCH, Eileen Steffen, RNC, Joseph Gaffney, MD, Terry Anderson, MD, Michael Guiliano, MD, Harriet Lazarus, MBA, Jeanne Craft, MD, FAAP, CMQ, Amanda Whelan, BS, Johanna Vidal-Phalen, MD, FAAP, Daniel Hirsch, MD, FAAP, Rob Koppel, MD, Jean Grazel, MSN, RN, BC, APN-C, and Martha Caprio, MD.
As per the 2010 census, over three million South Asians (defined as persons from India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives) are living in the United States (US), accounting for 1.2% of the population. New Jersey (NJ) has one of the highest proportions (2.3%) of South Asians (SA) in the country. Furthermore, this community is one of the most rapidly growing; increasing by nearly 133% between 1990 and 2010. Several stereotypes exist regarding SAs; they are considered to be successful based on measures such as income and education, but these measures do not correlate with the health of this community. There is growing evidence that SAs are burdened with 3-5 fold higher morbidity and mortality associated with chronic diseases such as coronary artery disease (CAD) and Type II Diabetes (T2DM), with these diseases occurring up to ten years earlier. Recent research is also highlighting maternal and child health disparities such as high prevalence of Gestational Diabetes, Post-Partum Depression, Low Birth Weight, Obesity and Hemoglobinopathies.

Recognizing these trends, the South Asian Total Health Initiative (SATHI) at Rutgers Robert Wood Johnson Medical School held a conference “Caring for South Asian Families: Maternal and Child Health Issues in Clinical Practice” in New Brunswick in April 2013. This report is a brief summary of the conference discussions and recommendations to promote culturally competent services to this growing community.

Gestational Diabetes Mellitus (GDM)

SAs have higher rates of GDM compared to other ethnic groups. A study done in New York City showed a 95% increase in GDM in south and central Asian populations since 1990. In another study that included NJ mothers, the proportion of mothers with diabetes among Asian Indians was more than twice that of Caucasians or African Americans. The recognized link between fetal exposure to hyperglycemia and development of T2DM and obesity underscores the crucial importance of prevention and management of GDM in this ethnic group. Dietary practices among SAs may play a large role in the development of GDM. Specifically, SA diet (vegetarian or non-vegetarian) is particularly high in carbohydrates. Culturally tailored higher protein options need to be explored and discussed with SA pregnant women.

Post-Partum Depression (PPD)

PPD is consistently under-diagnosed in SA women known to suffer from increased rates of attempted self-harm and mental distress. Immigration status and lack of social support may be important contributors to the development of PPD. Suicide and self-inflicted injuries could result from conflicts within an extended family, spousal issues, female gender of the child and lack of confidentiality in close-knit, interrelated communities.

Pediatric providers should anticipate undiagnosed PPD in SA mothers and recognize the unique factors linked to PPD in SA women. It is critically important to include key family members in discussions around PPD recognizing the importance of family hierarchy in medical decision making. Evidence based culturally appropriate diagnostic tools to diagnose of PPD in SA women are currently not available, further research is needed in this arena.

Low Birth Weight (LBW)

There is a higher incidence of LBW and intrauterine growth restriction among children born to Asian Indian women compared to other ethnicities regardless of maternal age, education level or socioeconomic status. Traditional protective factors such as higher education, early prenatal care, older maternal age, and adequate health insurance do not provide protection to the Asian Indian population. Lower maternal weight gain and lower height have been associated with LBW. Factors such as maternal diet, anemia, acculturation and social support need further study. The incidence of LBW remains high in second generation SAs, suggesting a role of genetic and bio physiologic factors. Evidence linking LBW to T2DM and CAD, underscores the importance of understanding the determinants of LBW in this population known to be at high risk for these disorders. Fortunately, despite the increased incidence of LBW, SA infants have a low postnatal mortality.

Non Sickling Hemoglobinopathies (NSH)

NSH, the most commonly inherited disorders in the Indian subcontinent, are increasingly being reported in the Asian and SA population in US.
Despite representing only 5% of the population, Asians account for 50% of Thalassemia cases in the US.

Beta-thalassemia is the most common single gene disorder in India, with prevalence of carrier status as high as 10% in some communities.
The most NSH in SAs are Thalassemia: alpha and beta and Hemoglobinopathies S, D and E.8

Prevention of NSH through screening programs is an important strategy. Barriers to screening in the US include lack of knowledge among health care professionals and lack of culturally appropriate screening tools and programs to educate the SA community regarding the risks of these genetic disorders.

**Infant Nutrition**

Exclusive breast feeding for the first six months of life can be difficult to implement in SAs due to factors such as perceived difficulties in breast feeding, family preference for formula feeds, embarrassment about breast feeding, and undiagnosed PPD. Family and older women in the community have greater influence on breast feeding than medical professionals or breast feeding support groups. Studies from UK indicate that inclusion of influential female family members in antenatal educational interventions promotes breast feeding.9

Cultural practices such as pre-lacteal feeding, with honey, water or cow’s milk, and early introduction of solids must be recognized. Advising patients and key influential family members on accepted infant nutrition guidelines is therefore essential.

**Obesity**

SAs are estimated to have the highest worldwide prevalence of Type 2 DM, and have a higher fat mass, higher abdominal fat and higher triglycerides at lower Body Mass Index (BMI) than other ethnic groups, which has led to 2004 WHO recommendations of lowering the BMI cut-off for SAs.

Emerging data show similar obesity trends in SA children. In a UK study markers for T 2 DM such as fasting glucose, BMI, and triglycerides, were seen in many SA children by the age of ten. Yet there is a common misconception in this community that a “chubby child” is a healthy child. Physical activity levels are also low among SA children.

Given this trend, providers are encouraged to pay close attention to diet and physical activity in SA children.

**Conclusion:**

The SATHI conference, a first of its kind, has shed light on emerging trends of maternal and child health disparities in the growing SA community. While further research is needed, this paper serves to raise awareness and offers guidance on a culturally sensitive approach to SA families.

**References**


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