Advocacy Priorities for the Virginia General Assembly Session 2009

Submitted by:
Sam Bartle, MD, FAAP
Chair, Governmental Affairs Committee
Karin T. Addison, VA-AAP Lobbyist

The Virginia General Assembly convenes January 14, 2009. Policy discussions this year will surely be dominated by budget reduction strategies and the debate over tax increases. Governor Kaine’s budget addressed the state’s $2.9 Billion shortfall, but political observers expect the final shortfall to be closer to $3.7 Billion.

The environment at the General Assembly is becoming even more partisan as the Republican minority in the House of Delegates faces off against the Democratic majority in the Senate. Candidates for statewide office are lining up and legislators will cast votes with an eye to the elections in November.

As bills are introduced over the next few weeks, the Chapter will review those bills affecting the practice of pediatrics and the health and safety of the children we serve.

Please check the Chapter website beginning January 14th for position papers and archived Legislative Member Alerts. We will continue to use Member Alerts to alert you of advocacy opportunities. Chapter members are also invited to join Chapter Lobbyist Karin Addison on weekly conference calls hosted by the Medical Society of Virginia. Please reference your Member Alerts for the conference call information.

Thank you for your continued support and we hope to see everyone at the Pediatric White Coat Day on January 29th check the website www.virginiapediatrics.org to get details or 804/622-8135.
Several weeks ago my wife and I were going through some things in the back of the closet and found a wooden plaque designated as a yard sale item. I am not sure where it had come from or who had made it. I was struck by the words on the plaque which read “Life isn’t about waiting for the storm to pass. It’s about learning to dance in the rain.” Interesting and inspiring words for these troubled times. Most of us are very busy and strained by daily demands. It’s not easy whether you are working in a pediatric practice or running an academic pediatric center. At times it seems a season of storms one following another.

It’s in these times that the Chapter can thrive and bring new life with a variety of opportunities. Elsewhere in the newsletter read about General Assembly Day, advocacy issues, importance of breast feeding, education opportunities; ways that you can participate and dance in the rain. In the remainder of the commentary I would like to focus on one other issue—infant mortality.

The Chapter has been working with the Virginia Health Commissioner on the problem of infant mortality in our state. Infant mortality is not something that most of us think about on a day to day basis. It seems daunting topic especially if one works in an office setting. How can I have any effect on this public health issue? Yet the problem is real and each of us can make a difference.

On a state level the impact is huge. In 2007 more infants died in their first year than the number of adults killed in motor vehicle accidents. As a state we have not seen a significant change in infant mortality in the last 10 years. Virginia is one of the more wealthy states per capita why are we not among the lowest rates in infant mortality? While nearly 20% of these deaths are difficult to prevent due to congenital malformations and chromosomal abnormalities there is a significant percentage of infant deaths related to SIDS and another even larger group defined as disorders related to prematurity and low birth weight.

As pediatricians we can have an impact on infant mortality. Influence SIDS rates by encouraging all our parents, grandparents, and child care

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attendants to have babies sleep on their back on a firm mattress without extra pillows or pads in the crib. Make sure care in the hospital and discharge instructions emphasize that “Back is best”. We know that breast feeding does make a difference in numerous ways so promote breast feeding through our words and through our hospital policy. Discourage smoking by those caring for the baby. Connect parents and family members ready to make a change with the QUIT LINE. Make sure infants receive the recommended immunizations on a timely basis and encourage all that care for the baby talk with their doctor about adult immunization especially for pertussis and influenza (for moms either during the pregnancy or prior to discharge from the obstetric unit).

Our high school patients (as well as the younger ones) need to follow a healthy life style and avoid risk behaviors. Good pregnancy outcomes are more likely with healthy mothers. Healthy mothers are more likely if they have been healthy as adolescents. With the high incidence of obesity and overweight counseling about healthy eating and physical activity is key. Promote multivitamins with folic acid for all adolescents capable of childbearing. Make sure these young people are up to date on their immunizations. Find out what is creating concern. Mental health is often a significant issue at this point in time.

In summary pediatricians can collectively impact infant mortality using our long-established approach of promoting healthy choices to our patients one child and one family at a time. This approach to our patients as I think about it is just another way for pediatricians to dance in the rain.

Robert “Bob” Gunther, MD, MPH, FAAP
President, Virginia Chapter, AAP

Pediatric Research in Office Settings (PROS)
Brief Summary of Fall 2008 Meetings

Submitted by Thomas J. Sullivan, MD, FAAP
VA-AAP PROS Coordinator

PROS Chapter Coordinators met in Boston at the AAP National Conference and Exhibition on October 10th and 11th.

The group heard updates on the launching of two network projects – Brief Motivational Interviewing to Reduce Child BMI (BMIF) and Clinical Effort Against Secondhand Smoke Exposure (CEASE). Each study tests an innovative approach to delivering effective pediatric care on a topic of major clinical and public health importance.

An update on the Secondary Sexual Characteristics in Boys (SSCIB) study of pubertal onset emphasized that the study still needs new study sites – especially practices and clinics that see substantial numbers of African American and Latino children. SSCIB offers valuable training on the assessment of pubertal development plus enhanced reimbursement for sites with high minority populations.

Coordinators approved a proposal on evaluating a practical “common factors” approach to addressing the behavior problems that arise in office visits. Coordinators also reviewed and requested revisions of a new proposal on preventing oral health problems in infants and toddlers.

Attendees heard an excellent presentation on coordination between primary care medical homes and specialists. They also listened to updates on recently concluded PROS studies, the latest PROS publications, and new grant applications on several topics: pediatrician-mediated teen driving interventions, teen smoking cessation, and best treatment for children with persistent asthma.

For further information about PROS, go to http://www.aap.org/PROS/. For information about getting involved in PROS activities in VCAAP, contact PROS Chapter Coordinator Thomas J. Sullivan, MD, FAAP at thomas.sullivan22@verizon.net and Co-Coodinator Barbara Kahler, MD, FAAP at blkahler@msn.com. We have participated in several of the studies and will be glad to help you get started.
The way we’ve always seen it, strength, stability and confidence go hand in hand.

Professionals Advocate makes a difference in the lives of thousands of the Doctors we serve every year. Created by one of the nation’s oldest and most respected Doctor-owned and directed liability insurers, Doctors know ProAd shares their values and stands at the ready to protect careers, practices and professional reputations. With a Mid-Atlantic presence, as well as local knowledge, Doctors rely on the strength and stability of our expertise, as well as our commitment to fulfilling their needs. They can be confident they’re in qualified hands.

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Body Works: A Toolkit for Healthy Teens & Strong Families

*Parent-focused Adolescent Obesity Prevention Program Ready to Roll*

Childhood and adolescent obesity rates have tripled over the last three decades.

Many different physical activity, nutrition, and weight loss programs are now available to address the problem. Parents are turning to their healthcare professionals to help them choose the most reliable, safe, and effective solution for prevention of overweight and obesity.

With health care professionals and parents in mind, the U.S. Department of Health and Human Services’ Office on Women’s Health (OWH) developed a free, community-based adolescent obesity prevention program and toolkit called *BodyWorks*. Designed to improve family eating and activity habits, the program focuses on parents as role models and provides them with hands-on tools to make small, specific behavior changes to help the whole family maintain a healthy weight and prevent obesity.

*BodyWorks* trainer and Seattle-area pediatrician Monica Richter has been successfully implementing the *BodyWorks* program with families in her community since 2007.

Dr. Richter first came across the program online and thought it looked like the ideal program; it was free and incorporated the whole family. “A healthy environment and strong parental role models give kids a better start at managing their weight. The burden of healthy eating is too great to put on the child alone, the whole family should eat healthy and support one another,” said Dr. Richter.

Parents also play a role in the success of Dr. Richter’s program. Shelly Parker and her daughter completed the program last winter. “It is a wonderful tool for young girls to learn that the choices that they make today will affect the value of their life tomorrow,” said Parker.

Pediatricians can get trained to implement the program themselves, or refer their patients to a *BodyWorks* trainer at a local community-based organization, state health agency, non-profit organization, social service organization, health clinic, hospital, healthcare system, faith-based organization, worksite, and/or school and parent-teacher organization.

To find a program in your area, or learn more about how to bring *BodyWorks* to your community, go to www.womenshealth.gov/bodyworks.

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The 37th Annual HANS BERGER Symposium will be held May 18-19, 2009 at Virginia Commonwealth University Medical Center in the Hermes A. Kontos Medical Sciences Building. Distinguished faculty from epilepsy centers and neurophysiology laboratories across the country have been invited to the 37th Annual commemoration of Hans Berger’s birthday.

This symposium offers physicians, technologists and medical professional’s practical information in applying state-of-the-art electrodiagnostic testing in the clinical management of patients with epilepsy and related disorders. For more information and to register online visit www.cmeregistration.som.vcu.edu or call the VCU Office of Continuing Professional Development and Evaluation Studies at (804) 828-3640.
AAP Oral Health Initiative Offers Training Program

Submitted by: Robert C. Gunther, MD, MPH, FAAP
President, Virginia Chapter, AAP

The Virginia Chapter will soon benefit from a new program designed to elevate awareness of children’s oral health issues and to provide resources to help pediatricians care for their youngest patients’ oral health. Through a grant from the American Dental Association Foundation, the AAP Oral Health Initiative is launching a 3-year train-the-trainer program called, the Chapter Advocate Training on Oral Health (CATOOH). The CATOOH will feature a 1½-day live educational activity, as well as opportunities for ongoing mentoring. One representative from the Virginia Chapter (US and Canada) will be invited to participate over the next three years. Oral health disease poses a significant health threat to many children. Pediatricians are in a unique position to play an important role in children’s oral health outcomes since they typically see children early and often. As oral health topics have not been fully addressed in medical school and residency training, the AAP Oral Health Initiative has designed the CATOOH to train representatives to serve their local AAP chapters as Chapter Oral Health Advocates (COHAs). The COHAs will learn to train others (pediatricians, family physicians, general dentists, and allied health professionals) how to perform an Oral Health Risk Assessment, provide appropriate anticipatory guidance to parents and caregivers, and develop a management plan with referral to a dental home, as appropriate.

The COHA will be invited to attend the CATOOH at no cost to either the chapter or the participating physician. All travel expenses will be paid by the AAP Oral Health Initiative, and each COHA will return home with a comprehensive tool kit and list of resources to assist them in serving their chapters. The training for our district will likely occur in November 2009. This opportunity is a wonderful way to meet your colleagues from around the country and the state. Please chew on participating in this program and if you are interested in serving your Chapter as the Oral Health Advocate please contact Jane Davis at the Chapter office.

Camp Holiday Trails

Camp Holiday Trails celebrates 35 years of providing camps for children with special medical needs and respite for their families. We also thank the 38+ healthcare professionals, lead for co-Medical Directors and practicing pediatricians, Dr. Carlos Armengol and Dr. Gretchen Wasserstrom, who cared for our special campers and staff through a variety of camp programs this past year. Our summer residential camps continue to be our main focus, but an increasing number of organization are looking to partner for spring and fall family camp weekends. The United VA Chapter of the National Hemophilia Foundation and the UVA Ryan White Clinic are two ongoing partners. In 2009 the UVA Pediatric Cardiology division will partner for a family cardio camp weekend and look for additional information soon on similar partnerships for pediatric sickle cell and also oncology.

Camp Holiday Trails is a nonprofit camp and relies heavily, and is thankful for, the kindness and talents of volunteers to provide programs. Recruitment is underway for the 2009 Med Team and interested volunteers are encouraged to contact Tina LaRoche, Executive Director, at tina@campholidaytrails.org or ph. (434) 977-3781 for more information. Summer medical staff have housing, all the camp food you can eat and even childcare at Camp!

13th Annual Virginia Liver Symposium and Update in Gastroenterology Conference

The VCU School of Medicine will sponsor the 13th Annual Virginia Liver Symposium and Update in Gastroenterology Conference on February 21, 2009 at the Richmond Marriott Hotel. The program is designed for physicians and midlevel medical providers who treat patients with liver and gastrointestinal disorders. Call 828-3640 for more information. View the brochure and register online at www.cmeregistration.som.vcu.edu.
Red Reflex Examination in Neonates, Infants, and Children
Policy Statement Revision

Red reflex testing is an essential component of the neonatal, infant, and child physical examination. This statement, which is a revision of the previous policy statement published in 2002, describes the rationale for testing, the technique used to perform this examination, and the indications for referral to an ophthalmologist experienced in the examination of children.

Red reflex testing is vital for early detection of vision- and potentially life-threatening abnormalities such as cataracts, glaucoma, retinoblastoma, retinal abnormalities, systemic diseases with ocular manifestations, and high refractive errors. The American Academy of Pediatrics currently recommends red reflex assessment as a component of the eye evaluation in the neonatal period and during all subsequent routine health supervision visits1 (see also Bright Futures, available at www.brightfutures.org).

The red reflex test uses transmission of light from an ophthalmoscope through all the normally transparent parts of a subject’s eye, including the tear film, cornea, aqueous humor, crystalline lens, and vitreous humor. This light reflects off the ocular fundus, is transmitted back through the optical media and through the aperture of the ophthalmoscope, and is imaged in the eye of the examiner. Any factor that impedes or blocks this optical pathway will result in an abnormality of the red reflex. An abnormal red reflex can result from mucus or other foreign bodies in the tear film, corneal opacities, aqueous opacities, iris abnormalities affecting the pupillary aperture (pupil), cataracts, vitreous opacities, and retinal abnormalities including tumors or chorioretinal colobomata. Unequal or high refractive errors (need for glasses) and strabismus (eye misalignment) may also produce abnormalities or asymmetry of the red reflex. There may be significant variation in the red reflex in children from different racial or ethnic groups resulting from their differing levels of pigmentation of the ocular fundus. Nevertheless, the pediatrician who performs these evaluations on a regular basis will quickly become familiar with these variations in normalcy.

The red reflex test is properly performed by holding a direct ophthalmoscope close to the examiner’s eye with the ophthalmoscope lens power set at “0” (see Fig 1 on the AAP website http://aappolicy.aappublications.org/cgi/content/full/pediatrics;109/5/980). In a darkened room, the ophthalmoscope light should then be projected onto both eyes of the child simultaneously from approximately 18 inches away. To be considered normal, a red reflex should emanate from both eyes and be symmetric in character. Dark spots in the red reflex, a markedly diminished reflex, the presence of a white reflex, or asymmetry of the reflexes (Bruckner reflex) are all indications for referral to an ophthalmologist who is experienced in the examination of children. The exception to this rule is a transient opacity from mucus in the tear film that is mobile and completely disappears with blinking.

All infants and children with a positive family history of retinoblastoma; congenital, infantile, or juvenile cataracts; glaucoma; or retinal abnormalities should be referred to an ophthalmologist who is experienced in the examination of children for a complete eye examination regardless of the status of the red reflex, because these children are at high risk of vision- and potentially life-threatening eye abnormalities. Age of referral to an ophthalmologist depends on specific risk factors (eg, genetic condition, familial eye disease, etc), which can vary in age of presentation. However, it is still valuable for the pediatrician to perform red reflex testing on these patients to help determine if it is necessary to expedite this referral. Whenever an opacity or tumor is suspected, an expedited referral is indicated. Because of the urgent nature of diagnosis, it is prudent for the pediatrician to contact the ophthalmologist personally about the possible diagnosis and express (and document) the urgency of the appointment to the parent. It is also essential that the ophthalmologist follow-up with patients, send timely reports to primary care physicians, and make sure that the transfer of care back to the referring physician is clean and understood by all parties.

The purpose of this policy statement, which is a revision of the previous statement published in 2002, is to suggest a policy based on current knowledge and experience for examination of the eyes of neonates, infants, and children to minimize the risk of delay in diagnosis of serious vision-threatening or life-threatening disorders. Occasionally, some pediatricians find that red reflex testing can be facilitated by dilating the eyes of the subject. Although in infants, pupils are easily dilated by using various agents, significant complications sporadically have been reported with all commercially available dilating eye drops, including sympathomimetic agents such as phenylephrine and anticholinergic agents such as cyclopentolate.

Continued to back page.
Virginia Immunization Information System (VIIS)

Submitted by: Greg Dennis
Director of Virginia Immunization Information System
Virginia Department of Health

In August 2006, the Virginia Department of Health’s Division of Immunization (VDH/DOI) implemented Virginia’s statewide immunization registry for the public and private sectors, known as, Virginia Immunization Information System (VIIS). VIIS is a web-based application that has the ability to do direct input and data exchange. VIIS is based off of Wisconsin’s core registry, which is currently used in 13 other states.

VIIS offers the following benefits to users:

- To access immunization record for clients of all ages from multiple providers
- To reduce rates of under and/or over-immunization and increase rates of vaccination coverage
- To track and update immunization records
- To automatically see when vaccines are due from a built-in ACIP tracking schedule
- To print Reminder/Recalls
- To allow you to manage vaccine inventory
- To produces various reports (VFC, CASA, inventory management reports, immunizations needed reports, etc.)
- To print an Official Immunization Record that is an acceptable substitute for Section II of the School Entrance Health Form (MCV213F)

During the pilot we worked with various organization around the state to populate VIIS with past immunization history. Most of the data in VIIS is currently updated on a monthly basis from various health care plans throughout the state. We are also updating VIIS weekly and bi-weekly with immunization data from all local health departments, including Fairfax County, UVA, and demographic information from Vital Records. In addition there are many provider practices using VIIS in their offices, including UVA, Martha Jefferson, and several large practices throughout Virginia.

VIIS is constantly growing, with currently have 4.3 million clients with 21.5 million immunizations. To give perspective of how much VIIS has grown, in 2006, VIIS had a rate of less than 25% of VA children less than 6 years of age with two or more immunization enrolled in VIIS. Today we have 52% of VA children less than 6 years of age with two or more immunizations enrolled in VIIS. More information, including registration information, can be found on our website. Training for VIIS is be offered in both hands-on format, online on our website, as well as group training sessions scheduled throughout the state. Please check our website, more information will be available about group trainings on our website. Below is a link to the VIIS homepage:


We are also pleased to announce the arrival of the new VIIS program manager, Greg Dennis. If you are interested in learning more about VIIS, contact Reena Patel, VIIS Field Supervisor, at (804) 864-8073 or at Reena.Patel@vdh.virginia.gov.
Revised Daily Vitamin D Recommendations

Submitted by Robert C. Gunther, MD, MPH, FAAP

The AAP recently revised recommendations for daily intake of Vitamin D. The new daily intake of Vitamin D is 400 IU for infants, children, and adolescents beginning in the first few days of life.

Breast fed and partially breast fed infants are recommended to receive a supplement shortly after birth. These infants can use multivitamin preparations like “ADC” (this product contains Vitamin A and Vitamin C which are not necessary as well as Vitamin D). Perhaps better are preparations containing only Vitamin D like “Just D” (1 ml contain 400 IU in corn oil). Vitamin D only preparations may also be available through a compounding pharmacy. At this time supplementing the mother with high doses of Vitamin D in order to increase the Vitamin D level of the breast milk is not recommended. The Virginia WIC program currently does not cover Vitamin D drops but does hope to do so in the near future.

Toddlers, children, and adolescents can obtain Vitamin D through the intake of Vitamin D fortified milk (100u/8 ounce) as well as through fortified cereals and eggs (40 IU of Vitamin D-3 per yolk). Many pediatricians realize the children and adolescents in their practice may not be achieving the 400 IU through diet alone. Studies in the United States have documented a 30% or greater decrease in dairy product intake in adolescents from 1977-8 to 1994-8 so it is important to take a dietary history from the family.

It is well known that Vitamin D is produced through active synthesis in the skin by sunlight. However young people have less opportunity in many parts of the country for sun exposure. A variety of factors can affect sunlight exposure including skin pigmentation, body mass, degree of latitude, season, the extent of air pollution and cloud cover, the amount of skin exposed, and sunscreen use.

Vitamin D is not only useful in creating healthy bones and preventing rickets but also has other potential benefits such as improved immune function and decreased rates of certain cancers and Type-2 diabetes. Learn more at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;122/5/1142

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7 Myths About Charging for Telephone Care

Submitted by: Charles A. Scott, MD, FAAP  
Section on Telehealth Care, Executive Committee Member

It’s just part of the job; I shouldn’t charge for it.

Actually, the evaluation and management codes are clear about when telephone care is “bundled” and just part of the job because the care is related to a previous or subsequent visit or procedure. But under the new rules if the subject of the telephone call is NOT related to a previous visit (7 days prior) and does not lead to a visit within 24 hours of the call, then it is a separate service that can be reported. So don’t assume that ALL telephone calls are just part of the job. The link below will take you to an AAP News article explaining all this and more. http://aapnews.aappublications.org/cgi/content/full/29/2/28

I don’t believe it’s ethical.

The Committee on Bioethics reviewed the AAP policy statement on payment for telephone care “the issue of access to telephone care reflects the broader societal nature of access to care and the inequities that exist within our system.” In short, the burden of providing care to those that cannot afford it should not be placed on pediatricians alone; it should be shared by society. As such, “the AAP believes there are no ethical conflicts in charging for telephone care services rendered.” (Payment for Telephone Care, Section on Telephone Care and Committee on Child Health Financing, Pediatrics 118 October 2006 1768-1773.)

There is no process for charging for telephone care.

Wrong, wrong, wrong. There are CPT codes that have published relative values, and our section has developed a step by step toolkit that tells you how to begin the process for improving your documentation, using the appropriate codes, and charging for telephone care from start to finish. It covers everything--how to notify payers, patients… messages to put on your telephone greeting….sample documentation forms, and case vignettes on how to charge. The toolkit is available for FREE to AAP members and can be downloaded from the Practice Management Online Web site. http://practice.aap.org/telecarepmt.aspx

No one else in my area is charging for telephone care.

According to our survey, that won’t be the case for too long. Within the next 2 years approximately 85% of pediatricians responding stated that they will be charging for telephone care. About 40% plan to bill for all telephone calls within the boundaries of CPT and the AAP policy statement on payment for telephone care, and another 30% plan to bill only for after-hours calls. It’s a decision each practice has to make.

The money I might receive for telephone care just wouldn’t be worth the hassle of implementing the process. Have you looked at the published relative values units for the telephone care codes? It may be a while before the carriers recognize them and pay for them, but the value is there. If your contracts allow, you may be able to bill the patients directly for telephone visits. You’ll need to consider this a multi-year phase in program. But you can decide which kinds of telephone care you are going to charge for. Then as long as you are consistent with those charges and they are appropriate given the CPT guidelines and your agreements with payers, you should be all set. The simple fact is you would be getting paid for a service that you currently are already providing.

I’m afraid I’ll lose patients if I start charging for telephone care.

Practices said the same thing a few years ago about copayments and charging to complete school health or camp forms. According to our survey, 47% of the pediatricians reporting stated that patients understand and are supportive of the new policy. Another 41% responded that there was no significant reaction from their patients. About 17% stated that some patients have resented the policy, but only 1 respondent said that he or she had lost any patients as a result of charging for telephone visits.

No one is paying for telephone care.

That’s not what we’re hearing from our survey. When asked the sources from which they have received payment for telephone care, 68% of our survey respondents have reported payment from insurers; 76% have been paid by the patient’s guarantor. When asked for which services, respondents indicated that 41% had been paid for Care Plan Oversight codes, 50% had received remuneration for Physician Telephone Care Codes, and 9% had accepted payment for Nonphysician Provider Telephone Care codes. Undoubtedly there will be variation from state to state and payer to payer, but the tide is beginning to turn in our favor. Don’t miss the opportunity to advocate for your practice and your future.
Attention Young Physicians...

Make sure the young physicians in your chapter are aware of what’s available to them through the national AAP and the Section on Young Physicians!

REQUIREMENTS:

Any Candidate or Full Fellow of the American Academy of Pediatrics who is in the first 5 years of practice or under the age of 40 may join the section.

DUES:

Currently the annual membership dues are $10.00.

BENEFITS:

• ACCESS to the YoungPeds Network – www.aap.org/ypn
• ACCESS to the YoungPeds Connection – an online social networking site
• ACCESS TO THE Young Physician Section E-newsletter
• ACCESS TO THE Young Physicians Guide to the AAP
• Eligible to participate on the Section’s e-mail list
• Eligible to vote in elections for section leadership and apply for open leadership positions
• The SOYP also offers grants of up to $3,000 to AAP chapters for young physician outreach activities
• AAP NATIONAL CONFERENCE AND EXHIBITION CME SPECIFIC TO YOUNG PHYSICIANS
• Young physician reception at the AAP National Conference & Exhibition

For more information please contact Bridgette Mathis at 800/433-9016, extension 7864, or by e-mail at bmathis@aap.org.

Healthy Schools Program

School Health Framework

Submitted by: Robert C. Gunther, MD, MPH, FAAP
President, Virginia Chapter, AAP

The Alliance for a Healthier Generation is a partnership between the American Heart Association and the William J. Clinton Foundation with a mission to eliminate childhood obesity and to inspire all young people in the United States to develop lifelong, healthy habits.

The Alliance has created a Healthy Schools Program that includes a useful tool called the Healthy Schools Framework. The Framework outlines the best practice criteria for healthy schools. It looks at school policy/systems, school meal programs, competitive foods and beverages, health education, physical activity, school employee wellness, physical education, and before and after school programs rating the various criteria from bronze to platinum.

Pediatricians working with School Health Advisory Boards are encouraged to review the Framework and utilize it in their local schools to create a healthier school environment. The Framework combines most of the elements of the Virginia Governors Scorecard plus much more. More details at http://www.healthiergeneration.org/schools.aspx

Go for the Platinum!!
An Update on Newborn Screening in Virginia

Submitted by: William G. Wilson, MD

With the possible exception of childhood immunizations, screening of newborn infants for metabolic diseases is the most common individual public health activity in the United States. Through these programs, thousands of children have been identified and treated, resulting in better medical outcomes, prevention of many cases of mental retardation, and improved medical management.

Large-scale newborn screening in the U.S. began in Massachusetts in 1963, largely as the result of the work of Robert Guthrie, MD, a microbiologist who developed an efficient method for measuring the concentration of phenylalanine in blood spots dried on filter paper. The “Guthrie card” provided an efficient mechanism for transporting samples to a laboratory, and his method for measuring phenylalanine was later adapted for measurement of other amino acids. Subsequent advances in screening methodology allowed for the addition of screening tests for congenital hypothyroidism, sickling hemoglobinopathies, and a host of other disorders, all from the analysis of dried blood spots.

Although newborn screening was done in all states by the mid 1980s and was mandated in most, individual states differed markedly in the number of disorders for which screening was done. In addition, there was no mechanism in place to identify disorders for which screening should be done or to evaluate proposed screening technologies. The development of dried blood spot screening using “tandem mass spectrometry”, a method which could quantitate a number of different compounds from a single dried blood sample, raised the possibility of screening for a large number of disorders. In 2004, the Maternal and Child Health Bureau of the Health Resources and Service Administration (HRSA) commissioned the American College of Medical Genetics (ACMG) to develop a system for evaluating disorders for which newborn screening might be offered and to recommend a “consensus panel” for testing http://mchb.hrsa.gov/screening/summary.htm. This group eventually recommended a panel of 29 disorders (28 disorders screened from dried blood spots, plus hearing screening). The recommended panel includes six disorders of amino acid metabolism, five disorders of fatty acid oxidation, nine organic acid disorders, three hemoglobinopathies, and five other disorders (cystic fibrosis, galactosemia, hypothyroidism, biotinidase deficiency, congenital virilizing hyperplasia), as well as mandated hearing screening. In addition to these disorders for which screening is done, it was recognized that there are other disorders which might share some of the analytes measured in the screening process; these other disorders are considered “secondary targets” which might be serendipitously detected in the process of screening for the primary disorders.

Virginia’s newborn screening program, which began in 1965 with screening for phenylketonuria, has increased in scope over the years. Beginning March 1, 2006, the mandated disorders in Virginia are the 28 disorders (plus hearing screening) recommended by the ACMG/HRSA group. The Division of Consolidated Laboratory Services in Richmond uses tandem mass spectrometry as the primary testing modality for this panel, with other technologies used for several other disorders. As of September 2008, 46 states are now offering the ACMG/HRSA panel (http://genes-r-us.uthscsa.edu). The CDC has estimated that if all states had been screening for the “complete” panel of 28 disorders detectable by analysis of dried blood spots in 2006, over 6,400 “true” cases would have been identified.

(http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5737a2.htm)

The increase in the number of disorders included in the newborn screening panel has also resulted in an increase in the number of “false abnormal” results (patients who have an abnormality on their first newborn screen but who are found on subsequent testing or follow-up to be unaffected). A disproportionate number of these “first abnormal” results occur in premature or sick newborns, including infants receiving hyperalimentation. There are efforts underway to try to decrease the number of “false abnormal” results without diminishing the ability of the screening process to identify those infants who are affected and in need of treatment.

As the ability to treat other conditions improves, there will be increasing pressure on newborn screening programs to further expand the list of disorders for which screening is done. For example, there are pilot programs underway to evaluate the feasibility of screening for those lysosomal storage diseases for which enzyme replacement therapy is currently available, such as Pompe disease (alpha glucosidase deficiency), type 1 Gaucher disease (glucocerebrosidase deficiency), and Fabry disease (alpha galactosidase deficiency). In addition, some individuals have suggested broadening the term “treatment” to include not just medical or pharmacologic interventions but also the provision of

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New CDC Brief for Caregivers and Educators on Electronic Media and Youth Violence

New technology and youth seem destined for each other. They are both young, fast paced, and ever changing. Novel communication avenues, such as text messaging, chat rooms, and social networking Web sites, allow youth to easily develop new relationships. New technology has many social and educational benefits, but caregivers and educators are concerned about the dangers young people face by using these technologies. Specifically, some are using electronic media to embarrass, harass, or threaten their peers. Researchers at the Centers for Disease Control and Prevention (CDC) call this type of behavior electronic aggression.

Electronic aggression is an emerging public health issue. Research shows an increase of 50% between 2000 and 2005 in the number of young people who have reported being victims of electronic aggression. CDC’s Division of Adolescent and School Health and Division of Violence Prevention, along with the Adolescent Health Goal Team, have developed “Electronic Media and Youth Violence: A CDC Issue Brief for Educators and Caregivers.” The brief summarizes knowledge about this issue and provides suggestions for educators and caregivers on how to safeguard children from becoming victims of electronic aggression. Highlights from the research indicate that:

- 9% to 35% of young people say they have been the victim of electronic aggression.
- A 50% increase in electronic aggression occurred between the years 2000 and 2005.
- Electronic aggression victims are significantly more likely to use drugs and alcohol, receive school detentions or suspension, skip school, experience in-person aggression, have emotional distress, and have relationship problems with their parents.
- Victimization occurs through all forms of technology: 25% in a chat room, 23% on a website, 67% with instant messaging, 25% through an e-mail, 16% with a text message.

The brief also outlines steps educators, educational policy makers, and caregivers can take to address the issue of electronic aggression. Prevention suggestions include developing school policies on electronic aggression, establishing youth violence programs and educator training, creating a positive school atmosphere for students, and improving parent-child communication and parental monitoring of technology use. To further support parents, a companion parent tip sheet was also developed by CDC.

These resources are available online at the following link: Electronic Media and Youth Violence: A CDC Issue Brief for Educators and Caregivers.

The parent tip sheet can be accessed at the following link: Technology and Youth: Protecting Your Child from Electronic Aggression.

For more information about electronic aggression, please visit http://www.cdc.gov/ncipc/dvp/electronic_aggression.htm.

An Update on Newborn Screening in Virginia

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At present, newborn screening has been done to optimize the care of the infant who is being screened, and not directly for the benefit or counseling of the parents or family. Since most of the disorders for which newborn screening is being done are autosomal recessive disorders, a consequence of these screening programs is the identification of parents who are heterozygous carriers for these disorders by virtue of identifying their affected children. If future changes in newborn screening employ the use of DNA techniques, this will increase the direct identification of individuals who are carriers but are not affected themselves. At this time, the sickling hemoglobinopathies are the only disorders by virtue of identifying their affected children. If future changes in newborn screening employ the use of DNA techniques, this will increase the direct identification of individuals who are carriers but are not affected themselves. At this time, the sickling hemoglobinopathies are the only disorders for which heterozygous carriers for these disorders can be consistently identified directly through the screening process.

Virginia’s screening panel is now linked to the ACMG/HRSA panel, so that changes in their recommendations will result in changes in the Virginia panel. It will be important for pediatricians, family physicians, and other physicians and health professionals who take care of children to remain informed of developments in this area.
Breastfeeding-Schmestfeeding: Why Should Pediatricians Care and What Can We Do to Promote and Support It?

Submitted by: Ann L. Kellams, M.D., FAAP, IBCLC
Education Chair and Chapter Breastfeeding Coordinato

Though we as humans have a history of feeding our babies’ breast milk for hundreds of thousands of years, we have evolved into a society that thinks of formula as a convenient, decent, and in some cases, perhaps even better alternative. As pediatricians and advocates for mothers and families, we are often hesitant to make mothers feel guilty about their feeding choice even though we know there are risks. Yet, we seem to have no problem warning them not to smoke or use illegal substances or telling them precisely how they should strap their baby into the car or how and where their baby should sleep.

Why infant feeding is viewed as a lifestyle choice rather than a medical choice is beyond the scope of this article. WHY this is a problem and WHAT we can do about it in a nutshell, I will try to cover!

In 2007 the Agency for Healthcare Research and Quality released a HUGE report that looks at many studies concerning health outcomes for infants and mothers after breastfeeding. Their findings are as follows:

For infants:
- 50% reduction in ear infections;
- 42% reduction in atopic dermatitis for those who had a family history;
- 64% reduction in the risk of non-specific gastroenteritis infections;
- 72% reduction in the risk of hospitalization for a lower respiratory tract infection;
- 27% reduction in the risk of childhood asthma for those without a family history, and a
- 40% reduction for those with a family history;
- 7-24% reduction in the risk of obesity;
- 20-30% reduction in the risk of Types I and II Diabetes;
- 20% reduction in the risk of childhood leukemia; and
- 36% reduction in the risk of Sudden Infant Death Syndrome.

And for mothers:
- 4-12% reduced risk of Type II Diabetes after a history of gestational diabetes;
- 4% reduction in the risk of breast cancer for each year of breastfeeding; and
- 21% reduction in the risk of ovarian cancer.

The American Academy of Pediatrics, The American College of Obstetrics and Gynecology, The American Academy of Family Physicians, The American Dietetic Association, The Center for Disease Control, The US Preventive Services Task Force all recommend human breast milk for babies as their only source of nutrition for the first 6 months of life unless there is a specific contradication (of which there are few).

See the full AHRQ report at: www.ahrq.gov publication No. 07-E007.

That is the WHY. Babies and children have to be healthy in order to grow and develop and learn. We should all be promoting and supporting exclusive breastfeeding for all babies for the first 6 months!

Now the HOW:
First, consider signing this petition that calls on the new administration to put breastfeeding promotion and support on the forefront of the agenda for women and children’s health:

http://org2.democracyinaction.org/o/5162/t/4002/petition.jsp?petition_KEY=177

This petition is supported by the United States Breastfeeding Council of which all of the following organizations are members:

- Academy for Educational Development
- Academy of Breastfeeding Medicine
- American Academy of Family Physicians
- American Academy of Nursing
- American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American Dietetic Association
- American Public Health Association
- Association of State & Territorial Public Health Nutrition Directors

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Breastfeeding-Schmestfeeding: Why Should Pediatricians Care and What Can We Do to Promote and Support It?

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- Association of Teachers of Maternal & Child Health
- Association of Women's Health, Obstetric and Neonatal Nurses
- DHHS/Agency for Healthcare Research and Quality
- DHHS/Centers for Disease Control and Prevention
- DHHS/Food and Drug Administration
- DHHS/Office on Women's Health
- International Lactation Consultant Association
- Lamaze International
- National WIC Association
- USDA Food and Nutrition Service/Women, Infants and Children Program

Also:

The first weekend in November, 2009, the Academy of Breastfeeding Medicine will host its annual international meeting in Williamsburg, Virginia. In conjunction with that meeting, there will be a gathering of all of those in the state from all disciplines who are interested in promoting and supporting breastfeeding in the state. Please mark your calendars and stay tuned for more information about how you can stay involved in these efforts.

Right in Your community:

Review the recommendations from the AAP entitled “Breastfeeding and the Use of Human Milk:”

www.aappolicy.aappublications.org/cgi/content/abstract/pediatrics;115/2/496

Review the CDC’s recent Benchmark Report on Maternity Practices in Infant Nutrition and Care (mPINC) Survey at: www.cdc.gov/mpinc

Educate yourself with free online CME jointly sponsored by The University of Virginia School of Medicine and the Virginia Department of Health at: www.breastfeedingtraining.org

Participate in community outreach and prenatal education events that reach young children and expectant parents about the need to breastfeed their babies for at least six months. Studies show that the earlier women decide to breastfeed, even before they are pregnant, the better success they have, and that having an unsupportive spouse or family member is one of the biggest risk factors for stopping.

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Georgia High Court Finds for Plaintiff in Vaccine Case

On October 7th, 2008 the Georgia Supreme Court ruled to uphold a state appellate court decision in favor of a family suing the manufacturers of childhood vaccines. The family alleges that their child’s autism was caused by thimerosal-containing vaccines, and that their case should not be adjudicated before the Federal Court of Claims, or “Vaccine Court”, established as part of the National Childhood Vaccine Injury Compensation Act. The full text of the ruling is available from the Georgia Supreme Court, as is a news summary from Law.com.

While the focus on similar cases in the past has been on the merits of the various theories connecting autism and vaccines, the relevant outcome of this case is the court’s finding that vaccine injury claims of the kind alleged by the plaintiffs are not subject to the jurisdiction of the Vaccine Court or the liability protection afforded by the vaccine injury compensation system. The Georgia decision contradicts similar prior decisions on both the federal and state level, and is likely to be challenged in federal court. More information will be forthcoming from the AAP Division of State Government Affairs as it becomes available.
hydrochloride and tropicamide. These complications include elevated blood pressure and heart rate, urticaria, cardiac arrhythmias, and contact dermatitis. However, pupillary dilation has been performed routinely for many years in almost all new patients seen by pediatric ophthalmologists, with a very low incidence of toxicity. Hence, this procedure seems to be safe when performed in an office setting on infants older than 2 weeks. Nevertheless, to minimize liability exposure, physicians should discuss with the parents the nature and purpose of the proposed diagnostic procedure and any potential risks associated with the procedure or accompanying medications, including but not limited to pain, discomfort, bradycardia, respiratory depression, and hypertension, and document the provision of this information in the medical chart. Such informed-consent precautions are particularly important when testing preterm infants. Preterm infants seem to be particularly sensitive to the adverse effects of mydriatic eye drops; consequently, the concentration of these pharmacologic agents should be reduced.

For infants younger than 9 months: A combination drop of 0.25% cyclopentolate with 2.5% phenylephrine (Cyclomydril [Alcon Laboratories, Fort Worth, TX]) approximately 15 minutes before examination. Note that atropine drops should be avoided in young infants because of the potential for anticholinergic adverse effects. For infants older than 9 months: Tropicamide 1%, phenylephrine 2.5% ophthalmic drops; give 1 drop of either or both approximately 15 minutes before red reflex testing. A combination drop of 0.25% cyclopentolate with 2.5% phenylephrine (Cyclomydril) approximately 15 minutes before examination.

All neonates, infants, and children should have an examination of the red reflex of the eyes performed by a pediatrician or other primary care clinician trained in this examination technique before discharge from the neonatal nursery and during all subsequent routine health supervision visits. The result of the red reflex examination is to be rated as normal when the reflections of the 2 eyes viewed both individually and simultaneously are equivalent in color, intensity, and clarity and there are no opacities or white spots (leukokoria) within the area of either or both red reflexes.

All infants or children with an abnormal Bruckner reflex or absent red reflex should be referred immediately to an ophthalmologist who is skilled in pediatric examinations. It is essential that the referring practitioner communicate the abnormal findings directly to the ophthalmologist and receive confirmation back from the ophthalmologist that proper follow-up consultation was performed.

Infants or children in high-risk categories, including relatives of patients with retinoblastoma, infantile or juvenile cataracts, retinal dysplasia, glaucoma, or other vision-threatening ocular disorders that can present in infancy, should not only have red reflex testing performed in the nursery but also be referred to an ophthalmologist who is experienced in examining children for a complete eye examination regardless of the findings of the red reflex testing by the pediatrician.

Infants or children in whom parents or other observers describe a history suspicious for the presence of leukokoria (a white pupil reflex) in 1 or both eyes should be examined by an ophthalmologist who is experienced in examining children for a complete eye examination.

For these cases, a pediatrician or other primary care physician should contact an ophthalmologist who is experienced in examining children for a complete eye examination.

Kids activities are available through “Kids Cove” located at the Wyndham Hotel from 10:00am to 7:00pm (times may change). Call the hotel for more information.

We look forward to seeing you at the beach!