



PEDIATRIC NEWS

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California Chapter 2: the Los Angeles County, Inland Empire and Central Coast Chapter

WHAT COLOR IS YOUR WHEELCHAIR?

Mary Doyle, MD, FAAP

President, AAP California Chapter 2

Choosing a color for something is fun, for things like a new backpack, a bike, a balloon, a ball. Sometimes, choice of a color helps a kid accept an inevitable or unavoidable fate: a band-aid after a shot, a cast after a fracture, a brace to help with walking. But once in a while, a color choice can spell total despair or unrecognized hopelessness.

One of our patients at a California Childrens Services medical therapy unit was rendered a quadriplegic from a gunshot wound to the upper thoracic cord and he retained only minimal use of one of his arms. The bullet had also severely damaged his esophagus and multiple surgical attempts to repair it were fraught with recurrent infection and the eventual need for a cervical esophagostomy tube to drain his secretions and a gastrostomy tube for feeds. He presented to our unit after a four month hospitalization for the acute injury, seated in a rental wheelchair, with the esophagostomy bag pinned to the outside of his shirt, the gastrostomy tube coiled beneath the lower part of his shirt, in sagging, oversized pants that made no attempt to hide a diaper. He was to begin outpatient rehabilitation and be evaluated for his equipment needs.

When it comes to wheelchairs or braces, if there is a color involved, the patient gets to choose. This unfortunate 18-year-old man requested that the seat cushion and frame of his new wheelchair bear his gang color.

The functional goal for this patient was to independently operate a power wheelchair; his goal, however, was to “cruise” his territory, sporting his colors.

The staff knew from a home visit to assess his bath equipment needs that he lived in an area frequented by rival gang members. Was this patient inviting sure death and asking us to participate in his homicide or was it truly the request of a young person demonstrating undying allegiance to the only family he had ever known?

So, what color should we choose for this patient or all of the other children and young adults who live in a state where expenditures are in the red; where the budget is in the black because of cuts to the Healthy Families, Early Start and In Home Support Services programs; where legislators, political analysts and government advisors choose only to see black and white? AAP-CA Chapter 2 chooses and must continue to see gray: nothing is black and white when it comes to caring for children and young adults and it is going to take every crayon in the box to address the overwhelming issues we, as pediatricians, and our families currently face:

- 16% of California parents with children 17 years or younger report living in neighborhoods or communities where they feel their child is either sometimes or never safe.

Dr. Grant Christman, part-time child advocacy educator and ER attending at Harbor-UCLA has stepped up and accepted the chairpersonship on the Chapter's Committee on Injury, Violence and Poison Prevention. Though the committee's mission statement is not yet complete, the initial focus will be injury prevention in the larger context of safe neighborhoods, healthy environments, and sound nutrition and exercise education.

- 66% of children ages 0 to 18 residing in Los Angeles County are either foreign born or reside with at least one parent who is foreign born.ⁱⁱ

Dr. Albert Chang, member of the Board of Directors of the Chinese Historical Society of Southern California, retired professor of public health and part-time pediatrician for Los Angeles Juvenile Hall, is forming the Chapter's Committee on International Child Health. He hopes to eventually develop partnership or sister-city relationships with other countries and promote exchange activities between our Chapter and pediatricians from other countries.

- 10% of the children of California were uninsured in 2007; the reduction of Healthy Families insurance funding by \$178.6 million in the 2009-10 amended California budget could increase that number by hundreds of thousands.^{iii, iv}

AAP-CA Chapter 2 joined forces with the other three California Chapters and state coalition partners in August to request that Attorney General Jerry Brown and State Controller John Chiang investigate the legality of monetary cuts to the Healthy Families program.

- 58% of California youth between the ages of 12 and

17 years of age watch 2 or more hours of television on weekdays.^v

Dr's. Cori Cross, Tanya Altmann-Remer, Howie Reinstein, and Chris Tolcher have agreed to strategically plan with me and our new executive director, Ms. Marissa Green, as the Chapter's newly forming Committee on Media Relations prepares to put a true public face on the Chapter and use all forms of local media to spotlight children's health issues. Ms. Green brings her experience from the corporate public relations world. Dr. Tolcher is a frequent media spokesperson for both radio and the local TV news stations. Dr. Reinstein has done the same and serves as the Chapter's liaison to the media. Dr. Altmann-Remer is the author of *Mommy Calls* and serves on the executive committee of the National AAP Council on Communications and Media. Dr. Cross is creator of "SMART MOMS", a blog for pediatric information and is also member of that same National AAP Council.

Again, as your Chapter president, I choose to see gray. I ask that all of you step up and see gray with the rest of us before there is no color left at all for the children of California to choose.

References:

- i. Child and Adolescent Health Measurement Initiative. *2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website*. 08/01/09 from www.nschdata.org
- ii. Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2007 American Community Survey. 08/01/09 from www.datacenter.kidscount.org
- iii. [See Endnote 1]
- iv. California State Budget 2009-2010. *Amendments to the Budget Act of 2009 Expenditure Solutions*: Figure SWI-02. Department of Finance State of California. 08/11/09 from www.ebudget.ca.gov
- v. California Health Interview Survey for 2007. "Amount of TV watching on weekdays." 08/14/09 from www.chis.ucla.edu

LEADING OUR CHAPTER TO NEW HEIGHTS – MEET OUR NEW EXECUTIVE DIRECTOR: MARISSA GREEN



The Executive Board of AAP-CA Chapter 2 is pleased to introduce Marissa Green as our new Executive Director. Ms. Green holds a

Bachelor of Arts in Political Science and Communication and Culture from Indiana University. While attending Indiana Uni-

versity, she spent a semester in Washington, D.C. as part of The Washington Center's Nonprofit Management program where she

took classes in nonprofit management and interned for a grassroots organization called Youth Venture. This experience left her with a passion for those endeavors that contribute to guiding AAP-CA Chapter 2 in our development and future programs.

After graduating with honors from Indiana University, Ms. Green was accepted into Ruder Finn's Executive Training Program in public relations. Ruder Finn is one of the leading independent, international public relations firms and accepts only 13 trainees each quarter from a pool of hundreds of applicants. Ms. Green selected the health practice as her area of focus and spent her first years working with the American Nurses Association on a campaign to educate communities about healthy blood pressures. Ms. Green also had an opportunity to work on several oncology programs with Novartis Pharmaceuticals. These projects exposed Ms. Green to the world of patient research and directly influenced her to pursue a position with the Office of Public Affairs at Memorial Sloan-Kettering Cancer Center. As Media Coordinator for the group, Ms. Green worked with physicians and researchers

at MSKCC to highlight research in oncology and to promote their various programs.

Prior to accepting the position with Chapter 2, Ms. Green was with Edelman Public Relations, the number one independent, international public relations firm. During her time with Edelman, Ms. Green developed communications strategies to support research for an investigational device for glioblastoma multiforme and health care professional communications on behalf of Novartis Oncology. Her responsibilities included, media relations, budget management for programs ranging from \$200,000 to \$1.5M, managing teams of four or more, project development and overall strategic programming.

While with Edelman, Ms. Green transferred to the company's Los Angeles office. This move did more than create a new home for her – it also provided clarity regarding the next steps for her professional direction. Ms. Green realized that the expansive skill set gained from her corporate experience and foresight for change could benefit an organization with a mission aiming to truly make a difference.

In particular, Ms. Green brings organizational skills that will provide generous support to our active committees and broader membership. She has the background knowledge of health media that can help Chapter 2 become the go-to resource for media in our area. Her political science background brings to the Chapter a new perspective on advocacy and health policy. Beyond this experience and her skills, her creativity provides a fresh set of eyes to existing programs, and the capacity to build new opportunities for our membership to become more involved in ensuring quality care for our community's children and families.

We are excited to have Ms. Green on board and she is thrilled to have the opportunity to work with each of you during this important time, when our children need more support than ever. Should you have any questions about membership, committee opportunities or ideas for new projects that you would like support from the Chapter, please don't hesitate to contact Ms. Green at mgreen@aap.net.

VISION SCREENINGS: THE EARLIER THE BETTER

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Therapeutic Living Center for the Blind, Encino.

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Vision screenings are important for all children. For those with developmental disabilities, there is even greater need to recognize the value of vision screenings

and to foster awareness of learning differences within this population. A visual system that is compromised by a treatable but unidentified ocular disorder can nega-

tively impact the child's access to the world. It is critical for primary care providers to understand that non-verbal and emotionally labile children can be screened and may benefit from early intervention both by the pediatric ophthalmologist and developmental programs that specialize in visual impairments (W. Good, 2007).

Technology has improved, creating opportunities for the most medically fragile to survive. With this improved technology there has been an increase of children with developmental disabilities challenged by immature visual systems and who are living with compromised visual systems due to brain abnormalities. Cortical or Cerebral Visual Impairment (CVI) and Optic Nerve Hypoplasia (ONH) are two of the leading eye conditions affecting children in the United States. Either of these conditions can occur with developmental disabilities. Children with developmental disabilities and visual impairment are at the greatest risk of experiencing a world that is fragmented by their limited visual perception or intermittent visual input and complex physical challenges and health status. We can and should provide routine vision screenings that increase our ability to properly identify children who need services and link them to services in a timely fashion. And we can and should minimize the chance of undiagnosed or unrecognized visual impairments by increasing pediatricians' knowledge of the importance of vision to a child's development and access to the world.

One method used to detect ocular abnormalities in infants and children is the Red Reflex Exam. Since its introduction, the exam has been endorsed by several organizations including the American Academy of Pediatrics and the American Academy for Pediatric Ophthalmology and Strabismus. The red reflex exam has become an integral part of both ophthalmology examinations and well-child visits. The red reflex test is used to screen for abnormalities in the eye itself, opacities in the visual axis, and ocular misalignment. In order to perform the exam, a direct ophthalmoscope is used to view the choroidal light reflexes of each eye simultaneously. In the absence of ocular disease, the choroidal light reflexes of each eye are equivalent in color, intensity, and clarity. When ocular disease is present, the choroidal light reflexes of the two eyes are unequal. The Red Reflex Exam can provide the first clue that an infant or child has an ocular abnormality allowing early referral to a

pediatric ophthalmologist for further evaluation and appropriate treatment.

Nearly 75% of early learning is visual. Children who are blind or visually impaired are often met with great challenges. He or she miss much of what we call "incidental learning" necessary for communication and interpretation of the world around them. Knowledge gained through incidental experience may need to be taught to them in a more systematic way. For example, if an infant or toddler cannot see that you've turned down the lights and brought out the oil to begin a massage, how might they know what's coming next? Many of the things we take for granted in a child with normal vision may have to be described or shown in a way that is meaningful so they can begin to learn and predict what might happen next. We do this "meaning making" with all babies; it is even more important for the parent of a child who is visually impaired to follow a routine so that the baby begins to build memory for the experience.

It is critical that the medical community put an emphasis on routine vision screenings— the earlier the better. It should be mandatory for children with identified syndromes or obvious disorders to receive a referral from their pediatrician or primary care provider to a pediatric ophthalmologist for an exam, particularly if there is evidence of abnormality on the Red Reflex Examination. For example, children with particular syndromes, like CHARGE Syndrome, that are known to have an increased risk for ocular disorders (e.g. colobomas, cataracts), should have an eye exam by an eye specialist at birth. There is no need to wait. Parents should not be forced to demand this service, it should be routine. Too many parents have to demand an eye exam as they notice something wrong with their babies' eyes.

It is equally important that pediatricians or primary care providers share with parents that the visual system is crucial to development and if there is a problem suspected, early intervention services are available to them. Too often we see children with developmental delays whose visual system has not been evaluated or whose parents think that vision loss has less importance than a seizure disorder or developmental disability. Minimizing the need for intervention for visual difficulties can have a devastating impact on the child's ability to put his/her world together.

Parents rely on pediatricians for accurate information. It is not enough to say that the child with Down Syndrome “will catch up”. If parents express concern about how their child uses his/her eyes, and the pediatrician is unable to screen the child, they have a fundamental right to a thorough exam by a pediatric ophthalmologist. Ac-

cess to these resources should be universal and not limited to only those children whose parents demand them.

References:

Good, William V. (2007) An eye on vision screening for children with developmental disabilities. *Developmental Medicine & Child Neurology*, 49:485-485

CHAPTER 2 TAKES THE LEAD IN SUPPORTING THE NATIONAL CHILDREN’S STUDY

Neal Halfon, MD, MPH, FAAP

Principle Investigator, LA - Ventura County Study Center

On June 24, 2009 the AAP Chapter 2 voted to become a “NCS Community Collaborator” and lend institutional support to the National Children’s Study (NCS). The AAP local chapter is the first professional organization to formalize at the local level its support for the NCS, thanks to the leadership of its President and Vice-President, Dr. Mary Doyle and Dr. Laura Mabie.

The NCS is the largest longitudinal study of children’s health ever initiated in the United States. It will follow 100,000 children nationwide from before birth to age 21 to identify genetic and environmental factors that contribute to health disorders and conditions of childhood and adulthood. The goal is to collect information that will help prevent and treat some of the nation’s most pressing health problems including autism, birth defects, diabetes, ADHD, heart disease, and obesity, among others.

The NCS is a collaborative effort between the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the National Institute of Environmental Health Sciences, the Centers for Disease Control and Prevention (CDC), and the U.S. Environmental Protection Agency (EPA). The NCS was established in response to the Children’s Health Act of 2000, when Congress directed the NICHD and other federal agencies to undertake a national, long-term study of children’s health and development in relation to genes and environmental exposures.

Families who participate in the study will come from 105 study locations across the United States. The NCS will represent the nation’s children, meaning that it will include children from diverse socioeconomic and ethnic

backgrounds. At first, the study will collect information on women’s pregnancies, including their diets, chemical exposures, and emotional stress. When their children are born, the study will begin to follow and collect information about the children and the environments in which they spend time. At this point the role of pediatricians as liaisons between researchers and families will become crucial. Members of the study team will meet with families in both their homes and in clinical settings; information will also be collected remotely via telephone, the internet, or mail-in questionnaires. For each participant, there will be a minimum of 15 face-to-face visits over the course of the study: seven in the home and eight in a clinical setting, including a birth visit at the hospital or birthing center.

A total of 12,000 children will participate in California in 3 study centers: Northern CA (UC Davis), Los Angeles-Ventura (UCLA), and Southern & Central CA (UCI). Each study center investigates multiple counties. In most counties, the NCS will enroll 1,000 participants. Orange County is one of seven vanguard locations conducting a pilot phase of the study and started enrolling participants in April 2009. The first NCS California baby will be born in October 2009. Learning from the experiences of the Vanguard locations, the NCS-LAVSC will start recruiting participants in 2011 in Los Angeles County and in 2012 in Ventura County. The NCS-LAVSC will start enrolling participants in 14 randomly selected neighborhoods in Los Angeles County and it is projected to increase to a total of 56 neighborhoods.

The University of California- Los Angeles (UCLA) has partnered with Cedars-Sinai Medical Center, the

University of Southern California (USC), Charles R. Drew University of Medical Science, Research Triangle Institute (RTI), RAND Corporation, Los Angeles and Ventura Departments of Public Health, and Los Angeles and Ventura First 5, to establish a Los Angeles area Study Center for the NCS. Neal Halfon, MD, MPH, FAAP, Professor of Pediatrics, Health Services and Public Health at UCLA, is the Principal Investigator for the Los Angeles and Ventura Study Center. The NCS Los Angeles- Ventura Study Center (NCS-LAVSC) will include one of the largest NCS county locations in the United States, enrolling 4,000 children from Los Angeles County in addition to 1,000 children from Ventura County.

The current protocol indicates that in order to identify children who may be eligible to participate in the study, members of the NCS will canvas the randomly selected neighborhoods using a door-to-door recruitment strategy and invite pregnant women and women of childbearing age to participate. In each of the selected neighborhoods the study team will partner with local community agencies and organizations in order to achieve optimum participation. The official support of professional institutions such as the AAP Chapter 2 will be paramount for gaining trust in these communities.

The NCS gives an unprecedented and extraordinary opportunity to really discover what make our kids healthy, and what make our kids

sick. This is the one study that brings it all together – genetics, biology, behaviors, family, neighborhood, social determinants, the healthcare system and the environment – in an attempt to understand how all these factors interact with each other over time to produce health and disease. The NCS is the one study that can provide answers to questions that patients ask all the time: What causes preterm birth? What causes autism? What causes asthma? What causes obesity or diabetes in children? And perhaps most important, how can these conditions be prevented?

The NCS is one of the richest research efforts in the nation and will form the basis of child health guidance, interventions, and policy for generations to come.

CHAPTER 2 LAUNCHES NEW COMMITTEE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Susan Igdaloff, MD, FAAP

Chair, Committee on Children with Special Health Care Needs

Chapter 2 has not had a functioning committee for a number of years focusing on the needs of children with special health care needs and the pediatricians who care for them. The time is right to develop a functioning committee. Very recently a project has been implemented by the Director of the Department of Health Care Services to reform the California Children's Services Program. At this time, it is unclear what direction this will take, but it is imperative that the pediatric community be diligent in focusing our efforts on ensuring these children and youth with special health care needs continue to receive coordinated and family-centered care. In addition services are being cut back through Regional Center.

The development of such a committee will provide a home for chapter activity and discussion on broad

policy and fiscal changes such as those mentioned above. However, there are also ongoing issues that affect all pediatric practices providing care to children and youth with special health care needs that need to be addressed. Two key issues are implementation of the medical home and challenges involving adolescent health care transition.

If you have any questions or thoughts about the committee, please contact Susan Igdaloff, M.D. at momsadoc@aol.com. If you have an interest in participating in this committee, please contact Marissa Green, mgreen@aap.net or by telephone at 888-838-1987, by October 12, 2009, if possible.

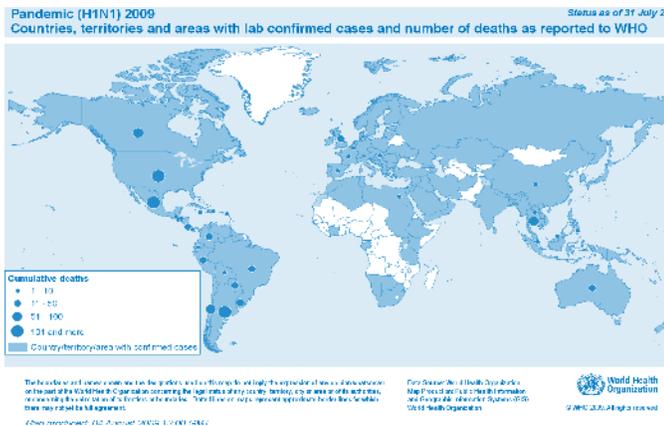
PANDEMIC INFLUENZA UPDATE

Wilbert Mason, MD, FAAP

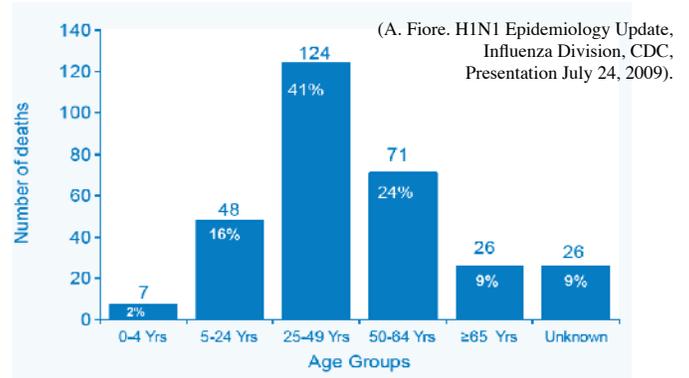
Immediate Past President, Chapter 2

On April 22, 2009 the Center for Disease Control reported 2 cases of febrile respiratory illness in children from southern California. Early epidemiologic investigations suggested that the virus causing the illness was influenza A H1N1 similar to a virus that had been causing influenza in several areas in Mexico. Molecular studies showed that the viruses were genetically similar to swine influenza viruses that had been circulating among pigs in the US since 1999. However, the viruses also had genetic traits found in swine viruses of Eurasian lineage making them novel agents not previously seen in swine or human populations. Subsequently, with the increasing recognition of cases in California, Texas and elsewhere in the US as well as internationally, an influenza pandemic was recognized. The novel virus responsible for the illness is now referred to as 2009 influenza A (H1N1). (<http://www.cdc.gov/flu/weekly>) [week 32].

The distribution of the infection is now world-wide and a pandemic was officially declared by the World Health Organization June 11, 2009.

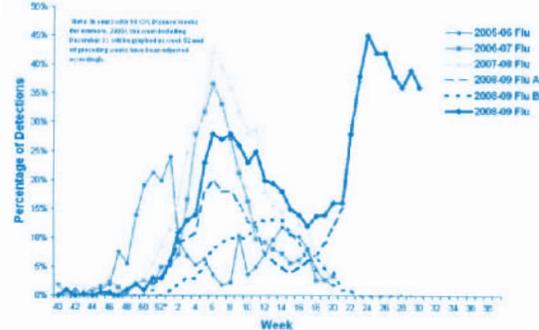


In the US, as of July 24, 2009, there had been 43,771 laboratory confirmed cases of 2009 influenza A (H1N1). By the end of week 32 (August 9-15, 2009) there had been a total of 7983 hospitalizations and 522 deaths reported to the CDC. (<http://www.cdc.gov/h1n1flu/update.htm>) In an analysis of the epidemiological case characteristics up to July 2009, the illness was found to occur equally in males and females; the median age in all cases was 12 years, 20 years in hospitalized patients and 37 years in patients who had died. (A. Fiore H1N1 Epidemiology Update, Influenza Division, CDC, Presentation July 24, 2009). Of hospitalized patients, 77% were < 50 years old and the largest proportion (34%) was in the 5-24 age group. The majority of deaths occurred in older age groups, but the largest increment occurred in the 25-49 age group, not in the elderly as in seasonal influenza.



In California, the current wave of influenza cases appeared to have peaked in week 24.

Figure 1. Influenza detections at sentinel laboratories/Respiratory Laboratory Network (RLN), 2005-2009.



(<http://www.cdph.ca.gov/programs/vrdl/Documents/InfluenzaUpdate081309.pdf>) Never the less, for the week ending August 18th, there were 1353 hospitalized cases, ICU admissions and deaths of which 115 were deaths.

The following table summarizes influenza activity in Chapter 2 Counties to date: (No data was available for Ventura.) (<http://www.cdph.ca.gov/programs/vrdl/Documents/InfluenzaUpdate081309.pdf>)

Jurisdiction	Hospital/ICU/Deaths	Hospital Rate/100,000	Deaths
Kern	9	1.05	0
Long Beach/LA	43/146	8.73/1.3	2/16
Riverside	17	0.78	1
San Bernardino	40	1.87	3
San Luis Obispo	2	0.75	7
Santa Barbara	6	1.39	0

The significance of this outbreak, in a season when influenza is rarely observed, is substantial and WHO, CDC, State and local agencies are working diligently to prepare for what is expected to be a very busy influenza season come this fall and winter. Chapter 2 has been very active in these preparations as well, working directly with local health departments (e.g. County of Los Angeles Public Health Department), State agencies (e.g. CDPH), and local and state coalitions. Dr. Mary Doyle recently convened a conference call with Dr. Laurene Mascola and other DPH officials enabling officers and members of the Chapter to inquire about issues in preparation for the upcoming season. We will summarize new developments regarding 2009 influenza A (H1N1) in the following sections.

NEW DEVELOPMENTS IN THE

INFECTION CONTROL ISSUES:

Case Definition

On August 20th the CDPH published a new definition for suspect pandemic (H1N1) influenza for the purposes of infection control. The new definitions are:

Any patient < 60 years old with a fever (>37.8C or 100F) and a new onset of cough. OR

Any patient whom a health care provider believes, based on the patient's history and illness, to have a high likelihood of being infected with pandemic (H1N1) 2009 influenza virus.

The change in the age criteria stems from the finding that 92% of hospitalized patients are < 60 years of age. Dropping sore throat, rhinorrhea, and nasal congestion from the definition was prompted by the observation that fever and cough most accurately define the syndrome, and are present in 75% of children with H1N1 influenza and 50-70% of adults. Withdrawing nasal symptoms and sore throat adds to the specificity without affecting sensitivity significantly.

(<http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1UpdatedRecforHealthCareSettings.pdf>)

Duration of exclusion period for infected individuals

On August 5th the CDC modified its guidelines regarding exclusion of individuals with the flu from contact with others. Persons with ILI should remain at home until they are afebrile (<37.8C or 100F) for at least 24 hours. This recommendation DOES NOT APPLY TO HEALTH CARE WORKERS who should still be excluded from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer.

(<http://www.cdc.gov/h1n1flu/guidance/exclusion.htm>)

Reporting of cases to the CDPH

Both the CDPH and LACDPH now will only accept reports of hospitalized confirmed or probable cases due to H1N1 influenza. There may be variations in requirements based on individual county health department requirements.

Confirmed case: ILI with a positive test by real-time RT-PCR or viral culture.

Probable case: ILI positive for influenza A, but negative for H1 and H3 by influenza RT-PCR.

Suspected case: Any patient < 60 years old with a fever (>37.8C or 100F) and a new onset of cough. OR

Any patient whom a health care provider believes, based on the patient's history and illness, to have a high likelihood of being infected with pandemic (H1N1) 2009 influenza virus.

(<http://www.cdph.ca.gov/HealthInfo/discond/Documents/CDPH-H1N1FluICRecHospitalized082009.pdf>)

Isolation precautions for hospitalized patients

Patients with suspected or confirmed case-status should be placed in "airborne infection isolation room" (AIIR) (negative pressure with 6-12 air exchanges per hour and vented to the outside.

(<http://www.cdph.ca.gov/HealthInfo/discond/Documents/CDPH-H1N1FluICRecHospitalized082009.pdf>)

Personal protective equipment (PPE)

PPE includes respiratory protection (e.g. N95 or higher level respirators), gowns, gloves, and eye or face protection. Respirator use has been mandated by Cal/OSHA regulations in caring for patients with known or suspected H1N1 influenza in the hospital setting.

(<http://www.dir.ca.gov/dosh/SwineFlu/SwineFlu.htm>).

Specific instructions can be found at

<http://www.cdph.ca.gov/HealthInfo/discond/Documents/CDPH-H1N1FluICRecHospitalized082009.pdf>

PREPARATION FOR THE PANDEMIC

INFECTION CONTROL ISSUES: *continued*

Infection control recommendations in outpatient settings

Suggestions for management of outpatients with suspected H1N1 influenza A were recently provided by the CDPH.

(<http://www.cdph.ca.gov/HealthInfo/discond/Documents/CDPH-H1N1FluICRecOutpatient082009.pdf>)

These suggestions may prove invaluable in managing outpatients during the coming flu season. Some general principles include the following:

1. Exposure to a known or suspected case of H1N1 influenza A alone is not an indication for hospital or emergency room visit.
2. Patients who report mild illness AND who have no underlying risk factors for complications need not be seen in the office.
3. Such patients can be screened by phone, given symptomatic therapy recommendations and instructed to contact their physician for signs of worsening illness. Patients with mild illness **should NOT be tested for influenza because test results will not influence treatment.**
4. Do **NOT** send patients to an emergency room unless you believe hospital admission may be necessary.

The above directive also discusses PPE use in clinics and physicians' offices and triaging patients in the outpatient setting.

VACCINE FOR 2009 INFLUENZA A (H1N1)

The CDC published their recommendations for the use of influenza A (H1N1) vaccine in the MMWR on August 21, 2009. It can be retrieved at the attached link. (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e0821a1.htm?s_cid=rr58e0821a1_e)

The highlights of these recommendations include the following:

1. Identification of 5 population target groups that will be the initial recipients of the vaccine. These are: pregnant women, persons who live with or provide care for infants < 6 months old, health care and emergency medical services personnel, children 6 months to 24 years old, and persons 25 to 64 years who have medical conditions that put them at risk for influenza-related complications.
2. Establishment of a priority for a subset of persons within the initial target groups in case initial vaccine availability does not meet demand.
3. Guidance on the use of vaccine in other populations as vaccine availability increases.

Based on discussions with Los Angeles County Public Health Department, it is expected the monovalent vaccine will be available on or about October 15, 2009. Of the 42,000,000 doses expected to be released initially, LA County expects to receive 1.3 million doses. Other Counties will receive proportionally smaller volumes based on their populations. All vaccines will receive 2 doses given > 21 days apart. It is anticipated that an additional 600,000 doses/week will be released thereafter for other populations. Distribution will be done through LA County Health Department.

Pediatricians are encouraged to sign up for receiving the necessary vaccine for their practices. There is a 100 dose minimum to participate in the vaccine effort.

The Chapter 2 website will announce when the vaccine is available and provide updates on the influenza season as it unfolds so stay tuned.

Other web sites with useful information on 2009 influenza A (h1N1):

<http://www.cdc.gov/h1n1flu/guidance/>
http://www.cdc.gov/h1n1flu/guidance_homecare_directions.htm
<http://www.cdc.gov/h1n1flu/update.htm>
<http://www.aap.org/securemoc/FluPolicy2009-10-Final0709.pdf>

<http://www.aap.org/advocacy/releases/may09swineflu.htm>
<http://www.cdph.ca.gov/HealthInfo/discond/Pages/SwineInfluenza.aspx>
<http://www.publichealth.lacounty.gov/acd/h1n1.htm>
<http://www.cdph.ca.gov/HealthInfo/discond/Pages/SwineInfluenza.aspx>

BREASTFEEDING MOMS GO TO WASHINGTON... AND SACRAMENTO

Touraj Shafai MD, Ph.D, FAAP
Chair, Breastfeeding Committee

Forty-nine states, the District of Columbia, Puerto Rico and the Virgin Islands have enacted various laws protecting breastfeeding mothers, but they are not uniform and most are not comprehensive. In the past year there has been a flurry of legislative activity nationwide to promote and protect the right of women to breastfeed their babies. In the State of New York, the Senate passed The Breastfeeding Mother's Bill of Rights (S1107A). Sponsored by Senator Liz Krueger (D-Manhattan), this legislation is based on the recognition that many women forgo the option of breastfeeding their infant, despite the health and economic benefits. Oftentimes women who forgo breastfeeding are those who can least afford it, low-income women, or women whose infant was placed on formula shortly after birth, sometimes without their knowledge.

The Breastfeeding Mothers' Bill of Rights requires that new mothers be informed of breastfeeding options before they deliver, while in the hospital, as well as after leaving that facility. In addition, it bans commercial interests (formula providers) from pressuring new mothers in the maternity hospitals. Included within the Bill of Rights:

- Before delivery: The right to information free from commercial interests, and which provides the nutritional, medical and psychological benefits of breastfeeding, as well as an explanation of some of the problems a mother may encounter and how to avoid or solve them.
- In the Maternal Healthcare Facility: The mother's right for her baby to stay with her after delivery to facilitate beginning breastfeeding immediately; to insist the baby not receive bottle feeding; to be informed about and refuse drugs that may dry up her breast milk; and 24 hour access to the baby with the right to breastfeed at any time.
- Upon discharge from Maternal Healthcare Facility: The right to refuse any gifts or take-home packets,

distributed by the maternal healthcare facility, that contain commercial advertising or product samples and to be offered access to breastfeeding resources in one's community.

As basic as some of these rights are, they are constantly violated. There is a very real problem of women feeling pressured out of breastfeeding because the information they received early in their child's life was manipulated by commercial interests more concerned with their bottom line.

The State of Rhode Island passed a tough new law to protect the mother's right to breastfeed her infant in public. This law replaced previous laws that prohibited mothers from breastfeeding in public and the violation of that law would result in prosecution for indecent exposure (and that was in 21st century not in medieval times).

The Breastfeeding Promotion Act (HR 2819 and Senate 1244) was introduced by Congresswoman Carolyn Maloney (NY) and Senator Jeff Merkley (Oregon) in the US Congress and the Senate. This Act will support mothers and babies by helping mothers to continue breastfeeding after they return to work. Many mothers indicate that returning to work is often a deterrent to their ability to continue breastfeeding. It includes several provisions:

- Amends the Civil Rights Act of 1964 to protect breastfeeding women from being discriminated against in the workplace.
- Provide tax incentives for businesses that establish private lactation areas in the workplace, or provide breastfeeding equipment or consultation services to their employees.
- Provides for a performance standard to ensure breast pumps are safe and effective.

- Allows breastfeeding equipment and consultation services to be tax deductible for families (amends Internal Revenue Code definition of “medical care”).

In our own Golden State, Congressman Kevin DeLeon introduced a bill (AB 513) that requires HMO coverage of lactation services. The bill passed the Senate Health Committee and will be heard in Senate Appro-

priation Committee. In addition, State Senator Fran Pavley’s bill (SB 257) requires every state agency or department to notify every female employee nearing maternity leave of the existing lactation accommodation laws. Stay tuned for more information on these pieces of legislation in support of breastfeeding mothers.

REPORT ON THE 2009 AMERICAN ACADEMY OF PEDIATRICS NATIONAL LEGISLATIVE CONFERENCE

Paula Whiteman, MD, FAAP, FACEP

Member-at-Large

Last April I had the opportunity to attend the 2009 American Academy of Pediatrics Legislative Conference. It was an opportunity to “learn to make a difference” and to “participate in the process”. I have never attended a more action-packed conference! For 3 days, practically every minute was accounted for. The first day started with registration over breakfast with introductory remarks by our AAP president, Dr. David Tayloe, and the Chair of the AAP Committee on Federal Government Affairs, Dr. Olson Huff. There were various workshops covering the topics of health care reform and advocacy training, such as the art of negotiation, coalition building, media training, and crafting your message. Speakers accompanied each meal. The first night we had the pleasure of listening to Amy Walter, the Editor-in-Chief of *The Hotline*.

The second day we practiced role playing, which was very informative. It gave us insight into the delicate balancing act that our officials make between fund raising and

keeping their constituents happy in order to get re-elected. Two of our meal-time speakers were female senators. We had the opportunity to meet Senator Kay Hagan (D-NC), who ran against Elizabeth Dole. She explained how difficult it is to have big tobacco as the biggest industry in her state.

Next we met Senator Amy Klobuchar (D-MN), who at the time was the sole senator from Minnesota. Both women were exciting and dynamic speakers. Then we were off to our congressional appointments. I was part of the California contingency of several doctors from across the state. We met with the legislative assistants for our state senators, Barbara Boxer and Dianne Feinstein. It was interesting to hear their take on the status of health care in our state. They explained that there is very little wiggle room for our senators to make further gains from other smaller states who receive more funding from the federal government. (California gets a mere eighty cents for every dollar paid.) They said that in this particular instance the unity

of our house representatives will be more effective in addressing the needs of our state. I met with the legislative assistants for my representative, Congressman Howard Berman (CA-28).

I never felt so connected to the system and it gave me a sense that an individual can still make a difference. It was a truly wonderful feeling walking across the capitol. There is still time for you to contact your individual congressman and senators as health care legislation is still being crafted and fine tuned.

The AAP has specific talking points that they are trying to get across. To learn more, please go to: <http://www.aap.org/advocacy/washing/chi97.htm> On the right hand side, please click on Principles of Access or go to: <http://www.aap.org/advocacy/washing/AAPEndorsed-PrinciplesonAccess.pdf>

The AAP feels that every child should have quality health care with the insurance to cover it. Currently, approximately 12% of chil-

dren in California are uninsured and the number is expected to increase.

They are promoting coverage directed to the special needs of children. Pediatric care focuses on prevention, immunizations, and developmental screenings as opposed to the treatment of multiple chronic conditions. Therefore, the emphasis is completely different

than that of adults. Thus, children should have a medical home with primary care pediatricians and access to specialists as needed.

Importantly, there should be payment rates that assure that children will receive all the recommended and necessary care.

When speaking with your representatives, it is important to craft your message by selecting a few

main points. Too many thoughts and your focus may get lost.

My main position was that every child deserves quality health insurance which covers comprehensive age appropriate benefits as recommended by the AAP, and that all the health care plans must provide adequate physician reimbursement. What's yours?

“ROADS SCHOLARS”: ADVANCING THE MEDICAL HOME IN VENTURA COUNTY

Chris Landon, MD, FAAP, FCCP, CMD

Member-at-Large

When I arrived in March of 1989 to become the new Director of Pediatrics at the Ventura County Medical Center UCLA affiliated Family Practice Residency I was faced by the immediate question “What is the role of the pediatrician?” The future of health care was here, womb to tomb care by one well-trained family practitioner. Setting up shop in a distant corner of the hospital, our children sitting next to the coughing old men of the medicine clinic, I had ample opportunity to contemplate this as I scooped out the dead fish from the aquarium. My predecessor, Charlie Fletcher, had persuaded Dr. Siegel to come up from CHLA to decrease the transportation burden for children with cancer and blood diseases, Dr. Allen from USC for neurologic disorders, and Dr. Moss (yes, the one the UCLA Auditorium is named after) for pediatric cardiology. Clearly our role as pediatri-

cians in rural Ventura County was to provide for children with special health care needs, to provide local expertise, and to unite care that was usually fragmented.

As the solo pediatrician in charge of teaching, clinic, and a full 28 bed ward it rapidly became clear that this vision needed eyeglasses. We recruited Dr. Paul Russell from the CHLA ER and began the search for support and information in our community, educating schools that may have had little experience with unique and rare conditions, and working on a new public private partnership with the County of Ventura to provide a new dedicated physical space and community resource for the diagnosis and treatment of children with complex conditions – a Pediatric Diagnostic Center. With the retirement of Dr. Allen, we recruited Dr. Bill Goldie and began the concept of “prin-

cipal care” for children and their families with complex neurologic disorders. An inadequate public transportation system led us to establishing pediatric practices within the Ventura County Health Care Agency Ambulatory clinic system and establishing school linked health care services.

Over the past two decades we have continued to refine this concept of pediatricians as specialists within a Family Practice community of care, of providing a medical home for children with special health care needs, providing community leadership in establishing immunization registries, child abuse prevention, and alcohol and other drug exposure.

The ROADS Scholar project has been the shoelaces tying together our now 14 pediatrician group practicing in settings ranging from

a 14,000 square foot women and children's clinic with visiting pediatric specialists to a two pediatrician blended public and private practice, to a solo pediatrician within a large family practice. We sought to demonstrate how a Practice Based Research Network can improve community awareness of pediatric issues, develop funding, develop innovative communication resources, provide collegial relationships between practices, and develop physician leaders. Following local and national needs assessments, our projects have included Reach Out and Read, Obesity, Asthma, Diabetes, Developmental Screening, Dental Varnish and Maternal Depression screening.

Pediatric Diagnostic Center (PDC) pediatricians within the system of care spend the first six months at PDC working with university pediatric subspecialists to improve warm handoffs of patients prior to moving to their medical home, learn school and mental health resources, teach family practice residents, nurse practitioners, medical students, and physicians assistants, and a culture of leadership and physician champion skills. Through monthly meetings face to face contact is maintained. Email, web based video education, and list serv are used for communication and community research project implementation are used to nurture physician champion skills within their medical setting.

The results have been astounding. Five physician champions from five different clinics are leading Reach Out and Read (over 800 books dispensed monthly, parent evaluation program), multi-disciplinary Obesity (Si, Se Puede)

management, Asthma (physician leader now directing agency wide Chronic Disease Initiative and pediatricians participating in testing of Asthma EqIPP), Diabetes (school-linked health service blood ketone monitoring and electronic medical record with health and economic endpoints), Dental Varnish (on-line video with CME credit), Maternal Depression Screening (new collaboration for intervention with California Lutheran University), Developmental Screening (First 5 funded with new health care navigator for screen positives).

Despite the shoelaces, keeping the research shoe on at times has been challenging. An anchor general pediatrician from PDC championed the Reach Out and Read project. The program parent evaluation phase was delayed by 18 months by unforeseen difficulties in practices accepting the administrative responsibilities. Over 800 books are now given out monthly and 250 surveys are undergoing analysis. The obesity program has drawn from prior funded projects of KidShape, BabyShape, KinderShape, and Get Moving!/Moviernos but with the goal of permanent commitment to positions not driven by grant funding. The Asthma program, initially Asthma Wizards, a school linked health services program, has spread through the physician champion and Bureau of Primary Health Care to a Chronic Care Initiative in which the pediatrician is the lead for adult and pediatric quality improvement registry based initiatives. The Diabetes project services 15 of our 120 children with diabetes. Funded by Abbott Diabetes Care, the impact of school linked health information

services on attendance, emergency room visits and economics for health care and family are undergoing analysis. The Developmental Screening project incorporated the AAP practice pre-screen and is being implemented. The Dental Varnish project in addition to clinic presentations has been made available through the PDC video magazine and is a model for distance education within our system of care. The adoption and incorporation of Maternal Depression Screening into our system of care led to concerns regarding the pediatrician responsibility of asking questions of an unregistered adult patient. It has led to partnership with California Lutheran University to provide on-site counseling and fostered collaborative research into attachment disorder

As we move forward in health care we will continue to provide quality family centered care to every child and family. Our goal is to provide a warm hand off to our adult colleagues of patients without the health care risks of obesity, school failure, failed families, and premature morbidity of inadequately treated chronic disease.

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Coming up in 2010

SAVE THE DATE!

**AAP CA2's CLINICAL
PEDIATRICS CONFERENCE**

**Hilton Palm Springs Resort
February 11 – 14, 2010**

**AAP CA2's ADVANCES IN
PEDIATRICS CONFERENCE**

**The Flamingo Hotel, Las Vegas
April 22 – 25, 2010**

**Please note:

The Flamingo Las Vegas Hotel is offering a special
"Early-Bird Room Rate" for those who book
their room reservations by October 31, 2009!
Please visit our website for more information.

COMMITTEES AND TASK FORCES 2009 – 2010

American Academy of Pediatrics, California Chapter 2 (Appointed Positions, except Nomination Committee)

Committees and Task Forces are the lifeblood of a successful organization. They focus on specific areas of interest and thrive on the interest and dedication of its members in accomplishing its goals. Listed below are the current committees and task forces of California Chapter 2

CHAPTER 2 COMMITTEES	CHAIRPERSONS TELEPHONE / EMAIL
• Adolescent Committee	• Vacant
• Breastfeeding Committee	• Touraj Shafai, MD 909/689-9220, shafaidocs@yahoo.com
• Children with Special Health Needs	• Susan Igdaloff, MD, 213 897-3186, Susan.Igdaloff@dhcs.ca.gov
• Community Outreach Committee	• Elliott Weinstein, MD 909/621-0973, elstwein@charter.net
• Committee on Service, Education & Mentoring (CSE)	• Al Yusin, MD 323/226-5692, tmy222@aol.com
• Electronic Communications Committee	• Vacant
• Environmental Health Committee	• Cyrus Rangan, MD 213/730-3220, crangan@ph.lacounty.gov
• Fetus and Newborn Committee	• George Franco, MD 310/459-7773
• Foster Care and Adoptions Committee	• Kerry English, MD 310/668-4872, kerrydoc@ca.rr.com
• International Children's Health Committee	• Albert Chang, MD 310-994-9974, albertchang@charter.net
• Infectious Disease Committee	• Wilbert Mason, MD, 323/361-2509, wmason@chla.usc.edu
• Injury, Violence and Poison Prevention Committee	• Grant Christman, MD, gpchris@ucla.edu
• Membership Committee	• Wilbert Mason, MD, 323/361-2509, wmason@chla.usc.edu
• Nominating Committee	• Elliot Weinstein, MD 909/949-8979, elstwein@charter.net
• Pediatric Practice Committee	• Christopher Tolcher, MD 818/340-3822, ctolcher@sbcglobal.net
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• Quality Improvement Committee	• Wilbert Mason, MD, 323/361-2509, wmason@chla.usc.edu
• Resident Advocacy Committee	• Eyal Ben-Isaac, MD 323/361-2110, ebenisaac@chla.usc.edu
• Scholarship Committee	• Edward Curry, MD 909/693-8865, Edward.s.curry@kp.org
• School Health Committee / Mental Health Task Force	• Michele Roland, MD 323/361-2153, mroland@chla.usc.edu
• Substance Abuse Committee	• Trisha Roth, MD 310/452-9782, trisharoth@aol.com
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• EDSI (Early Disease Screening Initiative)	• Helen DuPlessis, MD, 310/312-9213, hduplessis@verizon.net
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CLINICAL PEDIATRICS

Southern CA Pediatric Postgraduate Meeting

February 11-14, 2010

Hilton Palm Springs Resort

Topics that are planned to be discussed are:
Office orthopedic issues, sports medicine, sleep
apnea, infectious disease, dermatology,
and behavioral medicine
Up to 14.5 CME Hours

ADVANCES IN PEDIATRICS

*21st Annual Las Vegas
Postgraduate Pediatric Meeting*

April 22-25, 2010

Flamingo Las Vegas Hotel**

Topics that are planned to be discussed are:
Autism update, neurology, infectious disease,
GI, and pulmonary
Up to 16 CME Hours

For up-to-date information and registration forms, please visit our website at:

www.aapca2.org and click on "Future Events"

**Please note: The Flamingo Las Vegas Hotel is offering a special
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