PEDIATRIC NEWS

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American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

California Chapter 2

President's Report

It Was the Best of Times; It Was the Worst of Times

Reflections Immunization Controversies

By Wilburt Mason, MD, MPH, FAAP

Since the first of the year, it has been quite a rollercoaster ride with regard to immunization practice in the country and California. The year began on an up note. Dr. Robert Schechter published an article in the archives of general psychiatry (Arch Gen Psychiatry2008;65:19-24) in which he documented the continued increase in cases of autism reported in California subsequent to the removal of thimerosal from vaccines. Another nail in the coffin of the myth of thimerosal causation of autism. Or so we thought. Then came the news that the opening episode of a new ABC primetime drama "Eli Stone" was aired over the objections of the American Academy of Pediatrics in which a large jury verdict was awarded to a Mother of an autistic child based on evidence that the autism was due to thimerosal in an influenza vaccine. To its' credit the National AAP responded promptly and vigorously to the presentation. A strongly worded letter to ABC Television was sent by Dr. Rene R. Jenkins, President of the American Academy criticizing the network for a misleading and dangerous message presented in the show. In the letter she stated, "ABC will bare responsibility for the needless suffering and potential deaths of children from parent's decisions not to immunize based on the content of the episode."

Virtually at the same time as the Eli Stone controversy was unfolding, a measles outbreak in San Diego was getting underway. On January 13, a seven-year-old-boy who had been visiting Switzerland with his family returned to the United States. Eight days later he came down with cough, coryza, conjunctivitis and, three days later, the onset of a rash. He was seen in his pediatrician's office with a fever of 104 F and was tested in a local hospital's laboratory. Measles immunoglobulin M was positive on February 1st. The day after Eli Stone's debut. Coincident with the TV program, the first of 11 secondary cases of measles occurred in San Diego involving an unvaccinated in infants and children age ten months to nine years. Among the secondary cases were the patient's siblings, five children in their school, and four additional children who had been in the Pediatrician's office at the time the index case was there. Three of the children were less than twelve months of age and one of the three was hospitalized for two days for dehydration. Another infant traveled by airplane to Hawaii while infectious exposing another 250 people to the virus. The index case had not been immunized because of personal beliefs held by the family regarding immunizations. They had applied for and received a personal beliefs exemption so their children could attend school without being vaccinated. The school that they attended had an enrollment of 376 children from five to 14 years of age. Approximately 10% of the children held personal belief exemptions on file at the school. Of these, four had been vaccinated against measles, 11 were vaccinated during the outbreak and the remaining 21 without immunity to measles were placed under voluntary quarantine for 21 days after their last exposure. Overall during the outbreak, approximately 70 children exposed to children with the measles in the school, a day care center, the Pediatrician's office and other community setting placed under voluntary home quarantine because their parents either declined measles vaccination or they were too young to be vaccinated. Prompt case identification, prophylaxis and quarantine measures implemented by the San Diego department of Health limited the outbreak to a relatively small number of individuals. Nevertheless the event clearly underscored the potential for transmission of measles when it is introduced into a population with sufficient number of susceptible individuals.

Finally on March 7th, Jon and Terry Poling held a news conference in Atlanta reporting the results of a confidential decision by the National Vaccine Injury Compensation Program that awarded compensation because of injuries allegedly incurred from vaccination. This was a highly complex and possibly unique case in that the child had an underlying mitochondrial disorder that put her at risk for metabolic disruption from any types of inflammation or other stresses. The document was not made public, but it does state that the government concluded that vaccines aggravated a rare underlying metabolic condition that resulted in a brain disorder "with features of autism spectrum disorder". This set off a flurry of articles and interviews in the media reviving the debate around vaccines and autism and the role of thimerosal in the etiology

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AAP CA2 BOARD OF DIRECTORS 2006-2008

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Phone: 323/361-2509
Fax: 323/361-2661
email: wmason@chla.usc.edu

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Fax: 626/569-9346
email: madoyle@ph.lacounty.gov

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Fax: 818/375-3870
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email: bhh455@aol.com

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Fax: 526/988-7616
email: kubakloth@comcast.net

Luis Montes, MD, FAAP
Phone: 323/640-6769
Fax: 323/665-4228
email: lmontes@chla.usc.edu

Pejman Salimpour, MD, FAAP
Phone: 818/205-2555
email: psalimpour@nexcare.org

Glenn Schlundt, MD, FAAP
Phone: 626/449-8440
Fax: 626i/449-1321
email: gschlundt@rosecitypediatrics.com

Michelle Thompson, MD, FAAP
Los Angeles, CA 90027
Phone: 323/669-2122
email: michelle@vasflam.com

Paula Whiteman, MD, FACEP, FAAP
Phone: 310/423-8780
email: Paula.Whiteman@cshs.org

Area Representatives

Kern County
John Digges, MD, FAAP
Phone: 661/873-9333
email: jdigges@bak.rr.com

Riverside County
Christopher D. Dael, MD, FAAP
Phone: 909/358-5980
email: cdael@co.riverside.ca.us

San Bernardino County
Olusula A. Oyemade, MD, FAAP
Phone: 909/944-7099
Fax: 909/955-4865
email: Oyem4yu@aol.com

High Desert, San Bernardino County
Damodara Rajasekhar, MD, FAAP
Phone: 760/242-3004
Fax: 760/242-3009
email: drajasekhar@charter.net

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Fax: 805/473-3707
email: chairmanofthebored@msn.com

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Fax: 805/962-0644
email: charish@mac.com

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Phone: 310/517-3721
Fax: 310/517-4258
email: Barbara.A.Carnes@kp.org

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Phone: 805/493-1964
email: docksaul@aol.com

Lois Lipeles, MD, FAAP
Phone: 805/520-3248
email: lois.lipeles@ventura.org

Executive Director
Kathleen Shematek, MPH
Phone: 213/250-4876
Fax: 970/314-9984
email: kshematek@aap.net

SAVE THE DATE!

CLINICAL PEDIATRICS

Southern California Pediatrics Postgraduate Meeting

February 12 – 15, 2009

Hilton Palm Springs Resort

Palm Springs, California

ADVANCES IN PEDIATRICS

20th Annual Las Vegas Postgraduate Meeting

April 16 – 19, 2009

The Flamingo Las Vegas Hotel

Las Vegas, Nevada

Don't Forget To VOTE!

AAP California Chapter 2 elections are being held during May. Voting members have received their ballots ...please mail your ballots prior to May 21, 2008 or fax to 970-314-9984.

President's Report

continued from cover

of autism. (An excellent list of articles, editorials and interviews with regard to this event can be found at http://www.aap.org/advocacy/releases/autismnews.htm.) Numerous vaccines spokespersons jumped at the chance to comment on the event. These included radio shock jock Don Imus and actress Jenny McCarthy who were in the media. Even Republican Presidential Candidate John McCain commented that "there is strong evidence" that vaccine preservative was associated with autism. They tended to drown out the protestations from the Centers for Disease Control and others claiming that this was related more to the underlying condition the vaccine. "This does not represent anything other than a very special situation", stated Dr. Julie Gerberding who is head of the CDC.

On March 14, 2007, the CDC published talking points regarding the vaccine injury compensation case in the news. These talking points were created and distributed by Mary M. McCauley, MTSC, Acting Deputy, Associate Director for Communication Science, National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, and can be found on the Chapter 2 website at aapca2.org. It offers useful information to respond to parents concerns regarding immunization of children and the safety of the process of vaccine manufacture and delivery in the United States. The AAP website also offers a bounty of useful information with regard to thimerosal and vaccine safety.

So as the dust settles, what have we learned since the beginning of the year? First we now know from several studies, the most recent of which came from California, that removal of thimerosal from vaccines has not been associated with the reduction and the rate of autism. This was one of the most potent arguments put forth by anti-vaccine groups and it is now clearly established that autism, at least epidemiologically, is not associated with thimerosal. Second, we have learned that very liberal policy of personal belief exemption that exists in California has placed the population in some degree of jeopardy because of increasing numbers of unimmunized children in our communities. The experience from San Diego clearly shows that inadvertent introduction of measles into a community can cause spread of disease and tremendous loss of time and money in the attempts to contain the illness. To those who claim that their children will never be exposed to measles if they stay away from third world countries the experience in San Diego is a lesson. Switzerland is not a developing country nor is Japan from where another recent outbreak in the US originated. Parenthetically, the last large vaccine preventable disease outbreak in the United States, namely that of the mumps outbreak in the midwest two years ago, was imported from England also not a developing country. Finally, we have learned that the voices against vaccination of children are still active and regularly in the media supporting their cause.

We learned at the recent annual leadership forum in Chicago that the National Academy of Pediatrics is very concerned about media exposure that anti-vaccine activists are receiving and are working actively to improve the response time and the ability of the Academy with regard to this issue. The President elect of the Academy Dr. David Tayloe has made several recent appearances on shows like, Good Morning America and others placing the pro-vaccine message before the public. We also learned that they are working closely with some of the more responsible autism groups including, Defeat Autism Now (DAN) to emphasize the need for more research with regard to autism and offer hope for useful therapies for autism for families afflicted by the condition in the future. Even leaders of the autism community acknowledge that they don't want to add an epidemic of measles to the epidemic of autism in the United States today. Pediatricians need to become much more familiar with autism and its early diagnosis and management and provide this information to their parents, patients and families when the need arises. We will endeavor to keep this issue alive and information for you in this newsletter in the future.

COPEM Update

By Paula J. Whiteman, FACEP, FAAP

When parents say "We rushed to the Emergency Department!" this is not just a figure of speech. People just don't mosey on over to the ED. When the decision is made that their child needs that level of medical attention, they hurry on over and as a result, approximately 90% of children arrive by private conveyance. In an unexpected situation, odd hours, or an unfamiliar environment, people tend to head to the closest ED possible. Unlike the trained ambulance crew that transport the other ten percent, most parents are not thinking about which hospital is best equipped for treating pediatric emergencies. Thus, most infants and children arrive at their local EDs regardless of the hospital's Emergency Department Approved for Pediatrics (EDAP) status, the presence of a pediatric floor, or pediatric intensive care unit.

Here in Los Angeles County ambulances preferentially take sick and injured children to EDAP designated hospitals, because non-EDAP hospitals are not certified to meet the same standards. However since most pediatric patients aren't routed through this selection process, it would be prudent to make sure all EDs are raised to a minimum level of preparedness for pediatric emergencies. This would include having appropriately sized equipment and supplies, and a certain number of staff trained in pediatric advanced life support. The hospitals should also have quality improvement policies and procedures in place to maintain consistency.

To ensure that all hospital EDs are properly prepared for pediatric patients, the state of California Emergency Medical Services Agency recently proposed the 'Administration, Personnel, and Policy for the Care of Pediatric Patients in the Emergency Department.' This document sets forth recommendations similar to our (EDAP) standards which are used in Los Angeles County. Since our local EDAPs already meet these criteria, this is directed to non-EDAP facilities across the state. For a variety of reasons, however, many hospitals in Los Angeles County have opted out of the voluntary EDAP system. These hospitals will be affected by the new government requirements which are being finalized. Hopefully, EDs across the state will endorse these guidelines when the final version is published.

Coding for Dollars - and Contracting for Success

By Chris Tolcher, M.D., F.A.A.P. Chair, Pediatric Practice Committee

We work very hard doing what is best for children. And we all know that too often we don't get paid well for much of the work that we do. We even give away medical care for free—either to patients who have no insurance, or to patients whose insurance companies deny payment for the full extent of our services. And what about all of the medical care we provide over the telephone which saves children office and E.R. visits?

But how does a practicing pediatrician earn a better income without working longer hours and seeing more patients? We can do it by becoming expert at coding the most effectively for each patient visit, and also by negotiating contracts that get us the best reimbursement for our coding efforts. Both of these require a time investment on our part, for there is no "free lunch" when it comes to maximizing our reimbursement. We must first spend some time learning as much as we can about proper coding and contracting. How does a busy pediatrician do this? A great way to start is by attending the "Coding for Dollars and Contracting for Success" half-day seminar that we have put together for the pediatric provider on Saturday, May 10, 2008. It is being held at Pomona Valley Hospital Medical Center (in—you guessed it—Pomona) from 8AM until 12:45PM. It is affordable (only $50), and it includes a hot breakfast and coffee break. And don't worry about traffic since it's a Saturday morning commute!

We have a panel of excellent speakers who are very knowledgeable in the fields of coding and contracting with payers. Allen Schwartz, M.D., F.A.A.P., is a practicing pediatrician in San Diego who is also a member of the AAP National Committee on Coding and Nomenclature. He will be speaking on the subject of problem areas in coding—the dilemmas we face like mental health care, code bundling, using modifiers appropriately, and even an introduction to the new telephone care codes which are new in 2008 (just to name a few). His presentation at last year's seminar on the essentials of proper coding was well-received by those in attendance. But this year, Dr. Schwartz will focus on fine-tuning your coding skills, and no matter how experienced you may be, you are certain to come away with more pearls to become the best coder that you can be—your first step toward reaping better reimbursement without seeing more patients!

We will then have a panel of two speakers on the critical subject of negotiating contracts with insurance payers. Kim Fenton and Melissa Christian of Coastal Healthcare Consulting Group have a combined 42 years of experience working on the business side of healthcare, most of that dealing with physician-payer contracts. They have spoken at conferences sponsored by the San Diego County Medical Association, and other medical organizations, and they have very practical and money-saving advice to offer. They have experience on the "other side" of contracting for payers, but now work with physicians to help them get the best contracts with insurance companies. They will focus on the nitty-gritty of how to examine your practice's payer mix, and how to critically evaluate your contracts to determine where you are hemorrhaging money and how to take action. Most of us are much better clinicians than business people, so Kim and Melissa will show us how to go from teddy-bear in the exam room to bulldog in the boardroom (well, maybe that's a little exaggerated…). The title of their presentation is appropriate: "Work Smarter, Not Harder: Contracting Savvy for the Physician".

I must say that you would have to be somewhat crazy to pass up an opportunity to spend a few hours on a Saturday learning how to work more effectively and profitably without working yourself into the ground. This is a truly exciting conference, and I hope that as many of you as possible can take advantage of this opportunity. This is a practical way in which your AAP membership is being put to work for YOU—bettering your practice, and improving your bottom line. So do you want to work smarter—or harder? You decide.

Seating is limited, so contact our Chapter 2 Executive Director, Kathleen Shematek, now to reserve your space. She can be reached at (213) 250-4876. This meeting is co-sponsored by the Los Angeles County Medical Association and Synapse Practice Management.

No matter how experienced you may be, you are certain to come away with more pearls to become the best coder that you can be—your first step toward reaping better reimbursement without seeing more patients!

You are cordially invited to attend

"CODING FOR DOLLARS AND CONTRACTING FOR SUCCESS"

(a seminar on improving reimbursement and contracts with payers in pediatric practice)
Sponsored by the Pediatric Practice Committee
American Academy of Pediatrics, California Chapter 2

SATURDAY, MAY 10, 2008, 8 AM – 12:45 PM
Pomona Valley Hospital Medical Center
Pitzer Auditorium (in hospital, 1st floor)
1798 N. Garey Ave. Pomona, CA 91767
(off the 10 Freeway, East of the 57)

PROGRAM

8:00 – 8:30 am	**Registration, Hot Breakfast, and Social**
8:30 – 8:40 am	**Introduction and Opening Remarks: Chris Tolcher, MD, FAAP Committee Chair**
8:40 – 10.00 am	**Allan D. Schwartz, MD, FAAP** **Member, AAP National Committee on Coding and Nomenclature** **"Coding 2008: Sharpening Your Pediatric Coding Skills"**
10:10 – 10:25 am	**Coffee Break**
10:25 – 11:45 am	**Kim Fenton and Melissa Christian** **Coastal Healthcare Consulting Group, Inc.** **"Work Smarter, Not Harder: Contracting Savvy for the Physician"**
11:45 – 12:30 pm	**Panel Discussion, Case Studies and Q & A** **Facilitated by Glenn Schlundt, MD, FAAP**
12:30 – 12:40 pm	**Closing Remarks: Chris Tolcher, MD, FAAP**

(meeting supported, in part, by Los Angeles County Medical Association and Synapse Practice Management)

This meeting is directed to pediatricians and office staff responsible for contracting, coding, billing, and practice operations. There is a $50.00 per person charge. Reservations and inquiries: (213) 250-4876 or email: kshematek@aap.net. Mail checks/registration to AAP CA2, Box 527, 4067 Hardwick Street, Lakewood, CA 90712 or fax with credit card information to (970) 314-9984. Registration by May 8 is requested.

ADVANCE REGISTRATION – "Coding and Contracting"

Name and title of attendees _____

_____

Telephone _____ Email _____

Credit Card: Master Card Visa (circle one) Card # _____

Expiration Date _____ Signature _____

Name on Credit Card (please print) _____

Address: _____ ZIP Code on CC billing address

Total Amount: _____ Security Code on back of credit card

ACE Study Description

The Adverse Childhood Experiences (ACE) Study compares several common categories of adverse experiences in the childhoods of over 17,000 middle-class Americans with their health status, well-being, and social performance a half-century later.

The ACE Study began by accident in 1985 when, while operating a large weight loss program at Kaiser Permanente (KP) in San Diego, a high drop out rate was found, almost totally limited to patients who were successfully losing noticeable amounts of weight. In the course of exploring this counterintuitive situation, histories of childhood abuse were discovered and it became evident that while obesity might be the most obvious of a patient's problems, it often was the least important when compared to other information concealed by time, shame, secrecy, and social taboo. This unexpected finding led to the discovery that obesity was sometimes being used as an unconscious solution to unrecognized problems dating back to childhood. Indeed, while obesity posed clear long-term health risks, it often provided hidden, immediate benefits; many found it sexually, physically, or emotionally protective.

Further evaluation of these patients suggested that adverse childhood experiences might play a significant role in adult health and well-being of the general population. Discussions between Dr. Vincent Felitti at Kaiser Permanente and Dr. Robert Anda at the Centers for Disease Control led to creation of the Adverse Childhood Experiences (ACE) Study in which >17,000 adult KP members agreed to provide anonymously, during the course of comprehensive medical evaluation, intimate and detailed information about the following childhood experiences:

- childhood sexual abuse
- serious physical abuse
- chronic emotional abuse, and

growing up in a household where:

- they were physically or emotionally neglected as children
- someone was alcoholic or a drug user
- a household member was imprisoned
- mother was treated violently
- someone was mentally ill, institutionalized, suicidal, or chronically depressed

- both biological parents were not present during childhood.

These events turned out to be unexpectedly common in a middle-class population. For instance, one in 4 women and one in 7 men acknowledged contact sexual abuse during childhood or adolescence. One in 17 grew up in a household where one of its members was imprisoned. One in seven grew up in a home where mother was treated violently.

The ACE Study documented that adverse childhood experiences:

- are unexpectedly common in the general population, although well-concealed,
- have a profound effect on adult health and well-being a half century later, and
- are the prime determinant of adult health status in the United States, as well as of the social fabric of the nation.

The same cohort is being followed prospectively in order to match (a half-century later) adverse childhood experiences against outpatient medical utilization, pharmacy costs, emergency department visits, hospitalization, and death. The first of these prospective publications illustrated the relationship of adverse childhood experiences to psychotropic medications a half-century later.

The Adverse Childhood Experiences Study has direct and important relevance to the practice of medicine and to the field of social planning. Its findings indicate that many common public health and adult biomedical and mental health problems are the result of events and experiences present but not recognized in childhood. The ACE Study challenges as needlessly superficial the current conceptions of depression and addiction, showing them to have a very strong dose-response relationship to antecedent life experiences.

Further information about the ACE Study is available at www.ACEStudy.org and http://www.cdc.gov/NCCDPHP/ACE/

Vincent J. Felitti, MD
VJFMDSDCA@mac.com
Written for Trisha Roth, MD, FAP

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

CALIFORNIA CHAPTER 2 FACTS……

I already belong to the National AAP, why should I become a member of the California Chapter 2?

Advocacy

- Increase your knowledge of and participation in legislative and advocacy activities at a local level.
- Increase involvement in the legislative arena to positively influence the quality of pediatric practice and the welfare of children in your state.
- Provide opportunities for pediatrician involvement in major health issues that include participation in committees, collaboration with community agencies, and participation in office-based research.
- Promote the interests of California pediatricians in the American Academy of Pediatrics.
- Review timely information on legislative issues with opportunity to contact and inform legislators on issues important to pediatricians.

Leadership

- Provide pediatricians opportunities to participate in the local, state, and national legislative process on issues such as medical insurance for all children, reimbursement for pediatric providers, provision of medical home activities, provision of medical care to foster children and the transition from pediatric care for young adults.
- Provide opportunity to participate in Chapter and National committees.

Networking

- Network with other pediatricians with similar interests.
- Improve chapter membership participation on national AAP affairs.

Education

- Receive chapter newsletter and other informative mailings.
- Attend Continuing Medical Education meetings sponsored by the Chapter (discounted fees for Chapter members)
- Disseminate information on pediatric quality of care and safety issues of importance such as childhood obesity, violence, abuse, environmental health, and pain management.

What has your Chapter done lately?

- Members serve on various community and legislative-oriented committees promoting the well-being of children.
- Provide lectures to law enforcement, religious leaders and foster parent groups on various health issues pertaining to infants and adolescents including "shaken infant syndrome" and the prevention of child maltreatment.
- Development of working relationships with local governmental officials and agencies to facilitate improvements in health and mental health services for children, particularly those in foster care.
- Met with state program and lawmakers focusing on early hearing screening for newborns.
- Held "meet and greet" meetings with local legislators and fostered Chapter members' attendance at Legislative Day in Sacramento.
- Actively work with area pediatric residency programs to facilitate the development of advocacy rotations.
- Developed a Pediatric Practice Committee to focus on the business of being in practice.
- Completed a Strategic Plan to guide Chapter activities over the next two years.
- Participation in a coalition of provider groups to focus on childhood obesity.
- Work with local immunization coalitions to provide vaccines and training to pediatricians and their office staff.
- Committee on Breastfeeding is working with local hospitals to encourage new mothers to breastfeed their new babies.
- Provided $5000 in scholarships to promising local high school students through the Chapter's Medicine-Biologic Scholarship program.

Annual Chapter Dues:

Voting Fellows $165 Candidate Fellows $120 Post Resident Fellows $0 Residents $0

Whom do I contact?

Contact Executive Director Kathleen Shematek at 213/250-4876 or kshematek@aap.net.

You can visit the California's Chapter 2 Web page at www.aapca2.org**.**

 Reviewed 02/08

"Don't be left out! More than 90% of your colleagues are part of the pediatrics community through the American Academy of Pediatrics……you should be, too! AAP National and Chapter dues statements are going out now. Please participate in supporting AAP efforts on the national, state, and local levels on behalf of all children and the pediatricians who care for them."

EDSI: Early Developmental Screening Intervention

Do developmental and behavioral problems seem more prevalent in your practice?
Do anticipatory guidance and developmental monitoring cause problems with time management in your busy practice? Is it diffi cult to decipher the systems for referral for developmental or behavioral services?
Are you prepared for the new pediatric maintenance of certifi cation requirements?
Do you have the skills in designing and carrying out quality improvement cycles that are required for maintenance of certifi cation beginning in 2010?

Improving Preventive Care in Pediatrics

By Helen DuPlessis, MD, MPH
University of California, Los Angeles

National surveys show that parents value well child care as a source of information and reassurance. Pediatricians spend much of their time eliciting parent questions and concerns, listening to parents, and responding to their informational needs and any health and behavioral/developmental issues. Despite the importance of preventive care to parents and pediatricians alike, national surveys show that pediatricians face time management problems fi tting anticipatory guidance and developmental monitoring into their busy practice and also struggle to decipher the systems for referral for developmental or behavioral services. Pediatricians also face the challenge of fi tting the forthcoming revised Bright Futures guidelines and recent AAP statements on screening for developmental problems and autism in young children into practice. Improvement is important since parents often have unmet informational needs, and many developmental problems in young are not identifi ed or addressed until school entry.

The Early Developmental Screening and Intervention (EDSI) collaborative, launching in Fall 2008 in Los Angeles County, will help pediatricians improve effectiveness and satisfaction with preventive care for young children.

How do pediatricians benefi t?

The EDSI project supports Los Angeles pediatricians in putting effective, reliable and time-saving systems of preventive and developmental supports into practice.
Benefi ts to participants include:

- Learning quality improvement skills that are required for pediatric recertifi cation beginning in 2010;
- Putting effective, time-saving tools and strategies into practice with ongoing support for improvement from national faculty;
- Improving preventive care and health-promotion for young children;
- Receiving CME credits at no cost.

How does this help pediatricians meet maintenance of certifi cation requirements?

Beginning in 2010, pediatricians who were initially certifi ed after 1987 must demonstrate competency and evidence of quality improvement activities within their practice. Pediatricians must complete one complete quality improvement cycle every seven years to maintain certifi cation. It is planned that board-certified physicians who participate in EDSI will be eligible for credit for the Performance in Practice part of maintenance of certifi cation. Details of the new American Board of Pediatrics certifi cation requirements can be found at https://www.abp.org/ABPWebSite/.

How is the AAP involved?

Nationally the AAP is working with chapters to provide pediatricians with options to meet the quality improvement requirements for recertification. The AAP California Chapter 2 is in the process of developing a long term quality improvement support initiative for our members. We have partnered with EDSI faculty from the University of California, Los Angeles Center for Healthier Children, Families and Communities, and the Center for Healthcare Quality at Cincinnati Children's Hospital Medical Center in what we hope will be the fi rst of many efforts to support local pediatricians in improving care for their patients and families, and in meeting the new recertifi cation requirements.

Who can participate?

EDSI invites participation from leading pediatric and family medicine practices in Los Angeles County that are dedicated to providing excellent health care. Medical groups, clinics, and small group practices are all encouraged to participate. Residency Training programs are eligible to participate as well.

What is involved?

The quality improvement activities begin in Summer 2008. Over a 12 month period, participants attend three two-day Learning Sessions, each followed by an action period where they try out changes in their setting. Expert faculty will coach participants on practical strategies for change and assist them in applying key change ideas into their own organizations. Lead faculty include Marian Earls, MD, FAAP (Chair, American Academy of Pediatrics Learning Network) and Peter Margolis, MD, PhD (Co-Director, Center for Health Care Quality).

How do I learn more?

Contact EDSI by email at edsi@ucla.edu for more information and to discuss the project goals and requirements with project faculty. The EDSI project is accepting applications beginning in April 2008.

This is an official CDC Health Advisory Distributed via Health Alert Network

Measles outbreaks in the United States: Public health preparedness, control and response in healthcare settings and the community. A measles outbreak linked to an importation from Switzerland currently is ongoing in Arizona. The first case, with rash onset on February 12, 2008, occurred in an adult visitor from Switzerland who was hospitalized with measles and pneumonia. This hospital admission prompted verification of the measles immune status of approximately 1800 healthcare personnel and vaccination of those without evidence of immunity. Through March 31, 2008, nine confirmed cases have been reported to the Arizona Department of Health Services, and there are two suspected cases (one in a Colorado resident) and hundreds of contacts under investigation. The nine case-patients range in age from 10 months to 50 years. All but one were infected in healthcare settings, one of the five adult case-patients is a healthcare worker, and all cases were unvaccinated at the time of exposure.

In January and February 2008, San Diego experienced an outbreak of 11 measles cases, with an additional case-patient who was exposed in San Diego but became ill in Hawaii. The index case was an unvaccinated child who had recently traveled to Switzerland, where a measles outbreak is ongoing (see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5708a3.htm). Transmission in this outbreak occurred in a doctor's office as well as in community settings. Measles genotype D5 was identified from more than one case in the San Diego and Arizona outbreaks; this genotype is currently circulating in Switzerland (see http://www.eurosurveillance.org/edition/v13n08/080221_1.asp). Confirmed measles cases also have been reported from New York City (involving genotype D4, which is identical to the genotype responsible for a large ongoing measles outbreak in Israel; see http://www.eurosurveillance.org/edition/v13n08/080221_3.asp) and from Virginia (importation from India). In addition, two measles cases recently confirmed in unvaccinated siblings from Michigan may have resulted from exposure during a long stop-over in the Atlanta airport.

Although measles is no longer an endemic disease in the United States, it remains endemic in most countries of the world, including some countries in Europe. Large outbreaks currently are occurring in Switzerland and Israel. In the United States from January 1 through March 28, 2008, 24 confirmed cases of measles resulting from importations from endemic countries have been reported to the Centers for Disease Control and Prevention (CDC). These cases highlight the ongoing risk of measles importations, the risk of spread in susceptible populations, and the need for a prompt and appropriate public health response to measles cases. Because of the severity of the disease, people with measles commonly present in physician's offices or emergency rooms and pose a risk of transmission to other patients and healthcare personnel in these and in inpatient hospital settings. Healthcare providers should remain aware that measles cases may occur in their facility and that transmission risks can be minimized by ensuring that all healthcare personnel have evidence of measles immunity and that appropriate infection control practices are followed.

Transmission and case definition

Measles is a highly contagious disease that is transmitted by respiratory droplets and airborne spread. The disease can result in severe complications, including pneumonia and encephalitis.

The incubation period for measles ranges from 7 to 18 days. The diagnosis of measles should be considered in any person with a generalized maculopapular rash lasting ≥ 3days, a temperature ≥ 101ºF (38.3ºC), and cough, coryza, or conjunctivitis. Immunocompromised patients may not exhibit rash or may exhibit an atypical rash.

Recommendations

Rapid and aggressive public health action is needed in response to measles cases. Case investigation and vaccination of household or other close contacts without evidence of immunity should not be delayed pending the return of laboratory results. Preparation for other control activities may need to be initiated before laboratory results are known. Control activities include isolation of known and suspected case-patients and administration of vaccine (at any interval following exposure) or immune globulin (within 6 days of exposure, particularly contacts ≤ 6 months of age, pregnant women, and immunocompromised people, for whom the risk of complications is highest) to susceptible contacts. For contacts who remain unvaccinated, control activities include exclusion from day care, school, or work and voluntary home quarantine from 7 to 21 days following exposure. Persons who are known contacts of measles patients and who develop fever and/or rash should be considered suspected measles case-patients and be appropriately evaluated by a healthcare provider. If healthcare providers are aware of the need to assess a suspected measles case, they should schedule the patient at the end of the day after other patients have left the office and inform clinics or emergency rooms if they are referring a suspected measles patient for evaluation so that airborne infection control precautions can be implemented prior to their arrival.

Healthcare providers should maintain vigilance for measles importations and have a high index of suspicion for measles in persons with a clinically compatible illness who have traveled abroad or who have been in contact with travelers. They should assess measles immunity in U.S. residents who travel abroad and vaccinate if necessary. Measles outbreaks are ongoing in Switzerland and Israel, and measles outbreaks are common throughout Europe. Measles is endemic in many countries, including popular travel destinations, such as Japan and India. Suspected measles cases should be reported immediately to the local health department, and serologic and virologic specimens (serum and throat or nasopharyngeal swabs) should be obtained for measles virus detection and genotyping. Laboratory testing should be conducted in the most expeditious manner possible.

Preventing transmission in healthcare settings

To prevent transmission of measles in healthcare settings, airborne infection control precautions (available at http://www.cdc.gov/ncidod/dhqp/gl_isolation.html) should be followed stringently. Suspected measles patients (i.e., persons with febrile rash illness) should be removed from emergency department and clinic waiting areas as soon as they are identified, placed in a private room with

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the door closed, and asked to wear a surgical mask, if tolerated. In hospital settings, patients with suspected measles should be placed immediately in an airborne infection (negativepressure) isolation room if one is available and, if possible, should not be sent to other parts of the hospital for examination or testing purposes.

All healthcare personnell should have documented evidence of measles immunity on file at their work location. Having high levels of measles immunity among healthcare personnel and such 1 Healthcare personnel are defined as any persons (i.e., medical or non-medical, paid or volunteer, full- or part-time, student or nonstudent, with or without patient-care responsibilities) who works at a facility that provides health care to patients (i.e., inpatient and outpatient, private and public). documentation on file minimizes the work needed in response to measles exposures, which cannot be anticipated. Recent measles exposures in hospital settings in three states necessitated verifying records of measles immunity for hundreds or thousands of hospital staff, drawing blood samples for serologic evidence of immunity when documentation was not on file at the work site, and vaccinating personnel without evidence of immunity.

Recommendations for vaccination

Measles is preventable by vaccination. MMR vaccine is routinely recommended for all children at 12–15 months of age, with a second dose recommended at age 4–6 years. Two doses of MMR vaccine are recommended for all school students and for the following groups of persons without evidence of measles immunity2: students in post–high school educational facilities, healthcare personnel, and international travelers who are ≥ 12 months of age. Other adults without evidence of measles immunity should routinely receive one dose of MMR vaccine. To prevent acquiring measles during travel, U.S. residents aged ≥ 6 months traveling abroad should be vaccinated or have documentation of measles immunity before travel. Infants 6–11 months of age should receive one dose of monovalent measles vaccine (or MMR vaccine if monovalent vaccine is not available) prior to travel.

During a measles outbreak, additional vaccine recommendations should be considered: 1) children ≥ 12 months of age should receive their first dose of MMR vaccine as soon after their first birthday as possible and their second dose 4 weeks later, 2) healthcare facilities should strongly consider recommending one dose of MMR vaccine to unvaccinated healthcare personnel born before 1957 who do not have serologic evidence of immunity or physician documentation of measles disease, and 3) one dose of measles or MMR vaccine should be considered for infants ≥ 6 months of age.

Further information on measles and measles vaccine is available at state health departments' websites and at http://www.cdc.gov/vaccines/vpd-vac/measles/default.htm.

PROS

Heide Woo, MD

PROS—Pediatric Research in Office Settings—a Practice Based Research Network of the American Academy of Pediatrics whose mission is to improve the health of children and enhance primary care practice by conducting national collaborative practice based research.

"The easiest PROS study ever! All you need to do is be the kind of doctor you want to be in caring for your patients and their families! PROS does the rest!"

This is a recent description of the new PROS study which will be rolling out in 2008 called CEASE (Clinical Effort Against Second-hand smoke Exposure). CEASE will examine Pediatricians' effectiveness in counseling parents to quit smoking and/or establishing and enforcing no smoking rules in the home(s)/car(s). The study trains the Pediatricians in counseling and referrals and, if desired by the Pediatrician, recommending OTC or prescription medications to assist in smoking cessation. It also establishes office based changes that involve the entire staff in promoting health. The intervention has been PROVEN to work in smaller studies but our desire is to prove that this can be done at a national level.

This study will not only train you and your staff in delivery of this intervention, but also supply your office with a research assistant (or funds to hire your own). They will do all the consenting and data collection so you and your staff will be free to do the job that you WANT to do.

Because many of our parents see us much more than their own physicians, Pediatricians have a unique opportunity to promote not only the health of children, but also the parents--which additionally improves the health of our patients many fold! A true bargain for your time investment!

If you have parents in your practice who smoke, and you are interested in learning how to help them quit as well as lessen your patients' exposure to second hand smoke, please JOIN PROS. You can log on to www.aap.org/PROS and join or get more information on PROS and other PROS studies. A currently ongoing study is SSCIB (Secondary Sexual Characteristics in Boys) and another study soon to be launched is BMI2 (Brief Motivational Interviewing to reduce BMI) which is an OBESITY PREVENTION study. You can also contact me at hwoo@mednet.ucla.edu or (310) 825-6208.

AAP Chapter 2 - Winter Town Hall Meeting

Kenneth Saul, MD, FAAP

A few months ago we held the kickoff AAP Chapter 2 Town Hall Meeting, a quarterly get-together designed to bring local Pediatricians together, hear a good lecture and have a meaningful discussion on various controversies impacting suburban Pediatricians.

RESULTS / SUMMARY:

1. Lecture by Dr. Lieberthal on the new Bronchiolitis Guidelines: Dr. Lieberthal gave an excellent lecture on the new Bronchiolitis Guidelines including the lack of efficacy of Bronchodilators and Steroids, as well as the controversies surrounding how much oxygen these babies need. (Pulse Ox > 90 considered adequate)

2. Vaccine Reimbursement: There was a much-heated discussion about all the new expensive vaccines and frequent inadequate reimbursement from insurers. Members were reminded about the AAP statement recommending minimal acceptable reimbursement at at least 17% over cost. This statement hasn't been adhered to by many insurance companies, but it has seemed to help at least raise most of our rates so we won't lose money. Make no mistake, the rates are still inadequate for all the risks we take fronting so many thousands of dollars every month, but it is a step in the right direction.

3. Governor's Health Reform Plan: This discussion centered mostly on the unfair proposal of Pediatrician's paying 2% of gross revenue to help cover universal health coverage. The consensus was that with the insurance companies making billions per year and insurance executives making 9-figure compensation, it seems ludicrous for hard-working Primary Care doctors in the trenches to pay anything. One could also make the argument that "for profit" hospitals and big pharma could also afford to kick in some cash without having to descend so far down the food chain as us. Another point brought up was that if, after all of the above, we were forced to pay into the system, the bill should be paid by those of our former colleagues who got personally rich in IPA and HMO administration and then filed corporate bankruptcies without paying Pediatricians and other doctors.

4. Strep Treatment: Discussion that Cephalosporin's have a better cure rate than Penicillin, but consensus was that Penicillin is still the 1st line drug of choice.

5. Hepatitis B in Nursery: Discussion of some doctors waving the Hep B in the nursery for low risk mothers. Consensus was that it is still wise to follow the AAP Policy of giving the Hep B Vaccine to all newborns before hospital discharge.

6. Otitis RX: Discussion of possibly changing 2nd line choices for Otitis especially with the emergence of the 19A Pneumococcal Clone. Consensus was divided. High dose Amox was definitely still 1st line choice, but the audience (including the ID experts) was divided on 2nd line choices between 3rd generation Cephalosporin's (Ominicef or Suprex) and Augmenton ES. Very few in the audience favored Macrolides or Rocephin as a 2nd line choice.

7. Telephone Medicine: Discussion over wisdom of phoning in antibiotic drops without an office visit if there is uncomplicated eye discharge. Consensus was that most Pediatricians are comfortable doing this.

8. Rotateq: It was questioned whether Rotateq was cost effective in the suburbs. The audience vote overwhelmingly was in favor of giving Rotateq even in the suburbs.

9. PPD Frequency: High risk areas should be tested yearly, for sure, but no consensus from the audience on lower risk areas or borderline high risk. Some are going every 5 years, some every other year.

10. Drug Company Sponsorship: An objection was raised that drug company sponsorship could be perceived as a conflict of interest, just like the administration at Stanford and UCLA have objected recently. However, every email and call received supported the sponsorship format with consensus being that the Pediatricians could remain impartial.

11. Monitoring of Psychiatric Drugs: Because of the shortage of Pediatric Neurologists and Psychiatrists, especially ones who do not take insurance, there is immense pressure for Pediatricians to prescribe Stimulants and SSRIs. Many Psychiatrists feel the standard of care is to get pre-treatment EKGs, and monthly visits when using stimulants and see patients weekly when starting SSRIs no matter how well they are doing. Most of the members present at this meeting did not prescribe psychiatric drugs regardless of the pressure, but those that did, did not feel the Pediatric standard was that strict. One of our local Pediatric Cardiologists felt the data only supports pre-treatment EKGs for Stimulants if there are any cardiac symptoms or a history of cardiac abnormality. As for the frequency of visits, most behavioral Pediatricians felt 4-6 month intervals were fine if things were going well on Stimulants. There was less audience consensus on SSRIs since most do not prescribe them. Those that did, felt visits should be more frequent when starting SSRIs because of the Black Box warning, but not necessarily weekly, and some of the patient contact early on could be by phone . . . which takes us to item 12.

12. Phone Call Reimbursement: One member present said they had gotten some insurance companies to pay for Phone Call Consults, but most had not and the majority had not even tried. The AAP has printed a lengthy article on Telephone Reimbursement, but the insurance medical directors I have talked to say they are still not paying for it yet, even though they realize that by not paying for calls, many doctors are refusing to take calls and have a representative tell the patient to go to the ER. This costs the insurance companies infinitely more money than if they would pay the Pediatrician or Primary Care Physician a modest sum to consult over the phone. (Trips to the ER can often be avoided in this manner.) The Pediatric Practice Committee of the AAP is going to work hard in the next few months to convince the insurance companies how foolish their policy is for their company, our mutual patients and us.

Continued Patient Access To Medications

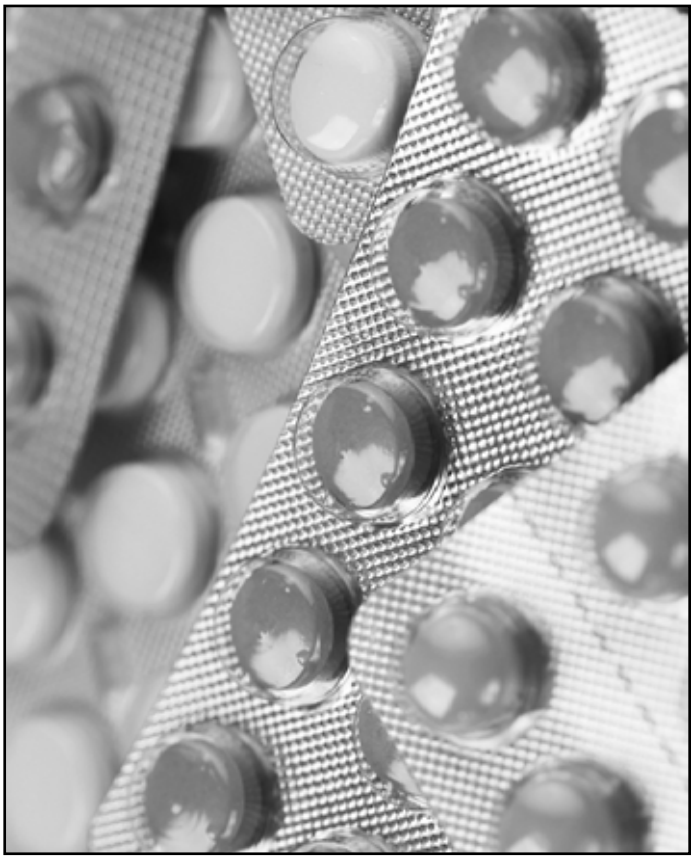
It has been called to the Academy's attention, as some of you may already know, that after May 23, 2008 the Centers for Medicare and Medicaid Services is requiring all pharmacies to submit the prescriber's National Provider Identifier (NPI) on all prescription drug claims to obtain reimbursement payment for Medicaid and Medicaid prescriptions. Prescription drug claims may be rejected by the insurer in instances when a prescriber does not have an NPI. This may result in your members' patients having to pay out-of-pocket for their medication.

Approximately one-third of all prescribers still have not obtained an NPI. Unless these prescribers obtain an NPI as soon as possible, their patients will be unable to obtain their prescriptions through Medicare or Medicaid and will again, end up having to pay out-of-pocket.

To ensure that your members' patients have continued access to critical medications, the Academy has been asked to urge its members obtain their NPI now, if they have not already done so. Members are directed to the following web site to obtain their NPI: https://nppes.cms.hhs.gov/NPPES/Welcome.do

It is recommended that members indicate their NPI on all of their prescriptions to avoid unnecessary phone calls from pharmacies.

If you have questions regarding the NPI, please contact Michele Vilaret at the National Association of Chain Drug Stores at 703/837-4221 or by email at mvilaret@nacds.org.



AAP CA2 Box #527
4067 Hardwick Street
Lakewood, CA 90712

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