



The Alabama Pediatrician

Summer 2010

From the President

Quality or Cookbook?

I'll admit it. The first time I heard "standardized encounter form," my flesh crawled. Standardized



James C. Wiley, MD,
FAAP Chapter President

encounter? I am a pediatrician—much of the thrill of my vocation is in the variation of ages, conditions, and encounters. I don't want anyone making that standard—read here: boring and monotonous! If 20 years in practice has taught me anything, it is that nuances make practice fun

and challenging.

"Live and learn; die and forget it all," quipped my urologist grandfather years ago. His point was that you better keep learning because when that's done...

With that in mind, I am glad to report that pediatricians across the state, including me, are learning that standardizing the bottom line of encounters doesn't result in a cookbook approach to care with robotic, mind-numbing office visits. Surprisingly, planning and standardizing the care actually informs the visit, allows more interaction and personalization, and most importantly, improves quality and outcome—that is, the patient and family are better served.

Our experience in the Asthma CQN Project has taught us that just this one intervention made a big difference in turning the quality dial toward more consistent evaluation of asthma severity and by extensive use of the NHLBI Guidelines for management. Add only one more intervention—a planned approach to care (written asthma control plan) and something dramatic happened. Patient satisfaction improved almost immediately. Far from feeling like an assembly line approach, planned care leaves the patient/family feeling listened to, valued and empowered to participate in managing their asthma. And how do the participating docs feel? Well, isn't listening to and empowering our patients why we chose pediatrics in the first place? It must be, because our third learning session was full of smiling pediatricians who know they have already improved the asthma care they deliver to their patients.

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Annual Meeting to feature Immunization Congress, visiting professor, sub-specialty spotlight

Make sure your calendars are marked for September 24-26, 2010 for the 2010 Annual Meeting and Fall Pediatric Update, which is slated to offer several special educational offerings in collaboration with our state partners.

Chapter members Susan Walley, MD, FAAP, and Ann Klasner, MD, FAAP, professors in the UAB Department of Pediatrics, have secured a \$3,000 grant from the American Academy of Pediatrics Julius B. Richmond Center of Excellence to fund a visiting lectureship featuring Karen Wilson MD, MPH, FAAP, of University of Rochester Department of Pediatrics, who will speak Saturday morning on "Effective Practices in Promoting Tobacco Use Cessation."

CME Chair Cathy Wood, MD, FAAP, has also developed a slate of medical and surgical subspecialists from UAB, who will provide three mini-lectures late Saturday morning that attendees will be able to tap for important take-aways.

Other topics at the meeting include: Neurologic Complications of Sickle Cell Disease: An Update on Screening and Prevention; Anaphylaxis: Killer Allergy; Emergency Preparedness: Public Health's Role and Responsibilities; Implementation of a Hospital-Based Shaken Baby Prevention Program; Growth Diagnosis: You Can Do Much Of It In Your Office; Pediatric Obesity: What Are the Latest Recommendations for Evaluation and Treatment?; Financing the Medical Home; Health Care Reform: How Will It Change Pediatrics?; and Pediatric Cochlear Implants – Advances in Technology & Outcomes (See speakers and topics on pp. 20-21).

The Saturday evening dinner, sponsored by Children's Hospital, will feature the presentation of the annual Master Pediatrician and Wallace Clyde awards, along with keynote presentations on early childhood investment by Business Council of Alabama CEO Billy Canary and Alabama Department of Children's Affairs Commissioner Marquita Davis.

Immunization Congress set as pre-conference

The weekend will also feature an Immunization Financing Congress on Friday afternoon, funded by a grant from the American Academy of Pediatrics and hosted by the Chapter Pediatric Council and the Practice Management Association in partnership with the Alabama Department of Public Health. The Congress will bring together representatives from public health, the payor community, pediatric practices and others to work on state- and practice-based solutions to save money on vaccines and increase our coverage rates.



DID YOU KNOW?
Alabama has dropped in vaccination coverage rates within a three-year period (2005 to 2008) from the top five to the 28th ranking in the National Immunization Survey!

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Alabama Chapter – AAP**Mission:**

The mission of the Alabama Chapter of the American Academy of Pediatrics is to obtain optimal health and well-being for all children in Alabama, and to provide educational and practice support for its membership so the highest quality of medical care can be achieved.

Values:

Children must be highly valued by society.

Each child must develop to his/her highest potential.

Children must have strong advocates for they have no voice of their own.

Pediatricians are essential to achieving optimal child health.

The work of pediatricians, and the profession of pediatrics, must endure and grow ever stronger.

Vision:

Children in Alabama are happy and healthy; Alabama pediatricians are professionally fulfilled and financially secure.

2010 State Legislative Wrap-Up

The 2010 General Session of the Alabama Legislature ended in late April with children's health and safety issues in better shape than were originally thought. When the session began, child advocates were deeply concerned about budget cuts projected to slash right to the core of programs and services upon which so many Alabamians rely.

The following is a wrap-up in terms of the Chapter's top legislative priorities:

Medicaid/CHIP funding: State lawmakers passed a General Fund budget totaling \$345 million for the state share of Medicaid's \$5.2 billion budget for FY 2011. Gov. Bob Riley signed the budget into law on April 21. In addition to passage of the General Fund and education budgets, legislators approved a one-year Nursing Home Privilege Tax to provide funds needed by the state's Medicaid program. The newly approved General Fund budget, which takes effect Oct. 1, 2010, effectively maintains the Alabama Medicaid program for another year, although \$196 million in the budget's revenue stream is contingent on approval of a federal matching rate (FMAP) extension now pending before Congress.

The state's children's health insurance program, ALL Kids, was protected in the General Fund budget as well. Children in families with incomes of up to 300 percent of the Federal Poverty Level will remain eligible for services under final funding allocations.

Protection of funding for Pre-K and Early Intervention/childhood services: Level funding turned out to be commonplace for many state programs and agencies. Nevertheless, during a time of many uncertainties, level funding rather than cuts is a huge win. This story rang true for Alabama's First Class pre-k program. Early Intervention, however, received a slight increase in funding from the Education Trust Fund.

A strengthened graduated teen driver license law: This bill, which provides for a strengthened, three-stage driver license system and was strongly supported by the Chapter and its members over the last two years, reached the "finish line" by passing both houses and being signed into law by Governor Riley! Although it made it through the process with some exclusions, the final bill remained strong enough to significantly improve the current law and ultimately save more lives. This year, the Chapter office continued to work with the Alabama Safe Teen Driver Coalition to lobby for this bill and create public awareness.

Several bills of varying restrictiveness regarding the prohibition of smoking in public places were introduced that addressed smoking in restaurants, enclosed public places, places of employment, private clubs, enclosed residential facilities and outdoor arenas, but none passed both houses. Another bill that would have required child death scene investigation protocols did not gain enough momentum to pass. Though put to rest for 2010, these issues are not dead and will almost certainly be tackled again next year.

The Chapter Area Representatives also worked hard this year to develop a "Key Contact" list to connect pediatricians one on one with lawmakers in the various districts of the state, serving as a "call tree" for action and as a means of educating legislators.

Annual Meeting to feature Immunization Congress, visiting professor lecture, sub-specialty spotlight, continued from page 1

The Congress will begin at 11:30 a.m. with lunch and keynote speakers David Tayloe, MD, FAAP, Immediate Past President of the AAP, and David Kimberlin, MD, FAAP, of the AAP Red Book Committee, followed by panel presentations and breakout sessions co-moderated by PMA members, and will wrap-up at 4:30 p.m. in time for the evening reception in the exhibits.

Look for registration information coming soon!

Top-notch education highlights 2010 Spring Meeting

More than 130 pediatricians and other pediatric healthcare providers attended the Chapter's 2010 Spring Meeting & Pediatric Update, held at the Hilton Sandestin Beach in April—representing the highest attendance at the meeting in more than five years!

Attendees enjoyed a strong sense of camaraderie at networking events, such as the opening reception, the “Not-So-Amazing Race” mixer on Saturday night, as well as a “Best Practices Sharing Session” on Saturday morning.

National and state speakers provided excellent presentations on dermatology, orthopedics, food allergy, newborn screening, influenza, hypertension, UTIs, violence prevention and other topics. Along with a national update by AAP President Judith Palfrey, MD, FAAP, Chapter President J. Wiley, MD, FAAP, joined forces with Marty Michaels, MD, FAAP, of the Georgia Chapter to present the value of pediatrics.

“Best topic collection of any meeting I’ve attended,” wrote an attendee on his evaluation.

Make plans now to attend next year’s Spring Meeting, set for April 28-May 1, 2011 at the Hilton!



LaDonna Crews, MD, FAAP, of USA's pediatric clinic, explains her practice's approach to spirometry at the CQN asthma learning session, which kicked off the conference.



Chapter Area Representative Mendy Blakeney, MD, FAAP, of Montgomery, congratulates Sarah Joiner, MD, FAAP, of Mobile, who won the “Not-So-Amazing Race.”



Networking with colleagues is one of the highlights of the Spring Meeting.

Linda Anz, MD, FAAP, AAP President Judith Palfrey, MD, FAAP, Bert Anz, MD, Susie Johnston and Carden Johnston, MD, FAAP, at the Saturday night mixer.

Standardized developmental screening in Alabama gets two shots in the arm this summer



The developmental screening webcast features an up close look at how to score the Ages and Stages Questionnaire-3.

Thanks to two new developments this summer, standardized developmental screening just got easier for pediatricians in Alabama.

Chapter co-produces online webcast training for pediatricians; six practices part of second-tier pilot

Along with the Alabama Department of Public Health and the Alabama Department of Mental Health, the Alabama Chapter-AAP has produced a one-hour video webcast on the Ages and Stages Questionnaire, “Standardized Developmental Screening: Using the Ages and Stages Questionnaire-3 (ASQ-3) Screening Tool” that is accessible on the ADPH web site at <http://www.adph.org/ALPHTN/Default.asp?id=4396>.

The training features background of the Alabama Assuring Better Child Health and Development project, which prompted the creation of the webcast; a session on the features and scoring of the ASQ-3; and a section on how to integrate developmental screening into practice, presented by

Pippa Abston, MD, FAAP, of Huntsville.

Anyone can access the webcast and view it at any time; the training will remain on the site indefinitely. All Chapter members and their staff are encouraged to take the training.

Six practices in Alabama, Acton Road Pediatrics in Birmingham, Adolescent & Pediatrics in Montgomery, Dr. Rekha Chadawalada of Sylacauga, Dothan Pediatric Clinic, Pua and Pua of Albertville, and Tuscaloosa Pediatrics, are viewing the training and have entered a second-tier pilot to collect data and receive technical assistance on use of the ASQ. Congratulations to these pediatricians!

Blue Cross Blue Shield adds developmental screening to standard PMD coverage

Thanks to the advocacy of the Pediatric Council, which made an in-depth presentation last year to payors on the advantages of covering standardized developmental screening, Blue Cross Blue Shield has added developmental screening coverage (three screenings at well-child visits between eight and 32 months) to its standard PMD plan, effective July 1.

The payor made the official announcement to the Chapter at the Pediatric Council meeting on June 10.

“This is monumental, both for pediatrics and children in Alabama,” said J. Wiley, MD, FAAP, Chapter President. “We are also gratified that the advocacy platform of the Pediatric Council is working.”

“We have been making this case now for several years, more formally last year in our presentation to Blue Cross,” echoed A.Z. Holloway, MD, FAAP, who chairs the Council. “We are thrilled and appreciate the willingness of the medical director and policy director to begin moving in the direction of preventive services for children.”

For a look at the policies of the three major payors, as well as all of the developmental screening tools for pediatricians in Alabama, visit the Chapter’s online developmental screening toolkit at www.alaap.org (click link under “Latest Resources”).



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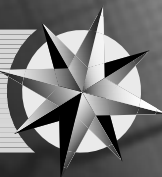
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Incorporating standardized developmental screening: the Anniston Pediatrics experience

By Lewis Doggett, MD, FAAP and Janice Clark, Anniston Pediatrics

Our office began the Alabama Assuring Better Child Health and Development program as one of the pilot sites to incorporate standardized developmental screening in January 2008. As we all know in pediatrics, it's very difficult to add "one more thing" to do, especially in the height of our season – winter! However, after much discussion and observance of our office flow, we incorporated the Ages & Stages Questionnaire in the following way:

1. Our charting system is not electronic, so the paper charts are prepared the day prior to the patient's appointment. An age-appropriate assessment form is placed in all the patients' charts scheduled for a Physical/Medicaid Screening for ages 9-mo., 18-mo., 24-mo. and 48-mo. These were the ages used in the pilot program and the ages we have continued to use.
2. Upon arrival of the patient, the receptionist gives the questionnaire to the parent/guardian for completion while they wait to be called by the nurse. We explain to the parent that these are questions that help the physician assess the development of his/her child. We also provide a letter for our patients with commercial insurance (other than Medicaid or ALL Kids) explaining the program as well as the cost involved and have them choose whether or not they want to participate. This letter is presented at each age the child is to be assessed, and the letters are placed in the child's medical record. [Editor's Note: This process will likely change now that Blue Cross offers coverage in its Standard PMD plan.]

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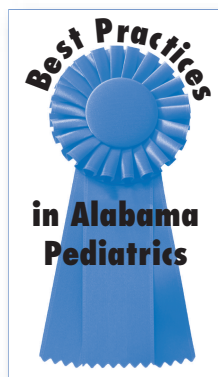
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**DeAnn Daniel RN, Sue Denson RN,
Mark Graves RN & Linda Honeycutt, RN**



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3. The nurse takes the form at the time she calls the patient to the back, allowing the parent more time if needed to complete the form. She also assists the parent if they have questions or do not understand a question.
4. The nurse prepares the patient for the Physical/Medicaid Screening, scores the form, and places the form in the chart for the physician to review.
5. The physician performs the physical exam and reviews the scoring. Questions are re-visited if the physician feels it is warranted and the scoring is adjusted if indicated. The results are discussed with the parent.
6. If the physician feels the child could benefit from Early Intervention, the chart is routed to our Referral Department. A copy of the score sheet is provided to Early Intervention and the parent is notified of the appointment date and time.



The program is working great! By completing the forms, the parents feel they are partnering with the physician and are very eager to see how their child is progressing.

Again, this is how our office implemented the program. Each office would need to assess flow and decide the best way it would work for them. It has not been a burden or slowed us down.

Dothan Pediatric Clinic becomes first Alabama practice to attain NCQA medical home certification

As reported in previous issues of *The Alabama Pediatrician*, four pediatric practices in Alabama have been part of a medical home pilot in partnership with Blue Cross Blue Shield of Alabama (BCBS), with the Alabama Chapter-AAP serving in an advisory role. At the heart of this process are the practices becoming certified as “medical homes” by the National Committee for Quality Assurance in order for BCBS to pilot new payment structures that support optimal primary care.

Blue Cross recently reported that Dothan Pediatric Clinic has become the first practice in Alabama—among all specialties—to seek and achieve NCQA certification! Fourteen practices in pediatrics, family medicine and internal medicine are part of the pilot, so this is a stellar achievement for DPC.

“The Chapter congratulates Dothan Pediatrics and is extremely proud that a pediatric practice was the first to attain this level of recognition,” said James C. Wiley, MD, FAAP, Chapter President.

Attaining medical home certification involves changes in practice organization to provide coordinated, evidence-based care in an environment that gives the patient and their families the information and resources necessary to effectively manage their own health and to navigate the often challenging healthcare system. NCQA has put together guidelines that outline important processes to form the framework for achieving these principles. For example, some of the guidelines affect patient access to records, timely communication procedures with the practice through telephone or email, referral tracking, and coordination of care with subspecialists when necessary.

“The transformation was very rewarding for our practice and we gained a lot from the experience,” said Michael Ramsey, MD, FAAP, who spearheaded the process at DPC, “although dealing with NCQA was frustrating at times.”

Having passed this major part of the process, Dr. Ramsey’s practice will now move forward with maintaining the new standards of practice, measuring patient satisfaction and working toward improving pre-defined outcomes that will be measured through claims data.

Meanwhile, Auburn Pediatrics, Anniston Pediatrics and Huntsville Pediatrics are moving in the same direction as part of the pilot.

Look for more updates on the project coming soon!

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Share the ATV safety message with new Children's Hospital video

By Kathy Monroe, Chair, Injury Prevention Committee

As many of you know, the Chapter embarked on a public awareness campaign about ATV safety two years ago in conjunction with Children's Hospital, VOICES for Alabama's Children and other partners.

At Children's Hospital, trauma alerts from ATV accidents had been steadily increasing, reaching epidemic proportions in the last several years. Alarming, the majority of these accidents involve children under the age of 14.

In a continued effort to educate parents, the division of Emergency Medicine and media departments at Children's Hospital recently produced a video on ATV safety, "ATVs and Kids DON'T MIX!" that we are rolling out to pediatricians' offices now. The video includes a testimonial from a young accident victim's family who wished they had said "no" to their child's ATV excursion—in spite of his miraculous recovery. We encourage you to order the five-minute video, show it in your waiting room or post it to your web site (if you are technologically savvy!).

To obtain a copy of this video, please write to: The Comprehensive Health Education Center for Kids, Children's Hospital, 1600 7th Avenue South, Birmingham, AL 35233 or call (205) 939-9377 or toll-free (866) 800-7259. The first 50 copies will be complimentary; after that, a \$10 charge will apply to cover costs of reprinting, postage and handling.

Also, just as a reminder, please consider routinely discussing ATV safety with your patients and their families. The current recommendations by the AAP are:

- No use by children younger than age 16
- No passenger riding
- Always wear a helmet
- No use on public streets
- No nighttime riding
- Never use under the influence of alcohol

Thank you!



On the ATV safety video, Kathy Monroe, MD, FAAP, Division of Emergency Medicine at Children's Hospital, explains the grave dangers of children riding on ATVs.

"From the President" continued from page 1

We can learn from the CQN asthma experience and expand standard encounter forms to other chronic disease states like ADHD, sickle cell, and diabetes, for starters. One of the valuable lessons from the collaborative is that it is fine to "borrow liberally and steal shamelessly." The Chapter will be moving forward with ways to move forward in this "Quest for Quality." We will begin with finding ways to share our CQN experience more broadly. If you are ready to get on board, just send me an email.

Thanks to all 12 practices in the collaborative. Your hard work and pioneering spirit will spill over to benefit more kids and pediatricians than we can imagine!

Event Calendar

2010

July 15
"Important Update on
Alabama's School
Immunization Requirements"
webinar
5:30 p.m. (details TBA)

September 24
2010 Chapter Immunization
Financing Congress
The Wynfrey Hotel
Birmingham, AL

September 24 - 26
2010 Annual Meeting
& Fall Pediatric Update
The Wynfrey Hotel
Birmingham, AL

October 2 - 5
AAP National Conference
& Exhibition
San Francisco, CA

2011

April 28 - May 1
2011 Spring Meeting &
Pediatric Update
Hilton Sandestin Beach, Destin, FL

Why quality and why now?

By Eric Tyler, MD, FAAP

Healthcare reform has passed and its impact on practicing physicians is yet to be determined. There is agreement, however, that the legislation is more about funding than about actually improving the quality of healthcare delivery. There is another, more subtle movement afoot driven by both public and private payors to assure that dollars spent are maximized. You can already see these tangible changes in the form of formulary restrictions, "pay for performance" and physician report cards.

The quality movement actually began in the early 1900's with a Boston surgeon, Dr. Ernie Codman, who thought it would be a good idea to catalog his surgical outcomes to determine what he was doing right—and wrong. This led him to make changes to improve outcomes of his patients, on whom he kept detailed files. His voice was lost in history.


Fast forward to 1999, when the Institute of Medicine documented that between 60,000 and 90,000 people a year die due to preventable medical errors. The conclusion: "We can do better than this." Time has passed with no appreciable changes, evidenced by such examples as the February 2009 incident involving two wrong leg amputations in the same month by the same head of the department of surgery at an academic hospital in Rhode Island! This has caused payors and purchasers of healthcare to say, "If the physicians themselves cannot improve performance, we are going to intervene." This is happening now.

Since 1999, studies such as those by Dr. David Nash at Jefferson School for Population Studies have identified three major problem areas affecting quality. The first is unexplained clinical variability in outcomes. Plotting the outcomes for three common surgical procedures, Dr. Nash's first-year results were all over the scattergram. Since then, the data have actually improved as the physicians were very open to change. Published estimates indicate that 40 cents of each healthcare dollar are wasted on tests that are not indicated, ineffective treatments or treatments that are indicated but not prescribed. The second problem, the defensive practice of medicine, is acknowledged and beyond the control of physicians. The last factor is traditional medical school training of physicians as strong individual warriors capable of leaving the castles of academia to go forth into the lands and fight disease as "Lone Rangers." Humiliation over lack of information about a patient's lab results or the differential diagnosis of mundane things like "itching teeth" created an indelible memory in young students and the anger from those training days still impact practice style and openness to new ideas.

The path to change starts with a paradigm shift. Physicians of 2010 and beyond are not roving Knights of the Round Table (although I still call my stethoscope "Excalibar" after Arthur's Sword), but leaders of healthcare teams that stretch across a continuum of care from office to hospital to ancillary services at schools, physical therapy and psychologists' offices. If that is the paradigm, then changes must be made in the style of practice. Eighty-five percent of the mistakes in medicine are errors of process; controlling the process can improve outcomes because the same path is followed for every patient. Look around your office for some processes that you can better control. Does your staff know what constitutes an emergency in your mind and what you want to do about them? That is a good place to start. Once you see one process change work for the good of your patients, you can find more. These take some time, but they do not cost much money.

At the heart of the payor efforts is the use of evidence-based guidelines for chronic disease management. While asthma is currently our Chapter buzzword, what about ADHD, diabetes, migraine headaches and obesity? Should these not be followed closely as well to have an opportunity to intervene before crisis occurs? The payers think so and I agree. There are good guidelines published by the AAP, the NCQA and at www.guidelines.gov. Template reminders for diabetes assure that patients get a foot exam every visit, an eye exam and a microalbumin once a year and a hemoglobin A1c. If these things are done every time, then none will be missed. If the staff knows the process for following an asthmatic, spirometry can be done before you see the patient.

No one can argue the value of an EHR to track patients in a registry so that all may be notified of a flu



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Pediatric Coding Corner

By Lynn Abernathy Brown, CPC

Deductibles and how they are changing

Many of us are used to the deductible due for major medical when supplies were billed, but lately, I am seeing many more with surgical deductibles. If you bill an Office Visit (E/M) and then a Surgical Procedure Code such as Cerumen Removal, 69210, you may see the 69210 code go to the patient's deductible. Pediatricians need to be aware of this change so that when they are about to "perform surgery" in the office, they are prepared when they get confronted on the next visit by the parent. I believe the best defense is to be as informed as possible about issues such as this so that you are prepared.

Coding tricks for ticks!

Coding for tick removal can be tricky. The simple removal with forceps of the tick will usually be coded as an E/M (Evaluation and Management Code). When the tick is imbedded or partially removed, it becomes more time-consuming.

Physicians are faced with a foreign body removal, but the Foreign Body Removal codes clearly state:

- 10120 Incision and removal of foreign body, subcutaneous tissues; simple
- 10121 Incision and removal of foreign body, subcutaneous tissues; complicated

The Coder's Desk Reference refers to 10120/10121 as follows:

The physician removes a foreign body embedded in subcutaneous tissue. The physician makes a simple incision in the skin overlying the foreign body. The foreign body is retrieved using hemostats or forceps. The skin may be sutured or allowed to heal secondarily. Report 10121 if the procedure is more complicated, requiring dissection of underlying tissues.

An incision can be made with any instrument as long as the documentation states an incision was made.

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Update from the Newborn Screening Advisory Committee

By Heather M. Taylor, MD, FAAP, Chair, Alabama Newborn Screening Advisory Committee and

S. Lane Rutledge, MD, FAAP, UAB Faculty Member

The Newborn Screening Advisory Committee continues to work to ensure primary care providers in the state are receiving the support and information they need to adequately care for babies with abnormal newborn screens. Recent efforts have included a presentation at the Spring Meeting in Destin and a push to make the web site more user-friendly for both families and practitioners (www.adph.org/newbornscreening). Ensuring that unsatisfactory rates remain low has also been a priority for the state newborn screening staff and they continue to increase their education efforts for nursery and laboratory personnel across the state.

There continue to be some instances of delayed or inappropriate follow-up for abnormal newborn screens. It is very important that infants with unsatisfactory screens have their screens repeated as soon as possible and that infants with abnormal screens have their screens repeated in the recommended time frame (included in the report of the abnormal screen). Infants diagnosed with sickle cell disease through the newborn screen should be referred to a pediatric hematologist, but penicillin prophylaxis should be started as soon as the diagnosis is made and should not be delayed until the patient sees the specialist.

If you receive an abnormal or unsatisfactory newborn screening result on an infant who is not your patient, you are encouraged to contact the caregiver to find out who their provider is (their information is on the newborn screening report) and/or notify the state laboratory that it is not your patient. If this is recurring routinely, you should work with your birthing hospital personnel to decrease the instances in which you are incorrectly listed as the follow-up physician.

Metabolic Screening Division Update

We are very excited to announce that Alabama now has two board-certified clinical biochemical geneticists. Maria Descartes, MD, has joined Lane Rutledge, MD, FAAP, in this field. Dr. Descartes has been working in biochemical genetics for four years and attained her board certification.

We continue to make 22-25 diagnoses a year of inherited disorders of metabolism by newborn screening (also about one mom per year is diagnosed with a disorder based on her newborn's findings). In the past year, we diagnosed our very first patient with tri-functional protein deficiency, a defect in long-chain fatty acid oxidation. We know that we are making a difference in these kids' lives.

And remember - it is the newborn screen, not "the PKU test!"

Why Quality and Why Now? continued from page 10

shot clinic. The ability of that same record to flash a standard reminder rather than another piece of paper fluttering to the floor makes it hard to miss. Along that same vein, e-prescribing takes away the proverbial bad handwriting of medicine and provides real-time allergy reminders as well as formulary offerings—saving valuable staff time. Mistakes will still occur, but the process will minimize them.

In conclusion, there are opportunities here for our profession to lead through change. You are all leaders in your offices and hospitals and provide an essential service to the children of our state. What happen to Ernie Codman? He tried to present his data to the Boston Medical Society and was booed off the stage and out of the society. His practice never recovered as he lost his referral base. Most visionaries pay a price. The irony here is what cost Dr. Codman his career for making a stand for quality improvement has the chance to save ours. You are not alone. The Alabama Chapter-AAP has resources for you and voices at the tables where these decisions are being made.

Chapter elections results in

The 2010 Chapter elections votes were tallied on June 30, with the following members elected: DeeAnne Jackson, MD, FAAP, of Birmingham, Area 1 Representative; Katrina Skinner, MD, FAAP, of Fairhope, Area 2 Representative; Eric Tyler, MD, FAAP, of Alex City, Nominating Committee member.

"Congratulations to each of these individuals, and many thanks to all of the nominees who ran for these offices, who put themselves out there to make the election process and our Chapter even stronger," James C. Wiley, MD, FAAP, Chapter President.



DeeAnne Jackson, MD, FAAP



Katrina Skinner, MD, FAAP



Eric Tyler, MD, FAAP

How is Ulesfia Lotion defined?

Non-neurotoxic pediculus capitis asphyxiator*

*As suggested by *in vitro* studies.

[a.k.a. Finally!]

Ulesfia Lotion is a first-line therapy—
FDA-approved to treat children aged
6 months and older with head lice

- Proven effective in 2 pivotal trials
- Non-neurotoxic formulation

www.ulesfialotion.com

Prescribe
Ulesfia Lotion
at the *first*
sight of
head lice



Not an actual patient.

Indication

Ulesfia™ (benzyl alcohol) Lotion is indicated for the topical treatment of head lice infestation in patients 6 months of age and older. Ulesfia Lotion does not have ovicidal activity.

Important Safety Information

Intravenous administration of products containing benzyl alcohol has been associated with neonatal gasping syndrome. Neonates (i.e. patients less than 1 month of age or preterm infants with a corrected age of less than 44 weeks) could be at risk for gasping syndrome if treated with Ulesfia Lotion.

Avoid eye exposure. Protect eyes during product application. Flush immediately with water if Ulesfia Lotion comes into contact with eyes. Consult a physician if eye irritation persists.

Contact dermatitis may occur with Ulesfia Lotion. If skin irritation occurs, immediately rinse with water and discontinue use of the product until irritation clears. If irritation continues, consult a physician.

Keep out of reach of children. Ulesfia Lotion should only be used on children under the direct supervision of an adult. For external use only; use only on scalp and scalp hair.

Most common application site adverse reactions were: application site irritation (2%), and application site anesthesia and hypoesthesia (2%), and pain (1%).

In a subset of subjects without symptoms prior to treatment, the most common monitored adverse reactions after treatment were: pruritus (12%), erythema (10%), pyoderma (7%), and ocular irritation (6%).

Please see brief summary of Prescribing Information on reverse.

 **ulesfia**™
(benzyl alcohol) Lotion 5%
Plays nice. Treats lice.

SHIONOGI PHARMA, INC.

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BRIEF SUMMARY OF PRESCRIBING INFORMATION Rx Only

Ulesfia™ (benzyl alcohol) Lotion

For topical use only • Initial U.S. Approval: 2009

INDICATIONS AND USAGE**Indication:** Ulesfia Lotion is indicated for the topical treatment of head lice infestation in patients 6 months of age and older.**Limitation of Use:** Ulesfia Lotion does not have ovicidal activity.**Adjunctive Measures:** Ulesfia Lotion should be used in the context of an overall lice management program:

- Wash (in hot water) or dry-clean all recently worn clothing, hats, used bedding, and towels.
- Wash personal care items such as combs, brushes and hair clips in hot water.
- A fine-tooth comb or special nit comb may be used to remove dead lice and nits.

DOSAGE AND ADMINISTRATION: Ulesfia Lotion is not for oral, ophthalmic, or intravaginal use. Using the guidelines in Table 1, apply sufficient Ulesfia Lotion to dry hair to completely saturate the scalp and hair; leave on for 10 minutes, then thoroughly rinse off with water. Repeat treatment after 7 days. Avoid contact with eyes.**Table 1: Ulesfia Lotion Usage Guideline**

	Hair Length	Amount of Ulesfia Lotion per Treatment
Short	0-2 inches	4-6 oz (1/2-3/4 bottle)
	2-4 inches	6-8 oz (3/4-1 bottle)
Medium	4-8 inches	8-12 oz (1-1 1/2 bottles)
	8-16 inches	12-24 oz (1 1/2-3 bottles)
Long	16-22 inches	24-32 oz (3-4 bottles)
	Over 22 inches	32-48 oz (4-6 bottles)

DOSAGE FORM AND STRENGTH: Ulesfia Lotion contains 5% benzyl alcohol and is supplied in 8 ounce polypropylene bottles.**CONTRAINDICATIONS:** None.**WARNINGS AND PRECAUTIONS - Neonatal Toxicity:** Intravenous administration of products containing benzyl alcohol has been associated with neonatal gasping syndrome consisting of severe metabolic acidosis, gasping respirations, progressive hypotension, seizures, central nervous system depression, intraventricular hemorrhage, and death in preterm, low birth weight infants. Neonates (i.e. patients less than 1 month of age or preterm infants with a corrected age of less than 44 weeks) could be at risk for gasping syndrome if treated with Ulesfia Lotion [see Use in Specific Populations].**Eye Irritation:** Avoid eye exposure. Ulesfia Lotion may cause eye irritation. If Ulesfia Lotion comes in contact with the eyes, flush them immediately with water. If irritation persists, consult a physician.**Contact Dermatitis:** Ulesfia Lotion may cause allergic or irritant dermatitis.**Use in Children:** Ulesfia Lotion should only be used on children (6 months of age and older) under the direct supervision of an adult. Keep out of reach of children.**ADVERSE REACTIONS - Clinical Studies Experience:** Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice.

The rates of adverse reactions below were derived from two randomized, multicenter, vehicle-controlled clinical trials and one open-label study in subjects with head lice infestation.

Skin, scalp, and ocular irritation were monitored in the clinical trials. All subjects were queried about the presence of skin and scalp symptoms; the results are presented in Table 2.

Table 2: Monitored Adverse Reactions - Application Site Symptoms

Event	Ulesfia Lotion	Vehicle
Application site irritation	2% (11/478)	1% (2/336)
Application site anesthesia & hypoesthesia	2% (10/478)	0% (0/336)
Pain	1% (5/478)	0% (1/336)

The subset of subjects who did not have pruritus, erythema, edema or pyoderma of skin and scalp, or ocular irritation prior to treatment were assessed for these signs and symptoms after treatment; the results are presented in Table 3.

Table 3: Monitored Adverse Reactions - Pruritus, Erythema, Pyoderma and Ocular Irritation with Onset After Treatment

Signs/Symptoms	Ulesfia Lotion	Vehicle
Pruritus	12% (14/116)	4% (3/67)
Erythema	10% (32/309)	9% (19/217)
Pyoderma	7% (22/308)	4% (10/230)
Ocular irritation	6% (26/428)	1% (3/313)

Other less common reactions (less than 1% but more than 0.1%) were, in decreasing order of incidence: application site dryness, application site excoriation, paraesthesia, application site dermatitis, excoriation, thermal burn, dandruff, erythema, rash, and skin exfoliation.

DRUG INTERACTIONS: Drug interaction studies were not conducted with Ulesfia Lotion.**USE IN SPECIFIC POPULATIONS - Pregnancy:** Pregnancy Category B

There are no adequate and well-controlled studies with topical benzyl alcohol in pregnant women. Reproduction studies conducted in rats and rabbits were negative. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

No comparisons of animal exposure with human exposure are provided in this labeling due to the low systemic exposure noted in the clinical pharmacokinetic study [see Clinical Pharmacology (12.3) in the full prescribing information] which did not allow for the determination of human AUC values that could be used for this calculation.

Pregnant rats were dosed with benzyl alcohol via subcutaneous injection at 100, 250, and 500 mg/kg/day. No teratogenic effects were noted at any dose. Maternal toxicity and decreased fetal weight occurred at 500 mg/kg/day. When pregnant rabbits received subcutaneous injections of benzyl alcohol at 100, 250, and 400 mg/kg/day, there were no teratogenic effects in offspring at any dose. In rabbits, maternal toxicity occurred at the two higher doses and was associated with decreased fetal weight at the highest dose.

Nursing Mothers: It is not known whether benzyl alcohol is excreted into human milk. Because some systemic absorption of topical benzyl alcohol may occur and because many drugs are excreted in human milk, caution should be exercised when Ulesfia Lotion is administered to a nursing woman.**Pediatric Use:** The safety and effectiveness of Ulesfia Lotion was evaluated in two multicenter, randomized, double-blind, vehicle-controlled studies which were conducted in 628 subjects 6 months of age and older with active head lice infestation [see Clinical Studies (14) in the full prescribing information].

Rates of adverse events in younger children (6 months to 12 years) were similar to those of older children and adults.

Safety in pediatric patients below the age of 6 months has not been established. Ulesfia Lotion is not recommended in pediatric patients under six months of age because of the potential for increased systemic absorption due to a high ratio of skin surface area to body mass and the potential for an immature skin barrier.

Neonates could be at risk for gasping syndrome if treated with Ulesfia Lotion [see Warnings and Precautions].

Intravenous administration of products containing benzyl alcohol has been associated with neonatal gasping syndrome. The gasping syndrome (characterized by central nervous depression, metabolic acidosis, gasping respirations, and high levels of benzyl alcohol and its metabolites found in the blood and urine) has been associated with benzyl alcohol dosages > 99 mg/kg/day in preterm neonates. Additional symptoms may include gradual neurological deterioration, seizures, intracranial hemorrhage, hematologic abnormalities, skin breakdown, hepatic and renal failure, hypotension, bradycardia, and cardiovascular collapse. Although expected systemic exposure of benzyl alcohol from proper use of Ulesfia Lotion is substantially lower than those reported in association with the gasping syndrome, the minimum amount of benzyl alcohol at which toxicity may occur is not known.

Geriatric Use: The safety of Ulesfia Lotion in patients over 60 years of age has not been established.**PATIENT COUNSELING INFORMATION:** [See 17.3 in the full prescribing information for FDA-approved patient labeling.]**Instructions to Patients:** This medication is to be used as directed by the physician. Use only on scalp and scalp hair. Avoid contact with eyes. As with any topical medication, patients should wash hands after application.

Instruct patients on proper use of Ulesfia Lotion, including the amount to apply, how long to leave it on the hair, and the importance of a second treatment 1 week (7 days) after the initial application.

Adverse Reactions: Inform patients that Ulesfia Lotion may cause eye irritation, skin irritation, and contact sensitization.

Instruct patients to inform a physician if the area of the application shows signs of irritation and any signs of adverse reactions.

DISTRIBUTED BY:

SHIONOGI PHARMA, INC.

Atlanta, GA 30328

MANUFACTURED BY:

Contract Pharmaceuticals Ltd.

Mississauga, ON L5N 6L6

Canada

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Join the Summer of a Million Books Campaign!

Across the nation, Reach Out and Read plans to give one million children a brand-new, age-appropriate book before Labor Day! ROR-AL challenges every Chapter member to help us reach our Alabama goal of 30,000 books by making a virtual donation for two books at www.roralabama.org.

**Reach
Out and
Read®**
Alabama



From the Coordinator

ROR mentioned as “exemplary program” in Kids Count Special Report, “Why Reading by the End of Third Grade Matters”

Last month, the Annie E. Casey Foundation reported the shocking news that 68 percent of America’s fourth graders and—even worse, 72 percent of Alabama’s fourth graders—scored below proficient on the National Assessment of Educational Progress (NAEP) reading test in 2009. Reading proficiently by the end of third grade is a crucial marker in a child’s educational development. Failure to read proficiently is linked to higher rates of school drop-out, which suppresses individual earning potential as well as our nation’s competitiveness and general productivity.

This report offers four recommendations to help our nation work together to solve the crisis in grade-level reading proficiency:

1. Develop a coherent system of early care and education that aligns, integrates, and coordinates what happens from birth through third grade so children are ready to take on the learning tasks associated with fourth grade and beyond.
2. Encourage and enable parents, families and caregivers to play their indispensable roles as co-producers of good outcomes for their children.
3. Prioritize, support, and invest in results-driven initiatives to transform low-performing schools into high-quality teaching and learning environments in which all children, including those from low-income families and high-poverty neighborhoods, are present, engaged, and educated to high standards.
4. Find, develop and deploy practical and scalable solutions to two of the most significant contributors to the under-achievement of children from low-income families—chronic absence from school and summer learning loss.

Reach Out and Read is mentioned on page 37 of the report as an “exemplary program” that focuses on children’s healthy development in pediatric primary care practices. To access the full report, please visit our web page, at www.roralabama.org-->Making Headlines.

Summer is an excellent time to learn more about how the Reach Out and Read program can benefit your practice through a presentation at a staff meeting or lunch. Contact me at roralabama@charter.net or 205-223-0097 for more information.

Walker Area Community Foundation spring grants include ROR-Alabama

Thanks to a \$7,500 grant from Walker Area Community Foundation, almost 5,000 children will receive new books through ROR-Alabama in pediatric practices and clinics serving Jasper and the surrounding areas.

“Thanks to the efforts of Jan Handy at the Walker County Board of Education and the generous citizens of our county, our children will not only receive brand-new books at their well-child visit, but their parents and caregivers will benefit from the advice of their pediatric healthcare provider on the importance of reading together,” said Paul Kennedy, President, WACF. “This will have a major impact on preparing our children in Walker County to be successful when they start to school.”

ROR-Alabama raises \$1,000 with Birdies for Charity

ROR-Alabama was one of 164 charities that participated in this year’s Birdies for Charity, a fundraising program that generates contributions based on the number of “birdies”—a total of 939—made by the Champions Tour players during the 2010 Regions Charity Classic.

Attendees at the Chapter’s 2010 Spring Meeting were encouraged to make pledges or donations on behalf of ROR. Free one-day passes to the tournament were also given to those who visited the ROR exhibit.

Congratulations to Patricia Robinson, MD, FAAP, and Pediatric Adolescent Medicine with 100 percent staff participation through donations and pledges! With 100 percent participation, practices and clinics were eligible to receive 50 brand new books for their ROR program.

NEWS FROM PUBLIC HEALTH

Pertussis on the rise in Alabama

Adolescents and adults need to receive vaccination to protect themselves

Pertussis, or whooping cough, is a highly contagious bacterial disease and can be deadly—especially in infants who are too young to be fully vaccinated. Because protection from childhood vaccination wanes over time, adolescents and adults need to be revaccinated in order to give herd immunity. This is especially important since pertussis cases have quadrupled in Alabama in the last year (2009), with adolescents and adults typically being the primary source of infection for infants and children.

Physicians are in the best position to educate parents and their adolescents about receiving a Tdap vaccination. Some key points of discussion about Tdap include:

- Effective for students aged 11 or older entering sixth grade beginning in the fall of 2010, a booster dose of tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap) must be given. This requirement will escalate by one successive grade each year for the following six years to include sixth through 12th grades (Fall 2016).
- Adolescents who have already received a booster dose of Td are encouraged to receive a dose of Tdap for protection against pertussis. A five-year interval from the last Td dose is encouraged, but an interval as short as two years may be used if pertussis immunity is needed.
- All adults should get a booster dose of Td every 10 years. Tdap is licensed for only one lifetime dose per person. Adults under age 65 who have never received a dose of Tdap should substitute it for their next booster dose.
- A dose of Tdap is recommended for adults under age 65 who expect to have close contact with an infant younger than 12 months of age.
- Healthcare workers under age 65 who have direct patient contact should receive a dose of Tdap.
- New mothers who have never received Tdap should get a dose as soon as possible after delivery. If vaccination is needed during pregnancy, Td is usually preferred over Tdap.
- Adolescents and adults who require a tetanus-containing vaccine as part of wound management should receive a dose of Tdap instead of Td if they have not previously received Tdap. If Tdap is not available or was previously administered, Td should be administered.

For more information, contact the Alabama Department of Public Health Immunization Division at 1-800-469-4599 or on the web at www.adph.org/immunization.

NEWS FROM MEDICAID

2011 budget still uncertain with FMAP extension hanging in balance

Although Medicaid's 2011 budget was satisfied with a lot of negotiation, tweaking and reworking in the 2010 General Session of the Alabama Legislature, it could have another blow, in the neighborhood of \$196 million, if the six-month extension of the federal medical assistance percentage (FMAP) is not passed in Congress.

At time of writing, the FMAP piece was taken out of legislation passed by the House, and Future Senate consideration of the remaining "tax extenders" package, HR 4213, remained uncertain.

The Academy will continue advocating for the FMAP adjustment to remain in the Senate's final tax extenders bill and in any House package. Chapter members are encouraged to continue making contact with their U.S. Senators.

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NEWS FROM MEDICAID

State Health Information Exchange update

As was reported in the last issue of *The Alabama Pediatrician*, the state has embarked on a multi-year initiative to building a statewide health information exchange (HIE) to improve the quality, safety and efficiency of health care delivered in our state.

Building on its Together for Quality e-health record, QTool, the Alabama Medicaid is receiving federal funding in order to implement this vision, along with the help of more than 100 stakeholders from across the state.

Several Chapter members, Practice Management Association members and Chapter Executive Director Linda Lee have been at the table over the last several months in workgroup meetings to flesh out this process in order to assure that the system built is of value to practicing providers.

One of the goals of the system is to satisfying EMR "meaningful use" requirements that physicians exchange patient information electronically with other providers outside of their practices who care for those same patients. Hopefully, the end result will provide accessibility of patient information that pediatricians did not have in the past that can help them better and more efficiently manage patient care. Such information could include immunization registry data, newborn screening results, and other data, all accessible with the push of a button.

An independent HIE commission that is representative of all providers, payers and patients is currently governing this process. The Alabama Chapter-AAP has a seat on this Commission to help shape this vision into a reality, not just for Medicaid recipients, but for all Alabamians.

Strategic and operational planning and the development of a requests for proposals for vendors for the HIE is currently underway, with the goal of having the system operational in 2011.

Medical home enhancement project moving along

Chapter members Marsha Raulerson, MD, FAAP, DeeAnne Jackson, MD, FAAP, A.Z. Holloway, MD, FAAP, and Cason Benton, MD, FAAP, are working with Medicaid on a multi-stakeholder workgroup to enhance the current Patient 1st program in an effort to bolster primary care practices further up the "medical home" ladder to improve care for Medicaid patients.

Led by Medicaid Medical Director Robert Moon, MD, the initiative is relying on technical assistance from the National Academy for State Health Policy and other states that are further along this continuum.

"We have evaluated the successes of multiple states and have decided to focus our efforts on an approach very similar to the North Carolina model of care coordination based in regions," said Dr. Moon. "We have identified some resources to begin in a small, probably regional manner and then expand the reach of the networks that will support the medical home."

The key component of this model is efficient care coordination that providers can rely on to assist their patients in getting to the specialty and ancillary care they need. Alabama Medicaid proposes to spearhead this coordination with the help of other state agencies and resources.

"Moving forward, we will be developing our exact approach through working with stakeholders, reviewing the North Carolina contracts, having on-site visits with experts in their program, and engaging our providers," Dr. Moon added. "We fully anticipate learning a lot as we define requirements for the medical homes and for the networks. We also plan to establish thoughtful quality and financial performance metrics to help us improve as we go forward."

Stay tuned for more information as the group's work evolves over the next several months.

Attention Healthcare Providers



NEW IMMUNIZATION REQUIREMENT FOR 6TH GRADE ENTRY

Beginning with the 2010-2011 school year, a dose of Tdap vaccine will be required for Alabama students ages 11 or 12 years entering 6th grade. This requirement will escalate by one successive grade each year for the following 6 years to include sixth through twelfth grades, beginning fall of 2016. You can help minimize the rush by encouraging vaccination well before the school requirement takes effect.

For more information, go to www.adph.org/immunization

2010 Annual Meeting & Fall Pediatric Update Speakers & Topics

Jennifer Chambers, MD, MPH, TM

Assistant Professor, General Pediatrics and Adolescent Medicine, Department of Pediatrics; Medical Director, International Adoption Clinic, University of Alabama at Birmingham, Birmingham, AL

- Update on International Adoption

Frederick Goldman, MD

Professor of Pediatrics, University of Alabama at Birmingham; Director, Lowder Stem Cell Transplant Program, The Children's Hospital of Alabama, Birmingham, AL

- Expanding the Role of Bone Marrow Transplantation in Pediatric Diseases

Lee M. Hilliard, MD

Associate Professor of Pediatrics, Division of Pediatric Hematology/Oncology, Department of Pediatrics, University of Alabama at Birmingham, Birmingham, AL

- Neurologic Complications of Sickle Cell Disease: An Update on Screening and Prevention

Druhan Howell, MD

Assistant Professor, Department of Pediatrics, University of South Alabama, Mobile, AL

- Anaphylaxis: Killer Allergy

Karen M. Landers, MD, FAAP

Assistant State Health Officer/Pediatrics Consultant, Alabama Department of Public Health, Tusculum, AL

- Emergency Preparedness: Public Health's Role and Responsibilities

David J. Lozano, MD, FAAP

Assistant Professor of Pediatrics, Pediatric Pulmonary Division, Department of Pediatrics, University of Alabama at Birmingham, Birmingham, AL

- What can our pediatric sleep disorders center do for you?

CHAPTER BRIEFS

Oral Health resources available to assist pediatricians and 1st Look providers

The Chapter has been made aware of several resources for pediatricians regarding oral health and, specifically, fluoride varnish application.

Academic Pediatrics, the journal of the Academic Pediatric Association, has published a Special Issue on Children's Oral Health, featuring commentaries from leading oral health figures as well as from Dr. David Satcher, 1998-2002 U.S. Surgeon General. The special issue features a call for "dentists, physicians and other health professionals who work with children to embrace a shared responsibility" for children's oral health and work to overcome the historic separation between dentistry and medicine." The issue, along with background information on the National Summit on Children's Oral Health, can be viewed on the AAP's Oral Health Web site at <http://www.aap.org/commpeps/doch/oralhealth/summit.cfm>.

The Association of State and Territorial Dental Directors and the National Maternal and Child Oral Health Resource Center (OHRC) has developed several new resources for use by those who perform fluoride varnish application in populations at moderate to high risk for dental caries.

- **Fluoride Varnish: A Resource Guide** - offers annotated lists of journal articles, materials, and organizations - <http://www.mchoralhealth.org/PDFs/ResGuideFIVarnish.pdf>.
- **Fluoride Varnish: An Effective Tool for Preventing Dental Caries** (fact sheet) provides information about fluoride varnish and its uses, effectiveness, safety, service delivery, and reimbursement - <http://www.mchoralhealth.org/PDFs/FIVarnishfactsheet.pdf>.
- **Fluoride Varnish** (policy statement) supports the use of fluoride varnish, beginning with tooth eruption, for individuals at moderate to high risk for dental caries as an effective adjunct in programs designed to reduce lifetime caries experience - [http://www.astdd.org/docs/FluorideVarnishPolicyStatement\(EcFebruary12010\).pdf](http://www.astdd.org/docs/FluorideVarnishPolicyStatement(EcFebruary12010).pdf).
- **Resource Highlights: Focus on Fluoride Varnish** (guide) provides a short list of high-quality journal articles, materials, and web sites on this topic - <http://www.mchoralhealth.org/highlights>.

Single or multiple print copies of the fact sheet and resource guide are available at no charge from OHRC at <http://www.mchoralhealth.org/order>.

Healthcare reform resources posted on Chapter web site

In an effort to educate pediatricians on the changes coming through the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), the American Academy of Pediatrics has produced resources on AAP priority issues within health reform implementation, including a PowerPoint on healthcare reform implementation, an overview fact sheet (very good information!) and one-page fact sheets on Support for Small Pediatric Practices, Age-Appropriate Benefits, Access to Care Through Pediatric Payment Rates, and Pediatric Workforce. To access, visit the Chapter web site at www.alaap.org.

CHAPTER BRIEFS

Register now! Important Immunization Update webinar for Chapter members

Please mark your calendars for Thursday, July, 15 at 5:30 p.m., when the Alabama Chapter-AAP, along with the Alabama Department of Public Health (ADPH), will host a webinar, “Important Update on Alabama’s School Immunizations Requirements.” The one-hour session will feature an overview of where we are with pertussis in Alabama by David Kimberlin, MD, FAAP, of UAB, including new information from the ACIP; New Tdap and PCV requirements and clarification of existing school immunization law and requirements for certificates of immunization by the ADPH Immunization Division Staff; and a review of all adolescent vaccine recommendations by Chapter Immunization Representative Tim Stewart, MD, FAAP.

To register, visit the Chapter web site at www.alaap.org.

Member News in Injury Prevention

Chapter Injury Prevention Committee Chair Kathy Monroe, MD, FAAP, has compiled an update on known member involvement in injury/violence prevention activities:

- Tricia Gibbs, MD, (resident member of committee) obtained funding from the Children's Hospital's Founders Fund grants and State Farm to host two Teen Driving Days at Brookwood Mall in Birmingham, distributing safe driving information to teens and parents who passed the booth.
- Dr. Monroe spearheaded a Teen Driving Summit, hosted by Children’s Hospital and funded by AllState, for 10 students from each Jefferson County High School. The day consisted of driving simulator training, evidence-based programs, and visits by legislators and keynote speakers. The students created posters on safe teen driving and public service announcement videos as part of a contest, which can be seen on www.chsys.org. The students were tasked with bringing their newfound knowledge back to their respective schools.
- Carden Johnston, MD, FAAP, is the new Chair of the AAP’s COIVPP’s Subcommittee on Violence Prevention. Locally, he arranged and financed Bob Sege MD, FAAP, to present “Connected Kids: Safe, Strong and Secure” at UAB Grand Rounds and at the 2010 Spring Meeting in April. Dr. Johnston has also attended community meetings of Parents Against Violence and Advocates for Youth to take advantage of the enthusiasm of local groups and is working with Children’s Hospital’s advocacy program to seek out fellow interest in exploring ways to work on violence prevention.
- Sarah Atkins, MD, presented an abstract “Introducing Advocacy and Injury Prevention Curriculum” to a Pediatrics Residency Program at the National Injury Free Coalition for Kids meeting. Dr. Monroe also worked with a medical student to interview parents on their knowledge of child passenger restraint laws and use. Through this research, the student also presented an abstract, “Analysis of Child Passenger Safety in Patients of a Pediatric Emergency Department,” at the same conference.
- Injury Prevention committee member Courtney Baxley, MD, a UAB resident, is also researching motorized vehicle injuries (scooters, go carts, dirt bikes and golf carts).

2010 Annual Meeting & Fall Pediatric Update Speakers & Topics

Amanda Soong, MD, FAAP

Assistant Professor of Pediatrics,
Department of General Pediatrics,
University of Alabama at Birmingham

- Implementation of a Hospital-Based Shaken Baby Prevention Program

Dennis M. Stryne, MD, FAAP

Rumsey Chair of Pediatric
Endocrinology Professor of Pediatrics,
University of California

- Growth Diagnosis: You Can Do Much Of It In Your Office
- Pediatric Obesity: What Are the Latest Recommendations for Evaluation and Treatment?

David T. Tayloe, Jr., MD FAAP

Pediatrician, Goldsboro Pediatrics;
Immediate Past President, American
Academy of Pediatrics, Goldsboro,
NC

- Financing the Medical Home
- Health Care Reform: How Will It Change Pediatrics?

Karen M. Wilson, MD, MPH, FAAP

Assistant Professor, Division of General
Pediatrics and Pediatric Hospital
Medicine, Golisano Children’s
Hospital at Strong, Rochester, NY

- Effective Practices in Promoting Tobacco Use Cessation

Audie L. Woolley, MD

Chief, Cochlear Implant Program,
Children’s Hospital of Alabama;
Associate Clinical Professor, University
of Alabama at Birmingham

- Pediatric Cochlear Implants – Advances in Technology & Outcomes

J. Wiley, Michael Ramsey, Linda Lee (non-CME)

- Chapter Annual Meeting/Reports

CHAPTER BRIEFS

CATCH grant proposals sought!

The 2011 CATCH Call for Proposals is now open! The Community Access To Child Health (CATCH) Planning Funds program provides grants in amounts from \$2,500 to \$12,000 for pediatricians to develop innovative, community-based initiatives that increase children's access to medical homes or to specific health services not otherwise available. Grants of up to \$3,000 are available to pediatric residents. Please check out our websites at:

<http://www.aap.org/catch/planninggrants.htm>

<http://www.aap.org/catch/residentgrants.htm>

The Call for Proposals ends July 30. Please contact your Chapter CATCH Facilitator, Jessica Kirk, MD, FAAP, (jlkirk@aap.net) at any time for technical assistance.




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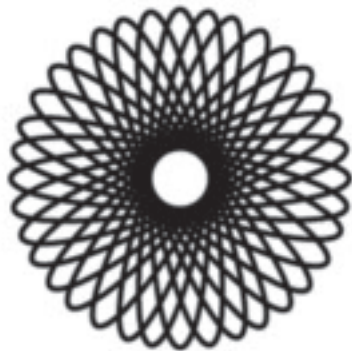
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