

THE IDAHO PEDIATRICIAN

Special Immunization Issue

American Academy of Pediatrics



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Chapter AAP

The Idaho Immunization Coalition

by Tom Patterson, MD

Vaccine preventable disease rates are at all time lows due to diligent research, effective immunization systems, and outreach. This success has come from a collaboration of private and public sectors. Nonetheless, there are still barriers to optimizing immunization protection from vaccine preventable diseases. Prior to modern day immunizations, many diseases impacted countless numbers of children with disability and, unfortunately, mortality. In recent decades, there have been advances in vaccines broadening the protection net for children and adults. As vaccine preventable illnesses diminish, such as polio, measles, pertussis and even now haemophilus, pneumococcus, rotavirus and varicella, the public loses valuable memory of the devastation of these diseases. Yet outside of the United States one million deaths occur annually from measles alone. Complacency sets in from a lack of knowledge of natural diseases and fears of adverse events, including autism, further add to the barriers to protecting our children and adults. Idaho continues to struggle to obtain higher immunization coverage rates.

The Idaho Immunization Program, funded jointly by the State of Idaho and the Centers for Disease Control, has grown in the past decade improving our rates considerably. The Idaho Immunization Program hosted an Immunization Summit in the fall of 2007 inviting public and private health sectors to formulate the problems facing our State and potential solutions. The group discussed the successes of the Canyon Area Immunization Coalition and proposed a Statewide Coalition. Idaho is the only state in the Nation without a widespread or statewide Immunization Coalition.

This brings us to May of 2008. The AAP Idaho Chapter held an Immunization Congress, funded by a grant from AAP National. The congress succeeded in bringing public and private sectors together to launch what is now the Idaho Immunization Coalition. The coalition is a 501 c3 non profit organization to enhance the existing immunization system in Idaho. The goal is to protect adults and children from vaccine preventable disease in an efficient, safe and enlightened manner and to maintain the statewide immunization registry. The Coalition will have an Executive Committee with Keith Davis, MD, President of the Idaho Academy of Family Physicians and my-self as co-chairmen. Subcommittees consisting of Education, Legislation and Vaccine Outreach will address specific issues. The state Immunization Program, the AAP, and AAFP Idaho Chapters are all on board to see the coalition to fruition. We are still coalition building and anyone interested in having a part in the coalition may contact me at tspatterson@saltzmed.com.

We have succeeded in many ways, though there is much work to be done to reach our goal of maximum immunization coverage in all populations.

President's Message

Greetings from Creighton Hardin, MD

First, I would like to give thanks to Dr. David Christensen for his three years as President; job well done. Also thank you to Dr. Jerry Hirschfield who is stepping down as chapter legislative chairman, after 14 years, his expertise and élan will be hard to replace. We are working on his replacement.

Newly on board with the Executive Committee is VP Tom Patterson, MD general pediatrician from Nampa and Kenny Bramwell, MD as Treasurer, emergency room physician from Boise. I've been a general pediatrician in Pocatello for 30 years and will try to represent the interests of Idaho kids and their pediatricians throughout the state. I could not do the job without the expertise from Sherry Iverson, Executive Director and able assistant Meghan Sainsbury.

Goals for the 2008-09 year:

- Aid with the development of the Idaho Immunization Coalition. The coalition was started and chaired by Tom Patterson, Nampa and Keith Davis, Family Practitioner from Shoshone and President of the Idaho AAFP. More on this will follow in subsequent newsletters.
- Continuing to partner with the Idaho Perinatal Project with, I'm sure, will be another lay midwife licensing bill.
- We would like to close the final gap in seat belt legislation for the 7-8 year olds.

I encourage pediatricians to find a passion and become involved. We would like a practice to participate in the Pediatric Research in the Office Setting AAP initiative. These are well designed projects of clinic significance. Also we would like dentist or physician interested in oral health to become the Idaho liaison to the AAP. If you are interested contact me hardcrei@cablone.net or Sherry Iverson iversons@slrhc.org.

Several new coordinators have stepped up to the plate: Kath Drake with Disaster Preparedness, Kenny Bramwell with Emergency Medical Services and pending Governor approval, Steve Felix on the Early Years Council.

We have 5 Catch grantees in the state and will showcase their projects in the future.

Save the Date

Evidence-Based Child & Teen Mental Health **The Ins and Outs of Child Psychopharmacology,**

Oct. 8, 2008

The First National Institute for Primary Care Providers, Oct. 9-10, 2008

The Westin Kierland Resort & Spa
Scottsdale, Arizona

<http://nursing.asu.edu/ace/courses/ebpctmh/index.htm>

Behavioral Aspects of Neurological Disease

"BAND" Conference

October 10-11, 2008

Sun Valley Resort - Idaho

<http://www.idahopsych.org/>

21st Annual Idaho Conference on Health Care

October 22-24, 2008

ISU/Pocatello

<http://www.idahopsych.org/>

Early Years Conference 2008

November 18-19, 2008

Boise State University

www.idahochild.org

Learning Resources International

2009 schedule

3 NEW COURSES

2009 Advanced Fetal Monitoring and Certification

Preparation Seminar in 17 Locations

2009 In-Patient Obstetrics Certification

Preparation in 2 Locations

2009 Legally Speaking in Tampa, FL.

Idaho Chapter, AAP Winter

Business Meeting & Dinner

Thursday, February 19, 2009

Quality Improvement

Nampa Civic Center

email: idahoaap@gmail.com to RSVP

2009 Idaho Perinatal Project

Winter Conference

February 19-20, 2009

Nampa Civic Center, Nampa, Idaho

For more information, call 208-381-4174



Creighton Hardin, MD
Idaho Chapter, AAP President 2008-2011
Pediatrician, Pocatello Children's Clinic

Vaccine Mandates for School Attendance

by Tom Rand, MD

State laws requiring immunizations for school attendance have been extremely effective in assuring high levels of immunization in school-age children. The laws also provide for exemptions, that is, rules allowing parents to decline immunizations, and for what reasons. One need only compare immunizations coverage of 2-year-olds to the very high coverage of elementary students to realize the impact of these requirements.

Vaccines for school attendance were expanded in Idaho approximately 4 years ago. For kindergarten entry, required vaccines are 5 DTaP, 3 polio, 2 MMR, 3 hepatitis B, and age-appropriate Hib. The implementation of the DTaP and MMR requirements were a bit exasperating for pediatric practices, since children that had just passed their 4th birthday were excluded from some preschool programs until they received further vaccines. Such children were not behind by CDC vaccine schedule, and parents were confused that their clinics said they were already up to date. Admittedly, more 4-year-olds were immunized than without the rules but at the cost of exclusion from preschool and a lot of hassles. After more time than we thought imaginable, the wording of the rule corrected this conflict for pre-kindergarten children.

Other states have requirements for varicella, pneumococcal conjugate, or hepatitis A vaccines for school and/or childcare attendance. In Idaho, a current issue is whether to add a requirement for varicella vaccine. Idaho is one of only three states that has no requirement for varicella vaccine. This has a direct public health impact. In the years before widespread immunization against varicella, children generally acquired natural immunity from chickenpox at a young age. As rates of varicella immunization rise, unimmunized preschool children have a higher probability of remaining susceptible to varicella until they acquire chickenpox at an older age when more complicated infection is likely. A requirement for varicella immunization would assure that unimmunized children “don’t slip between the cracks” to remain at risk for severe chickenpox at an older age.

I do not think that we can simplistically implement a requirement for varicella immunization. Many providers continue to undersell varicella immunization and regard the vaccine as optional. There is a widespread belief that varicella vaccine is not as safe as other vaccines and the particularly erroneous conclusion that natural chickenpox is better than immunization. A state law requiring varicella immunization needs to be preceded by widespread education.

Providers of pediatric vaccines need to dialogue over the merits of requirements for varicella vaccine. Two doses by age 4-6 years are recommended in the CDC schedule, but is it wise to require two doses when more than 20% of children have had zero? Do mounting mandates for immunization trigger a backlash of vaccine opponents? Will the number of exclusions counterbalance the requirement?

RSV & INFLUENZA

Go to www.idahoap.org for the latest in trends, recommendations, Synagis criteria, and links relative to RSV & Influenza.

The Idaho Immunization Program

Andy Noble

Promotion/Education
Idaho Immunization Program

The Idaho Immunization Program (IIP) oversees the federal Vaccines for Children (VFC) program for the state of Idaho. Idaho has an enhanced VFC program that provides almost all recommended vaccines for *all* children 0-18 years of age. One of the main focus points for the IIP is increasing the number of children completing the recommended immunization schedule. Idaho has below average immunization rates. In fact, in 2006, Idaho had a rate of 68.2% for the 4:3:1:3:3:1 (DTaP, Hep B, MMR, IPV, Hib, and varicella) immunization series which is almost 10% below the national average according to the National Immunization Survey.

Idaho's low immunization rate can be attributed to a few key factors:

- Patients are not returning for their 12-18 month immunizations. Two of the most commonly missed immunizations in Idaho are the 4th dose of DTaP and the 1st Varicella, recommended at 12-18 months of age.
- Immunization records are not being screened at all well and sick child visits. These are excellent times to assess what a child might be missing. If a child is unable to be vaccinated during a sick child visit, it is a great time to schedule the next immunization visit and get them back on track.
- Providers are not utilizing an automated recall system to determine if patients are due for, or behind on, immunizations. Idaho's Immunization Reminder Information System, or IRIS, is a statewide system that allows providers to track the immunization status of patients.
- Parents have concerns about vaccine safety. Immunizations have been hotly debated in the media, and parents are often misinformed. Physicians are the number one trusted source for information by parents. If you would like assistance in answering tough questions regarding vaccinations, please call the IIP.

As part of the VFC program, the IIP conducts annual quality assurance reviews (QAR's) with over 200 pediatric and family practice VFC providers throughout the state of Idaho. This year, the IIP is focusing not just on the Standards for Pediatric and Adolescent Immunizations but also immunization rates within the practice. While visiting VFC providers that have achieved an immunization rate of 90% or greater, several best practices have been identified. These practices are easily implemented and directly affect and improve immunization rates and quality of care.

★Implement a Remind and Recall System

- Reminder/ recall is a system which can automatically generate immunization lists of patients that need to be reminded of upcoming immunizations or scheduled for missing immunizations. IRIS can help with reminders.
- Patients who receive reminder phone calls of upcoming appointments more than one day in advance have a lower no-show rate.

★Utilize a Forecasting System

- The immunization schedule is complicated, and some vaccinations can be missed. Providers who require staff to utilize a forecasting system, like IRIS, reduce the number of invalid doses given and ensure that all immunizations a patient needs are identified.

★Receive Ongoing Education

- Providers who receive and provide ongoing education opportunities for staff tend to make fewer screening and administration errors.

C.A.T.C.H. GRANT CORNER

The Community Access To Child Health (CATCH) Program is a national program of the American Academy of Pediatrics (AAP) designed to improve access to health care by supporting pediatricians and communities that are involved in community-based efforts for children. The CATCH Program began in 1991 under a grant from the Robert Wood Johnson Foundation.

The CATCH Program provides pediatricians with:

- Training
- Technical Assistance and Resources
- Peer Support and Networking Opportunities
- Funding Opportunities

For more information go to:
www.aap.org/catch

Obesity Trends Among U.S. Adults

Pediatric Obesity and Weight Management Community Assessment

Naya Antik, MD

Why did I seek for a CATCH Grant?

- (1) Concern for increasing rates of pediatric obesity: nationwide and locally;
- (2) Lack of family awareness regarding patient's growth status;
- (3) Lack of awareness of resources for families with obese kids; and
- (4) Lack of community resources for pediatric weight management.

More Idaho Statistics

- 26% of the 160,000 Idaho kids ages 10-17 yo are considered overweight or obese.#
- Hispanic children have almost doubled the rate of overweight/obesity than non-Hispanic children (49% vs 24%).
- Kids with public insurance have almost double the incidence compared to those with private insurance (40% vs 22%).
- 29% of low-income children ages 2-5 years participating in WIC are overweight/obese.*

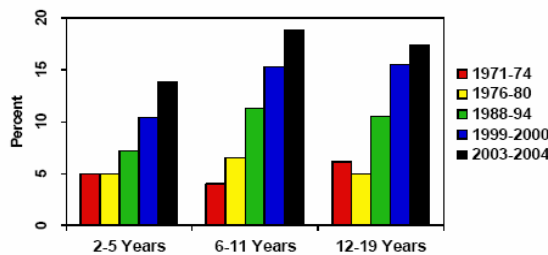
2003 National Survey of Children's Health

My Question

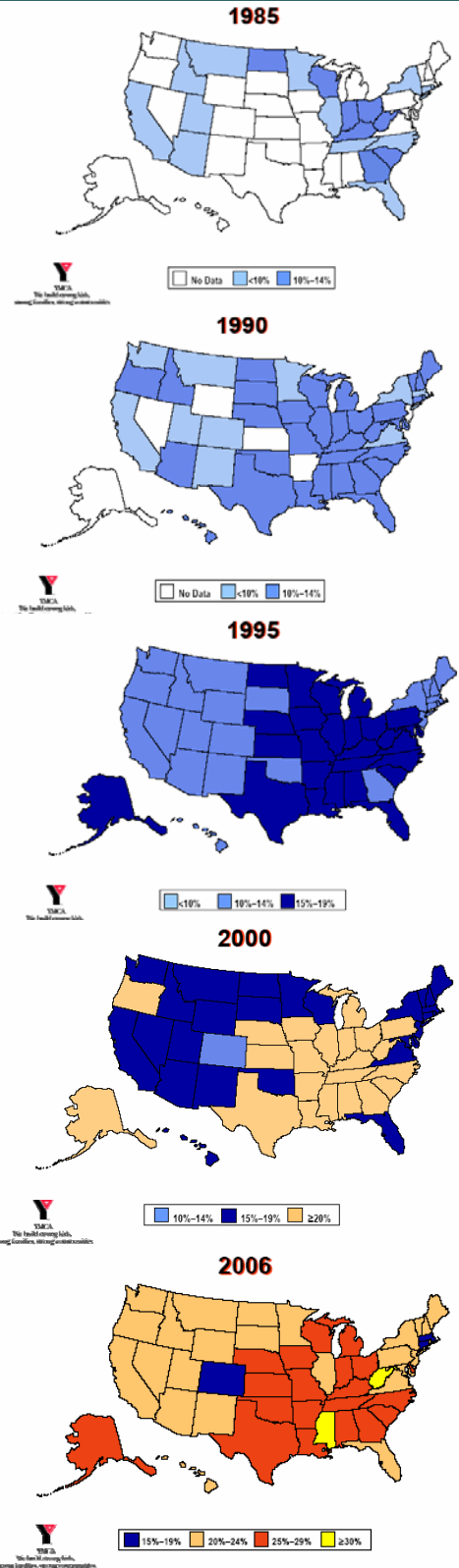
Is there a need for a comprehensive pediatric weight management program here in the Treasure Valley?

More information to come regarding my research in future Newsletters.

Increasing Prevalence of Overweight Children



Source: CDC/NCHS and NHANES



Idaho Medicaid Preventive Health Assistance (PHA) Benefit

Preventive Health Assistance or **PHA**, is a benefit for Medicaid participants. The Behavioral PHA provides opportunities designed to help families live a healthy lifestyle. The Wellness PHA rewards parents for keeping their children up-to-date on well child checks and immunizations.

Wellness PHA

Who is eligible?

The children whose parents pay a monthly premium (\$10 or \$15) for their child's Medicaid coverage are eligible for the Wellness benefit.

How does it work?

Children can earn 30 points every 90 days for keeping current on well child checks and immunizations current. One (1) point = \$1.

How can these points be used?

The points will automatically be used to help pay Medicaid premiums. Wellness PHA points can't be exchanged for vouchers.

Behavioral PHA-

Weight Management

Who is eligible?

To qualify for this benefit potential participants must complete a PHA Health Questionnaire and return it to the Department. The questionnaire must indicate that the child or Medicaid eligible adult is over the age of five (5):

- Have a Body Mass Index (BMI) in the

obese range or underweight (95th percentile and above or 5th percentile and below for children)

and

- Want to improve health through weight management.

How does it work?

Points are earned by signing up to participate in monitored weight management activities.

What can these points buy?

Weight Management participants receive a voucher to help pay for their weight management program fees at a participating vendor.

Behavioral PHA-

Tobacco Cessation

Who is eligible?

To qualify for this benefit a potential participant must complete a PHA Health Questionnaire and return it to the Department. The questionnaire must indicate that the child or Medicaid eligible adult wants to quit using tobacco.

How does it work?

Points are earned by signing up to participate in tobacco cessation activities

What can these points buy?

Tobacco Cessation participants receive a voucher to help pay for tobacco cessation products at a PHA participating vendor.

After earning PHA points

Points can trade in (one (1) point= \$1) for vouchers that can be used at pharmacies that accept PHA vouchers.

Participants cannot receive both Weight Management and Tobacco Cessation PHA benefits at the same time.

PHA Health Questionnaires may be obtained online at www.medicaid.idaho.gov and click on Preventive Health Assistance (PHA) or call toll-free at: (877) 364-1843.

More Information

If you would like more information about PHA, you can visit the website at www.medicaid.idaho.gov, click Preventive Health Assistance (PHA), call toll-free at: (877) 364-1843, or email us at: medicaidphaprogram@dhw.idaho.gov

Milk is Milk

A new study, published in the July issue of the *Journal of the American Dietetic Association (JADA)*, examined the composition of conventional milk, milk labeled "rbST-free", and organic milk. In the first peer-reviewed study of its kind, the data show only minor differences among the three. The authors concluded that "label claims were not related to any meaningful differences in the milk composition variables measured."

The study examined 334 retail whole milk samples with three label claims related to farm practices: conventional, from cows not treated with rbST and USDA-certified organic, gathered from stores across the country. The variables measured were quality (antibiotic residue levels, bacterial counts), nutritional value (fat, protein, solids-not-fat) and hormonal composition (bST, insulin-like growth factor-1 [IGF-1], estradiol and progesterone). Statistical analysis determined that there is little difference among the three types of labeled milk.

Mean concentrations of variables analyzed in milk with labels related to three types of dairy-farm management

	Conventional	rbST-free	Organic
Protein (%)	3.14	3.15	3.22
Bacterial counts	11	26	22
Estradiol	4.97	6.63	6.40
Progesterone	12	12.8	13.9
IGF-1	3.12	3.04	2.73
Somatotropin (bST)	.005	.042	.002

This table is for reference only. See study for units and statistical significance.

Vicini et al. Survey of retail milk composition as affected by label claims regarding farm management practices. *JADA*, 2007.

Five Easy Ways to Enjoy **Nutrient-Rich Family Meals**

ENRICHING
FAMILY 2
MEALTIMES

Research shows that American children and adults are missing some of the key nutrients we need to look great, feel better, and be stronger. Some of these shortfall nutrients are calcium, potassium, magnesium, vitamins A, C, and E. Children and older adults may also be missing iron, folate, vitamins B₁₂ and D. Here are five easy ways to help put power nutrition into your family's meals:

Enjoy **GRAINS** for folate, fiber, and energy.

GO WITH THE GRAIN – especially 100% whole grains – at least one serving at every meal. Start off quick and easy with a bowl of whole grain cold cereal or hot oatmeal for breakfast. Move onto a satisfying sandwich on whole wheat bread for lunch. Then finish up with brown rice or whole grain pasta at dinnertime.



Enjoy **FRUITS and VEGGIES** for vitamins and more.

FRUITS AND VEGETABLES – fresh, frozen, dried, and canned in their own juice – are nature's most appetizing vitamin 'pills.' Get your fruits and veggies the easy way: 2 servings at every meal plus 1 to 2 fruit or veggie snacks per day. From A to Z, the choices are endlessly delicious – from a snack of sliced apples to stir-fried zucchini for supper.

Enjoy **NUTS/SEEDS** for vitamin E and magnesium.

YOU CAN GET THE MAGNESIUM AND VITAMIN E that most Americans are missing – with sunflower seeds, pumpkin seeds, almonds, pecans, cashews, and other nuts. Just add a serving (1 ounce or a small handful) to your daily intake. Sprinkle almonds on cereal or on a fruit salad. Enjoy sunflower seeds or dry-roasted cashews as a high-energy snack.



Enjoy **MILK PRODUCTS** for calcium and vitamin D.

PACKED WITH BODY-BUILDING NUTRITION, DAIRY PRODUCTS – fat-free or lowfat milk, yogurt, and cheese – are delicious and good for you too. To get the calcium, potassium and vitamin D you may be missing (plus protein, phosphorus and more), all it takes is three servings a day: 8 ounces of milk (fat-free, 1% or 2%) with every meal will meet this goal.

Enjoy **MEAT, FISH, POULTRY, and BEANS** for protein.

MEAT IS A SOURCE OF HIGH QUALITY PROTEIN necessary for children to grow physically and mentally. Choose lean beef and pork, skinless poultry and fish to minimize your saturated fat intake. A 3-ounce serving of one of the 29 lean cuts of beef (like top sirloin, brisket, T-bone, and 95% lean ground beef) has less than 200 calories and less than 10 grams of fat – along with plenty of ZIP (zinc, iron, and protein) and flavor!



DEVELOPMENTAL CHECKUPS FOR ALL CHILDREN

Three Good Choices for Practices and Providers: ASQ, PEDS and PEDS:DM

Margaret Dunkle and Janet Hill

Every young child needs regular developmental checkups. Quick, easy developmental screening picks up problems before they become obvious or have a chance to fester and grow. It also opens the door to intervention early on, when it can do the most good.

Early intervention works. And the sooner a possible problem is spotted and effectively addressed, the sooner the child will reap the benefits. Developmental screening tools alert providers to areas of a child's development – from movement and mental health to language and learning – where they need to take a closer look and follow up with assessment, diagnosis, services and treatment.

Regular developmental checkups with a good screening tool are as much a part of good pediatric practice as regularly measuring a child's height and weight.

The American Academy of Pediatrics recommends that physicians do developmental screenings with a high-quality tool at least three times before a child's third birthday – at the 9-month, 18-month, and 24- or 30-month pediatric visits. <http://pediatrics.aappublications.org/cgi/reprint/118/1/405.pdf>

For preschoolers (children ages 3-5), the AAP also recommends regular developmental screenings. <http://www.pediatrics.org/cgi/content/full/108/1/192>

Three general developmental screening tools stand out from the rest – ASQ (*the Ages and Stages Questionnaires*), PEDS (*Parent's Evaluation of Developmental Status*), and PEDS:DM (*PEDS: Developmental Milestones*). These tools cover all developmental domains and:

- Are accurate – correctly identifying at least 70% of infants, toddlers and preschoolers with and without disabilities, delays or developmental problems – and backed up by solid research;
 - Are short, low cost, and easy to administer and score;
 - Rely on what parents know and observe about their child, which also makes them appropriate across many cultures;
 - Can be completed in many settings – in a pediatric or family medicine practice, in a child care center or Head Start program, during a home visit to a family with a young child, or even online; and
- Provide a great way to communicate with parents, make the most of every well-child visit, and comply with state and federal requirements.

These three tools are billable under CPT Code #96110 (developmental screening) in fee-for-service medical settings, compatible with electronic medical records (EMR), and either already available online or will be shortly.

ASQ, PEDS and PEDS:DM are alike in that they are all high-quality. They also have some differences: for example, the age ranges they cover, the time they take to administer and score, available languages and reading level, the questions they ask, and their “feel.”

A health care provider cannot go wrong with any of these tools. The table below provides information about ASQ, PEDS and PED:DM so that a provider can make the right choice for his or her office or practice.

Margaret Dunkle is Director of the Early Identification and Intervention Collaborative for Los Angeles County and Senior Fellow with the Center for Health Services Research and Policy at George Washington University. Janet Hill is Coordinator of the California Early Childhood Comprehensive Systems Project and Health Program Specialist at the California Department of Public Health.

**Are you a member of the AAP?
Are you under 40?**

<http://www.aap.org/sections/ypn/yp>

- Input into AAP young physician initiatives
- A subscription to the Section Newsletter (published 3-4 times per year)
- Guide to the AAP CD ROM
- Section Web Page
- CME from the Section Programs at the AAP National Conference and Exhibition (NCE)
- Reduced fees for educational programs (as a candidate fellow or post residency training fellow)
- Email list and Web site for young physician issues
- Communication with other young physicians
- Young physician representation in the AMA and other organizations

**Join the Section on
Young Physicians!**

Developmental Checkups – Three Good Choices for Practices and Providers: ASQ, PEDS and PEDS:DM*

Margaret Dunkle

Tool	Description	Developmental Domains Covered	Accuracy**	Age Range	Adm. Time	Scoring	The Science Behind the Tool	Languages & Reading Level	Costs	To Purchase & for Details
ASQ <i>ASQ</i> Ages and Stages Questionnaires Parental-report about a child's skills and behavior	30 questions (answered <i>yes</i> , <i>sometimes, not yes</i>), plus 7-8 unscored <i>Overall</i> questions. Parents indicate a child's developmental skills, using one of 19 age-specific questionnaires.	All Domains Covered communication, gross motor, fine motor, problem-solving, and personal-social skills	Sensitivity: 70-90% Specificity: 76-91%	4-60 months (5 years) Can be given as young as 3 months	15-30 minutes	Pass/fail score for each developmental domain. Provides a cutoff score in each developmental domain (2 standard deviations below the mean).	Standardized on 8,530 children from diverse ethnic and socioeconomic backgrounds, including Spanish-speaking. Validated on 1,613 children. Published validation studies.	English, Spanish, French and Korean Vietnamese expected in 2009. Unpublished versions in additional languages available from publisher. Reading level varies from 3rd to 12th grade.	Initial purchase: \$199 per kit (either paper or CD-ROM), including <i>ASQ User's Guide</i> and 19 age-specific forms to be copied as screenings are done. <i>To administer, score, interpret each screen:</i> \$4.60 (copying age-specific forms and staff time).	Paul H. Brookes Publishing Company, PO Box 10624, Baltimore, MD 21285, 800-638-3775; www.brookespublishing.com and www.agesandstages.com . <i>For ASQ-Online (expected 2009)</i> , see www.patienttools.com .
PEDS <i>PEDS</i> Parents' Evaluation of Developmental Status Parental-report about parental concerns	10 questions (the same for all ages, answered <i>yes</i> , <i>no</i> , <i>a little</i>). Parents identify "concerns" they have in each developmental domain.	All Domains Covered expressive language and articulation, receptive language, gross motor, fine motor, school, self-help, social-emotional, behavior, and global-cognitive	Sensitivity: 74-79% Specificity: 70-80%	0-95 months (7 years, 11 months)	2-10 minutes	Low, moderate or high risk for each developmental domain. Provides algorithm to determine whether to refer, do additional screening, or reassure parents that development is normal.	Standardized on 6,360 children from diverse ethnic and socioeconomic backgrounds, including Spanish-speaking. Validated on 1,279 children. Published validation studies.	English, Spanish, Arabic, Chinese, French, Haitian-Creole, Indonesian, Laotian, Malay-Indonesian, Portuguese, Russian, Somali, Swahili, Taiwanese, Thai and Vietnamese 4th to 5th grade reading level.	Initial purchase: \$30 for starter set, including <i>Brief Guide to Scoring and Administration</i> , and Scoring and Interpretation forms for 50 children. Bulk discounts for forms. <i>To administer, score, interpret each screen:</i> \$1.20 (purchase copies of one-page PEDS forms and staff time). Cost per screen of PEDS-Online ranges from \$1-\$2 if licensed by a provider to \$9.95 if done individually online.	Ellsworth & Vandermeer Press LLC, 1013 Austin Court, Nolensville, TN 37135, 888-729-1697, fax 615-776-4121; http://www.pedstest.com . <i>To request a trial license for PEDS-Online</i> , email eglas-cofcp@pedstest.com .
PEDS:DM <i>PEDS:DM</i> Developmental Milestones Parental-report about a child's skills and behavior	6-8 items or questions , depending on the age level. Parents indicate a child's developmental skills, using one of 22 age-specific questionnaires.	All Domains Covered expressive and receptive language, gross motor, fine motor, self-help, social-emotional, behavior, and reading and math (<i>for older children</i>)	By domain: Sensitivity: 75-87% Specificity: 71-88% Across ages: Sensitivity: 70-94% Specificity: 77-93%	0-95 months (7 years, 11 months)	3-5 minutes	Pass/fail score for each developmental domain. Provides a cutoff score for children below the 16th percentile in each developmental domain. The <i>Assessment Version</i> enables users to compute age-equivalent scores and percentage of delayed or advanced development.	Standardized on 1,296 children from diverse ethnic and socioeconomic backgrounds, including Spanish-speaking. Published validation studies.	English and Spanish Less than 2nd grade reading level.	Initial purchase: \$275 for kit, including reusable laminated form, grease pen, <i>Family Book, Professionals' Manual</i> , Case Study and 100 patient recording forms. <i>To administer, score, interpret each screen:</i> \$1.10 (purchase scoring forms and staff time).	Ellsworth & Vandermeer Press LLC, 1013 Austin Court, Nolensville, TN 37135, 888-729-1697, fax 615-776-4121; http://www.pedstest.com .

*The research for this table of developmental screening tools was supported by the California Department of Public Health's Maternal, Child and Adolescent Health (MCAH) Program.

There are two types of **accuracy. **Sensitivity** refers to the percentage of children with a disability or problem who are correctly identified by the screening tool. **Specificity** refers to the percentage of children without a disability or problem who are correctly identified by the screening tool.

Communicating with Vaccine-hesitant Parents

By Tom Rand, MD

The types of parents who did not previously challenge vaccines are now reluctant to immunize their children. Excessive clinic time is needed to answer questions about vaccines, and our best effort does not automatically result in acceptance of immunizations. What drives the change in parents' attitudes? How can we communicate effectively in brief discussions in clinic? What are national organizations doing to counter unbalanced sensational media coverage and misinformation?

Asking questions to determine the source of hesitancy helps regain a sense of partnership between parent and provider. Does the parent know someone whom vaccines are said to have harmed? Is the resistance to immunization based on safety concerns or cultural/religious/personal belief, and is there a relative or some authority that has pressured the parent?

The absence of diseases controlled by vaccines makes parents fear side effects of vaccines more than the diseases prevented. I point out that any child can pick up whooping cough, tetanus, invasive pneumococcal infection, or chickenpox. The unimmunized child has a very real risk of these diseases. There are a number of other diseases that are rare in the U.S. but will return if immunizations are neglected: measles, mumps, invasive Hib infection, and hepatitis A. With current immunization levels, an unimmunized child does not have much risk of acquiring these, but all the families who have accepted immunizations bear the burden of risk for immunizations in order that disease levels are low. Many families will understand that it is not fair to get a "free ride" from herd immunity, and immunizations are a responsibility toward community health as well as protection for the individual.

Once having identified that the risk of vaccine-preventable diseases varies, some parents will accept a greater number of vaccines selectively. Then I give them the opportunity to identify specific vaccines that they are concerned about side effects. Sometimes the concerns will be eliminated by brief answers. When more in-depth information is needed, I direct them to balanced sources of information such as Immunization Action Coalition at www.immunize.org. Families will continue to come to providers that respect their concerns, and many will accept immunizations routinely in time. Document vaccines that the provider recommended but the parent declined at each visit. When assessments of immunization levels are tabulated for a practice, the offered but declined vaccines should not count against a practice's level of immunization coverage if records are kept for declinations.

Some clinics will develop an immunization champion, usually a nurse, who can assist with these discussions. Many resources are available. Paul Offit had a series of articles in *Pediatrics* "Addressing Parents Concerns ...". A new book by Martin Myers that can be reviewed at www.dovaccinescausethat.com provides a clear approach to judging validity of vaccine information that will appeal to the intelligent layperson.

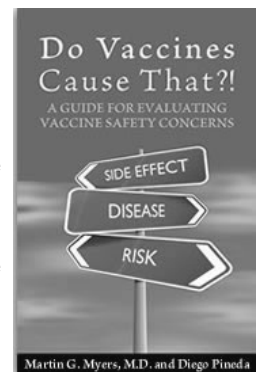
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K9 Buddies

Developing Canine relationships for families with a child who is blind or visually impaired -

**By Aerial Gilbert R.N.
Outreach Manager
Guide Dogs for the Blind**

Guide Dogs for the Blind is recognized worldwide as a model for innovative training, unprecedented support following graduation and success rate of their Guide Dog partnerships. Since 1942 we have partnered more than 11,000 specially trained mobility dogs with people who are legally blind, generally over the age of 16, throughout the US and Canada.

A relatively new initiative for us is the K9 Buddy Program, modeled after a program at the Australian Guide Dog School. The K9 Buddy Program matches specially selected dogs to become wonderful companions to visually impaired children and young adults.

K9 Buddies are offered free-of-charge, as are Guide Dogs. However, a K9 Buddy dog differs from a Guide Dog in a few key ways.

The K9 Buddy dogs come from Guide Dogs' own colony, but are not qualified to work as mobility assistance dogs (guide dogs) and they are not considered service animals. Therefore, K9 Buddies are not granted access to public places (i.e. restaurants, shopping malls, hotels, public transportation, etc.)

Additionally, K9 Buddies are primarily placed in the eight Western states – the same territory in which we have puppies being raised and the staff to support these programs. These states include Arizona, California, Colorado, Idaho, Nevada, Oregon, Utah and Washington.

Many children who are blind or visually impaired grow up with a fear of dogs, with their vision loss they experience dogs moving quickly or jumping up on them. The K9 Buddy Program allows children to forge a positive relationship with a dog by encouraging them to be a primary caregiver of a well-behaved canine.

A dog can contribute to the heightening of sensory development, motivating a child to learn and enhancing self-esteem. By learning to care for a dog as a pet, the child will master some of the basic skills necessary to care for a future mobility dog.

K9 Buddies will also have the opportunity to experience the human-animal bond that is so integral to the Guide Dog partnership. This relationship will allow them to make a more informed choice about their future mobility options as well as motivates them to learn their mobility skills.

We believe a child who may never be a candidate for a Guide Dog will also benefit from being a K9 Buddy Recipient. A study by Kay Alicyn Ferrell PhD, *Project Prism: A Longitudinal Study of Developmental Patterns of Children Who Are Visually Impaired*, states "over 50% of children with a visual impairment have multiple disabilities."

Our K9 Buddy recipients are consistent with Ferrell's study and we see the need to continue to encourage the parents of these children to educate themselves about the benefits of our K9 Program. The bond children create with their K9 Buddy helps to foster a sense of caring, companionship and responsibility into their daily life.

Families interested in applying for a K9 Buddy will be interviewed in their home to evaluate the environment as well as to determine the particular traits the family is looking for in a dog so an appropriate match can be made. After the appropriate match is made, the family will be given training and guidance from Guide Dogs for the Blind staff, prior to being granted a K9 Buddy.

The requirements to become a K9 Buddy Recipient are listed below:

The K9 Buddy program matches dogs with blind youth under 18 years of age who have been diagnosed by an ophthalmologist as legally blind or with a degenerative eye disease that will render them legally blind.

A K9 Buddy might be a good choice for a blind youth who exhibits the emotional stability and maturity needed to care for the dog (feeding, grooming, and exercising) and will treat it humanely.

The K9 Buddy applicant and family must be the primary care providers for the dog and monitor as well as encourage the applicant to actively participate in the care of the dog.

The applicant's home must have a secure backyard or dog run and be a safe environment for a dog.

The K9 Buddy Program also connects the child and their family with our community of puppy raisers, staff and other supporters. The program informs the family about the services of Guide Dogs for the Blind and connects the family with other services provided by agencies and organizations for the blind.

We have successfully placed 27 K9 Buddies in the eight Western states and we are looking to serve more in the future. As pediatricians you have the most direct contact with families of blind children and are able to recommend the program if you feel that a child may benefit from having a K9 Buddy.

If you would like to find out more about the K9 Buddy Program and how to apply, please call the Outreach office at Guide Dogs for the Blind at 800-295-4050 or visit www.guidedogs.com





Do you remember when ...

I need my next set of shots?
 Let IRIS help you remember.
 For more information ask your healthcare provider.

birth	2 month	minimum age for first dose	4 month	minimum interval from previous dose	6 month	minimum interval from previous dose	12 month	minimum interval from previous dose	15 month	minimum interval from previous dose	4-6 years	minimum interval from previous dose
Hep B	Hep B	birth	Hep B	4 weeks	Hep B	4 weeks	MMR	on or after 1st birthday	DTaP	6 months	MMR	4 weeks
	IPV	6 weeks	IPV	4 weeks	IPV	4 weeks	Var	on or after 1st birthday	18 month	minimum interval from previous dose	IPV	4 weeks
	DTaP	6 weeks	DTaP	4 weeks	DTaP	4 weeks	Hep A	on or after 1st birthday	Hep A	6 months	DTaP	6 months
	PCV	6 weeks	PCV	4 weeks	PCV	4 weeks	PCV	8 weeks			Var	3 months
	Hib	6 weeks	Hib	4 weeks	Hib	4 weeks	Hib	8 weeks				
	Rv	6 weeks	Rv	4 weeks	Rv	4 weeks						

Make sure children 9-12 years are protected. Give meningococcal, Tdap booster, MMR #2, 3 dose hep B series, 2 dose hep A series, 3 dose HPV series, and 2 dose varicella series unless there is reliable history of the disease or vaccination.



“Nadie se enferma” (no one gets sick)

by

Anabel Navarro

The annual Families All Together (FAT) Night at the end of February, sponsored by St. Luke’s Center for Community Health YAK (Youth Adult Konnections) program and Wood River Middle School, is organized to provide resources and fun for families of the community. Dr. Scott Willison, a Boise State University researcher, and I were invited by Healthy Tomorrows’ Project Director (Mary Lou Kinney) to help gather information from families on what they did or didn’t know about Idaho’s programs for children’s health coverage. We were also asked to disburse some information—in Spanish and English—about The Idaho Health Plan: Coverage for Children and Youth. The evening consisted of multiple agencies providing information, food and informative workshops. During the event, we were able to interview many families and youth about health care coverage. Due to my fluency in Spanish, I was able to obtain great information from Spanish speaking families and youth.

The “nadie se enferma” (no one gets sick) is a reply I heard frequently from Spanish-speaking families when I asked them about health care coverage for their children. The phrase is usually followed by another response, “nos da miedo pedir ayuda, porque algo puede pasar legalmente,” which means that these families do not apply for health coverage for their children (often times even when the children are U.S. citizens or have a Resident Alien card) because they fear potential legal problems for the undocumented adults. So, when their children get desperately sick or have an accident, many families take them to the hospital in Ketchum. Currently, one of the families is struggling with a \$7000 bill because of using this “emergency” method of dealing with health needs.

Dental care for some Spanish-speaking families in Blaine County has also been a challenge in the past. One mother described how she took her 5 children to Jerome (about an hour’s drive from Hailey) for dental care. At times, the appointments could not be done all in one day, so she would have to make multiple trips in a week to Jerome. Three months ago, the city of Hailey obtained a dentist that provided services to Idaho Health Plan (Medicaid and SCHIP) patients. This access has made a world a difference to her and other families in similar situations.

With the short time we had with these families at this FAT event, it’s evident that information and education of health coverage for families—and especially for children and youth in these families—is a critical and vital issue for health care prevention strategies and health coverage opportunities. When families don’t know the advantages of having health and dental care for their children and are not given direction on how to obtain the information (income guidelines and criteria), children and youth suffer—over the short and long term of their lives. And, as one teacher attending the FAT event stated “and in the end it hurts all of us” when children and youth in Idaho do not get needed health and dental care.

Anabel Navarro received her Bachelor’s of Fine Arts at Boise State University and is currently seeking a master’s degree in Counseling with an Addictions Studies Focus. Anabel works for the College Assistance Migrant Program (CAMP) as their Recruiter/Retention counselor. For more information about the Healthy Tomorrows: “Starting Points for Idaho Youth” Project, please e-mail mkinney@mtnstatesgroup.org For health care coverage information for children/youth up to 19 years old, please dial 2-1-1.

“You have within you right now
Everything you need to deal with whatever
The world can throw at you.”

-Brian Tracy

A Community Pediatrician's Guide to Supporting Military Children During Wartime

By CPT Bonnie Geneman, MD - Resident Pediatrician
and MAJ Keith M. Lemmon, MD, FAAP
AAP Uniformed Services West Chapter Vice President, Adolescent Medicine Specialist

Madigan Army Medical Center – Department of Pediatrics
Ft. Lewis, WA

In today's fast paced military environment and the era of multiple deployments, there is an entire generation of military children affected by the absence of one or both parents. Recognizing that a military member's deployment has a variety of impacts on his or her family, the military is making an effort to reach out to children and provide them with the tools to cope with this unique military family stressor.

Many parents notice behavioral changes in their children before, during or after parental deployments. This is not unusual and is most appropriately addressed through meaningful discussion. Parents may hesitate to talk about their children's behavioral changes or other family challenges, feeling that they need to maintain a strong front in support of the deployed family member. In actuality, discussing the emotions, stressors and changes in the family dynamic can be helpful for all family members.

Military Youth Deployment Support Video Program

Military pediatricians, in conjunction with the American Academy of Pediatrics (AAP), created an animated feature for elementary-aged children to them something they can relate to and use as a starting point for discussion. "Mr. Poe and Friends Discuss Reunion after Deployment" is a dynamic cartoon, which provides young children with interesting characters and stories to relate to as they think about their own feelings in relation to deployment. It covers maternal and paternal deployment as well as single parent deployment. The cartoon also highlights some of the unique challenges that reunion after deployment poses and helps normalize many of the emotions that a child can wrestle with during these challenging times. (Video available at www.aap.org/sections/unifserv/deployment/index.html)

Also included in this uniquely targeted video support program, is "Military Youth Coping with Separation: When Family Members Deploy." Created by a military adolescent medicine specialist, military pediatricians and the AAP, this video is specifically made for older children and adolescents. It features interviews with real teens going through family member deployments and it touches on a broad range of emotions and fears that an older child or teen may face. Adolescence can be challenging enough without the additional stress of a parent's deployment. It is a time where many older children and teens do not feel comfortable sharing their emotions or they may feel that their emotions are wrong or abnormal. This video strives to show that any emotion is normal and acceptable and that there are other kids going through the same thing at the same time. A great supplement to this video is the accompanying Interactive Military Youth Stress Management Plan, an interactive tool developed to walk teens through the process of identifying their specific stressors and developing effective methods to cope with them effectively. The stress management plan was developed in conjunction with Dr. Ken Ginsberg who is an adolescent medicine specialist and a pioneer in child and adolescent resilience concepts into usable formats. (Video and Stress Management Plan available at www.aap.org/sections/unifserv/deployment/index.html)

All of the videos mentioned above are available free of charge and can be ordered or watched online. It is recommended that a caregiver (parent, teacher, grandparent) watch the selected video with the child/adolescent and spend time afterward discussing the feelings experienced during the video. This is an excellent way to open up lines of communication regarding potentially uncomfortable feelings. Watching the videos with other children experiencing parental deployment can also be helpful. The intent is that each child will gain a better understanding of their own emotional reactions to deployment while learning positive ways to cope with these reactions.

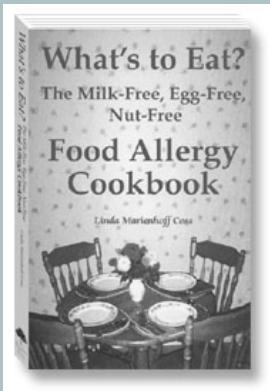
In addition to video media as a form of support, there are other excellent military child and youth resources available to parents and youth serving professionals (see table).

There are many resources and supportive organizations available for families and military youth during this time of lengthy and recurrent deployments. Please become familiar with these resources and provide information and support to military children and youth when they visit your practice.

Military Child and Adolescent Support Web Sites

AAP Deployment Support Website	www.aap.org/sections/unifserv/deployment/index.html
Zero to Three – CTAMF	www.zerotothree.org/site/PageServer?pagename=key_military
Sesame Street – Talk, Listen, Connect	www.sesameworkshop.org/tlc/
Military One Source	www.militaryonesouce.com 1 800 342-9647
Army Behavioral Health	www.behavioralhealth.army.mil/families/index.html
Army Reserve Child and Youth Services	www.arfp.org/skins/cys/cys_home.aspx
Operation Military Kids	www.operationmilitarykids.org/public/home.aspx
Our Military Kids –Activity tuition assistance for children of deployed Reserve/NG members	www.ourmilitarykids.org/

Book Review:



An ever-increasing number of patients are being diagnosed with severe food allergies, and these children's parents naturally look to their pediatrician for help in managing this very difficult condition. One of the most challenging tasks for parents is the one that must be dealt with every day: preparing tasty and nutritious meals that meet the requirements of their child's "strict avoidance" diet

Food allergy sufferers will be excited to learn that my second cookbook, "What Else is to Eat? The Dairy-, Egg-, and Nut-Free Food Allergy Cookbook," is now available at www.FoodAllergyBooks.com. This book features recipes for foods that everyone can enjoy, whether they have food allergies or not. Main dishes, side dishes, breakfast foods, and baked goods are all included. With an emphasis on fast and easy recipes that use "normal," easy-to-find ingredients, this book is designed to make life easier for those who must follow a dairy-, egg-, and nut-free diet.

One of them has all their shots.

For more information ask your healthcare provider.



IMMUNIZATION LINKS & RESOURCES

- AAP Child Immunization Support Program: <http://www.cispimmunize.org/>
- National Network for Immunization Information: www.immunizationinfo.org/
- www.vaccineprotection.com *Provided as a service by Sanofi Pasteur, Inc.*
- **Shot Line** – A direct line for physicians, nursing personnel, childcare providers, and school nurses to an immunization nurse who will provide immediate answers to your immunization questions. www.cdhd.idaho.gov or call 321-BABY
- Idaho Immunization Program: <http://www.healthandwelfare.idaho.gov> *follow medical/immunization link on the left of the home page*
- Idaho Immunization Coalition: www.idahoimmune.com
- Vaccinate Your Baby: <http://vaccinateyourbaby.org/> *An Awareness Campaign from Every Child by Two*

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