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IDAHO CHAPTER

American Academy of Pediatrics

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A quarterly publication of Idaho Chapter AAP

President's Corner

By David Christensen, MD

Our chapter submitted the following two resolutions for consideration at this year's Annual Leadership Forum.

1.Whereas the volume of new medical information published each year continues to steadily increase, with wide variation in quality and relevance of published studies, and

Whereas remaining current in areas other than one's primary specialty is becoming increasingly difficult for many physicians, often leading to information over load, and

Whereas the Academy is organized into sections with experts in each subspecialty who remain current in their subspecialty but may have difficulty remaining current in other subspecialties, therefore, be it

Resolved that the Academy generate a strongly suggested annual reading list of the 10 most important articles published during the year for all pediatricians, and be it further

Resolved that each section generate a suggested annual reading list of the 2-5 most important articles published during the year for pediatric subspecialists in that section and that the reading lists be published annually in the March issue of Pediatrics.

2.Whereas AAP members are increasingly knowledgeable and reliant upon personal computers, and

Whereas successive editions of the Red Book have become more weighty and un wieldy (992 pages in 2006), and costs of paper, printing and postage are constantly increasing, and

Whereas previous Red Book resolutions did not include any fiscal note as to how a change in Red Book format for members might affect national AAP finances, therefore be it

Resolved that the AAP ask members to specify in the 2007-8 membership renewal cycle one format in which they wish to receive their next (2009) Red Book, and be it further

Resolved that the identical text of the hard copy 2009 Red Book be available at no extra charge to members as either a 1) hard copy, 2) CD-ROM, 3) PDA or 4) on-line version while continuing to charge a fee for "Red Book Plus" and for annual updates.

As a reminder, resolutions voted on at this year's Annual Leadership Forum can be reviewed on the AAP website Members Only Channel. Go to the AAP website, log on, then click on the link "2006/2007 Resolutions" under the "Annual Leadership Forum" heading in the right hand column.

"Nothing is too small to know, and nothing is too big to attempt. "
-William Van Horne

ENFORCING UNDERAGE DRINKING LAWS

Did you know that underage drinking is one of the most serious public health problems in our nation? Suicide, highway deaths, drowning, violent injury, unwanted pregnancy and sexually transmitted diseases are some of the frequent consequences of alcohol use by teens. New research also indicates that memory and learning can be significantly impaired by early alcohol use or binge drinking, and it also increases the chances of future drug use and addiction. Far too many teens obtain alcohol from friends or family members, who may not realize the potential consequences. As healthcare providers , you are in a critical position to assist families in understanding how important it is to talk about substance abuse with their teens and to learn about other prevention measures

The Idaho Prevention Partnership has resources to help you support healthy lifestyles for your patients and their families. Please review the attached order form and select any or all of the posters and brochures listed. These resources are available to you at no cost and the RADAR Center at Boise State has a multitude of resources to assist you and your patients.

The Idaho Prevention Partnership is a diverse coalition of governmental, community, and private organizations dedicated to reducing underage drinking. They focus on implementing practices recommended by the Institute of Medicine National Research Council report.

Please join us in our mission to prevent and reduce underage drinking in Idaho for the health and well-being of our children, families, and communities.

Thank you,

Nancy Lopez
Enforcing Underage Drinking Laws
Statewide Coordinator

Expanded Partnership

Jared Olson
Traffic Safety Resource Prosecutor
884-7325

Loretta Stadler
Mothers Against Drunk Driving
853-3700

Pam Eaton
Idaho Retailers Association
342-0010

Andrea Jackson
Jacksons Food Stores
888-6063

Jermaine Galloway
Boise PD Community Policing
433-0155

Kevin Settles
Idaho Lodging and Restaurant Association
869-0864

Karen Des Aulniers
Students Against Destructive Decisions
381-3049

Sherry Iverson
Pediatric Association
381-3049

Shelli Rambo-Roberson
Adolescent Pregnancy Prevention Program
334-2284

Laura Thomas
Community Resource Development Specialist
334-6866

Partnership Members

Nancy Lopez,
EUDL Coordinator
528-5702

Sharon Harrigfeld
Alan Miller
Lisa Stoner
Idaho Dept. of Juvenile Corrections
334-5100

Kevin Bechen
Josephine O'Conner
Office of Traffic & Highway Safety
334-4467

Kay Bennett
Idaho Liquor Dispensary
947-9460

Lt. Robert Clements
Sgt. Gregory Harris
Bureau of Alcohol Beverage Control
884-7060

Georgia Girvan
Regional Alcohol Drug Awareness Resource
426-4105

Matt McCarter
Bethany Gadzinski
Dept. of Education
332- 6960

First Lady Laura Otter
Nancy Evans
Executive Assistant
334-2100

Terry Pappin
Pharis Stanger
Dept. of Health & Welfare
334-6542

New Hepatitis A and Varicella Recommendations

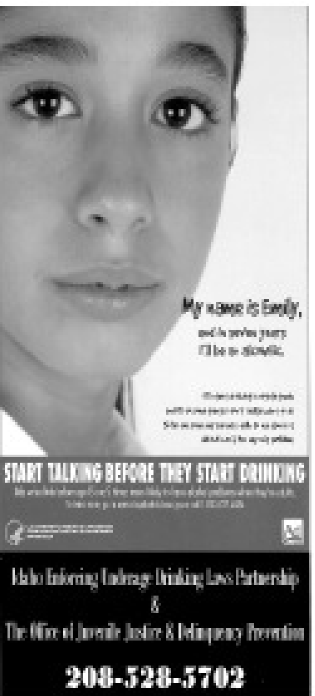
1) **AAP Recommends Universal Immunization for Hepatitis A** The AAP is recommending that all children should receive hepatitis A vaccine at 1 year of age (12 –23 months) as a 2-dose regimen. The 2-dose series should be administered at least 6 months apart.

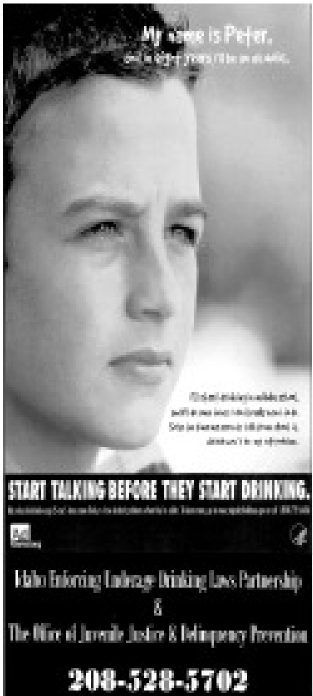
2) **Two Doses of Varicella Vaccine Now Recommended** The AAP now recommends a 2-dose varicella immunization strategy. Children 12 months through 12 years of age should receive two 0.5 ml doses of varicella vaccine, separated by at least 3 months. Children 13 years of age or older without evidence of immunity, should receive two 0.5 ml doses of varicella vaccine separated by at least 28 days. *Go to aap.org/membercenter to view the policy statement.*

Order Form for Start Talking to Kids Before They Start Drinking Campaign

Alcohol Remains the #1 Drug of Choice for Youth ages 12 to 17

Reported by the War on Drugs from the National Institute on Alcohol Abuse & Alcoholism





2004 Survey of Idaho Students Grades 9-12:

- 66% had at least 1 drink of alcohol on 1 or more days during their life
- 26% had their 1st drink of alcohol before the age of 13
- 40% had at least 1 drink of alcohol on 1 or more occasion in the past 30 days
- 28% had 5 or more drinks of alcohol in a row in the past 30 days
- 4% had at least 1 drink of alcohol on school property, 1 or more days within the last 30 days

At least 62,000 Idaho youth drink each year!

Data supplied by:
2004 Idaho Youth Risk Behavior Survey, SDE

Complete Attached Form and either e-mail, fax or mail request to: RADAR Network Center at BSU
1910 University Drive,
Boise ID 83725-1860 or fax to 208-426-3334.

_____ Yes! Send me a resource packet to start the conversation with my patients about talking to their kids about underage drinking.

_____ Yes! Send me a sample packet of educational materials available from Idaho Regional Alcohol Drug Awareness Resource Center.

_____ Yes! Add my e-mail address to the Idaho Regional Alcohol Drug Awareness Resource Center electronic mail list for updates on new materials.

Business:_______________ Attn:_______________ E-mail: _______________

Mailing Address:_______________ City: _______________ Zip Code: _______________

Please indicate the number of posters ordered: Emily _________ 8 x 11 Tyler _________ 8 x 11 Peter _________ 8 x 11

The Asthma Control Test (ACT)
By Thomas Patterson, MD, Treasurer, Idaho, AAP

Asthma management has changed over the last 3-4 decades with an evolution from bronchoconstriction as the primary pathology to the addition of inflammation and remodeling. As our understanding of what is important has changed, our treatment approach has changed as well. The question is whether this has made an impact in our patient's lives.

While the current asthma prevalence has increased over time to 20.5 million Americans (6.2 million children) in 2004[1], the number of deaths is declining with 3700 in 2004[1]. Mortality commonly relates to a lack of awareness of the severity of Asthma. The severity of this problem is reflected in the Asthma in America Survey of 2509 patients or parents of patients with asthma, published in 1998. Data from a more recent Canadian study in 2006 confirmed sub-optimal Asthma control. Of 893 patients, 97 % thought their asthma was well controlled though only 47 % had controlled disease based on the Canadian Asthma Consensus Guidelines[2].

The NIH goals of Asthma management are now 15 yrs old and when first published, the majority of the goals were quite lofty. On the brink of the updated NIH Guidelines many of these goals are easily achieved in the majority of patients. Measurement of achievement of the goals however, remains difficult requiring innovative new tools.

One such tool developed with the NIH guidelines in mind, is easy to do and allows us to ask the same questions to every patient at every visit in an efficient manner. The tool is the Asthma Control Test or ACT. It is a self-administered, brief five-question assessment for patients 11 years to adult. The Childhood ACT is available for patients 4-11 years of age. It is clinically validated by specialist's assessment and spirometry[3]. The ACT is supported by the American Lung Association as well.

The test is a single page questionnaire of five questions for age 12 yrs and up, and four child questions paired with three parent questions for ages 4 to 11 years. The maximum score is 25 and a score of less than or equal to 19 indicates that a patient's asthma may not be controlled. A score greater than 19 indicates that a patient's asthma is most likely controlled.

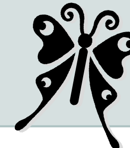
The ACT augments the medical history and physical exam for our patients and helps in the decision making process for an asthma management plan and follow up. It allows an easy, clinically validated tool to assist in step up and step down therapy[4]. As well, it can guide your asthma education with the patient. The ACT has been validated for longitudinal follow up as well[5].

The AAP Idaho Chapter is currently working towards getting the ACT out to our members in Idaho to support their asthma management practices.

1. American Lung Association Epidemiology and Statistics Unit Research Program Services. *Trends in Asthma Morbidity and Mortality*. July 2006. Available at: www. Lungusa.org. Accessed November 2, 2006.
2. FitzGerald JM et al. Can Rs[ir J. 2006; 13:253-259.
3. Nathan RA et al. J. Allergy Clin Immunol. 2004; 113: 59-65.
4. Schatz M et al. J Allergy Clin Immunol. 2006; 117: 549-556.
5. Schatz M et al. J Allergy Clin Immunol 2006; 117:995-1000.

If nothing ever changed, there would be no butterflies

-Author Unknown



You are so stupid.
You can't do anything right.

Stop crying or I'll give you something to cry about.

Your children learn how to be a parent from you. Break the circle of violence. Ask for help. For counseling referrals, parenting advice, and ways to cope with anger, call the 2-1-1 Idaho CareLine. Dial 2-1-1 or 1-800-926-2588 or visit www.idahocareline.org.

April is Child Abuse Prevention and Awareness Month.

The Idaho Chapter would like to congratulate the following 2006 Award Recipients:

Greg Fredericksen
Child Advocate of the Year
For his work insuring Child Passenger Safety programs statewide.

Lloyd Jensen, MD
Pediatrician of the Year
For his Dedication and Service to the Children of Idaho and throughout the world.

IRIS
Immunization Reminder Information System
Organization of the Year
For their Dedication and Service to the Children of Idaho through Immunization Registry.

MedImmune, Inc.

The Idaho Chapter, AAP would like to thank MedImmune, Inc for it's support of the Chapter's Annual Winter Meeting held on February 22, 2007 at Boise State University.

President Elect Candidates Address Your Questions

As was indicated at the recent Annual Leadership Forum by the Chairperson of the National Nominating Committee, Dr Richard Tuck, there is an effort to have the AAP President-elect candidates address more issues pertinent to the various AAP entities. Therefore, the NNC is requesting that you submit to me questions you would like the candidates to address. The NNC hopes the opportunity to pose these questions will come from and be available to the grass roots of the sections, committees, councils, and chapters. The deadline for submission is April 30. After April 30, all questions received will be forwarded to the chairperson of the appropriate management committee (Chapter Forum Management Committee, Section Forum Management Committee, Committee Forum Management Committee or Council Management Committee) for review.

Each management committee chair will determine what three questions of those submitted should be provided to the candidates for their response.

The 12 questions selected will be provided to the candidates, and their 350-word responses will be posted to the Member Center of the AAP Web site throughout the summer months. This is in addition to the questions to which they will respond via AAP News over the next few months. In this way, the NNC hopes that you will learn more about the stance of the candidates on issues important to your members and therefore make an informed decision when voting in the September 2007 election.

If you have any questions about this process, please don't hesitate to contact me (jpage@aap.org) or Dr Richard Tuck rtuck@aap.net), chair of the National Nominating Committee.

Thank you.
Janice K. Page, MPA
Director, Board of Directors Administration
American Academy of Pediatrics
E-mail: jpage@aap.org

‘Tis the season ...

Thomas H. Rand, MD PhD

Imagine a pathogen that reliably causes outbreaks at the same time every year, resulting in greater than 120,000 hospitalizations of infants each outbreak. Of course, you know this pathogen to be respiratory syncytial virus (RSV). By their second birthday, virtually all children have had a respiratory illness with RSV, and half of children have had RSV twice. Immunity is short-lived, so that RSV causes repeated upper and lower respiratory tract infection at all ages.

Immunoprophylaxis against RSV is expensive; consequently, this is applied only for the highest risk infants with significant prematurity, chronic lung disease, and cardiac disease. Indications for use of the monoclonal antibody product Synagis (palivizumab) can be referenced.[1] Synagis must be given monthly by intramuscular injection to these high risk infants. A new liquid formulation of Synagis no longer requires the lengthy time for reconstitution. Primary care providers are encouraged by insurers to provide injections of Synagis in their clinics. Respigam (human immunoglobulin selected for high titers against RSV) is no longer available. The next generation monoclonal antibody product to replace Synagis will be called Numax, and this product is undergoing clinical trials currently.

In time, we expect a vaccine against RSV will be available for routine infant immunization, but there have been significant difficulties in vaccine development. The complexity of protective versus pathologic immune responses was highlighted by experience with an experimental RSV vaccine in the 1960s: an alum-precipitated formalin-inactivated vaccine led to enhanced disease in vaccinated children during subsequent RSV infections.

The onset and duration of the annual RSV outbreak is not exactly like clockwork. Relatively small shifts in timing of the RSV outbreak sometimes necessitate dosing of Synagis earlier or later than usual. Use of hospital and other medical resources is profoundly affected by changes in the RSV season. The Centers for Disease Control and Prevention has strongly encouraged the development of local and regional systems to alert clinicians to the onset and end of the RSV outbreak in their area. These systems have used either laboratory or hospitalization data. Across our region, three systems are currently active:

Boise, Idaho: Graphs of data from the laboratory at St. Luke’s Regional Medical Center are posted on the Idaho AAP Chapter website www.idahoaap.org/idmonitor.htm

Spokane, Washington: Data from PAML laboratories are compiled by the hospital epidemiologist at Sacred Heart Hospital and emailed to interested providers.

Salt Lake City, Utah: Graphs of data from the laboratory at Primary Children’s Hospital are posted on University of Utah Pediatric Infectious Diseases website www.ped.med.utah.edu/GeneralInfo/InfDis files/resp.pdf

The timing of RSV outbreaks varies between different parts of the US, and at an individual location timing of outbreaks varies from year to year. RSV activity starts earlier in southern and coastal areas. Florida has a notoriously long RSV season because of both climate and frequent travel. The northern interior of the US has the shortest RSV season. National data[2] indicate median duration of RSV activity 15 weeks. For comparison as displayed on the Idaho AAP Chapter website, data from Boise 2000-2006 indicate median duration of RSV activity 12 weeks. During this period onset of the season varied from December 11 to January 19 (median January 9) and end of the season varied March 28 to May 12 (median April 10). Figure 1 illustrates the year-to-year variability of RSV season with data from a laboratory in Omaha, Nebraska, a site similar to Idaho in the epidemiology of RSV.[2]

Anyone is welcome to visit the website www.idahoaap.org/idmonitor.htm that includes graphs of influenza and RSV activity and recommendations. We all want to do a good job applying what limited preventive measures that we have, and we want to be prepared in the clinic and hospital to help our patients with bronchiolitis.

Healthier Eating:
Getting Where You Need to Be

The Dietary Guidelines for Americans recommends these food groups within ***MyPyramid*** *as a good source of important nutrients that help provide the foundation for a healthy diet.**

Whole Grains	Vegetables	Fruits	Milk and Milk Products Low-fat and Fat-free

Increased intakes of fruits, vegetables, whole grains and fat-free or low-fat milk and milk products are likely to have important health benefits for most Americans, according to the Dietary Guidelines. They are encouraged for a healthful diet and are sources for specific nutrients of which many Americans are not getting enough – calcium, potassium, fiber, magnesium, vitamins A, C and E.

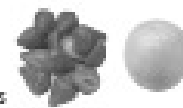
Copyright © 2006 National Dairy Council®

Be sure to include the recommended amounts every day:

Whole Grains
3 (1 oz.) equivalents
(at least 1/2 of all the grains eaten should be whole grains)
One ounce serving equals 1 slice whole-wheat bread, 1/2 cup brown rice, 5 whole-wheat crackers, 1/2 cup oatmeal

Vegetables
2-1/2 cups
One serving equals 1 cup chopped or florets of raw/cooked broccoli, 2 medium carrots, 2 cups of raw, leafy greens = 1 cup cooked, leafy greens

Fruits
2 cups
One serving equals 1 cup sliced, chopped or cut-up fruit, about 8 large strawberries, 1 large orange, 32 seedless grapes



Dairy Foods
3 cups of low-fat or fat-free milk or milk equivalents
One serving equals 1 cup milk, 1 container (8 oz.) yogurt, 1-1/2 oz. cheese

Source: Dietary Guidelines for Americans, 2005 (6th Edition). www.healthierus.gov/dietaryguidelines.
*The foods listed here are part of the MyPyramid food groups, which also include meat & beans and oils. Please visit **www.mypyramid.gov** for more information.

Partial Care and Psychoso-

Creighton Hardin, MD

This is a letter I sent to the Director of Health & Welfare about our group's concern of the overuse of psychosocial rehab and partial care. If you have similar concerns in your area please email me at hardcrei@cableone.net or contact Richard Armstrong.

Richard Armstrong, Director
State Health and Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036

Dear Mr. Armstrong:

Our Pediatric group sees the most Medicaid children in Pocatello (approximately 30% of our practice). We are very concerned about overuse of partial care and psychosocial rehab from all of the private agencies that provide these services for children.

These services can be useful for families of children with serious emotional/behavioral disturbances (autisum, pervasive developmental disorders, severe conduct disorders). But we are often asked to sign referrals, as the medical home physician, to these agencies when just a short time prior we had seen the child for a check-up and the family brought up no special concerns of emotional problems. We obviously question who is directing these families to these agencies and how these families are qualifying for services, and when the services will no longer be needed.

These are very expensive services that State Medicad pays for: $10 an hour for partial care or up to $13,000 per year per child, and psychosocial rehab costing $44 an hour or up to $30,000 per year per child.

We would like to suggest the following:
#1– More stringent entry criteria for both types of services.
#2– Limiting the number of years the child can receive these services,, much like IBI (intensive behavioral intervention) that has a three-year lifetime limit per child.
#3-A standardized form to the medical home physician outlining who referred the family to the agency, the criteria met for services, the progress toward goals, and how the family is learning these skills, the cost, and the estimated termination date.

We want these services for the family and children who truly need them, but I am afraid the free market has too many hands in the State's "cookie jar".

Sincerely,
Creighton A. Hardin, M.D.

BABIES AND HEARING LOSS

AAP RECOMMENDATIONS FOR THE MEDICAL HOME

ONE MONTH OF AGE -
Ensure that all hearing screening is completed before 1 month of age. This includes the first screen soon after birth, and any second screen that may be needed. Encourage parents to make and keep an appointment for any needed re-screens with their birth hospital.
If the initial screen was missed, or in the case of a home birth, direct the parents to make a screening appointment at their local Infant Toddler Child Development Center.

THREE MONTHS OF AGE-
Ensure that a 'pediatric' audiological assessment is completed before the infant is 3 months of age.
Who should be referred?
All infants who "refer" from hearing screening programs.

All infants and children with risk factors identified by the Joint Committee on Infant Hearing that includes medical, family history, and family or physician concern.

SIX MONTHS OF AGE-
If hearing loss is identified, ensure that early intervention services are initiated before the infant is 6 months of age.
Ensure that child has been referred to the Idaho Infant Toddler program for early intervention service coordination, and to the Idaho School for the Deaf and Blind outreach program for specialized early hearing interventions in the family's home.

Taken from Idaho Sound Beginnings' Babies & Hearing Loss: A Guide for Providers. For more information go to
www.cdhh.idaho.gov
www.aap.org
www.hearandnow.org
www.idahocareline.org
www.babyhearing.org

I took Allison to the doctor for her 2-year-old check. They had her do coordination tests, like stacking blocks and walking. And then the doctor said, "Allison, can you stand on one foot for me?" And she walked over and stood on his foot.

CAR SEAT SAFETY

The Idaho Chapter is currently in it's second year administering a statewide Car Seat Safety Grant.

The Goal of the CPS Project is to reduce death and serious injuries of children from motor vehicle crashes by increasing proper use of seat belts, booster seats, and child safety seats in Idaho. The objectives are:

1. Reducing the barrier of cost of seats to parents, grandparents, and other child guardians by providing seats at reduced or no cost to families of needs.

2. To increase every community's knowledge of the proper use of child restraints by offering car seat checks and one on one instruction and installation with the distribution of each seat purchased by this grant.

3. To offer education and re-certification training to certified car seat technicians who provide the community passenger safety checks and community education.

If you need any assistance with car seat safety in your area, please contact your region's representative.

Motor vehicle crashes continue to be the leading cause of traumatic death and injury to children in Idaho.

In 2005, 3,846 children under 7 years of age were involved in motor vehicle crashes. Of those children involved in those crashes, 41 children received fatal or serious injuries.

The National Highway Traffic Safety Administration (NHTSA) estimates that child safety seats are 69% effective in preventing fatalities and serious injuries. NHTSA also estimates that at least 4 out of 5 children who should ride in booster seats do not do so.

Low income households with children often require the services and assistance from governmental, non-profit, and faith-based organizations and agencies to meet their fundamental needs. These needs include housing, food, and medical assistance. Given these well studied and documented conditions, it is assumed that low income households with children require assistance for their child safety restraint needs.

Children are not miniature adults. They need special restraints because of their anatomical differences.

- An infant's head is proportionally larger and heavier than an adult.
- Children's legs are shorter in relation to the rest of the body.
- Infant's shoulders are narrow and flexible.
- A child's pelvis is small, rounded and not fully developed until puberty.

The National Highway Traffic Safety Administration estimates child safety seats are effective in preventing 69% of fatalities and serious injuries. NHTSA also states that in 9 out of 10 cases, child safety seats are put in vehicles incorrectly or the child is unrestrained improperly.

Child Passenger Restraints are designed to protect children by preventing ejection and distributing crash forces throughout the body and to less vulnerable areas. Child restraints must be used consistently and properly to protect children.

Region	Agency	Contact Name	Phone	Email
Region 1	Kootenai Medical Center	Teri Farr	208-666-2003	tfarr@kmcmail.kmc.org
Region 2	Moscow Police Department	Marie Miller	208-885-2254	mmiller@uidaho.edu
Region 3	Canyon County Ambulance District	Russell Simmons	208-466-8800	simmonsrs1@msn.com
Region 4	Safe Kids Treasure Valley	Alissa Lean	208-381-3033	leanali@slrmc.org
Region 5	Safe Kids of the Magic Valley	Page Geske	208-737-2432	page@mvrmc.com
Region 6	Southeastern District Health Department / Safe Kids Southeastern Idaho	Cherie Nelson	208-478-6315	cnelson@phd6.state.id.us mmann@phd6.state.id.us
Region 7	District Seven Health Department	Timalee Geisler	208-522-0310	tgeisler@phd7.state.id.us

Idaho Summit on the Uninsured
Friday, May 11
7:30-11:45 a.m.
Owyhee Plaza Hotel
No charge

Approximately 220,000 Idahoans are currently without health insurance, including approximately 42,000 children. The impacts of the uninsured are felt by all of us regardless of whether we ourselves have health coverage -- as taxpayers, employers, health care providers, insurers, etc. During this half-day conference you will hear internationally known author and healthcare futurist Ian Morrison speak on the Future of the Healthcare Marketplace, then hear Idaho-specific data and plans to address access and coverage for the uninsured. Diverse viewpoints will be represented in a panel discussion on the impacts of the uninsured and perspectives on appropriate and feasible solutions for Idaho.

For more information or to RSVP for this event, please contact Corey Surber, Saint Alphonsus Advocacy & Community Health Coordinator, at coresurb@sarmc.org or call 208-367-7078.

SAVE THE DATE

Chapter Summer Meeting
Focus: Asthma
Friday, May 18th
6—8pm
at the CAZBA, Boise
More information online @ idahoaap.org

Go to www.everychildmatters.org to download ***Homeland Insecurity… American Children at Risk.*** The book's key message: new investments in children must be made a political priority in the forthcoming presidential election.

The American Academy of Pediatrics has resources for parents, teachers, students, physicians, children and teens to help cope with the recent campus shooting tragedy at Virginia Tech on www.aap.org.

The International Institute for Alcohol Awareness (IIAA) just launched the **Not In Our House** website www.notnrhouse.org

www.idahoaap.org

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