

IDAHO CHAPTER

American Academy of Pediatrics



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A quarterly publication of Idaho
Chapter AAP

April is *Child Abuse Prevention Month*. The Idaho Chapter of the American Academy of Pediatrics, along with St. Luke's Children's Hospital, are working together to raise the awareness of child abuse and Shaken Baby Syndrome throughout the state. Onesies were designed especially for newborns that read "Fragile, Handle with Care." During the week of April 3rd, we would like every newborn in a hospital throughout the state to receive a onesie and an informational packet be given to the parents about the importance of handling babies with care. In addition to the onesie distribution, we plan to hold a press conference in newborn nurseries statewide with pediatricians discussing the risk of shaking a baby, how to sooth a crying baby and the importance of handling with care.



If you are interested in participating or receiving more information about Child Abuse Prevention, please contact us or go to our website—www.idahoap.org.

Fragile!



**HANDLE
WITH CARE**

When Your Baby Cries...

Check to see if the diaper needs changed.
Or perhaps a feeding should be arranged.

Snuggle your baby and gently rock
Or take out the stroller and go for a walk.

Go for a ride in the family car.
(Use a car seat both near and far).

Play some soft music - Mozart is nice,
Or croon to your baby in a sing-song voice.

If you choose, a pacifier might do the trick
Or call the doctor if you think baby's sick.

Give baby a back rub, or talk with a friend
If it seems like the crying will never end.

Yet the crying will stop. You just don't know when...
So be patient breathe deeply, and count to ten.

Get someone else to tend your dear little one.
While you exercise, shop, and have some fun.

On make sure baby's safe and off you go
To another room - it's a good thing, you know.

Sometimes babies cry, and that's all right.
Both during the daytime and late at night.

But even when the crying is hours long,
Hurting a baby is always wrong.

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN®
Idaho Chapter

IDAHO CHAPTER AWARD RECIPIENTS—2005

Representative Richard Wills & Jeannette Risch – Child Advocate of the Year

For their work on the Booster Seat Legislation

Susan Bradford, MD – Pediatrician of the Year

*For her dedication and service to the children of Idaho through her work on the
Community Access to Child Healthcare Program*

Pat Williams & the Idaho 211 Care Line Staff – Organization of the Year

For their dedication and service to the children of Idaho through the 211 CareLine.

At the District VIII meeting in February 2006 –

The Idaho Chapter received the

2005 Award of Chapter Excellence

for an outstanding program effectively furthering the objectives of the association. A special achievement award was presented to **Coeur d'Alene Pediatrics for distinguished service and dedication to the mission and goals of the academy** for their exceptional and innovative care provided by this outstanding pediatric practice to the children of Northern Idaho.

HASTLE FACTOR FORM -- TERRANCE NEFF, M.D.

We are all well aware of the difficulties that we face navigating the “insurance maze”. At this time however, we are dealing with insurance issues individually instead of working together. The American Academy of Pediatrics has developed the *Hassle Factor Form*, a monitoring tool which we can use to document problems as they occur. The Idaho Chapter, as an organization, can then address these problems in an appropriate manner with the commercial insurance companies and Medicaid.

How will this form help? Specific examples strengthen our arguments. We may find one problem that is specific for one region or one office. Alternately, we may find a problem that is statewide and pervasive. Either way, having a clearer understanding of the nature of the problem and speaking as a group will increase our ability to be effective in resolving these problems. **But, we need your help to make it work.**

We started using the Hassle Factor Form in Idaho in 2005. We have had six issues identified as problems. Of those, three were billing issues that were resolved with coding education. One was resolved via discussions with the insurance company involved and two were of a general nature that was not specific enough to address. Not a bad track record for our first year!

How does this work? You can get a copy of the Hassle Factor Form at the Members Only Channel (MOC), www.aap.org. Once in the MOC, click on “Reimbursement” or “State Government Affairs” on the left side of the screen. You can also find the form by searching for the Hassle Factor Form on the MOC.

Each time you encounter a problem, whether it is a first time or a recurring hassle, fill out the form and fax to me at (208)-667-0876 or (email-neff@cdapeds.com). You may want to have your office manager or another staff person complete the form. Please be as specific as possible with your “hassle”.

The Idaho Chapter will compile this information, research your complaints and use this information in our advocacy work with the insurance companies, Medicaid or other agencies.

I encourage you to use this form. Speaking with one voice will help us provide the quality care the children of Idaho deserve.

President-Elect Candidates 2006

O. Marion Burton, MD, FAAP—Columbia, SC



Dr. Burton, a community pediatrician is Associate Dean for Clinical Affairs and Director of Community Pediatrics at USC School of Medicine.

A graduate of Clemson University and Medical University of SC, he trained at MUSC and Medical College in Georgia. For two decades he practiced pediatrics in Anderson, SC and taught in a local primary care residency. In 1991 he joined USC School of Medicine to establish a Division of Community Pediatrics. Later named Associate Dean for Clinical Affairs, he oversees the 210-physician multi-specialty group, conducts faculty locum tenens programs for rural pediatricians, and is senior medical consultant to the state's public health and Medicaid agencies. He helped establish 75 partnerships placing public health professionals with practicing physicians to create medical homes for children.

His faculty group cares for children in University Primary Care offices, the SC Juvenile Justice System and clinics for children with special health care needs.

He is Past President of the South Carolina Medical Association, SC Pediatric Society and is AMA Delegate for the AAP. He was Chapter and District CATCH Facilitator, national Chairperson of the DCF and Community Action Group, member of the Task Force on Committees and Sections, Chairperson of the AAP Council on Committees, and in that capacity regularly attended AAP Board of Directors and Advisory Committee to the Board on Committees and Sections meetings.

Recognitions include the Abraham Jacobi Award and National Army Guard Flight Surgeon of the Year.

Dr. Burton and his wife, Debbie, have six children and three grandchildren.

Renee R. Jenkins, MD, FAAP—Deerwood, MD



Dr. Jenkins is professor and chair, Department of Pediatrics and Child Health and Howard University and adjunct professor of Pediatrics at George Washington University, both in Washington, DC. She graduated from Wayne State University School of Medicine and completed her residency at Jacobi Hospital in New York City. After completing a fellowship in Adolescent Medicine at Montefiore Hospital, Dr. Jenkins started a program at Howard. In 1994, she was appointed Department Chair, and during her tenure directed the departmental training program and practice plan.

As a candidate member, the Committee on Adolescence provided Dr. Jenkins' first service opportunity. She's served on many task forces and committees, including Task Forces on Pediatric AIDS, and Reimbursement, the Committee on Federal Government Affairs, and chaired the Committee on Community Health Services. Renee is past-president of the DC Chapter. Her section membership include Adolescent Health and Community Pediatrics.

Adolescent health and underserved children have been the foci of Dr. Jenkins career, both nationally and in her community. Dr. Jenkins was president of the Society for Adolescent Medicine, and chair of the Pediatric Section of the National Medical Association. She is a member of the American Pediatric Society, Ambulatory Pediatric Association and the Institute of Medicine, serving on its Board on Children, Youth, and Families. In DC, Renee and colleagues started the Center for Youth Services, and she chaired the Mayor's Committee on Teen Pregnancy Prevention.

Dr. Jenkins is married and has one daughter, a medical student at Medical College of Wisconsin.

WIC Policy Change

Beginning January 1, 2006, the Idaho State WIC program changed their policy on formula issuance for infants and children. The Idaho State WIC program currently has a contract with Mead Johnson Nutritionals to provide the following standard iron-fortified infant formulas:

- Enfamil with Iron
- Enfamil LIPIL
- Enfamil Prosobee
- Enfamil Prosobee LIPIL
- Enfamil Lactofree LIPIL
- Enfamil Gentlease LIPIL (will be available after January 1, 2006)

Effective January 1, 2006, formulas that are nutritionally equivalent to the above mentioned formulas will not be available to Idaho WIC participants.

Special formulas, such as Enfamil AR LIPIL, Nutramigen LIPIL, Alimentum Advance, Neosure Advance and EnfaCare LIPIL will still be available to infants and children with physician-diagnosed medical conditions if they have a current prescription. These formulas may also be covered by Medicaid.

Any patient on non-contract, nutritionally equivalent, standard formula as of January 1, 2006, may be allowed to stay on that formula until one year of age. They will have to follow WIC protocol and be challenged at 2 and 4 month intervals with a contract formula to assess their continued needs.

The Idaho WIC program is committed to providing the best care to our participants while at the same time providing the most cost effective utilization of funds for all WIC participants. We would greatly appreciate your support of our revised policy and request your assistance in educating your WIC participating patients regarding this new policy.

Clinical Trials Will Focus on Preventing Type 1 Diabetes

Studies will also try to protect beta cells in new-onset patients

TYPE 1 DIABETES TRIALNET has exciting new research opportunities for your patients and their families. TrialNet is an international network of Diabetes experts dedicated to discovering new approaches to prevent and treat Type 1 Diabetes. TrialNet is conducting a variety of clinical trials aimed at understanding more about the markers associated with Diabetes risk, Diabetes prevention, and early treatment of Type 1 Diabetes. TrialNet has clinical sites throughout the Pacific Northwest, including Idaho.

PEOPLE NEWLY DIAGNOSED WITH TYPE 1 DIABETES: TrialNet is testing new therapies seeking to preserve insulin secretion in people newly diagnosed with Type 1 Diabetes.

RELATIVES OF PEOPLE WITH TYPE 1 DIABETES: The goal is to identify people who are at risk for developing Diabetes for enrollment in both observation and prevention trials. The screening involves a simple blood draw for the presence of Diabetes related autoantibodies. Participants do not need to travel to Seattle to participate in the screening. The study can be completed through mail, e-mail and telephone and the blood draw can take place in your office, clinic or lab.

SIBLINGS WITH TYPE 1 DIABETES: Type 1 Diabetes Genetics Consortium is an international effort to identify genes that are involved in the Type 1 Diabetes disease process. Participation does not require travel to Seattle; the study can be completed through mail, e-mail, telephone and a local blood draw.

TrialNet is funded by the National Institutes of Health, and supported by the American Diabetes Association and the Juvenile Diabetes Research Foundation.

Please inform families with Type 1 Diabetes about these exciting research opportunities. For more information please call the Benaroya Research Institute at 800-888-4187 or (206) 341-0688 or e-mail diabetes@BenaroyaResearch.org.



**“While we try
to teach our
children all
about life,
our children
teach us what
life is all
about.”**

-unknown



***Congratulations to Marilyn Fuller.
Her new grandchild, Hallie.***

IMMUNIZATION SCHEDULE CHANGES

The AAP, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the American Academy of Family Physicians have released a new Harmonized Childhood and Adolescent Immunization Schedule for 2006. A copy of the immunization schedule and catch-up schedule for January-December 2006 is attached. The changes to the previous childhood and adolescent immunization schedule, published in January 2005, are as follows:

-The importance of the Hepatitis B vaccine (HepB) birth dose has been emphasized. Vaccination of infants born to Hepatitis B surface antigen (HBsAg)-negative mothers can be delayed in rare circumstances, but only if a physician's order to withhold the vaccine and a copy of the mother's original HBsAg-negative laboratory report are documented in the infant's medical record. Administering four doses of HepB is permissible (e.g., when combination vaccines are administered after the birth dose); however, if monovalent HepB is used, a dose at age 4 months is not needed. For infants born to HBsAg-positive mothers, testing for HBsAg and antibody to HBsAg after completion of the vaccine series should be conducted at age 9–18 months (generally at the next well-child visit after completion of the vaccine series).

-A new Tetanus Toxoid, reduced Diphtheria Toxoid, and Acellular Pertussis vaccine recommended by ACIP for adolescents (Tdap adolescent preparation) was approved by the Food and Drug Administration (FDA) on May 5, 2005, for use in the United States. Tdap is recommended for adolescents aged 11-12 years who have completed the recommended childhood Diphtheria and Tetanus Toxoids and Pertussis/Diphtheria and Tetanus Toxoids and Acellular Pertussis (DTP/DTaP) vaccination series and have not received a Tetanus and Diphtheria Toxoids (Td) booster dose. Adolescents aged 13–18 years who missed the age 11-12-year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent Td boosters are recommended every 10 years.

-Meningococcal Conjugate vaccine (MCV4), approved by FDA on January 14, 2005, should be administered to all children at age 11-12 years as well as to unvaccinated adolescents at high school entry (age 15 years). Other adolescents who wish to decrease their risk for Meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated with MCV4 or Meningococcal Polysaccharide vaccine (MPSV4) for prevention of invasive Meningococcal Disease. Vaccination with MPSV4 for children aged 2-10 years and with MCV4 for older children in certain high-risk groups is recommended.

-Influenza vaccine is now recommended for children aged >6 months with certain risk factors, which now specifically include conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration.

-Hepatitis A vaccine is now universally recommended for all children at age 1 year (12-23 months). The 2 doses in the series should be administered at least 6 months apart.

-The catch-up schedule for persons aged 7-18 years has been changed for Td; Tdap may be substituted for any dose in a primary catch-up series or as a booster if age appropriate for Tdap. A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose.

To view the schedule as published in the MMWR, please visit:
www.cdc.gov/mmwr/preview/mmwrhtml/mm5451-Immunizationa1.htm.

BENEFIT OF MEMBERSHIP

One great benefit of being a member of the American Academy of Pediatrics is the opportunity of joining sections. The AAP has dozens of sections on specific topics of interest that provide you additional education, links to other doctors around the country interested in the topic, and great new ideas.

Dr. Bourquard is on the section of Breastfeeding and encourages all pediatricians to join him. For more information on sections that you may join-go to www.aap.org/sections/intro.htm.

Members of the Idaho Chapter are involved in the following sections:

- Administration & Practice Management (SOAPM)
- Adolescent Health (SOAH)
- Adoption & Foster Care (SOAFC)
- Allergy & Immunology (SOAI)
- Anesthesiology & Pain Medicine (SOA)
- Breastfeeding (SOBr)
- Child Abuse & Neglect (SOCAN)
- Children With Disabilities (SOCWD)
- Community Pediatrics (SOCP)
- Developmental & Behavioral Pediatrics (SODBP)
- Emergency Medicine (SOEM)
- Gastroenterology & Nutrition (SOGN)
- Infectious Diseases (SOID)
- Orthopedics (SOOr)
- Pediatric Dentistry (SOPD)
- Pediatric Pulmonology (SPPu)
- Perinatal Pediatrics (SOPPe)
- Residents
- Telephone Care (SOTC)
- Young Physicians (SOYP)

PRESIDENT'S CORNER

Preventing Head Injuries in Children

David Christensen, MD • Pediatric Critical Care • St. Luke's Children's Hospital

Bicycle riding, skateboarding, and rollerblading are fun—and great forms of exercise. More than 70 percent of children ages 5 to 14 ride bikes, yet many parents underestimate their child's risk of sustaining a serious injury during this activity.

Bicycles are associated with more childhood injuries than any other consumer product except the automobile. In 2003, more than 285,000 children age 14 or under were treated in US emergency rooms for bicycle-related injuries, with head injury accounting for the majority of injuries causing permanent disability or death.

Bicycle helmets reduce the risk of head or brain injury by as much as 85 percent. Universal use of bicycle helmets by children ages 4 to 15 could prevent 135 to 155 deaths and up to 45,000 head injuries annually. One study showed that in the 5 years following the passage of a state mandatory bicycle helmet law for children ages 13 and under, bicycle-related fatalities decreased by 60 percent.

Unfortunately, just 41 percent of children age 5 to 14 wear helmets when participating in wheeled activities, and more than 35 percent of children whose helmets wear them improperly. A correctly fit helmet is positioned on the head so it sits low on the forehead and is parallel to the ground when the head is upright. Install or remove inside pads to make the helmet snug, and adjust the chinstrap so it also is comfortably snug. The helmet should not come off or fall over the eyes when the wearer tries to shake it loose. Any helmet that is involved in a crash or otherwise damaged, or is more than 5 years old, should be replaced.

Encourage helmet use by:

- Letting your child help choose his/her helmet.
- Providing a properly fitting helmet for your child.
- Insisting that your child always put on a helmet before he/she rides. If your child breaks the rule, remove bicycle privileges for several days to a week.
- Always wearing a helmet yourself when you are riding.
- Buying stickers to "jazz up" a helmet.
- Praising your child for wearing a helmet.

Parents can protect their children from wheel-related injuries in other ways:

- Teach general safety rules as well as street safety rules.
- Provide protective clothing appropriate to the activity, such as proper shoes, and knee, wrist, and elbow pads.
- Ensure that your child's bike is the proper size and is in good working condition.



The annual winter meeting was a success.

Thank you all for attending!



When I approach a child, he inspires in me two sentiments: tenderness for what he is, and respect for what he may become.

-Louis Pasteur

WWAMI Idaho Offers a New CME Bioterrorism Course:

The course is available on the web
www.ahecbt.org

The course is a **new continuing medical education** course (6.5 hours) for primary care physicians and other health-care professionals. The web-based course is being offered to WWAMI family physicians at NO COST.

The course **objectives** include: identification of bioterrorism agents and symptoms, prevention, and initial management of exposed patients.

It is designed, written, and **presented by Idaho physicians**, including James Blackman, assistant dean, Idaho WWAMI; S.R. Blue, medical director, HIV Clinic, Family Medicine Residency; Ted Epperly, program director and chair of the Family Medicine Residency of Idaho; and Chris Hahn, state epidemiologist of Idaho.

For **more information** go to www.ahecbt.org or contact the WWAMI Idaho Office for Clinical Medical Education at (208) 327-0641 or email to Dana Ellis at danae@u.washington.edu

CONSTIPATION IN CHILDREN contribution by Henry R. Thompson, MD

What is Constipation?

Constipation is defined as either a decrease in the frequency of bowel movement, or the painful passage of bowel movements. Children 1-4 years of age typically have a bowel movement 1-2 times a day and over 90% of them go at least every other day. When children are constipated for a long time, they may begin to soil their underwear. The medical term used to describe the soiling that occurs in chronically constipated children is encopresis.

How common is constipation?

Constipation is very common in children of all ages. Of all visits to the pediatrician, 3% are in some way related to this complaint.

How is constipation treated?

Treatment of constipation varies according to the source of the problem and the child's age and personality. Some children may only require changes in diet such as an increase in fiber, fresh fruits, or in the amount of water they drink each day.

Other patients may require medication such as stool softeners or, on occasion, laxatives. Stool softeners are not habit forming and may be taken for a long time without worrisome side effects.

A few children may require an initial "clean out" to help empty the colon of the large amount of stool. This typically entails the use of laxatives by mouth or even suppositories or enemas for a short period of time.

It is often helpful to start a bowel training routine where the child sits on the toilet for 5-10 minutes after every meal or before the evening bath. It is important to do this consistently in order to encourage good behavior habits.



How does your healthcare provider know this is a problem?

- If your child has hard or small stools that are difficult to pass.
- If your child consistently skips days without having normal bowel movements.
- If your child has large stools and painful bowel movements.
- Other symptoms that can accompany constipation are stomach pain, poor appetite, and crankiness.

In most cases there is no need for testing prior to treatment for constipation. However, sometimes, depending on the severity of the problem your doctor may order x-rays or other tests to clarify the situation.

Why does constipation happen?

At least 25% of visits to a pediatric gastroenterologist are due to problems with constipation. Millions of prescriptions are written every year for laxatives and stool softeners.

In some infants, straining and difficulties in expelling a bowel movement (usually a soft one) can be simply due to an immature system, with rectal muscles not relaxing at the right time. It should be remembered that some healthy breast fed infants could skip several days before having a movement. Later, constipation can start when the child's diet does not include enough fiber or fruits.

Once the child has been constipated for more than a few days, the retained stool can fill up the large intestine (the colon) and cause it to stretch. An over-stretched colon cannot work properly and therefore, more stool is retained. To pass a large and hard bowel movement then becomes a painful experience for the child, who would naturally avoid going to the bathroom ("withholding behavior").

In children, constipation can begin when there are changes in the diet, the time of toilet training, following travel, or after a viral illness. Older children can begin withholding when they need to go to the bathroom but are afraid to use the toilet outside of their home. School or summer camps, with facilities that are not clean or private enough, are common triggers for withholding in this age group.

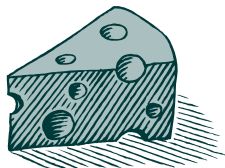


Children are the living messages we send to a time we will not see. -John Whitehead

5 Reasons to Serve String Cheese

- ⇒ **Healthy.** String cheese is packed with a powerful nutrient package that helps kids build strong bodies. The American Academy of Pediatrics urges kids to choose milk, yogurt and cheese for the calcium they need. Just one ounce of most cheese provides 20 percent of their recommended daily calcium intake.
- ⇒ **Low fat.** Most string cheese is low fat mozzarella which can easily average into your weekly meal plan. In addition to its great taste, cheese packs a powerful nutrient punch.
- ⇒ **Convenient.** String cheese is pre-packed in single servings that appeal to children. It's easy to store and serve with a good shelf life which makes it great for satellite operations. It's also a labor-free entrée.
- ⇒ **Popular.** Kids love the taste and novelty of eating string cheese. And if they love it, they eat it. Plus, cheese is ideal for people who are lactose intolerant, due to its minimal amount of lactose.
- ⇒ **Tooth-friendly.** Cheese may also protect against tooth decay because several commonly consumed varieties of cheese have been demonstrated to decrease the adherence of cavity-causing bacteria (i.e., *Streptococcus mutans*) to the mineral component of teeth. Furthermore, cheese's texture, which stimulates salivary flow, and its protein, calcium, and phosphate, which neutralize acids and remineralize enamel, as well as its range of fatty acids, many of which are potent antimicrobial agents, may contribute to this food's protective effect against tooth decay.

Websites: www.nutritionexplorations.org,
www.3ADay.org



Nutritious Steps towards Healthy TEETH

Nutrition is an important contributor to dental health. Next time you grab a beverage to drink, look at the ingredient list. If the product contains malic, tartaric, citric or phosphoric acid, than it can be corrosive to the tooth's protective enamel coating. In the past it was thought that sugar was the culprit, but according to Dr. Von Fraunhofer, a professor of dentistry, "Sugar does cause problems, but it's no where near as injurious as the acids." These acids draw calcium out of tooth enamel.

On the other hand, a nutritionally balanced diet, as suggested by the new dietary guidelines, will help promote a healthy smile. Interestingly, milk and several commonly consumed varieties of cheese are not only noncariogenic, but may also protect against tooth decay. Milk, particularly caseins, has been demonstrated to decrease the adherence of cavity-causing bacteria (i.e., *Streptococcus mutans*) to the mineral component of teeth. Cheese's texture, which stimulates salivary flow, and its protein, calcium, and phosphate, which neutralize acids and remineralize enamel, as well as its range of fatty acids, many of which are potent antimicrobial agents, may contribute to this food's protective effect against tooth decay. Eating cheese at the end of a meal or in combination with other fermentable carbohydrates reduces the cariogenicity of the latter. In fact, the American Academy of Pediatric Dentistry advises parents to choose cheese along with other nutritious foods as a caries-protective snack.

and your family to better dental health, as suggested from a recent study published by the American Dental Association. The likelihood of experiencing caries was almost 4 times greater among those children who did not eat breakfast regularly. Although children commonly consume presweetened cereals for breakfast, the authors suggest that, "It is possible that the relationship between sugars in breakfast cereals and caries could be mitigated when children consume presweetened cereals with milk."

Eating breakfast is one more component that will help you

Tips for a healthy smile!

- Limit intake of beverages containing "harmful acids".
- Encourage nutritionally balanced diets containing plenty of fruits and vegetables, whole grains, milk, cheese and yogurt, lean protein sources and healthy fats.
- Limit between meal snacks and if snacks are provided, choose nutritious foods such as cheese, fresh fruit and raw vegetables.
- Provide breakfast and don't forget the milk.
- Visit the dentist regularly.

Ref:

American Academy of Pediatric Dentistry. *Diet and Dental Health, AAPD Fast Facts*, 1999-2000.
Bowen, Scandinavian J Nutr, 2002
Bruce et al, *JADA*, 2004
Kashket & DePaola, *Nutr Rev*, 2002.
Moynihan and Peterson, *Public Health Nutr*, 2004.
Vacca-Smith et al, *Archs Oral Biol*, 1994.
von Fraunhofer & Rogers, *Gen Dent*. 2004



For more information, please contact us at the Idaho Dairy Council 208-327-7050.

For study findings, CDC releases, and current pediatric news & updates go to www.idahoap.org

The American Academy of Pediatrics will be implementing a new database system in January 2006. This web-based system will bring greatly enhanced data, reporting and web connectivity capabilities. In addition, the new system will allow for the implementation of anniversary-year membership cycles. **What does this mean for members?** Go to www.idahoap.org to find out.



For new definitions and principles of family-centered care and the explanation of how cultural competence should be integrated throughout your work with family-centered care go to www.idahoap.org.



Preventing Abusive Head Trauma Among Infants and Young Children: A Hospital Based, Parent Education Program

Full Abstract or Article Available at
www.pediatrics.org

Pediatric Emergency Medicine Conference
Tamarack Resort, Idaho
July 2006
www.stlukesonline.org/pemc2005/index.html

Pediatric Mental Health Symposium ♦ May 6, 2006 ♦ www.match-acces.org

www.idahoap.org



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of Pediatrics**
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