A New Year, A Look Back

A Happy New Year to all of our members and anyone else who might be reading our esteemed newsletter! While the MDAAP operates on a traditional “academic” year, starting off July 1, the National AAP asks for our Annual Report in December. While the process is a bit tedious, it is good to reflect on the accomplishments of the chapter over the past year. Indeed, we have come a long way.

Some of our major efforts have been highlighted in past issues of the newsletter – for example, the creation of a performance improvement network, partnership with Children’s National Medical Center on an asthma project and funding from the Blaustein foundation to support this effort. We have also highlighted the launching of our statewide Reach Out and Read program. An area we haven’t promoted as a member benefit is our advocacy efforts. Yes, we put in a year-end summary from our lobbyist Pam Kasemeyer each Spring, but the work the chapter does year round really does improve the lives of children and pediatricians in Maryland.

For the annual report we highlighted some of our successes in Annapolis this past year:

- We helped pass a heat-exercise bill: HB 1080 was introduced by Delegate Jay Walker relatively late in the Session after our fitness committee chair Amy Valasek, MD, FAAP brought to the Chapter’s attention the fact that Maryland was one of only a few states that had no requirements for the adoption of or adherence to heat acclimatization guidelines for student athletes.

- Chapter efforts were also instrumental in getting a ban on arsenic in chicken feed passed last year, making Maryland the first state to do so. The recent reports of significant arsenic contamination of rice in this country, likely due in part to use of arsenic-contaminated chicken manure as fertilizer, illustrates the importance of eliminating arsenic that can contaminate our food supply.

- We worked with DHR to pass a bill on an alternative response to child maltreatment. HB 834 created an alternative response to children who are found to be at low risk of harm after a report to child protective services, instead of straightforward investigation. The Chapter stronglysupported and helped create language in the bill that created an advisory board to work with DHR in developing an implementation and evaluation plan. Two pediatricians were placed on the advisory board – Scott Krugman, MD, MS, FAAP and Wendy Lane, MD, MPH, FAAP.

- We improved child safety in automobiles. HB 313 clarified and strengthened Maryland’s child safety seat requirements based on new recommendations from the National Highway Traffic Safety Administration (NHTSA) and the American Academy of Pediatrics. Additionally, HB 55 expanded the current prohibition on the use of wireless communication devices to all young drivers under the age of 18, not just those with learner’s permits or provisional licenses. The bill also clarified that the current ban on text messaging, which is a primary offense, applies to all drivers and includes administrative penalties for young drivers under that age of 18.

Additionally, we worked to assure that pharmacists could not administer vaccines to children and that the Medicaid payment increases would move forward (which they did for all pediatricians, including subspecialists). When not in session, Pam, Paula, our committee chairs, and many of our members are working with legislators and policy makers in state agencies to improve the delivery of health services to children.

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In addition to the three highlighted areas above, we also had the chance in our annual report to let National know that we are involved in 29 topic areas ranging from breastfeeding to disaster preparedness. In this section, we highlighted some of the great work being done by our chapter champions and committee members. This past year we made great progress in advancing oral health (Champion Rachel Plotnick, MD, FAAP), early hearing detection (Champion Susan Panny, MD, FAAP), behavior/emotional health (committee chair Ken Tellerman MD, FAAP and task force leader Larry Wissow, MD, MPH, FAAP), and breastfeeding (co-chairs Dana Silver MD, FAAP and Ned Bartlett MD, FAAP).

As you can see, there is a lot going on. The only way to make a difference in the professional lives of pediatricians and the health of the children of Maryland is to get involved. Please do not hesitate to contact us if you have an interest in anything….we are here to help you succeed.

- Scott Krugman, Chapter President

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**Message from the Executive Director**

Happy New Year to each of you and to your family as well. I wish you a year of health, happiness and prosperity and involvement in your AAP Chapter!

I hope each of you has noticed how activity within the chapter expands every month. In the chapter office, we have been busy with a special campaign to raise funds for the MDAAP Foundation to help provide mechanisms for the foundation to fulfill its mission to promote early literacy. To date, we have raised over $13,000. If you have not yet made your gift, it is not too late to do so. Here is the link to the reply form - http://www.mdaap.org/reply%20form%202.pdf.

We also have a number of educational opportunities available, each of which requires preregistration. Here are a few of these upcoming educational events:

1. **Feb 19** - Pediatric Dermatology dinner and seminar in Columbia
2. **Feb 27** - Hospitalists dinner and seminar at MedChi
3. **March 23** - Special Needs Children all day seminar in Prince George's County

**Dates to be announced for these programs:**

1. Obesity seminars open to Howard County doctors and those who serve Howard County patients
2. Fluoride varnishing trainings on the Eastern Shore on April 27, and in Southern Maryland on May 4, for EPSDT providers
3. Dr. Edisa Padder will be providing trainings in developmental screening for childcare providers, and MDAAP has a small grant to provide developmental screening training for any interested physician.

And that’s just what I know of now! There’s a lot you can take advantage of, to make the most of your MDAAP membership. In addition, there is still availability to sign up and enroll your practice in Reach Out and Read, and many of you are participating in our Asthma Quality Improvement project with Children’s National Medical Center.

We are always striving to do more, so if there are areas in which you are interested and things you want to see our chapter do, please feel free to call or email me or Scott Krugman, our chapter president.

Also, remember that there are so many of you that I haven’t yet met. I would really like to visit with you, even if only for a short while, so give me a call, and let’s set up a date and time to talk.

*Your chapter is here to provide service to you, our members, so let’s hear from you!*
Currently, almost one third of children and adolescents in the United States are either overweight or obese. As the prevalence of obesity increased, so did the prevalence of the co-morbidities associated with obesity, leading our country to one of its greatest health crises.

Imagine being the parent of a 12-year-old girl who starts her day taking Atenolol for her high blood pressure. She worries about “carb count” at lunch because she takes insulin for her diabetes. After school, she is not playing soccer because her knees are hurting. She ends her day wearing a Bi-PAP machine because she has sleep apnea. It’s difficult to imagine a day in the life of this girl. If you talk to her, she will tell you that she hates going to school because her friends tease her about her weight. As a parent and a pediatrician, I am concerned that we are raising the first generation of American children who will not live as long as their parents.

The alarming truth is that obese children are set on a path to becoming obese adults. So when my new patient is a 17-year-old man who weighs 348 pounds, it’s hard not to feel that the boat has been missed because the problem started when he was 7 years old. The likelihood of childhood obesity persisting into adulthood is related to age, parental obesity, and severity of obesity. It has been found that having an obese parent makes it more likely that an obese child will continue to be obese into adulthood. In longitudinal studies, an obese 6-year-old has a 50 percent chance of being an overweight adult. By age 12, the likelihood that an obese child will carry his or her excess weight into adulthood is as high as 80 percent. In a large population study, about 75 percent of adolescents with severe obesity remained severely obese as adults.

Children who become obese adults contribute significantly to increased health expenditures. Do you ever wonder why we are seeing more teenagers being admitted for diabetic ketoacidosis? From the 1980s to 1990s, the percentage of hospitalizations for obesity-associated diseases increased among 6-17-year-old children. The hospital discharges for diabetes nearly doubled, gallbladder diseases tripled, and sleep apnea increased fivefold. When examining both childhood and adult obesity, an estimated quarter of the nation’s health care costs are attributed to obesity. As public health advocates, we would want to see those staggering billions of dollars put into prevention so that every child can have a healthy life.

The solution to the problem of childhood obesity is not simple. Many factors, including genetics, environment, metabolism, lifestyle and eating habits, are believed to play a role in the development of obesity. However, more than 90 percent of pediatric obesity cases are idiopathic; less than 10 percent are associated with hormonal or genetic causes. Endocrine causes of obesity are identified in less than 1 percent of children and adolescents with obesity. Some believe that healthy weight starts prenatally and that environmental and nutritional influences during critical periods of gestational development can have permanent effects on an individual’s predisposition to obesity. Research is ongoing, and we are learning more every day, but until the leptin gene “magic bullet” therapy becomes standard of care, we are left to struggle.

Pediatricians around the country, including here in the Howard County area, are taking a variety of steps to encourage healthy eating habits and lifestyles among their patients and families. For example, my mission as a pediatrician is to help families raise healthy children together. At every well visit, I talk to my families about body mass index (BMI) for their child. BMI is the accepted standard measure of overweight and obesity for children two years of age and older, and it varies by age and gender. Electronic medical records have been such a great asset in this task. The Centers for Disease Control and Prevention (CDC) uses the term childhood obesity to indicate a BMI relative to a child’s age that is at or above the 95th percentile. I would encourage my pediatric colleagues to develop protocols for their practice that will address proper management of overweight and obese children.

We would not let an asthmatic patient walk out of a pediatrician’s office without a prescription for Albuterol. All pediatricians are urged to review the Prescriptions for Healthy Active Living information developed by the American Academy of Pediatrics. A number of helpful tools are available on the website, such as the Rx for Healthy
We wanted to share with you information on the AAP’s 2013 Legislative Conference taking place in Washington, DC April 28-30, 2013. Strong, consistent chapter participation in past conferences has helped spread participants’ knowledge and enthusiasm for child health advocacy to communities and states across the country. We hope to continue this tradition this year and look forward to seeing many of you and members of your state chapters in April.

The conference educates experienced and novice child health advocates about the Academy’s federal policy priorities through interactive skills-building workshops and in-depth training sessions.

Over the past 23 years, more than 2,200 pediatricians have attended this conference and remained active advocates for children and adolescents at the community, state and federal levels. The AAP Committees on Federal Government Affairs and State Government Affairs will be hosting the conference to help pediatricians learn how to successfully work with Congress and state legislatures to advance child health priorities through legislation, regulation and grassroots activity. At the end of the conference, attendees will visit with members of Congress and their staff on Capitol Hill to put their new skills to immediate use.

At past Legislative Conferences, the Academy has hosted guest speakers from Congress, the Administration, Washington media and state government, including U.S. Department of Health and Human Services Secretary Kathleen Sebelius, U.S. Representatives Frank Pallone (D-N.J.), Lois Capps (D-Calif.) and Anna Eshoo (D-Calif.), and former ABC News Political Director Amy Walter.

Early bird registration for the conference is $550, extended to AAP members through March 15, 2013. After that date, the fee increases to $625. Each individual will be responsible for airfare, hotel accommodations and meals outside of group functions.

A copy of the conference brochure can be found here and online at federaladvocacy.aap.org/legcon2013. To register and to learn more about Continuing Medical Education information for the conference, please visit pedialink.aap.org/visitor/cme/cme_finder, enter “Legislative Conference” and search.

Please contact Katy Matthews in the AAP Department of Federal Affairs with any additional questions at (800) 336-5475, ext. 3312, or kmatthews@aap.org.
The January 2, 2013 edition of Time Magazine contained a very interesting article entitled “Is the Medical Community Failing Breastfeeding Moms?” http://healthland.time.com/2013/01/02/is-the-medical-community-failing-breastfeeding-moms/

This article illustrates how little guidance physicians receive in medical school and residency in regards to breastfeeding. We learn the science behind lactation and the benefits of breastfeeding but we don’t learn how to support breastfeeding moms when they are having problems. Breastfeeding may be natural, but it is not always easy.

The AAP’s 2012 Breastfeeding and the Use of Human Milk policy statement tells us that we should “Promote breastfeeding as the norm for infant feeding.” The AAP recommends women breastfeed exclusively “for 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant.” If we are strongly encouraging mothers to breastfeed, we need to back that up with knowledge, skills, and support. If a mother chooses not to breastfeed, it should be a medically informed decision, not just one based on what she hears from her friends and family.

Where can physicians who are in practice learn more about breastfeeding support? First, get to know your local lactation consultants and find local breastfeeding support groups and services (at some hospitals, La Leche League, WIC, etc.). Next, stock up on some excellent resources:

Wellstart International has excellent, free “Lactation Management Self-Study Modules” authored by Audrey Naylor, MD, DrPH, FAAP and Ruth Wester, BA, RN, PNP http://www.wellstart.org/Self-Study-Module.pdf

www.breastfeedingbasics.org is also free, authored by Mary O’Connor, MD, FAAP and Linda Lewin, MD, FAAP.

The University of Virginia and the Virginia Department of Health has developed a Breastfeeding Friendly Performance Improvement activity, which is approved by the American Board of Pediatrics for MOC Part 2 and Part 4 points http://www.breastfeedingtraining.org

The AAP’s Section on Breastfeeding has a Health Professionals Resource Guide with many references. In addition, The Breastfeeding Residency Curriculum has great talks, case studies, etc. Both can be accessed at www.aap.org/breastfeeding

The Academy of Breastfeeding Medicine www.bfmed.org offers “What Every Physician Needs to Know about Breastfeeding” annually. The next meeting will be November 21, 2013 in Philadelphia. Their website also has truly useful and excellent protocols on breastfeeding topics such as breastfeeding the late preterm infant, hypoglycemia, mastitis, supplementation, and breastfeeding the hypotonic infant.

Excellent books and eBooks to have for your office may be purchased through the AAP, including “Breastfeeding Telephone Triage and Advice” by Maya Bunik, MD, “Breastfeeding Handbook for Physicians” from AAP and ACOG, and “The New Mother’s Guide to Breastfeeding, 2nd edition” edited by Joan Younger Meek, MD

Use these resources. In addition, consider joining the AAP Section on Breastfeeding. Membership includes copies of some of these books, ready access to national experts on breastfeeding via a list serve, and more. Please contact me if you have any questions or are interested in a speaker at your hospital.

Dana Silver, MD, FAAP
Co-Chapter Breastfeeding Coordinator
dsilver@lifebridgehealth.org
As pediatricians we know the pain that the death of a child causes a family. The recent tragedy in Newtown, CT serves as a reminder of the gun violence that children face every day in this country. This event has renewed our resolve to assure that children have a safe environment in which to grow and learn. We share every AAP member’s heartfelt desire to respond as strongly and actively as possible to this horrific incident and to do all we can to prevent such tragedies in the future.

The AAP leadership and staff have been working since the moment that news of the tragedy broke to respond to this event. In this email, we would like to catalogue the actions that the AAP has taken since Friday and to alert you that we have sent a letter to President Obama and Congressional leadership to communicate the Academy’s policy priorities to protect the nation’s children. We strongly urged the country’s leaders to take up gun control and improve access to mental health services for all children and adolescents. We also are asking each of you to write your member of Congress to convey the same message. Please click here to access a template message for your members of Congress.

We have been working since last Friday to provide information and resources to our members and the public, to support the Newtown community, and to identify next steps in our continuing advocacy for improved safety and mental health for infants, children, adolescents and young adults. We are focusing on three main areas of action, information and communication:

1) Helping children and families (and pediatricians) in the aftermath of traumatic events;

2) Reinforcing our commitment to strengthen preventive and treatment mental health services for children and youth; and

3) Reiterating and advocating for our firm commitment to the AAP policy on firearms safety.

**Immediate response:** In the immediate aftermath of such a crisis, we recognize that our members will be on the front lines caring for children and parents who are feeling the effects of grief and fear associated with tragedies of this magnitude. We also know that the media will be searching for reliable advice to help the nation’s families to cope.

On Friday, the day of the shooting, both AAP.org and HealthyChildren.org featured resources specific to disaster response, school shootings, and talking with children in times of crisis. This page includes a special section on talking with children, which has been featured prominently in the media over the past several days. This list of resources also contains a link to the AAP policy on firearm injuries published in October 2012, which includes a call for restoration of the ban on the sale of assault weapons to the general public. In addition to being featured prominently on our websites, these resources were distributed widely via social media.

Also on Friday, through its Disaster Preparedness Advisory Council (DPAC), the AAP connected the federal government’s response team to the AAP Connecticut Chapter leaders, to ensure that pediatricians’ viewpoint and expertise were reflected in efforts to help children. AAP leaders also offered support to the AAP Connecticut Chapter as members’ needs are identified.

**Media response:** Beginning on Friday and through today, AAP spokespersons have contributed to stories in the Associated Press, USA Today, Denver Post, New York Daily News, the Boston Globe, and on NPR, as well as in social media.

- David Schonfeld, MD, FAAP, DPAC member, has been interviewed for many media stories following the shooting and has briefed other pediatricians who have been responding to requests from the media and others. http://usat.ly/UdGDle

- AAP past president Dr. Judy Palfrey and Dr. Sean Palfrey were featured in a Boston Globe article capturing the profound effect that violence toward children has on pediatricians. http://b.globe.com/Ym0NMC

- Dan Fagbuyi, MD, FAAP, member of DPAC and the Council on Communications and Media (COCM), was interviewed by NPR http://n.pr/TZsLrj and participated in a Facebook chat hosted by USA Today, advising parents on how to talk with their children in the wake of tragedies, and the importance of shielding them from extensive media coverage over the weekend.


- COCM members also blogged about this topic: Gwenn O’Keeffe, MD, FAAP, for Parenting magazine; Claire McCarthy, MD, FAAP, blogged for Boston.com; and Wendy Sue Swanson, MD, FAAP, for Seattle Children’s Hospital.

- Vic Strasburger, MD, FAAP, was interviewed for an ABC News story about violence in entertainment media.
President's message: On Friday, Dr. McInerny issued a statement that was disseminated via Web, social media and the AAP media mailing list as well as to the staff and leadership. This message was picked up by many television news programs as coverage of the shooting unfolded.

Community support: Dr. Schonfeld traveled to Newtown to meet with Sandy Hook elementary school staff, teachers/staff in the school district, pediatricians, mental health professionals and others in a position to help children to provide “just-in-time” training and support. Members interested in accessing relevant training can access “Supporting Children’s Mental Health Needs in the Aftermath of a Disaster: Pediatric Pearls” at http://adph.org/ALPHTN/index.asp?id=5276

The Connecticut chapter has communicated the following: The CT Chapter of the AAP has been working since Saturday morning to coordinate efforts to help wherever and whenever possible. We have been in contact with those directly involved, including the Newtown School Medical Advisor, the Governor’s office, and chapter members. The generous response from our members has been heartwarming. They have offered their time, their expertise and their love. We know we need to take care of the affected families, all the children of the Newtown community, and our members who live and take care of children there.

The CTAAP has a close, on-going collaborative relationship with the CT Council of Child and Adolescent Psychiatry. There was an email sent to members of both organizations on Saturday asking for volunteers. We received over 150 responses within 24 hours. The CTAAP members will be working with mental health colleagues for the next weeks, months and sadly, probably years.

We wish to thank all of our AAP colleagues from across the country who have sent messages of support and offers of help. We all appreciate it more than you can imagine.

Policy and advocacy: The AAP statement on Firearm-Related Injuries in the Pediatric Population, published in October, is central to advocacy moving forward on this issue. The AAP supports reinstatement of the ban on assault weapon sales, a ban on the sale of high-capacity magazines, mandatory waiting periods and background checks for all gun purchases and other strict gun control policies. Counseling about safe storage of firearms and ammunition also is important.

The AAP leadership and staff are working closely with partner organizations to raise the voice of the nation’s pediatricians on Capitol Hill and among state legislatures. We also will join in coalition with child advocacy organizations, including the Brady Center, to ensure that appropriate legislation is developed to promote the safety of children. When Congress reconvenes in January, AAP representatives will be there, leading the charge to effect change by pushing for legislation, funding and policy recommendations that support community mental health systems and respond quickly to ameliorate toxic stress.

Member support and advocacy tools: There are many actions that individual pediatricians can take at this time to help children and families. For example:

- Send a letter-to-the-editor to your local paper, asking for changes in gun laws, media violence, and mental health support. You can start with this sample letter (AAP login required), which is approximately 200 words. The letter can be personalized according to your own experience and your community. Remember to check with your local paper for word limits and submission instructions. You can find appropriate media contacts for your local area on federaladvocacy.aap.org, under the “Media Outreach” tab, where you will find a media database searchable by zip code.
- On the home page of federaladvocacy.aap.org (login required), you will find a draft email and speaking points to share with your federal legislators called “Keeping Children Safe” to urge swift, bold Congressional action to keep children healthy and safe.
- Talk with your school administrators and/or local school district officials about daily safety and security measures as well as disaster plans and drills.
- Talk with parents and children who come into your office to gauge how they are feeling and help them cope after this national tragedy.
- As a routine, include discussion of “media diets” with parents and kids of all ages. Screen time, exposure to violence, and use of social media can all impact children’s and adolescents’ mental and emotional health. Ask parents to have the conversation with other parents about guns in the home.
- Address firearm safety as part of your routine anticipatory guidance with children of all ages. Ask about the presence of firearms in the home, and counsel parents who do keep guns to store them unloaded in a locked case, with the ammunition locked separately. While the
safest home for children is one without a gun, safe storage practices can significantly reduce the risk of gun injury or death.

- Advise families to remove guns from the home of any child or teenager who is depressed. Educate families that suicide attempts with a gun are very likely to be fatal, and that the presence of a gun in the home is associated with increased risk of suicide among adolescents.

As noted, AAP.org and Healthychildren.org are excellent starting points for information and resources. In addition, we are providing several sets of speaking points for members on firearm injury prevention, school safety, and mental health (including toxic stress). With the addition of violent media entertainment and the media’s reporting of violent events, these are the main areas in which our information and advocacy efforts are centered. AAP staff and leaders have developed a web resource tailored for AAP members’ use in responding to this situation in their own communities. It includes many of the resources mentioned above, as well as issue briefs and other communication and advocacy tools.

Longer term response: The AAP is in the process of identifying representatives from key AAP Committees, Councils, and Sections to assist AAP leaders to identify appropriate short- and long-term recovery strategies when there has been a school shooting.

We want to emphasize that support for the children, families and school community of Newtown remains a priority, and we will stay in close touch with the Connecticut AAP Chapter. Those who care for children will continue to look for ways to comfort, support, nurture and protect them. We call on all decision makers to do the same. At this time, we urge continued support and vigilance for the well-being of the Newtown community.

We know that there are many AAP members and colleagues who have worked tirelessly to protect children and prevent future tragedies. Thank you to the entire AAP community for pulling together to respond to this event in the best way possible.

Thomas K McInerny, MD, FAAP • President
James M Perrin, MD, FAAP • President-Elect
Robert W Block, MD, FAAP • Immediate Past President

**Pediatric Council**

A new, reinvigorated Pediatric Council of the Maryland Chapter of the American Academy of Pediatrics met at Med Chi Headquarters in Baltimore on January 8th.

MDAAP members Mike Levitas and Jim Rice currently lead the Council. AAP Chapters in many states have effectively used the Pediatric Council as a forum for pediatricians and health insurance plans to discuss pediatric issues related to access, quality and coverage. Accomplishments of successful Pediatric Councils include securing more appropriate vaccine reimbursement, payment for Bright futures recommendations, addressing obesity coverage, and securing coverage for developmental screening.

The inaugural meeting of Maryland’s new Council focused on building a coalition of pediatricians and payers who will agree to meet regularly to discuss key issues in a collegial atmosphere. Pediatric medical directors were in attendance from the major private and public insurers in the State. Carefirst, United Healthcare, Aetna, Johns Hopkins Healthcare, Amerigroup, Maryland Physicians Care, and Medstar Family Choice were represented. Several pediatricians including Maryland Chapter leadership were present as well. The agenda was developed from a survey of members and included discussion of coverage for durable medical equipment, formulary issues, and pediatricians and insurers partnering to improve HEDIS measures.

Representatives from MedChi as well as the Maryland Insurance Administration added valuable information to the discussion. An interesting theme that came up in at many points during the meeting regards distinguishing patients covered under self insured plans. For example, the MIA does not have jurisdiction over self-insured plans, and patients in these plans may have different formularies and be subject to different policies regarding coverage of a variety of services. Understanding this distinction is critical to pediatricians interacting with insurers in advocating for patients and their practices.

Moving forward, Pediatric Council meetings will occur on a bimonthly basis at the MedChi/MDAAP offices in Baltimore. The initial meeting time of 4 to 6 pm seemed to work reasonably well for pediatricians and medical directors alike. Dates for future meetings will be announced and agendas will be available in advance of the meeting when possible. MDAAP members interested in Pediatric Council are encouraged to contact the Council chairs or chapter leadership to suggest issues for future agendas and are invited to attend meetings in person.
The Maryland School for the Deaf (MSD) has many valuable services to offer your deaf and hard-of-hearing patients and their families. The MSD staff is anxious to work with you, the child’s pediatrician, in providing optimal care for deaf and hard-of-hearing children. The MSD staff welcomes your questions or comments and invites you to visit. Contact Erin Rae Buck Skees at (301)-360-2054 or erin.buck@msd.edu to arrange a tour.

About the Maryland School for the Deaf
“We are a school, and academic instruction is our business,” -Superintendent James E. Tucker

- Cost: Free to Maryland residents. (Out-of-state students pay tuition).
- Available to deaf and hard-of-hearing Maryland children from birth to age 21.
- Students in grades K-12: approximately 400
- Family Education and Early Childhood Department (children birth to age 5 and families): approximately 100
- Average classroom student-to-teacher ratio: 7:1
- MSD graduates who go on to college: 75% or more
- New state-of-the-art Elementary School/Family Education Complex entirely conceived, designed, and constructed for maximal education and communication access for deaf and hard of hearing children
- K–12 Day Students: 70%; Residential: 30%
- iPads and tablets: Increasingly used school wide
- Computer labs: 1 in each academic department
- Computers, interactive whiteboards, and projectors: at least 1 in every classroom
- Videophones: readily accessible to facilitate communication among families, students, teachers, and staff
- Registered Nurse on duty 24/7 when students are on campus

An MSD Education...
- Provides extraordinary support to children and families.
- Offers fully accredited comprehensive educational programs and supportive services that give children direct access to learning, the curriculum, and to the full public school experience.

- Serves children across the spectrum of intellectual and physical abilities, including those with moderate to severe additional disabilities.
- Supports an environment of full participation where students actively engage in academic, extracurricular, and social life.
- Opens doors to education through bilingual instruction; fluency in ASL and written English.

MSD provides family education, early childhood services, Pre-K, and Kindergarten through Grade 12 educational programs on campuses in Frederick and Columbia, Maryland. On both campuses, MSD implements Maryland’s Common Core Curriculum in conjunction with a supportive environment and comprehensive programs and services.

Family Education and Early Childhood Department
This Department provides free statewide services to families and their young deaf and hard of hearing children, including those with additional disabilities.

Services, provided at no cost to families residing in Maryland, include...

- **Home Visits** – to families statewide help them cultivate language skills through play and develop networks of local resources.
- **Family Education Centers** – on each campus welcome families and children who participate in our programs, services, and classes.
- **Classes** – regularly scheduled and available for infants, toddlers, and families. Full- and half-day classes are available for 3-year olds. Children benefit from hands-on activities that focus on emerging language and communication skills, learning through play, and social skill development. Our early learning curriculum is compatible with the Maryland State Curriculum and supports children’s readiness for elementary school.
- **Daily Pre-K** – expands school readiness skills for children who are age 4 by September 1.
- **Speech Therapy Services** – support children’s language development and auditory perception, individually and in groups.
- **Cochlear Implant and Hearing Aid Services** – facilitate auditory, speech, and language development
before, during, and after a child completes the implant process or receives a hearing aid. Services include home visits, center-based classes, spoken language enrichment sessions, collaboration with cochlear implant centers and therapists, and on-site mapping.

- Parent Group Meetings–held weekly provide information and support on many topics and opportunities to interact with other families.
- American Sign Language (ASL) Classes–offered at both campuses to parents and the extended family promote communication with children and a strong foundation for language and literacy learning.
- Regional Parent Meetings and Special Events–connect families with local and regional communities.

The Maryland Early Hearing Detection and Intervention program identified 224 infants with hearing loss between the years 2009-2012. Early identification of Maryland’s deaf and hard of hearing children allows the Family Education and Early Childhood Department (FEECD) at MSD to foster early language and literacy. FEECD currently serves 100 children from ages birth through five and their families.

K-Grade 12

MSD is a dually accredited school by Middle States Association (MSA) and the Conference of Educational Administrators of Schools and Programs for the Deaf (CEASD) and is known for commitment to educational excellence. MSD provides Maryland’s top-ranked public school education. Our goal is for every student to acquire fluency in American Sign Language and English, have access to a public school curriculum, and complete high school with either the Maryland State High School Diploma or Certificate of Program Completion.

ASL and English are the primary languages of instruction and English literacy (reading and writing) is at the heart of every class from K through Grade 12. Speech therapy and auditory training are available to all students, and students who can access auditory language learning benefit from spoken language sessions that reinforce curriculum instruction.

In addition to strong academic programs, MSD students have opportunities to gain work experience during their High School years. Many MSD High School students develop job skills through internships or paid work in area businesses and agencies. MSD’s Work-To-Learn Program serves students who meet specific requirements for vocational rehabilitation services. Through this successful partnership between MSD and the Maryland State Department of Education (MSDE) Division of Rehabilitation Services (DORS), participating MSD students receive training and support as they gain work experience.

Auditory Language Learning at MSD

Many MSD students have usable residual hearing, use hearing aids, or have cochlear implants. These students benefit from focused instruction and specialized services that support MSD’s bilingual Early Childhood and Pre-K–12 educational programs.

Students with hearing aids or implants who have the potential to access academic instruction through spoken English are immersed into the languages of ASL and English through MSD’s comprehensive academic programs, including oral/aural instruction and the full array of classroom and therapy services. As children develop a strong language base, they progress toward fluency in both ASL and English with excellent success. In MSD’s communication rich environment, students engage in meaningful interaction with teachers using visual, oral, and printed English communication.

Students with hearing aids and/or cochlear implants and their families benefit from exceptional support at MSD. For each student, assessments guide the development of a communication plan that integrates the best and most appropriate approaches for language learning. MSD partners with regional hospital audiology and implant centers as well as with hearing aid and implant manufacturers and service providers. These partnerships facilitate service coordination, promote education and information exchange, ensure the monitoring of students’ devices, and support students and families.

Family Support and Resource Center

Family support and engagement at all ages is critical for student achievement. MSD provides a statewide program with office locations on both campuses to help families and professionals resolve concerns and make informed decisions regarding the education of deaf and hard of hearing children. The Centers are staffed by a parent Coordinator, who also travels to locations throughout the State. The program gives families and professionals the support they need to help deaf and hard of hearing children reach their full potential.

For more information about the Maryland School for the Deaf please visit the web site at: www.msd.edu
Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP)
Pilot Launched!

The State of Maryland, in collaboration with the Johns Hopkins Bloomberg School of Public Health, the University of Maryland School of Medicine, and Salisbury University, has launched their pilot of the Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP). The goal of B-HIPP is to support pediatric PCPs in addressing the mental health care needs of their young patients. The program is initially being piloted in Western Maryland (Hagerstown, Cumberland, Oakland), Southern Maryland (Prince Frederick), the Eastern Shore (Easton, Chestertown, Salisbury), and practices throughout Maryland which are part of the Patient-Centered Medical Home Learning Collaborative, with plans to offer services statewide beginning in Summer 2013.

Components of B-HIPP include: 1) phone consultation service, 2) continuing education, 3) mental health referrals and resource networking (including linkage to family navigators), and 4) social work co-location, currently being piloted through Salisbury University. This service is provided at no cost to PCPs or their patients, and providers are welcome to participate in whichever components best suit their needs. PCPs can join by completing an Enrollment Form which includes providing some basic contact and demographic information, as well as completing a brief needs assessment. They must agree to general guidelines and understand that B-HIPP cannot assume care of their patients.

Our team of mental health consultants is prepared to respond to both general and case specific questions about a variety of subjects including: diagnostic questions/approaches; medications; sequelae of trauma, abuse, and neglect; early childhood development; substance abuse; school behavior and learning issues; and parenting and family issues. Calls will be referred to our best-matched resource.

For more information visit our website at http://web.jhu.edu/pedmentalhealth/bhipp. If you would like to enroll or have questions please email Program Director, Meghan Crosby Budinger, MS, LCPC at mcrosby@jhsph.edu.

Dr. Alice Heisler

Dr. Alice Heisler, a behavioral pediatrician and long time faculty member at University of Maryland School of Medicine, died October 18, 2012 from pancreatic cancer. Dr. Heisler was an active member in the Emotional Health Committee of the Maryland Chapter of the American Academy of Pediatrics and had long been dedicated to helping medical students, pediatric residents, fellows in developmental-behavioral pediatrics, and community pediatricians provide better care for the emotional problems in the children for whom they provided care.

She graduated from the University of Maryland School of Medicine in 1963, completed her internships and residency in Pediatrics at University of Maryland, and then did one year of fellowship training in Genetics at Rhode Island Hospital before returning to Maryland to complete a fellowship in Behavioral Pediatrics. She then joined the faculty at University of Maryland and played a key roll in the development of one of the first resident block rotations in Behavioral Pediatrics in the country. She was the director of the Behavioral Pediatric Clinic at Maryland for many years and was responsible for helping many children and their families with a variety of behavioral and adjustment problems ranging from ADHD and autism to coping with chronic or terminal illness in the child, death of a family member, or divorce in the family. She also served as a consultant to several Baltimore City Public Schools including Sharp Leadenhall School and saw patients at Columbia Pediatric Practice and University of Maryland’s Bel Air offices. She continued her important work on the faculty at University of Maryland teaching residents until forced to stop because of her illness. She was especially well known for her skill in teaching core behavior management techniques to both trainees and families. Consistently, the trainees who worked with her, as well as the families for whom she provided care, describe her as one of the kindest, most caring people they ever knew. She will be much missed by the Maryland pediatric community.
When guitarist Jimmy Page was assembling a new band in the late Sixties after the break-up of the British blues band, the Yardbirds, two members of The Who weighed in on the new band’s prospects. Drummer Keith Moon stated they would “go down like a lead balloon”; Bassist John Entwistle went a step further and, alluding to the crash-and-burn demise of the Hindenburg, said it would be “more like a lead zeppelin.” After their manager changed the spelling to “Led” to avoid the wrong pronunciation (how would you say lead guitarist for Lead Zeppelin?), the band, who actually used a picture of the Hindenburg disaster for their debut album, went on to turn Led into a great deal of gold and platinum. There is no indication that their Stairway to Heaven had any lead paint on its bannisters, or that anyone suffered any lead poisoning from listening to their music.

The lines above from their classic song can apply to many environmental health issues: do we allow exposure to various toxic substances and treat the effects, or do we eliminate the exposure and prevent those toxic effects from occurring? Many substances, lead included, find their way into common usage before their toxicities are appreciated. Once the hazards are known, the arduous task of changing the road we’re on and eliminating the use of the dangerous substance begins. The history of lead poisoning illustrates the time it can take to make such a change in course.

**Historical Uses of Lead**

Lead, in various forms and compounds, has been widely used for thousands of years. The ancient Egyptians used lead-containing kohl as an eye cosmetic. The ancient Romans (whose name for lead, plumbum, gives this element its symbol, Pb) used metallic lead for pipes and cooking utensils and used lead compounds in pottery glazes and as an additive to wines (perhaps contributing to the decline of their Empire). In more recent times, lead solder was commonly used as a sealant in food and drink containers. Lead carbonate, an opaque white pigment, was used to make paint that covered well, dried more quickly, gave a smooth finish and resisted moisture. It was widely used in both housing and in industrial settings in the last century. Tetraethyl lead was used as a gasoline additive beginning in the 1920’s to boost engine performance and fuel efficiency. This widespread use of lead paint and leaded fuel led to an enormous environmental lead burden. Though acute lead poisoning was being more widely recognized in the 1950’s, it wasn’t until 1977 that the used of lead-based paint in housing was banned. The phase-out of lead from gasoline did not occur until 1975 through 1986.

**Routes and Sources of Exposure**

Lead, in the many forms noted above, does not undergo degradation and persists unchanged in the environment. Oral ingestion of lead is by far the most common route of exposure. Deteriorating paint and renovation of older housing produces both large lead-containing particles and microscopic contamination of house dust. Decades of leaded gasoline use have contaminated soils, especially in urban and industrial areas and heavily-travelled roadsides. The hand-to-mouth habits of young children put them at great risk when exposed to lead in house dust and soils.

Lead ingestion may also occur from contaminated water (especially hot water) in lead pipes, and from metallic or alloyed lead in children’s toys and jewelry, or such items painted with lead-based paints (usually imported from China). Lead glazing on pottery and ceramics (from Mexico and China), old pewter or soldered cookware and a variety of folk remedies are additional potential sources of lead ingestion.

Parental occupations and hobbies may also bring lead into the home. Lead smelting, automobile repair and battery recycling, industrial lead paint exposure, fishing weights, firearm ammunition and lead caming for stained glass are additional potential sources of lead exposures.

Airborne inhalation of lead is a less common route of exposure. This has been dramatically reduced since the elimination of lead from gasoline, but may also occur from lead-based industries (such emissions have also continued on page 13
been strictly regulated), fumes from burning lead paint, and inhalation of fine particles from renovations and disturbance of lead-contaminated household dust.

**Toxic Effects**

Lead is a known neurotoxin whose effects appear to be irreversible, and the child's developing brain is especially susceptible to these toxic effects. These are believed to be due to interference with neurotransmission and disruption of cell migration during brain development. Symptoms of acute toxicity include headache with agitation or somnolence, accompanied by abdominal pain and constipation. This can progress to vomiting, stupor and convulsions and is a medical emergency. Before chelation therapy was available, lead encephalopathy (with blood lead levels > 60 mcg/dL) resulted in death and permanent brain damage with seizures and intellectual disabilities in a large percentage of affected children. The elimination of lead from gasoline and paint has dramatically reduced the incidence of lead encephalopathy and symptomatic lead poisoning.

Other neurodevelopmental problems, including cognitive impairment, hyperactivity, inattention, school failure, and aggressive and delinquent behavior have been reported at lower blood lead levels, but there is no single finding or group of symptoms specific to lead toxicity. A decline in IQ scores with rising blood lead levels above 10 mcg/dL has been established in several studies, with recent evidence also suggesting a higher rate of decline at levels < 10 mcg/dL.

Lead exerts toxic effects on the kidneys, increasing the risk of renal dysfunction and hypertension later in life. Lead also interferes with hydroxylation and activation of Vitamin D, affecting bone metabolism and growth. Impaired heme synthesis is another effect of lead, leading to a microcytic hypochromic anemia.

**Screening**

A venous blood lead level is the preferred test to screen for significant lead exposure. Blood lead levels have been demonstrated to peak at age 2 years and then decline, even without intervention. As such, children at risk for lead exposure should be tested at age 1 year and 2 years. Federal policy requires these blood lead levels in all children receiving Medicaid insurance (and for 3-6 year olds not previously tested). Maryland law requires testing for children living in zip codes considered to be high-risk for lead exposure, based on the percentage of older housing. Additionally, all children should be screened for lead exposure, asking if they live or visit homes built before 1978, especially if peeling paint is present or interior remodeling is being done; if there are any siblings or playmates with elevated lead levels; if anyone in the household has a work or hobby-related exposure to lead; or if the child lives near a lead-based industry. International adoptees, immigrants and refugees should also be screened upon entry to this country.

In May, 2012, the CDC revised their guidelines based on recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention. All children with a blood lead level of > 5 mcg/dL should be monitored for changes in their lead levels until investigation for the source of exposure and mitigation have been completed. The previous level of concern was 10 mcg/dL.

**Management**

There is no form of treatment as effective as primary prevention of exposure to lead. Identification and elimination of sources of environmental exposure to lead will result in fewer and fewer children with significant lead levels and their associated toxicities.

In older homes where lead paint is likely to be present, keeping children from direct contact with painted surfaces, especially if flaking or peeling, is extremely important. Keeping children out of these homes during renovations is also crucial. Frequent washing of children's hands and toys will reduce the risk of hand-to-mouth exposure to lead in house dust, and regular wet-mopping and wet-wiping of floors and painted windows and door frames will help reduce the amount of lead-contaminated dust. Avoiding outdoor play on bare soil, particularly in urban/industrial neighborhoods, will decrease the likelihood of ingestion of lead-contaminated soil.
The following will summarize the recommendations for management of elevated lead levels, based on the blood lead level. At all levels, assessment for the source of lead is necessary, and steps should be taken to eliminate this source. Dietary evaluation to assure adequate intake of iron, zinc, calcium, protein and vitamin C should also be performed. A hemoglobin and/or hematocrit should be checked to identify a coexisting iron deficiency anemia, and iron supplementation should be given to correct a deficiency, if found.

<table>
<thead>
<tr>
<th>Lead Level (mcg/dL)</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Identify source if possible and eliminate exposure. Monitor blood lead level (BLL) within 3 months</td>
</tr>
<tr>
<td>10-14</td>
<td>Confirm BLL within 1 month, monitor q 3 months. Notify local health dept. – a BLL of 10 triggers regulatory action for rental housing in Maryland</td>
</tr>
<tr>
<td>15-19</td>
<td>Confirm BLL within 1 month, repeat within 2 months. Refer to Lead Poisoning Prevention Program (LPPP)</td>
</tr>
<tr>
<td>20-44</td>
<td>Complete medical/developmental/environmental eval. Confirm BLL within 1 week; consider abdominal X-ray if ingestion suspected. Refer to health dept. and LPPP for case management</td>
</tr>
<tr>
<td>45-69</td>
<td>Confirm BLL within 24-48 hours. Full evaluation as above. Remove child to lead-free location. Begin oral chelation in consultation with experienced clinician.</td>
</tr>
<tr>
<td>70 and above</td>
<td>Hospitalize immediately, confirm BLL and begin IM chelation with dimercaprol and EDTA in consultation with experienced clinician</td>
</tr>
</tbody>
</table>

Oral chelation uses succimer (dimercaptosuccinic acid or DMSA), which enhances urinary excretion of lead. This medication is administered three times a day for 5 days, then twice a day for an additional 14 days. Parenteral chelation begins with IM dimercaprol (BAL or British Anti-Lewisite), six divided doses per day for at least 3 days. Calcium disodium EDTA (CaNa2 edetate) is started 4 hours after the first BAL dose, and continued for 5 days. Chelation is not recommended for BLL < 45 due to toxicity and lack of documented neurocognitive benefit. Lead levels should be checked 1 to 3 weeks after chelation for a rebound, as lead stored in bone mobilizes into the circulation.

Resources for guidance in managing children with lead poisoning include the Mt. Washington Children’s Hospital Lead Clinic (410-367-2222) and the Mid-Atlantic Center for Children’s Health and the Environment (MACCHE) (1-866-622-2431 or online at www.childrensnational.org/macche).

Great strides have been made in reducing exposure to lead, but environmental sources still exist, particularly in older housing units. The persistence needed to continue to reduce children’s exposure to lead and work to eliminate this entirely preventable disease will require each of us “to be a rock, and not to roll.”

References:
Website: CDC Lead Poisoning and Prevention Program: http://www.cdc.gov/nceh/lead/
FREE!

Training on state mandated developmental screening of children

Contact:
Marti Grant, R.N., M.A., Consultant
443-621-8361 (cell) or by email at garymarti1@verizon.net

Dessert will be provided for lunch time training at your practice location!

You and Your Staff Will Learn About:

• The American Academy of Pediatrics (AAP) Policy on developmental screening of all children under 6 years of age
• Why early screening for development is important
• Current approved/recommended screening tools in Maryland
• Nuts and bolts on implementing the recommended ASQ or PEDs screening tool in your practice
• How to interpret and document screening results
• Referral resources and tracking of referrals

Developmental Screening Training is a collaborative project of the Department of Health and Mental Hygiene, Family Health Administration, Office for Genetics and Children with Special Health Care Needs, the Maryland Chapter of the American Academy of Pediatrics, and The Parents’ Place of Maryland

Don’t wait!
Get your training for state mandated developmental screening.
Save the Date for a Family Event!

In response to member feedback, the Chapter is exploring hosting a family event for members in Howard County in the spring, most likely in April. Currently we are looking at hosting the event in Centennial Park in Columbia. The event would be held on the weekend from around 11 – 3 and would include food and games.

If you are interested in attending the event or helping us plan the event, please contact Lynne Peters at 410-878-9704 or lynne@mdaap.org.

The MDAAP Young Physicians Section Invites New Members

The Young Physicians Section of the Maryland Chapter of the AAP is dedicated to helping young physicians get more involved in the AAP.

We meet every 6 weeks or so in an informal setting to socialize, network, and discuss issues facing young physicians today. The Section is open to pediatricians under 40 years old, or less than 5 years out of training. We especially encourage residents and fellows still in training to join this group.

If you are interested in getting updates about Young Physician Section activities, meeting times and places, please contact Julie Ellis, Section Chair, at julie.e.e Ellis@gmail.com.

Future meeting dates are:
Wednesday, January 23
Thursday, March 7
Tuesday, April 23
Thursday, June 6

All are welcome! We look forward to meeting you!