Where We Are Going, This Year

Each summer, the leadership of the MDAAP gets together to plan for the upcoming fiscal year. This past June, the newly designated “Leadership Council” (formerly known as the Executive Committee) met and reviewed our strategic plan to come up with this year’s goals and objectives. Our organization has made great strides recently in creating an efficient, well-run member and advocacy organization. One big step forward was the approval of a new set of bylaws which more accurately reflects how our organization runs. We have 4 main goals this upcoming year to help us achieve our mission of supporting and encouraging pediatricians in the promotion of optimal health for all of Maryland’s children and adolescents.

The first important goal is to increase our membership. As a volunteer member organization, we are only as strong as our membership. This year we will continue to stress the value of MDAAP membership to pediatricians throughout Maryland, focusing on young members and pediatricians who are national AAP members, but not members of our chapter. Anyone who is interested in helping our Secretary-Treasurer Diana Fertsch and our regional representatives in this vital effort is welcome to join in and volunteer.

The second major goal for this year is to provide opportunities for the professional development of our members. Helping pediatricians succeed as pediatricians is a huge member value. This past year, we have expanded Reach Out and Read across the state, helped enhance mental health resources for primary care pediatricians and participated in our first quality improvement MOC project. In addition to what we accomplished this past year, we are expanding our support for hospitalists, helping hospitals promote breastfeeding in nurseries, and helping pediatricians have access to more resources for parents in the areas of mental health, dental health, violence prevention, and poverty.

The final area on which we will be focusing is chapter operations. As mentioned above, we have approved new bylaws. There are other organizational opportunities to work on this year, including revamping and enhancing our committees and creating clearer roles and expectations for our leaders. Most important of all is communication with our members. While we often rely on email, we try to keep our messages succinct, newsworthy, and not too frequent. If you haven’t stopped by our newly renovated website (www.mdaap.org), please do so. The information on it should help all members understand what is going on with the organization, as well as provide useful content for pediatricians and patients (click on the BI-PED link). We will continue to be strong advocates for children and increase our media presence to become the voice for Maryland’s children.

Almost all of our meetings are open to any member, so check out the calendar and come to a Leadership Council meeting or open forum this year. We have a ton of work to do, and anyone with an interest in helping will be signed up and supported. As always, please do not hesitate to provide us with any feedback on how we are doing or what you would like to see us work on. We are regularly asking for your input, and are only as effective as our members make us.
Message from the Executive Director

Help us help others to benefit from chapter membership

I hope that all of you feel that your membership in the Maryland Chapter of AAP is valuable to you and that it gets more valuable every day. With two upcoming CME events in October (plus, hopefully, more on the way) and chapter and national leadership opportunities, each member physician has many ways to benefit from his/her membership.

The chapter, as I hope you all know, is very involved and engaged in advocacy efforts in Annapolis and in Washington. This is a vital activity that an individual physician usually can’t do alone. Another important activity of the chapter includes a newly invigorated Pediatric Council, which continues to provide quarterly interaction with payors, working to resolve issues brought up by members.

Our efforts with quality improvement and Part 4 MOC credit were very successful during the last fiscal year, and we look forward to another wonderful partnership with Children’s National Medical Center this fall.

We have continued the legacy of providing valuable benefits and opportunities for our physicians, begun many decades ago by our chapter founders, but no organization can grow without new members. Our chapter currently has 900+ members, but we know the number of pediatricians and pediatric specialists in our state is much larger than that. There are some practices that feel having one of their doctors as a member of the chapter is enough. There are other groups that have no members in the state chapter, but only belong to the national AAP. Still other groups of pediatricians don’t belong at all.

To continue the work we do and to further upgrade what we offer to our members, we need each and every pediatrician and specialist in the state to join us. If you know of a pediatrician who is not a Maryland state member, or you work with doctors who do not belong, we ask that you help us (and them!) by extending an invitation to join MDAAP. In addition to the cost of national membership, chapter membership is only $150. A doctor is able to join either national and the local chapter or the local chapter alone. We invite you to help us help your fellow pediatricians by asking them to join us in the important work we do in improving the health of Maryland’s children.

For more information on why chapter membership is important, I invite you to contact our president, Dr. Scott Krugman, or any of our officers, board members or members of our leadership council. A listing of those physicians is included in this issue of the newsletter.

Come on, join us… you’ll be doing the right thing to benefit both your patients and yourself!

MDAAP Members Receive National Appointments and Awards

The Maryland Chapter, American Academy of Pediatrics is pleased to announce that two of our members were appointed to positions within the national organization.

Congratulations to:

Dr. Larry Wissow, FAAP - Committee on Psychosocial Aspects of Child and Family Health (COPACFH) for a 6-year period.

Dr. Natella Yurievna Rakhmanina, FAAP - Committee on Pediatric AIDS (COPA) for a 6-year period.

We are also pleased to share that Dr. Eric Levey, FAAP, Immediate Past President, was awarded a Special Achievement Award by the American Academy of Pediatrics for his service as the chapter president. This award was given at the August District III meeting and will be presented to Dr. Levey at the Chapter’s annual educational event on October 5, 2013.

Dr. Susan Panny, FAAP, Chapter Champion for EHDI, was recently recognized by the Academy and the Section on Senior Members for her outstanding contributions to child health advocacy. Our chapter nominated Dr. Panny for the 2013 Section Advocacy Award. In its letter, the Academy stated, “Your nomination for the 2013 Section Advocacy Award and the documentation of your efforts on behalf of children and families is convincing testament to your exemplary record of commitment and accomplishments in speaking up for children.”
Pertussis, an acute infectious disease caused by the bacterium *Bordetella pertussis*, is known for causing uncontrolled, violent coughing, making it hard to breathe. Pertussis most commonly affects infants and young children and can be fatal, especially for babies from birth to 12 months.

Recent outbreaks of pertussis motivated state health departments, health care agencies and Managed Care Organizations (MCO’s) to distribute information to health care providers on recommending pertussis vaccinations to individuals at risk for contracting or spreading the disease. Amerigroup and other MCO’s also provide their members with information on the importance of preventive care and getting vaccinated.

Although pertussis often goes unrecognized and unreported, state health departments have seen a recent increase in reported cases. Factors contributing to the rise in reported cases include:

- Increased awareness and improved recognition of pertussis among clinicians
- Greater access to and use of laboratory diagnostics, especially Polymerase Chain Reaction (PCR) testing
- Increased surveillance and reporting of pertussis to public health departments
- Waning immunity from vaccines

Vaccines for prevention of pertussis
Several vaccine formulations are available to prevent pertussis. Some are combined with vaccines to prevent other diseases and reduce the total number of shots a patient receives in one office visit. In the United States, DTaP, Tdap and Td vaccines are most common.*

- **DTaP** is given to children ages 6 and under. Children should receive five doses of DTaP: one dose at ages 2, 4 and 6 months, with additional doses between 15–18 months and 4–6 years.
- **Tdap** and **Td** are given to older children and adults.
- **Td** is a tetanus-diphtheria vaccine given to adolescents and adults as booster shots every 10 years or after exposure to tetanus under some circumstances.
- **Tdap** is also a tetanus-diphtheria vaccine containing protection against pertussis. Adolescents ages 11–18 (preferably between ages 11–12) and adults age 19 and older should receive single doses of Tdap, especially if in close contact with infants.
- Expectant mothers should receive Tdap during each pregnancy, preferably between 27–36 weeks.
- **Tdap** is also given to children ages 7–10 who were not fully immunized against pertussis. Tdap can be given, regardless of when Td was last received.

* Updated January 2013 by the Centers for Disease Control (CDC): Uppercase letters in these abbreviations denote full-strength doses of diphtheria (D) and tetanus (T) toxoids and pertussis (P) vaccine. Lowercase letters “d” and “p” denote reduced doses of diphtheria and pertussis used in the adolescent/adult formulations. The “a” in DTaP and Tdap stands for acellular, meaning the pertussis component contains only a part of the pertussis organism.

Vaccine administration CPT codes
Medicaid providers must use vaccines provided by the Vaccines For Children (VFC) program for patients from birth to age 19. The Health and Human Services Commission recently announced a rate increase applicable to VFC administration services. Amerigroup and other Maryland MCO’s now reimburse eligible primary care providers and specialists at increased rates for dates of service from January 1, 2013, through December 31, 2014. Currently, Medicaid pays a maximum administration fee of $15.49 per vaccine. Providers should bill the usual and customary charge for administration of each vaccine.

Vaccine resources
- For questions about enrolling in the VFC program and ordering vaccines, contact the VFC consultant in your jurisdiction. Refer to Section 7 – Appendix V of the Maryland Healthy Kids provider manual.
- For questions about vaccine reimbursement, refer to the Maryland Healthy Kids provider manual or call the Maryland Healthy Kids program at 410-767-1683.
- For questions about vaccine administration, call the Center for Immunization at 410-767-6679.

Sources
Centers for Disease Control: www.cdc.gov/vaccines/vpd-vac/pertussis/default.htm
**AAP District II and III Meeting**

*Dr. Susan Chaitovitz, FAAP*

In early August, Chapter Vice President Susan Chaitovitz, MD, FAAP, and Executive Director Paula Minsk, M.Ed, CFRE, attended the annual AAP District III meeting, this year combined with District II (NY State). Facilitating the meeting, also from Maryland, were District III Chairman David Bromberg, MD, FAAP, and District III Vice Chairman Daniel Levy, MD, FAAP. One main theme of the meeting was Practice Transformation. With health information technology as its foundation, practice transformation in pediatrics will likely lead us from a system of fragmented care into a system of coordinated care and eventually, to an integrated care system in which services are delivered by care teams. Discussions focused on how this transformation will happen, who will drive the change and possible future payment models. As an extension of practice transformation, we spent time discussing mental health and innovative models of coordinating mental health with the pediatric medical home. Multiple speakers cited the Maryland Behavioral Health In Pediatric Primary Care (B-HIPP) program as a model and credited Maryland Pediatric Psychiatrist and MDAAP leader Larry Wissow, MD, FAAP, for his leadership in this program. Finally, the meeting ended with a conversation on Gun Violence Prevention. This discussion ranged from national political agendas to state policy to anticipatory guidance provided by pediatricians in the medical home. Nationally, restrictions on research into gun-related deaths and injuries have been lifted, which should allow for more data collection on this public health issue and assessment of which interventions are the most successful.

**DOCs in the Park**

The DITP spring wrapped up with a fantastically successful field day/environmental education day at Carroll Park for the Samuel Morse Elementary School in West Baltimore. Organized with the Governor’s Partnership for Children & Nature and supported by many state-wide partners, as well as DITP and Saint Agnes volunteers, the event had 17 stations for almost 200 children and 75 parents. Nearly all families reported learning about the importance of 60 minutes of daily active outdoor time and local park resources, and noted they were more likely to return to the park after the event. Score!

Community park events were the highlight for the DITP summer season. Our DITP group was asked to talk with families at two Baltimore City community events: the Druid Hill Farmers’ Market and the National Night Out Event in Herring Run Park. DITP coordinator Mike Dorsey and Dr. Maria Brown helped educate families at these events about the importance of healthy active outdoor time. Both were well attended with families eager to learn about how they can involve themselves in their park communities.

Next up is planning for our fall events. With generous funding from the National Recreation and Parks Association, DITP is gearing up for a great autumn season of engaging Baltimore families in outdoor active fun. If you would like to join the Children & Nature Task Force physicians to model healthy active living at any of these events, please contact Maria Brown (mbrown44@jhmi.edu). Also, please check for updates and “like” us on Facebook!

**Saturday, Sept 7th: Middle Branch Water Festival:** Docs in the Park will be present from 12-4pm at this day-long event. Other than our area, activities include kayaking, canoeing, learn to row opportunities, crabbing, fishing and arts & crafts. This is a great chance to explore this part of Baltimore’s waterfront and learn how it plays into the “Swimmable Harbor 2020” campaign. www.middlebranchwaterfrontfestival.com

**Sunday, October 13th: Leakin Park:** This Docs in the Park event is being held on the “2nd Sunday” event for October which includes free rides on the miniature trains operated by the Chesapeake and Allegheny Steam Preservation Society, opportunities to visit the historic chapel and mansion house of the original Winans estate, guided walks through a traditional Hopi Labyrinth, and hikes on the park’s many walking trails.

**Saturday, November 9th: Herring Run Park:** Looking to have a repeat of our first Docs in the Park event on a beautiful autumn day!
Docs in the Park is a local partnership of Baltimore City Recreation & Parks, physicians, naturalists and educators. Docs in the Park creates events in City parks that demonstrate the health benefits of children & families playing and exploring outdoors.

Why spend time outside?
60 minutes of daily active outdoor time allows children to enjoy healthier weights, higher self-esteem, better concentration and school performance, lower anxiety and depression and lower risk of heart disease and diabetes.

Should I talk to my doctor about playing outside?
Yes, ask your doctor about healthy outdoor activities in your neighborhood!

UPCOMING FREE FAMILY EVENTS IN CITY PARKS!

**SEPTEMBER 7**th **12-4 PM**
Middle Branch Waterfront Festival in Middle Branch Park, Waterview Avenue at Hanover Street

**October 13**th **12-4 PM**
Family Fun Days in Gwynns Falls/Leakin Park, Eagle Drive entrance off Windsor Mill Road

**November 9**th **12-4 PM**
Herring Run Park, Parkside Drive and Elison Avenue

For more information contact Mary Hardcastle at 410-396-7020 or mary.hardcastle@baltimorecity.gov

Visit the website at [http://bcrp.baltimorecity.gov/SpecialPrograms/ChildreninNature.aspx](http://bcrp.baltimorecity.gov/SpecialPrograms/ChildreninNature.aspx)

DITP supports the Mayor’s Healthy Baltimore 2015 initiative to realign all agency priorities to support increased physical activity in the City of Baltimore.
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 PCP’s 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 PCP’s or their patients, and providers are welcome to participate in whichever components best suit their needs. PCP’s 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.

TWO EXCITING EDUCATIONAL EVENTS COMING UP IN OCTOBER

Please print out registration forms and mail to the chapter office

MDAAP, 1211 Cathedral Street, Baltimore, MD 21201

American Academy of Pediatrics Maryland Chapter Educational Event

“Training Physicians to Deal with Obesity in Practices”

All MDAAP and AFP members who live or work in Howard County are invited to attend this education event on Tuesday, October 1st, 2013. Fully funded by the Horizon Foundation, this event will be FREE of charge. Following dinner and networking opportunities, Sandra Hassink, MD, and Alan Lake, MD, will be the keynote speakers. Subsequent to the in-person event, there will be an additional educational session via webinar on Thursday, October 17th, 2013.

Please join us in learning about national and state perspectives on obesity while being educated in motivational interviewing techniques!

American Academy of Pediatrics Maryland Chapter Educational Event and Leffler Lecture/ Awards Lunch

Please join us for this educational event, “Sports Medicine in the Private Practice” featuring John Wilkens, MD, Richard Hinton, MD, Amy Valasek, MD, Frank Dawson, MD, and Gerry Gioia, PhD, on Saturday, October 5th, 2013. Breakfast, lunch, physician networking and opportunities to spend time with sponsors at their exhibit tables will be provided. Educational lectures and a workshop on lower extremity exams as well as the chapter’s annual Leffler Lecture will take place, concluding with the annual chapter awards ceremony. Don’t miss out on this significant opportunity to learn, network, and honor your colleagues!

Please visit the chapter website for registration forms. You must send in the registration form to attend.
Maryland Chapter
American Academy of Pediatrics
Saturday, October 5, 2013
Educational Event and Leffler Lecture/Awards Lunch

**Program**

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<th>Time</th>
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<tr>
<td>8:00-8:30am</td>
<td>Registration &amp; Breakfast</td>
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<td>8:30am</td>
<td>Brief Introductions</td>
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<td>8:30-9:30am</td>
<td>Overuse injuries of the lower extremity, John Wilkens, MD</td>
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<tr>
<td>9:30-10:30am</td>
<td>Acute injuries of the lower extremity, Richard Hinton, MD</td>
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<td>10:30-10:45am</td>
<td>Break, visit the exhibits</td>
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<tr>
<td>10:45-11:15am</td>
<td>Workshop on lower extremity exams, Amy Valasek, MD &amp; Frank Dawson, MD</td>
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<tr>
<td>11:15-11:30am</td>
<td>Break</td>
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<td>11:30-11:45am</td>
<td>Introduction of the luncheon speaker</td>
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<td>11:45-12:45pm</td>
<td>Concussion Update, Gerry Gioia, PhD</td>
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<td>12:45-1:00pm</td>
<td>Q&amp;A</td>
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<td>1:00-1:45pm</td>
<td>Chapter Awards</td>
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**Registration costs**

- **$60.00:** MDAAP members for the full program, includes breakfast & lunch
- **$85.00:** Non-members for the full program, includes breakfast & lunch
- **$40.00:** Leffler Lecture & Awards program only, includes lunch

Please return this completed portion with payment to: MDAAP, 1211 Cathedral Street, Baltimore, MD 21201 or fax 410-649-4131.

Name: ____________________________________________________________
Address: __________________________________________________________
Phone: __________________________________________________________________________
Email: ____________________________________________________________
Dietary Restrictions (if applicable): _____________________________________________

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Number Attending: ______  Names of those attending: __________________________________________

Amount Enclosed: $______

*This event will be held at the Wellness Center at Howard County General Hospital (Medical Pavilion) at 10710 Charter Drive, Suite 100, Columbia, MD 21044

*Questions: Paula Minsk, Executive Director, 410-878-9702 or paula@mdaap.org
Maryland Chapter, American Academy of Pediatrics  
Tuesday, October 1, 2013  
*Training Physicians to Deal with Obesity in Practices*  
*This event is funded through a grant from the Horizon Foundation*

**Program**

6:00-6:30pm  
Registration, Dinner and Networking

6:30-7:30pm  
Session 1 – Dr. Sandra Hassink: National Perspectives on Obesity

7:30-8:30pm  
Session 2 – Dr. Alan Lake: State Perspectives on Obesity

8:30-9:00pm  
Session 3 – Dr. Sandra Hassink: Motivational Interviewing

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Who is eligible to register for this free event?  
All MDAAP & AFP members who live or work in Howard County may register at no charge.

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Please return this completed form to: MDAAP, 1211 Cathedral Street, Baltimore, MD 21201 or fax 410-649-4131

Name: _______________________________________________________________  
Address: __________________________________________________________________________

Phone: __________________________________________________________________________

Email: _______________________________________________________________  
Dietary Restrictions (if applicable): _____________________________________________

Please check all that apply:

☐ MDAAP Member  ☐ AFP Member

☐ I will participate in the October 17th call-in webinar from 12-1:15 pm. Physicians who register for the October 1st in-person sessions are encouraged to register for the October 17th webinar.

Names of those attending: ________________________________________________

________________________________________________________________________

________________________________________________________________________

Please note – There will be an additional educational session held via webinar on October 17, 2013 from 12-1:15pm. Call-in information will be distributed at the in-person training. An extensive resource notebook will be distributed. Follow up, questions and explanation of materials will be the subject of this webinar. **To obtain full credit, physicians should register for both events.**

**This event will be held at the Wellness Center at Howard County General Hospital (Medical Pavilion) at**  
10710 Charter Drive, Suite 100, Columbia, MD 21044

Questions: Paula Minsk, Executive Director, 410-878-9702 or paula@mdaap.org
The most recent statement of the Joint Committee on Infant Hearing (JCIH), endorsed by the AAP, addresses early intervention (EI) for children who are confirmed to be deaf or hard-of-hearing (D/HH). Most of the document deals with standards for EI systems and providers, but there are several points of interest to pediatricians. The document encourages the expansion of current data systems to include detailed case level data on interventions provided and developmental outcomes, which will be used to establish an empirical evidence base for specific EI interventions.

The document has 11 specific goals and the JCIH benchmark is that each specific goal be achieved for >90% of the children/families in each state/territory. The goals are:

1) Prompt referral to EI and prompt implementation of services.
2) Access to EI service coordinators with expertise in serving D/HH children from birth to 3 years of age.
3) Access to qualified EI providers with additional specialized skills and knowledge across the spectrum of communication choices, including American Sign Language (ASL), listening and spoken language and other specialized integrated visual and listening/spoken language systems.
4) Access to qualified EI providers with the appropriate expertise to maximize developmental outcomes for children who are D/HH and have other disabilities.
5) Access for children/families from non-English speaking homes to culturally and linguistically competent services of the same quality/quantity as provided to families from the majority culture.
6) Monitoring of developmental progress every 6 months from birth to 36 months of age, using standardized norm-referenced tools for language, communication modality, social/emotional, cognitive and fine and gross motor skills for all D/HH children.
7) Monitoring and follow up for all children with any degree of hearing loss, including slight, unilateral, auditory neuropathy, chronic/recurrent conductive, fluctuating or progressive hearing loss and immediate intervention services when indicated.
8) Families will be active participants in the EHDl system.
9) All families will have access to other families with children who are D/HH and who are appropriately trained to provide support, mentorship and guidance.
10) Individuals who are D/HH will be active participants in the EHDl system.
11) All families/children who are D/HH will have access to support, mentorship and guidance from individuals who are D/HH.

The issues of greatest interest to pediatricians have involved prompt referrals, judging the quality of the EI services a patient is receiving, finding resources for families, developmental monitoring and concerns about additional database and other responsibilities.

The pediatrician, as the primary pediatric care provider, has a responsibility to see that each child who is confirmed with hearing loss is referred to EI within the required time frame. In Maryland, the audiologist confirming the hearing loss will usually, but not always, make the referral. This JCIH document defines timely access to EI services as referral to Part C within 48 hours of the confirmation of hearing loss, but the federal Part C regulations promulgated in 2011 provide for referring as soon as possible and, in no case, later than 7 days after confirmation. According to the JCIH, hearing loss only needs to be confirmed; the entire work-up recommended by the AAP Guidelines need not be completed before referral. In fact, referring the child to EI as soon as there is a reasonable suspicion of hearing loss, even before formal audiologic confirmation, is encouraged and can get your patient into services more quickly. The regulations require that services be implemented within 45 days of referral. A child who is D/HH must be in habilitative services by 6 months of age, at the latest, for optimal language and communication development, so there is considerable urgency. When the pediatrician must make the referral, valuable time can be lost if the pediatrician does not promptly get the results of the diagnostic evaluation from the audiology provider. In general, the audiologist will immediately enter the results in the Maryland Infant Hearing Program Database. Pediatricians

continued on page 10
who are registered Database users can access the results immediately via the Database (or find out immediately that the family did not keep the appointment). Any pediatric practice can register as a Database user. Simply fill out the Database Registration Form, found in the Chapter website’s EHDI section, and call Erin Filippone, the Maryland Infant Hearing Screening Program Audiologist at 410-767-6732 (or 6730, if busy) to get your password and instructions. She can also be reached at: erin.filippone@maryland.gov. Registration requires a licensed pediatric health care provider but practice staff may be designated as the actual users. If desired, the EHDI chapter champion and/or program audiologist will be glad to visit your practice in person to help your staff get started using the Database. The Database can be very useful to your practice because each baby’s history is available to all of a baby’s providers in one place, 24/7, in one standardized format. The Database is an OZ system: an online, real-time, HIPAA-compliant, secure, password-protected, tiered-access, multiple-user database. The OZ esp™ data system will soon be securely connected to CRISP, allowing providers to enter hearing-related follow-up information into one data system, eliminating the need for duplicate data entry into multiple systems. But practices still need to be registered. (Register today!) Prompt referral is also expedited when the practice has an existing relationship with their local EI program. A list of EI (Maryland Infant and Toddler Program) contacts can also be found in the Chapter website’s EHDI section.

Once referred, all D/HH children should have an EI service coordinator with expertise in serving D/HH children. The JCIH requires EI service coordinators to have an impressive knowledge base and skill level. According to the JCIH, the EI service coordinator should be able to answer the parent’s questions about deafness and hearing loss, causes of hearing loss, screening and diagnostic technologies, amplification and communication choices, communication development from infancy through early childhood (including language, auditory, speech, signing and social and emotional domains), medical details such as the likelihood of progression or improvement in hearing levels, and existing auditory and visual technology. The EI coordinator is also expected to have expertise in educational strategies for infants and toddlers who are D/HH, knowledge of specific resources and skill in family/parent adjustment counseling specific to children who are D/HH. Some jurisdictions will have sufficient EI coordinators with such specific expertise. Unfortunately, some smaller, less densely populated jurisdictions, with fewer children who are D/HH and fewer resources, may not. In such cases, the family will likely turn to their pediatrician to answer these questions. Fortunately, the AAP has prepared materials addressing these issues at the basic level and these “issue briefs” can be found in the Chapter website’s EHDI section. Most of these materials can be downloaded and/or printed for the practice to use in answering parent’s questions and/or given out to families.

Once your patient has an Individual Family Service Plan (IFSP), how will you know if they are getting the services they should have? Information from parent surveys suggests that the best way is to ask the parents if they are getting the services they think they need and if they are satisfied with them. If parents are in contact with the parents of other children who are D/HH, they will quickly find out what is available and what has worked for other families. A relationship with the state Family-to-Family Information Center (F2F) will expedite your referrals to parent and peer support organizations as well as introductions to the deaf community and the guidance and mentorship that D/HH individuals can provide. The Parents’ Place of Maryland (F2F) and Parent Connections, specifically for families with children who are D/HH, both provide free services to families and their pediatricians statewide. (The Parents’ Place of Maryland: Website www.ppmd.org, Phone 410-768-9100 (Voice or TDD), e-mail info@ppmd.org.) (Parent Connections: Contact Cheri Dowling, Phone 443-518-0941, e-mail CAD800@AOL.com) Brochures for both groups are in the Chapter EHDI webpage, along with brochures for many other parent/family resources.

The JCIH document requires that all children with any degree of hearing loss should have their development evaluated every 6 months from birth to 36 months of age, using standardized, norm-referenced tools for language, communication modality, social/emotional, cognitive and fine and gross motor skills. In many cases, the responsibility for monitoring the child’s development will fall on the pediatrician. The Chapter has an ongoing initiative to encourage the use of standardized tools for developmen-
tal assessment and can provide practices with assistance and training in using these standardized tools and incorporating routine developmental assessment and monitoring into your office’s workflow patterns. Contact the Chapter (410-878-9702) if your practice would like to participate in this project. (The Chapter’s EHDI webpage has a chart/algorithm for the monitoring and follow-up of children who have not been documented to have hearing loss but who have risk factors for later onset hearing loss.)

While there is still much work to be done, Maryland is fortunate in having many resources for children who are D/HH. The Maryland School for the Deaf (MSD), a public school free to Maryland residents from any part of the State, has 2 campuses (Frederick and Columbia) and provides family education and early childhood services in the home as well as on campus. Each local school district in the State provides an education with appropriate specialized instruction and resources for children who are D/HH. The Eastern Shore Educational Consortium pools resources to provide specialized services to D/HH children through out that area. Although state insurance mandates do not apply to all plans, Maryland law mandates insurance coverage of hearing aids for children. The Maryland State Department of Education (MSDE) operates a Hearing Aid Loaner Bank that can loan a hearing aid until the family can acquire one for the child. A number of programs serve children who are D/HH and have other issues. MSD provides expanded services for children who are D/HH and also have other disabilities. MSD has plans to implement a program for D/HH children with autism spectrum disorders later this year. The Family Support Network (FSN), a part of MSDE, serves the families of children, birth to 3 years of age, with disabilities or developmental delay, including those who are D/HH. The FSN provides information about community services, referrals, opportunities to network with other families and linkage to experienced parents whose children have similar special needs. (The Family Support Network and other MSDE programs can be contacted at 1-800-535-0182.) The non-public Gateway School of the Hearing and Speech Agency also serves D/HH children with other issues such as developmental delay and autism. The DREAM (Deafness Related Evaluations and More) Clinic at the Kennedy Krieger Institute specifically serves children who are D/HH and have other special needs. Maryland is also fortunate in being geographically close to the vast intellectual resources of Gallaudet University. A number of organizations provide peer and family support. The Governor’s Office of the Deaf and Hard-of-Hearing gives the interests of Maryland’s citizens who are D/HH a high-level presence in State government. Details on many of these resources are available in the Chapter EHDI webpage.

References:

Foundation Distributes Over 2700 Books to Existing Reach Out and Read Practices

The Foundation of the Maryland Chapter of the American Academy of Pediatrics completed its first-ever mini-grant program. The mini-grant awarded funds for the purchase of new books for existing(non-Maryland Expansion Sites) Reach Out and Read(ROR) Programs within the state of Maryland and practices who would like to have the Reach Out and Read Program but don’t qualify for the Maryland Expansion Grant.

Thanks to the generous donations of chapter members, the Foundation was able to provide 2,776 books to 12 practices through the mini-grant program. These books will be distributed to children between the ages of 6 months and 5 years at well-visits. The Foundation continues to seek support from members for the program so that the grant program can be offered twice a year.
The Maryland State Advisory Committee on Immunizations – August 13, 2013 Minutes of the Committee

Submitted by Anne Bailowitz, MD, FAAP

Dr. Bailowitz was introduced as the new commissioner, representing MDAAP.

Subcommittee Updates:

Registry: none; Dr. Bailowitz suggested that Baltimore City Health Dept’s Registry Coordinator, John Lamoureux, be added to the subcommittee due to his extensive experience with Baltimore City’s registry. The Chair will check whether non-Commissioners can serve on subcommittees.

HPV: Dr. Bailowitz and Dr. Jim Rice (also of MDAAP) volunteered to participate in this subcommittee; Dr. Bailowitz will review CDC online resources and contact DHMH to assemble educational tools for parents and providers on HPV immunization.

Adolescent: Tdap and MCV4 will be required of entering 7th grade students in September, 2014; specifics from DHMH to follow in early 2014.

School Immunization Requirements, 2013: All K-12 students are required to have 2 doses of each component of the MMR vaccine, i.e. Measles, Mumps and Rubella. Previously, the requirement was 2 doses of Measles, 1 dose of Mumps and 1 dose of Rubella. This information is being communicated to schools.

The next meeting of MSACI is November 12, 2013 @ 6 pm. These meetings are open to the public.

The Strength to Heal

This is the motto for Army Medicine, and the members of MDAAP have the unique opportunity to help build this Strength. The Army Medical Department needs your help.

One of the most-challenging recruiting missions for the Army is their physician recruiting mission. Next year the Army is looking for 60 physicians of various specialties to serve full-time and 183 to serve part-time in the Army Reserves. Army Medicine has over a 200 year history of advancing medicine, reducing human suffering, and providing humanitarian aid worldwide.

Army physicians serve as commissioned officers, and their patient population is soldiers and their families. There are both tangible and intangible benefits for this service. There are opportunities for advanced training and schooling, and base pay is not dictated by RVU’s. Army physicians receive 30 days paid vacation and the honor of serving one’s country.

There are financial rewards for Army service as well. The Army offers stipends to residents in return for service as either a full- or part-time Army physician following training. There are also cash bonuses up to $400,000 and loan repayment up to $250,000.

A final program members may be interested in is Military Accessions Vital to the National Interest (MAVNI). This program offers an expedited path to American citizenship in return for military service.

The members of MDAAP can help today. The local physician recruiting team is led by SGM Daniel Murphy, and he has requested members’ help in setting up presentations to residents or individual interviews with interested physicians. He is able to bring in both Active Duty and Reserve physicians to these presentations as well. He can be contacted at Daniel.l.murphy.mil@mail.mil or 443-844-0722.
It’s unlikely that Mick Jagger had methemoglobinemia when he wrote the above lyrics, but he would, indeed, have been blue, and likely feeling very low down if he did. This condition could have occurred from water contaminated with high levels of nitrates, so it is quite important to know, as Randy Newman does, what’s in the water that you drink, especially if it comes from a well. If this water is high in nitrates, it is possible to go to the well once too often and end up cyanotic from methemoglobin.

We are surrounded by nitrogen. It’s in the air we breathe, it’s in the soil where agricultural plants and livestock are raised, where fertilizer use and animal waste increase its presence, and it often finds its way into our water supply. It is in the water where nitrates can have adverse ecological effects on the environment and also be harmful to human health. Nitrate and nutrient pollution in bodies of water leads to an overgrowth of plankton, including algae and dinoflagellates. The overgrowth of these organisms increases water turbidity, preventing sunlight from reaching submerged aquatic vegetation. Lack of sunlight results in the death of these plants, which provide critical spawning grounds for fish, crabs and other aquatic life. Some of these plankton can also produce substances directly toxic to aquatic animals and humans, making bodies of water unsafe for swimming and recreation. Blue-green algae (cyanobacteria) produce neurotoxic and hepatotoxic compounds and may cause toxic shellfish poisoning. Dinoflagellates can cause toxic red tides and include the genus Pfiesteria, which produced neurologic and skin disorders in humans in Maryland and North Carolina several years ago. When masses of these single-celled organisms die off, their decomposition consumes oxygen in the water, leading to large hypoxic and anoxic dead zones in which oxygen-dependent creatures cannot survive.

Nitrates in drinking water present another source of potential toxicity. The EPA has established a standard maximum contaminant level (MCL) for nitrates of 10 parts per million (ppm, or 10 mg/L) and 1 ppm for nitrites. These levels apply only to public water supplies; the EPA does not regulate private wells, which provide water for 15-20% of US households. Proximity to heavy agricultural activity increases the risk of nitrate contamination from fertilizer use and animal waste; high nitrate levels also serve as a marker for potentially high fecal coliform and pesticide levels, compounding the health risks. A 1994 survey of nine Midwestern states found 13.4% of wells exceeding the MCL for nitrates, with a high of 24.6% in Kansas. Wells in 15 North Carolina counties with heavy livestock activity were sampled in 1998, with 10.3% above the 10 ppm limit for nitrates.

Ingested nitrates are rapidly absorbed from the small intestine, and about 70% is excreted in the urine within 24 hours. Toxicity does not come directly from nitrates, but from the conversion of nitrates to nitrites by the intestinal flora. Infants, especially those under 6 months of age, are at particular risk by virtue of a higher gastric pH, which allows for the proliferation of gut bacteria that reduce nitrate to nitrite. The nitrite, in turn, converts ferrous iron (Fe^{2+}) in hemoglobin to ferric iron (Fe^{3+}), resulting in methemoglobin, which is incapable of carrying oxygen and produces clinical cyanosis at levels as low as 3%. Other symptoms, including tachycardia, tachypnea, dizziness, headache and altered mental status, begin to appear as the level increases to 20%. Infants fed formula made with high-nitrate well water can present with a “blue baby” syndrome.
due to methemoglobinemia. Breastfeeders whose mothers drink this water do not have this risk, as the breast milk does not contain corresponding high nitrate levels. Infants under 6 months of age also have lower levels of methemoglobin reductase, which converts ferric iron back to ferrous iron to regenerate hemoglobin. Adult levels of this enzyme begin to appear at about 6 months, unless there is a genetic reductase deficiency, which would also predispose affected adults to methemoglobinemia. (Certain chemical exposures, mainly oxidizing agents, can also cause methemoglobinemia; these include topical anesthetics like benzocaine, found in Ora-Gel; sulfonamides; naphthalene; quinine; aniline dyes; sodium nitrite ingestion and silver nitrate burn therapy).

Treatment of methemoglobinemia begins with eliminating the source of exposure, which is generally sufficient at levels < 20%. When levels reach 30%, methylene blue (1 mg/kg IV over several minutes) will reduce methemoglobin to hemoglobin. Oxygen at 100% will aid in recovery, with hyperbaric oxygen used for higher levels of methemoglobinemia. Consultation with a Poison Control Center or a Pediatric Environmental Health Specialty Unit (the nearest is at Children’s National Medical Center) is recommended in treating this condition.

Increased levels of nitrates in drinking water have also been associated with an increased risk of hyperthyroidism, Type I diabetes, birth defects and spontaneous abortions. Some studies have also shown an increased risk of cancer of the esophagus, stomach, colon, nasopharynx, bladder and prostate, as well as non-Hodgkins lymphoma. This increased risk may be due to conversion of nitrates to N-nitroso compounds, which have been demonstrated to induce cancer in a variety of organs in animal studies. Other chemical toxins in the water, such as pesticides, may also contribute to this higher risk.

Families using well water should have their water tested for nitrates and coliforms annually, and before the arrival of a new baby, especially if formula feeding is contemplated. It is best to test the water during wet seasons when runoff may increase the contamination of the well. Charcoal filtration does not remove nitrates; ion exchange resins and reverse osmosis systems will, but are expensive.

Assuring a clean water supply free of contaminants like nitrates is important for all of us, especially our youngest patients. Limiting nitrate exposure will keep these infants from feeling low down and blue. All’s well that ends well, but all wells may not keep our young friends well.

Reference:

Free updated resource on child passenger safety

Help your patients use the correct car safety seat for their age, weight, or height by giving them a “Rx for Your Child’s Safety.” This half-page handout briefly describes the most current AAP recommendations for rear-facing or forward-facing car seats or boosters, and for when a child has outgrown a booster and is ready for a seat belt. It also has referral information for Maryland Kids in Safety Seats so parents can get personalized assistance with car seat installation. The document is available in tear-off packages of 100, and provided free through funding by the Maryland Highway Safety Office.

To view it go to: http://miemss.org/EMSCwww/PDFs/Prescription_Pad_2013_Z.pdf.
To order contact CPS@miemss.org or 410-706-8647.
Caring for the breastfed baby must also include attention to and caring for the mother. When examining a breast-feeding newborn in the hospital or in your office, it is critical to inquire about any issues the mother might have with nursing, such as pain or engorgement. It is equally critical to observe the mother while nursing.

Nipple soreness is the most common complaint breastfeeding mothers have in the first few days, particularly among primiparous women. Actual nipple pain is not normal, and nipple soreness or discomfort beyond the first minute or so of a nursing session and beyond the first few days requires evaluation. Persistent pain can lead to complications such as mastitis and early cessation of breastfeeding.

Nipple pain in the first few days is almost always due to poor positioning and latch. In addition, if a baby is not latching correctly, milk transfer will be diminished, eventually resulting in poor weight gain and impaired milk production.

A properly latched baby will have a wide angle at the corner of the mouth and “fish lips” (the lips flanged outward around the breast). The entire areola does not have to be covered, but neither should the baby be latched solely on the nipple. This deeper latch allows the nipple to reach farther back in the baby’s mouth, toward the junction of the hard and soft palates. Mothers should be comfortable during nursing, with the infant’s head in a straight line with her body (tummy-to-tummy or chest-to-chest). When a baby comes off the breast, the nipple should not look flattened.

Evaluation of a mother with sore nipples should include a feeding history, observation of breastfeeding, examination of the mother’s breasts and nipples, and an oral-motor examination of the infant. If an infant has ankyloglossia (“tongue-tie”) she/he will have difficulty with establishing and maintaining a deep latch. Ankyloglossia occurs in approximately 3-5% of term infants, but has been noted in one study to occur in close to 13% of infants referred for breastfeeding difficulties. Not all infants with tongue-tie will have problems breastfeeding, but early identification and treatment (via frenotomy) of those in whom it does cause issues can prevent significant pain in the mother and possible poor growth in the infant. ENT’s can perform frenotomies, but they are also relatively simple procedures, which a pediatrician can and should consider learning to do in the office. Babies may also have disorganized or dysfunctional suckling for other reasons, such as hypotonia.

Besides observing and correcting latch and positioning, there are other things a physician can do to help the mother-infant dyad in this situation:

- Recommend manual expression before feeding.
- Suggest nursing on the unaffected breast first with the affected side exposed to air.
- Let expressed breast milk dry on the nipple and areola between feedings.
- Recommend moist healing with appropriate ointments, such as medical grade lanolin (if the mother is not wool allergic) or a hydrogel dressing (e.g. ComfortGel, Soothies).
- Rarely, temporarily stop nursing on affected side and replace it with manual (hand) expression or pumping. If a mother is this sore, she should still be expressing her milk every three hours to establish and/or maintain her milk supply. Hand expression can be as effective and less painful than a pump if a mother does it correctly. (http://newborns.stanford.edu/Breastfeeding/HandExpression.html)
- Recommend acetaminophen or ibuprofen (for the mother) just before nursing.

(continued on page 16)
Traumatized, cracked nipples sometimes can be a nidus for infection, usually bacterial, but candida infection can also occur. One might consider using an antibiotic ointment, such as mupirocin, polymixin/bacitracin, or neomycin. It is not necessary to rinse these medications off the nipple prior to nursing. If there is an apparent glob of ointment it can be gently daubed off. An all-purpose nipple ointment (APNO) has been a popular treatment for women with nipple pain. APNO traditionally contains an antibacterial (mupirocin), antifungal (miconazole powder) and topical steroid (0.1% betamethasone) ointment. However a recent well-designed study comparing APNO to lanolin found no significant difference in breastfeeding exclusivity and duration, as well as other complications, such as mastitis at 12 weeks.6

One final popular treatment for nipple pain is nipple shields. Nipple shields are flexible and made of silicone. They are worn over the mom’s nipple during a feeding. They are sometimes used short-term to protect the nipples during nursing while they heal. A 2010 review of the literature found no evidence for effectiveness.7 The authors commented that use of shields may be seen as a quick fix and may preclude a thorough evaluation of breastfeeding to determine and treat the true problem. If the nipple is not flat or inverted and is just getting sore because of a bad latch, the nipple shield should not be used. Nipple shields force the baby to nurse too shallowly. Mothers who do use a nipple shield should be followed by a knowledgeable health professional to help them transition away from its use as early as possible and to screen for milk supply changes or other breastfeeding problems.

A discussion of the management of nipple pain would be remiss without pointing out the absolute importance of other community supports for breastfeeding mothers. Referrals should be made to area lactation consultants, WIC lactation services, breastfeeding support groups (many hospitals now have them) and/or La Leche League groups.

Nipple pain is a common problem in the mother-infant dyad and one which a pediatrician can and should help manage.

References:

Text4baby: Health Messages for New Mothers and Mothers-to-be

National AAP is a key supporter of text4baby, a FREE health text messaging service providing accurate, text-length health information for mothers with babies up to age 1. Mothers can join by texting “BABY” (or “BEBE” for Spanish) to 511411 to receive weekly text messages (timed to their due date or their baby’s birth date) throughout pregnancy and up until baby’s first birthday. The content—developed and routinely updated in collaboration with the AAP—provides patient education on a variety of topics critical to infant health, all consistent with the Bright Futures Guidelines. Independent research demonstrates that text4baby increases users’ health knowledge, facilitates interaction with doctors, improves appointment and immunization adherence, and users are three times as likely to feel prepared for motherhood than non-text4baby users. Tell mothers to text “BABY” to 511411.

Check out www.text4baby.org for more information and to order FREE pre-printed materials.
Sugary Drinks Tied To Obesity Among Preschoolers

By Genevra Pittman

NEW YORK (Reuters Health) - Five-year-olds who drink sugar-sweetened sodas, sports drinks or juices every day are more likely to be obese than those who have sugar-sweetened beverages less often, according to a new study. Although the link between sugary drinks and extra weight has been well documented among teens and adults, researchers said that up until now, the evidence was less clear for young children.

“Even though sugar-sweetened beverages are relatively a small percentage of the calories that children take in, that additional amount of calories did contribute to more weight gain over time,” said Dr. Mark DeBoer, who led the study at the University of Virginia in Charlottesville. He and his colleagues surveyed the parents of a nationally-representative group of 9,600 children when the kids were two, four and five years old. The children were all born in 2001. Parents reported on their income and education, as well as how often children drank sugary beverages and watched TV. The children and their mothers were weighed at each survey visit. The proportion of kids who had at least one soda, sports drink or sugar-sweetened juice drink each day ranged from 9 to 13 percent, depending on their age. Those children were more likely to have an overweight mother and to watch at least two hours of TV each day at age four and five.

After accounting for those influences as well as families’ socioeconomic status, the researchers found five-year-olds who had at least one sugary drink each day were 43 percent more likely to be obese than those who drank the beverages less frequently or not at all. Kids were considered obese if they had a body mass index - a measure of weight in relation to height - above the 95th percentile for their age and gender, as calculated by the U.S. Centers for Disease Control and Prevention. About 15 percent of five-year-olds in the study were obese.

Four-year-old sugary beverage drinkers also tended to have a higher rate of obesity than non-drinkers - but that finding could have been due to chance, the researchers reported Monday in Pediatrics. Among two-year-olds, there was no link between sugar-sweetened beverages and obesity.

In a statement sent to Reuters Health, the American Beverage Association trade group wrote, “Overweight and obesity are caused by an imbalance between calories consumed from all foods and beverages (total diet) and calories burned (physical activity). Therefore, it is misleading to suggest that beverage consumption is uniquely responsible for weight gain among this group of children, especially at a time in their lives when they would normally gain weight and grow.”

The researchers said kids who drink sports drinks and other beverages with added sugar may not make up for the extra calories by eating or drinking less of something else. That could be in part because sugar wouldn’t satisfy children’s appetite as well as something with protein and fat. Drinking milk, on the other hand, “will contribute to satiety and not as big of an increase in total intake as something that is pure sugar,” DeBoer told Reuters Health. His study did not take into account kids’ other eating habits and physical activity.

Dr. Y. Claire Wang, who studies childhood nutrition and obesity at the Columbia University Mailman School of Public Health in New York, said she wasn’t surprised by the findings. “This is really just adding to the evidence we already know that (drinking) sugar-sweetened beverages in childhood is associated with weight gain. It’s definitely one of the major, if not the main, driver in childhood obesity,” Wang, who wasn’t involved in the new research, told Reuters Health. One of the study’s co-authors, Ryan Demmer, is also a researcher at Columbia.

DeBoer said parents should be aware of where young kids are getting extra unhealthy calories and stick with water and milk for beverage options. Wang recommended whole fruits over fruit drinks and juices.

“It’s not to say that you’re going to ban all these sugary things… from people’s childhoods,” she said. “It’s just they’re supposed to be very rare treats.”

Questions to ask your health insurance company or HMO about your child’s access to habilitative services benefits

Maryland Insurance Administration

Before you call your insurance company or HMO, please refer to the “Parents’ Guide to Habilitative Services.” This guide is available at http://www.mdinsurance.state.md.us.

1. My child needs physical therapy and/or occupational therapy and/or speech therapy. Are these services covered under my plan?

2. Do I have coverage for habilitative service benefits under my plan?

3. Are there any limitations on habilitative services coverage under my plan? If so, what are they?

4. Are there any exclusions from coverage under my habilitative services benefit? If so what are they?

5. What cost-sharing will be applied to habilitative services for my child?
   - Deductible ________________________________
   - Copayment amounts___________________________
   - Coinsurance ________________________________

6. Does my deductible apply to each calendar year or to a benefit year? If it applies to a benefit year, when does the benefit year begin and end?

7. Do I need a referral? If so, how do I get one?

8. Do I need prior authorization? If so, how do I get prior authorization?

9. Do I have better benefits if I use in-network providers? If so, who are the in-network providers in my area?

10. I think I need more information; may I please speak with a supervisor? (as needed)

ACA Implementation Resources for Pediatricians in Maryland

On October 1, 2013, open enrollment for individuals and families to sign up for health insurance in the new Affordable Care Act (ACA) marketplaces (formerly known as exchanges) will begin. The marketplace will allow people to compare and choose which type of health insurance plan will work best for their families. Public health insurance programs like Medicaid and the Children’s Health Insurance Program (CHIP) are still available before, during, and after open enrollment, and one streamlined application will make it easier for people to find out which plan will best meet their needs.

New AAP Resource for Parents and Families of Patients

Making sure families are aware of the options available to them for pediatric patients through the marketplaces and what to look for in their insurance plans is extremely important. To help pediatricians assist their parents and families of patients navigate the marketplaces, the AAP has created state specific documents just for families. Every state, regardless of whether your marketplace is being managed by the state or federal government, has its own document with information regarding the marketplace.

We have included the documents for Maryland in this newsletter and have provided you with a link to it on the AAP Web site as well. These documents were designed to be distributed to parents, families, and young adult patients, so please disseminate them to your chapter membership to be used in their practices. You should also feel free to post them on your Web sites or circulate them in any manner you wish to be most beneficial to pediatricians and their patients and families.


Resource for Pediatrician Business Small Business Owners

The ACA also provides health insurance coverage options for small business owners (those with 50 or fewer employees), such as pediatric practices. We are also providing you with an additional resource designed to assist your pediatrician members who qualify as small business owners. This state specific document, also attached to this
The July 2013 edition of the Maryland Poison Center ToxTidbits is now on our website! In this issue: Fentanyl and Acetyl Fentanyl. Many overdoses and deaths with these potent illicit opioids have occurred recently in the United States and Canada.

View and download ToxTidbits from our website: http://www.mdpoison.com/healthcareprofessionals/toxtidbits.html

(***Note that the location of ToxTidbits issues has changed on our new website. Update your bookmarks to this new URL to view ToxTidbits issues).

To subscribe to ToxTidbits, send an email to: mpcnewsletter-subscribe@lists.umd.edu.
To unsubscribe, send an email to: mpcnewsletter-unsubscribe@lists.umd.edu.

For comments or questions about ToxTidbits and MPC health professional education programs, contact:
Lisa Booze, PharmD, CSPI • Clinical Coordinator
Maryland Poison Center
University of Maryland School of Pharmacy
220 Arch Street, Office Level 1 • Baltimore, MD 21201
410-563-5583 • 410-528-7505 (Fax)
lbooze@rx.umaryland.edu • www.mdpoison.com

For poison emergencies, call 800-222-1222

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**Maryland AAP Leadership**

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**Committee Chairs**

- Adolescent Medicine: Dr. Oscar Taube
- Child Maltreatment/Foster Care: Wendy Lane, MD
- Pediatric Council: Mike Levitas, MD & Jim Rice, MD
- Emergency Medicine: Diane McDonald, MD
- Injury & Poison Prevention: Richard Lichenstein, MD
- Emotional & Mental Health: Kenneth Tellerman, MD
- Environmental Health: Michael Ichniowski, MD
- Fetus and Newborn: Sue Dukerian, MD
- Hospitalists: Sybil Pentsil, MD & Jason Custer, MD
- Infectious Diseases: Anne Bailowitz, MD
- Legislative Issues: Mel Stern, MD
- Sports Medicine & Fitness: Amy Valasek, MD
- School Health (COSH): Maura Rossman, MD
- Special Needs/ Disabilities: Stephen Nichols, MD

**Liaisons**

- Dentistry: David Hasson, DMD
- Military: Christopher Watson, MD
- Public Health: Jacqueline Douge’, MD

**Chapter Champions**

- Breast Feeding: Dana Silver, MD & Edward Bartlett, MD
- Childcare: Edisa Padder, MD
- Disaster Preparedness: Richard Lichenstein, MD
- PROS: Dianna Abney, MD
- Oral Health: Rachel Plotnick, MD
- Medical Home Asthma: Virginia Keane, MD
- Early Hearing Detection & Intervention (EHDI): Susan Panny, MD

**Directorships**

- Membership: Diana Fertsch, MD
- Senior Physicians (>60y/o): Ambadas Pathak, MD
- Young Physicians (<40y/o): Julie Ellis, MD

**Newsletter Editor**

- Michael Ichniowski, MD

**Task Forces**

- Immunizations: James Rice, MD
- Infant Mortality: Renee Fox, MD
- Medical Home: Diana Fertsch, MD
- Mental Health: Larry Wissow, MD
- Obesity: Alan Lake, MD
- Children & Nature: Maria Brown, MD
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!

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

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

Don’t wait!
Get your training for state mandated developmental screening.
The Patient Protection and Affordable Care Act (ACA) provides health care coverage options for small business owners (50 employees or less) through the Small Business Health Options Program (SHOP).

- **SHOP** is the health insurance exchange/marketplace for small businesses.
- Small business owners such as pediatric practices are not required under the ACA to provide employees with health insurance, but may qualify for tax credits if they do offer employees health insurance through the SHOP.
- You can also apply for insurance any time in 2014, with coverage starting the following month.

**What is a SHOP marketplace?**

- The SHOP is a health insurance exchange/marketplace for small businesses, intended to help small businesses buy health insurance.
- Small employers are those with 50 or fewer full-time equivalent employees. Part-time employees can also count toward the 50 employee threshold.
- Visit healthcare.gov for more information on how to count your employees.
- Each state will have its own SHOP exchange/marketplace, which may be combined with the exchange/marketplace for individuals and families.
- The SHOP marketplace in Maryland is called Maryland Health Connection and can be found online at www.marylandhealthconnection.gov/.
- In the 33 states where the federal government is running the health insurance exchanges, small businesses will be able to offer one health plan to their employees. In states with state based exchanges, business owners may be able to offer multiple health plans to their staff, but this will be at each state’s discretion. Check with your state’s SHOP marketplace to find out your options.

**Am I required to provide health insurance to my staff?**

- If you have 50 or fewer employees, you are not required by the ACA to provide your staff with health insurance. However, if you do offer your employees coverage through the SHOP, you may qualify for tax credits.
- Businesses with more than 50 employees who do not offer qualified health insurance may be subject to an “Employer Shared Responsibility Payment” beginning in 2015.
- If you plan to use the SHOP, you must offer insurance coverage to all of your full-time employees (those working 30 hours or more per week).
- In most states, to be eligible to participate in the SHOP, 70% of your employees offered coverage must enroll in your SHOP plan. Check with your state’s SHOP marketplace to see if the percentage differs.
• There are additional criteria regarding which of your employees count toward the 70% threshold. For example, employees who are covered by a spouse’s insurance would not be included in the calculation. Be sure to review this information to ensure you are calculating correctly.

• If you do not meet the 70% threshold, there will be a special open enrollment period from November 15, 2013-December 15, 2013 to allow qualified employers to offer SHOP coverage to their employees.

• Small business owners can also decide whether or not they will offer family coverage to their employees. Family coverage may be especially important for child dependents of your employees.

What if I already provide my staff with insurance?

• If you already provide your employees with insurance, you can keep the coverage you already have.

• You also have the option to change your current insurance and offer a plan through the SHOP and possibly earn tax credits.

Will I qualify for small business tax credits?

• Tax credits are available if you obtain coverage through the SHOP.

• If you have fewer than 25 full-time equivalent employees making an average of $50,000 or less, you may qualify for employer health care tax credits.

• You must also pay at least 50% of your full-time employees’ premium costs.

• Coverage of part-time employees or employee dependents is not required to qualify for tax credits.

• Owners of, or partners in, a small businesses, do not count as employees for the purpose of qualifying for the tax credit.

• Beginning in 2014, the credit is worth up to 50% of your contribution toward employees’ premium costs.

Can I use my existing insurance agent or broker?

• Yes. Licensed agents and brokers are permitted to sell insurance in the SHOP exchange/marketplace.

• If you already have an insurance broker you can continue to use him/her. If you do not, there will be people available to assist you as you navigate your way through the SHOP.

If I choose to provide insurance through the SHOP, what do my employees need to do?

• If you choose SHOP insurance coverage your employees can sign up for it online.

• You or the exchange/marketplace can notify your employees and tell them what they need to do to sign up.

• The exchange/marketplace can help you set up an e-mail distribution list or download the offer of coverage in order to distribute it to your employees.

• Your staff will decide whether or not to accept the coverage you offer.

• Coverage will not take effect until you, as the employer, accept the plan.

• After the open enrollment period is over you can see who has accepted coverage and calculate the total cost to you and then decide whether or not to approve the plan or search for other SHOP options.

An example of how the tax credit works:

Number of Employees: 10
Wages:
$250,000 total or
$25,000 per employee
Employer contribution to employee premiums: $70,000
Tax credit amount:
$35,000 or 50% of the employer’s contribution

For more information on how the tax credit works and how to determine if you qualify, you can visit IRS.gov or talk to your tax advisor or accountant.

For American Academy of Pediatrics resources on what ACA implementation means for pediatric practices and patients, visit www.aap.org/ACAmarketplace.
THE AFFORDABLE CARE ACT AND YOU:
WHAT YOUR FAMILY NEEDS TO KNOW

Benefits and protections are already available.

**Expanded Coverage:**
- Children under age 26 can be covered by a parent's health insurance policy.
- Children under age 19 can't be denied coverage because of a pre-existing condition.

**Benefits:**
- Families can choose a pediatrician as a child’s primary care doctor.
- New private health plans must cover the cost of preventive care.
- Out-of-pocket costs are capped at $5,950/individual/year and $11,900/family/year.

**Protections:**
- Insurance companies can no longer set lifetime dollar limits on health benefits.
- Insurance companies can no longer drop people if they get sick.

Having health insurance is now a requirement.

As of January 1, 2014, almost all Americans will be required to have health insurance or pay a penalty.

- **If you have access to affordable insurance through your employer:** You do not need to change insurance coverage if you don’t want to.

- **If you do not have access to affordable coverage:** You can get health insurance through your state’s marketplace. Enrollment for new coverage begins October 1, 2013.

The marketplace is a new way to get health insurance for you and your family.

- You can buy insurance directly from an insurance company or through a broker, or you can sign up through your new state marketplace. Through the marketplace, you can also find out if you qualify for Medicaid or the Children’s Health Insurance Program (CHIP).
Through the marketplace, you can find out what the cost of health insurance will be for you and your family.

Your application in the health insurance marketplace will tell you if you are eligible for financial assistance to help you buy private insurance. The amount of assistance depends on your family’s yearly income. You may also have no cost if you qualify for Medicaid or CHIP.

The marketplace offers a number of different health plans, and families should compare plans to ensure they meet their needs.

The marketplace offers 4 different levels of health insurance plans. Those least expensive (bronze) have fewer benefits and higher out-of-pocket costs. Those that are the most expensive (platinum) have more benefits and lower out-of-pocket costs. Make sure you choose an insurance plan that works for your family.

Families, especially those who have children with special health care needs, can make sure the plan they purchase includes:

• Access to pediatric specialists and pediatric surgical specialists
• Preventive care, such as well-child check-ups and immunizations
• Habilitative services to help a child keep, learn, or improve functioning
• Rehabilitative services such as physical or speech therapy
• Vision and dental care (dental plans may be sold separately)

Make sure your current pediatrician is included in the plan you choose.

On the Maryland Health Connection website, you can look up your family’s current pediatrician to see if he or she participates in the plan you choose. Choosing a plan that includes your pediatrician will allow you to stay within your current medical home.

Have questions? There are people who can help.

Your state’s marketplace has people who can help you compare plans and enroll your family in coverage.