



Speaking for Maryland's Kids

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President's Message Virginia Keane, MD

As the economy tanks and we all fasten our seatbelts for a bumpy ride it is good to know that the federal government appears to be looking out for kids. SCHIP has passed, and we are told that even as the nation sees a growing number of uninsured individuals this should not be the case for children, who will be covered by SCHIP. We are told to prepare for increased demand for appointments, as more children come off the rolls of the uninsured. Some of us are asking: Where will I find the time? Can I afford to take on these new patients?

The other day I heard a teaser on the radio for a public radio piece, "Where Have All the Doctors Gone?" My immediate response: "Gone to states where they get paid!" Yes you can sing it, though not joyfully.

Developmental screening is a perfect example of the quandary we are facing. Since November I have given seven presentations on the use of standardized developmental screening tools according to AAP guidelines for general developmental screening and autism screening. The chapter is



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- * GBMC has Article Published in PEDIATRICS Journal

planning regional workshops and office based training. Over the next two and a half years we hope to reach every practice that cares for children with the important message that it is essential to use standardized screens at 9,18 and 24-30 months, and autism screens at 18 and 24 months. Part of this message includes the good news that Medicaid will pay for this service: You will get paid \$12.50 for up to two units of 96110 during a single visit. Part of this message is that most CareFirst Blue Cross Blue Shield plans are not paying for this code. They continue to insist that the payment for this service is bundled in the well child visit payment, even though many plans pay less than Medicaid for the visit. They also insist since the code says it includes a report that a written report needs to be generated, even though the code also specifically says it includes NO PHYSICIAN WORK. Medicaid says a simple phrase: "passed, routine anticipatory guidance", or "Failed, referred to infants and toddlers" written directly on the scoring sheet will suffice. BC/BS wants a full page report.

Meanwhile a recent article, hidden deep in the Baltimore Sun, reported that Bill Jews, former CEO of BC/BS continues to fight in court over the size of his sever-

ance package: he wants it doubled from nine to eighteen million dollars. Nine million dollars would pay for seventy four thousand developmental screens, enough for several years.

I think it's time to let the public know what is happening. Attached to this news letter you will find a sample letter to the editor and notice you can put in your office informing families of this situation. Please consider personalizing them and using them: submit the letter to your local paper, hang the sign in your office. If your contracts allow, consider billing patient out of pocket for developmental screening: that is sure to get them on the phone with their benefits manager.

We need to continue to do what is right for children, AND we need to be compensated appropriately.

Or, we can move to the Midwest.

Working for you and Maryland's children.

Virginia Keane, MD, FAAP
President

Please open, print and
use the following two
attachments:

“Letter to the Editor”

“Notice to Families Re-
garding Developmental
Screenings”

Breastfeeding Lecture Series Coming to Maryland!

Dr. Thomas Hale, a world-renowned expert on breastfeeding pharmacology, and author of the book Medications and Mother's Milk, will be a visiting lecturer in the Baltimore area March 3rd and 4th, 2009. This lecture series is thanks, in part, to a grant from the AAP's Section on Breastfeeding.

Dr. Hale's itinerary will be:

March 3rd

8am – 9am Pediatric Grand Rounds, Sinai Hospital

12:30pm – 1:30pm Pediatric Grand Rounds,
Franklin Square Hospital

Guest lecturer, Lactation Consultant Share Conference, Greater Baltimore Medical Center (GBMC)

6:30pm – 7:30pm Dinner lecture at GBMC

March 4th

8:30am – 9:30am Pediatric Grand Rounds, Johns Hopkins Hospital

12pm – 1pm Noon Conference, Department of Pediatrics, University of Maryland

All lectures will be free and open to the public. The dinner lecture at GBMC will be by size-limited and by reservation only. Those who are unable to attend will be able to join in via teleconference. Further details on this and all the other lectures will be forthcoming via emails from the Maryland AAP.

In addition to this wonderful opportunity, we want to remind you that the Maryland Breastfeeding Coalition has excellent breastfeeding information and resources available on their website, www.marylandbreastfeeding.org. We also offer a Speaker's Bureau to provide lectures on breastfeeding to any hospitals or organizations.

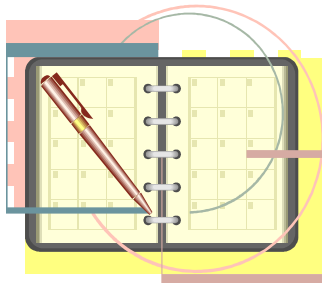
Please contact Dana Silver, M.D. at dsilver@lifebridgehealth.org if you have questions about the visiting lecture series or the Speaker's Bureau.

SUBMISSION OF HEALTH FORMS

The community pediatricians on the executive committee recently expressed dismay at the increasing number of varied health forms requested of us. We are asked to fill them out for our patients' daycares, schools, special camps, and other activities. The paperwork burden is immense.

Some of us have taken short cuts with the forms, attaching the printed vaccine record, writing "normal exam with no health concerns", having our staff fill in current measurements, and giving it back to the parents. In general, this has been adequate documentation. Our response to complaints is that the staff of the institution requiring the data may fill in the blanks using what we have provided. Try this approach to ease the ever-increasing demands on our time.

The chapter plans to partner with the state education department to help create an appropriate single form, hopefully with an electronic version, to be used state-wide for health status documentation. This uniformity would be very helpful to our practices. Anyone interested in helping in this effort or providing input may contact the chapter office.



**LEGISLATIVE CONFERENCE CALL EVERY THURSDAY
9:00 P.M. (PLEASE READ YOUR BLAST E-MAILS FOR
DETAILS)**

Upcoming Meetings

March 12-15, 2009 ALF	April 19-21, 2009 Legislative Conference Washington, DC
March 25, 2009 Wednesday, Executive Committee Meeting, 5:30-9:00 p.m., St. Agnes Hospital	May 12, 2009 Tuesday, Executive Committee Meeting, 5:30-9:00p.m., Sinai Hospital
April 14, 2009 Tuesday, Executive Board Teleconference Call 8:00 p.m.	June 5, 2009 Annual Planning Meeting

Concussion In the Pediatric Patient

Each year, there are an estimated 1.6 million to 3.8 million sport-related concussions. A concussion, or mild traumatic brain injury (MTBI), is a complex pathophysiologic process affecting the brain induced by traumatic biomechanical forces. Concussions occur both in helmeted and non-helmeted sports.

Concussions, contrary to common belief, frequently occur without loss of consciousness. Signs and symptoms include, but are not limited to, headaches, confusion, loss of consciousness (LOC), amnesia, dizziness, nausea, vomiting, mood changes, lack of motor coordination, poor proprioception, blurred vision, ringing in the ears, Slurred speech, difficulty concentrating, feeling "foggy", sleep disturbances and increased sensitivity to light. If an athlete experiences more severe symptoms such as prolonged LOC, neck pain with point tenderness to palpation, bilateral parenthesis, bleeding and/or fluid draining from the ear, and/or excessive vomiting after closed head trauma emergency transport and evaluation is recommended.

A trained professional should examine any athlete that sustains a concussion. It is now recommended that any pediatric athlete that exhibits signs of a concussion should not be allowed to return to competition the same day, even if symptoms clear within 20 minutes. When a player shows ANY symptoms or signs of a concussion the following steps should follow the acute injury:

The player should not be allowed to return to play in the current game or practice.

The player should not be left alone; and regular monitoring for deterioration is essential over the first 24 hours following injury.

The player should be evaluated by a physician prior to return to activity.

Return to play must follow a medically supervised stepwise process.

Recovery from concussions takes time and rest. Acetaminophen (Tylenol) can be taken to relieve headaches. However, the athlete is not considered asymptomatic until all pain relievers are discontinued. In more severe concussion modifications should be made in both physical exertion as well as mental (school work, video games, text messaging, and television viewing) activity.

There is individual variation in recovery times from concussion. It is well-known that some conditions predispose an athlete to a more protracted recovery time. These conditions include history of prior concussion (personal or familial), learning disability, ADHD, mood disorders, migraine history or epilepsy. High school athletes' recovery tends to be more

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prolonged than the college or professional athlete. Full recovery is defined as asymptomatic at rest and with exertion without pain modulators. An athlete evaluated in the emergency department (even with negative imaging) should be re-evaluated prior to return to play. **No clearance to play sports should be given in the emergency department.** Once asymptomatic the athlete should follow a step-wise progression back to activity.

Return to Play Protocol:

- No activity, complete rest until asymptomatic
- Day 1: Light aerobic exercise such as walking or stationary cycling, no resistance training.
- Day 2: Sport specific exercise (i.e, skating in hockey, running in soccer), progressive addition of resistance training at steps 3 or 4.
- Day 3: Non-contact training drills.
- Day 4: Full contact training after medical clearance.
- Day 5: Game play.

The athlete should continue to proceed to the next level if asymptomatic at current level. If any post concussive symptoms occur, the patient should drop back to the previous asymptomatic level and try to progress again after 24 hours.

Neurocognitive testing can help to objectively evaluate the concussed athlete's post-injury condition and track recovery back to baseline for safe return to play. It is one component in the evaluation of the athlete with concussion, but gives some objective data to an otherwise subjective condition. The IMPACT test, is one web based neurocognitive test that can be used. This test is comprised of a battery of sub tests that evaluate cognitive function, memory, vision and reaction time. Those interested in having baseline IMPACT testing or an evaluation after a concussion should contact Stephanie Adams, MS, ATC at 410-337-7900 x1273 for proper evaluation.

The SCORE (Safe Concussion Outcome, Recovery, and Education) Program specializes in the evaluation and management of children and adolescents with concussions. The SCORE program specializes in the evaluation and management of concussions in children. To identify and monitor the different types of symptoms, the SCORE program uses specialized neuropsychological testing techniques, including computer-assisted technology that are highly sensitive in detecting concussion-related symptoms. The SCORE Program is available at the Children's Outpatient Center of Montgomery County, Rockville, MD and will be available in the Baltimore area in the upcoming months. For more information, Katea Selby, Senior Coor-

inator, can be contacted at 202-476-2429.

Suffering a second concussion before the symptoms of a previous concussion have resolved has resulted in 30-40 deaths in the last decade from Second Impact Syndrome (less than 24 years of age). Prevent your athlete from Second Impact Syndrome and Post Concussion Syndrome by educating your athletes about concussions and preventing their premature return to activity after head injury.

Related Links:

- Centers for Disease Control and Prevention
www.cdc.gov/ncipc/
- Brain Injury Association of America
www.biausa.org
- Prague Guidelines
http://www.upstate.edu/uh/pmr/concussion/pdf/prague_guidelines.pdf

Teri McCambridge, MD



Maryland Child Abuse Medical Providers (CHAMP) January 2009

Introduction

The lack of medical expertise in the evaluation of child abuse and neglect in some Maryland counties is significant, while others are being well served. In 2006, the Governor signed legislation authorizing the Maryland Department of Health and Mental Hygiene to help develop a statewide network of health care professionals to fill this gap (MD Code, Health – General. 13-2201).

Objectives

The Maryland CHAMP program aims to ensure that children who are possible victims of child maltreatment receive optimal evaluations and care through the development of a statewide network of health care professionals with expertise in child maltreatment. These professionals should be valuable resources to their counties/regions, providing medical consultation to child protective services, law enforcement, the

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state's attorney's office, as well as pediatricians and others in the medical field. CHAMP professionals should also help bolster community prevention efforts and provide training.

CHAMP Physicians

The Maryland CHAMP program is directed by Howard Dubowitz, MD, MS, a professor of pediatrics at the University of Maryland Medical Center. Faculty include: Drs. Charles Shubin (Mercy Hospital, Baltimore; 410-500-5568), Scott Krugman (Franklin Square Hospital, Baltimore County; 443-777-7128), Mitchell Goldstein (Johns Hopkins Hospital, Baltimore; 410-955-6143), Mesa Baker (Baltimore City Child Advocacy Center, CAC; 410-396-6147), and Wendy Lane (University of Maryland Medical Center Baltimore; 410-706-7865).

Current physicians participating in CHAMP include: Dianna Abney (Charles; 301-609-6833), Fayette Engstrom (Talbot), Allen Haworth (Allegany), Paul Lomonico (Harford), Carla Paylor (Frederick), Rich Porter (Garrett), Evelyn Shukat (Montgomery), Robert Wack (Carroll), and Jenny Wehberg (Wicomico). Additional counties served include Howard (Dr. Lane), Baltimore County (Dr. Lane) and Anne Arundel (Dr. Dubowitz; 410-706-6144).

There are varying arrangements in Maryland's other counties. In Prince George's, children are seen by FNE-Ps (Forensic Nurse Examiners); in Kent, Queen Anne's, Caroline and Dorchester counties, children are taken to the Talbot County CAC (410-822-1000 x5667).

We're hoping to expand the CHAMP program to Somerset, Worcester, Calvert and St. Mary's counties – hopefully in the coming few months. We are also working to develop relationships with current providers in Prince Georges and Washington counties.

How CHAMP works

We are working collaboratively with the public agencies and building upon existing structures, particularly child advocacy centers (CACs).

CHAMP faculty recruit, train, and provide ongoing consultation and training to physicians who become local experts. CHAMP activities include clinical forensic services, training, and court testimony. The initial focus has been on sexual abuse, but we plan to address physical abuse and neglect, as well as prevention.

The CHAMP program pays for physician training, ongoing work, and equipment. Faculty provide 24/7 backup, and review all consultations to ensure continuous quality improvement. Three times a year, we hold half-day training sessions at the University of Maryland, Baltimore. These trainings are open to all CHAMP physicians and interested FNE-Ps.

Most families are referred to CHAMP physicians from the public agencies, particularly CPS and law enforcement.

How can CHAMP help me?

CHAMP physicians can:

1. Advise you on how to approach a case where you are concerned about possible abuse. This includes guidance on whether to report or not.
2. Inform you about how the public agencies work in your community.

Provide in-service training regarding how to address child maltreatment

Interested to participate in CHAMP?

We wish to engage with all Maryland physicians and forensic nurse examiners (FNE-Ps) interested in working in the field of child maltreatment. If you're interested, please contact Howard Dubowitz, MD, MS at (410) 706-6144 or hdubowitz@peds.umaryland.edu

Our group at GBMC just had an article published in the January print edition of Pediatrics.

I've attached a copy to this newsletter for your information.

**Best, Howard J. Birenbaum, M.D.
Past President Maryland Chapter AAP**

Reduction in the Incidence of Chronic Lung Disease in

PEDIATRICS[®]

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Very Low Birth Weight Infants: Results of a Quality Improvement Process in a Tertiary Level Neonatal Intensive Care Unit

Howard J. Birenbaum, Abby Dentry, Jane Cirelli, Sabah Helou, Maria A. Pane, Karen Torres, Norma Gungon and Stephen Liverman Starr, Clifford F. Melick, Linda Updegraff, Cynthia Arnold, Angela Tamayo, Virma

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The online version of this article, along with updated information and services, is located on the World Wide Web at: <http://www.pediatrics.org/cgi/content/full/123/1/44>

New Chair for COPAM

Crossan O'Donovan, MD has resigned as Chair of MD COPAM. We are very grateful for all of his years of dedication to this committee. His contribution to the MD Chapter, AAP is immeasurable. He will continue to serve on the committee with Terry Nguyen, MD as the new Chair.

THANK YOU DR. O'DONOVAN FOR SERVING US SO WELL!!

The committee looks forward to having your expertise still working with them.



Maryland AAP Leadership

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