



The Enchanted Pediatrician

fall 2009

Newsletter of the New Mexico Pediatric Society, the Land of Enchantment Chapter of the American Academy of Pediatrics

Congratulations, members of the New Mexico Pediatric Society!

Joanne M. Ray, D.O.

Members of the AAP recently elected O. Marion Burton president-elect in the first only online election. The voting figures are in, and we can be proud that our election had a greater percentage of members participating than the national average.



AAP President Elect
O. Marion Burton, MD

Of the 44,408 fellows eligible to vote in the election, 20 percent (8755) usually cast their ballots. Our percentage was 28 percent. Of our chapter's 211 eligible fellows, 60 voted.

That doesn't seem like a lot—60 of us—but our percentage is greater than most chapters nationally. The chapter that had the highest percentage of voting fellows participating in the election was South Carolina (Burton is from South Carolina) with 42 percent and New York Chapter 1 with 40 percent (I believe Burton's opponent, Anne Francis, belongs to that chapter).

Last year our chapter had the highest percentage of votes cast in District VIII. This year we were beaten by Alaska (32 percent) and Wyoming (30 percent). Others in our District ranked third at 29 percent. Arizona, a very active chapter, tied us, as did Idaho.

This shows we have a good, solid core of member participation. Let's build up that core by spreading the word that the New Mexico Pediatric Society is composed of a great group of pediatricians who really care about their patients and colleagues and who care about what happens to our parent organization. NEXT YEAR—50 PERCENT!

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President's Corner



THE MEDI-GAP

No, I'm not discussing Medicare. I use this phrase partly to catch your eye and partly because it blends two words—medical and gap—and thereby provides the focus for the first part of my commentary.

It implies a void that exists between two places. It implies that something might drop into this void.

This void exists in the Medical World—our Medical World. What's dropping into the gap is a vulnerable premature infant, one who needs your protection.

By now you know that the AAP's Redbook Committee has changed recommendations for the administration of Synagis to prevent RSV infection in premature and sick infants. The new guidelines were released this July and were met with shock and consternation; subsequently, they have become embroiled in a political mess.

No, I am not a MedImmune shill. Nor have I received a dime from this company which, as you know, manufactures Synagis and gets paid a very large chunk of money for each vial injected into the thighs of our little patients. In fact, I've suggested to them that more babies would get Synagis if they'd reduce the cost. I do have a cordial relationship with the drug reps who work with our offices to enroll babies in the Synagis administration program. Partly because of this relationship, we at the Pediatric Council have been able to develop our Universal Prior Authorization/Statement of Medical Necessity form that makes all of our jobs a lot easier. No one, including the insurance companies, wants to stop using this form.

The new Synagis guidelines continue to provide good coverage for the most premature infants—those under 32 weeks gestation---and that hasn't changed. The subset of preemies from gestational age 32 to 34 6/7 (the "new" 35-weeker) are the babies who are dropped into the void with these guidelines. They receive Synagis only up to three months of age, and will receive no more than three doses. A really complicated chart that determines eligibility can be found in the Red Book on page 566. Also, these babies will receive Synagis only if they attend day care or have an older sibling. (What if they are preemie twins? Is a twin a sibling? My head hurts already.)

So What About the Medi-Gap?

Economic reasons have been cited by the Redbook Committee in the new guidelines. It provides no evidence that three doses of Synagis provide the same protection against RSV as do five doses. The Redbook Committee has rejected countless scientific studies (they usually cite industry—MedImmune—"taint") but has provided none that support the new guidelines. Infectious disease experts shake their head at the lack of data. Some state Medicaid administrators, notably South Carolina and California, have decided to use the old guidelines—period.

And here grows the gap. At the District VIII meeting in Calgary, Alberta, Canada, we learned that AstraZeneca, the company that has purchased MedImmune, was pretty ticked at not being able to sell five doses of Synagis for each preemie. According to Dave Tayloe, our AAP president, AstraZeneca threatened to sue the AAP if the new guidelines were adopted. After meeting with members of the Redbook Committee, the AAP decided to back them, threat or no threat. MedImmune representatives had already alienated the Redbook Committee years ago with a hardball stance regarding Synagis. This AstraZeneca move really hurt the cause. Politics!

I just saw five 33-weekers fall through the gap.

At our Pediatric Council meeting August 7th, we were still grappling with the new guidelines. We had no idea that Big Pharma and the AAP were going head to head. In our own little state, we met to discuss our own little Universal Synagis form. Our own gap became evident to me, but it isn't little.

The insurance companies, as expected, were happy to adopt the new guidelines. One of them had already started to place them into their computer system. Fewer Synagis doses means less money spent, and more money kept in their bank accounts.

Other council members couldn't appreciate the concern over the new guidelines because—this is where you come in—they don't have to care for these 32-34 6/7 weeks gestation babies. Their jobs don't put them in the hospital in Las Cruces, or Roswell or Clovis or Farmington or Albuquerque when a preemie is born. They don't feel our helplessness when we look at that tiny, four pound body and wonder "What's going to happen to him when he gets RSV?" Those babies, especially the tiny ones under 2,000 grams, really get to me. They ignite my passion for this cause. They are why I continue to argue that more Synagis is better than less Synagis, and demand to see the evidence that gives them less protection, and get aggravated at the economic argument put forth by people who haven't touched a preemie in years.

Four more preemies have fallen into the gap.

So we have a divide, a gap—nothing new. If your job distances you from these patients, please be sympathetic about our desire to find a way to protect them. Don't get in our way. If your job places you in the hospital at night, caring for a preemie, fearing for a preemie's safety, and in your office staring at the Synagis administration form, I have one recommendation for you: Fight for your patient. If that preemie is five days older than the three months cut-off age, ask for Synagis anyway. Provide all the information you can about your patient in the narrative section of the P.A. form. If it's denied, submit an appeal. You are doing the right thing. Some of your peers won't understand why you do this, but that doesn't make it wrong. The insurance company may reject your appeal. Consider asking for a hearing. I haven't lost a hearing yet when an appeal has gotten to that level. If you should fail and your patient gets sick with RSV, then it is off your conscience and onto the insurance company's. You have done all you could do.

Let's do what we can to close this gap.

WELCOME ANNE



Please welcome our new Executive Director, Anne Hanika-Ortiz!! We had a very good response to our job posting, which provided some great choices. Ben Hoffman and I interviewed the five finalists, and were unanimous in our selection of Anne for the job. Please read the article about her in this newsletter.

Anne's been on the job only a few weeks and already she's injected energy and insight into our operations. She attended our Fall Leadership Conference where she received some good training on our organization's structure and goals, and she is off to a great start. She's already asked me many questions about the Pediatric Society in her early training and, as a result, I ask myself "Why do we do it this way?" That kind of interaction will lead us to develop an even more relevant chapter, one that is more important to you and your patients. Anne will help us grow. Thanks for choosing us, Anne!

Short notes

Dr. Ananya (Oni) Guha's project titled "Familias Fuertes" was selected to receive the AAP Section on Medical Students, Residents and Fellowship Trainees (SOMSRFT) Anne E. Dyson Child Advocacy Award. Oni was honored at the SOMSRFT meeting during AAP's NCE in Washington, D.C. She was also presented with a plaque and check for the project and gave a presentation to the assembled residents, students and pediatric fellows about the project. Oni has agreed to write an article about her project for our winter newsletter! For more information please visit the Dyson Award website at www.aap.org/sections/ypn/r/funding_awards/anne_dyson.html.



The phones rang off the hook from 5 to 7 pm on Tuesday, October 27, every time KOB TV televised the state-wide phone number for the 14th annual Child Health Hotline staffed by volunteer NMPS residents and pediatricians during the evening news. About 80 percent of the 200 callers statewide had questions about seasonal flu and H1N1 symptoms, treatment and clinics providing flu vaccine. Many thanks to our own President-Elect Dr. Ben Hoffman for coordinating this event. And...many, many thanks to Drs. Connie Connors, Stephanie Nevarez-Fernandez, Fátima Gutierrez, Jennifer Maito and Felipe Zanghellini for donating their time and energy to support this effort.

Mark Your Calendars! The 2010 Wylder lectures will be held June 5-6, 2010

Learn more about UNM Pediatrics Grand Rounds and Noon Conferences at <http://hsc.unm.edu/som/telehealth/hc.shtml> (listed as #20 under menu). If you would like to receive the monthly conference schedule, please contact Susan L. Quintana @ 505-272-3909.

AAP's Practical Pediatric Course will be held at the Eldorado Hotel in Santa Fe from December 3-5, 2009. This course is designed for pediatricians, family physicians, pediatric nurse practitioners, and other allied health professionals caring for children. Practical Pediatrics CME Courses feature nationally prominent faculty presenting topics that highlight current issues in pediatrics. Each course combines lectures, interactive seminars, and question-and-answer sessions to allow the opportunity for direct interaction with faculty in solving problems encountered every day in practice.

There was not a dry eye in the house on Friday, October 23, as members of the NMPS watched winners accept the Voices For Children 2009 Spirit of Hope awards in Albuquerque. The Amy Biehl Youth Spirit Awards celebrate New Mexico youths, ages 13 through 26, for their vision, initiative, and dedication to community service. Alejandra Carmona and Fionna Walters were the winners for all the work they do to help others in the spirit of Amy Biehl, whose inspiring but tragic story is available at <http://www.amybiehl.org/amy.php>. Former NM first lady Alice King's son and NM's attorney general Gary King presented the first annual Alice King Public Service Award. (See <http://www.entrepreneur.com/tradejournals/article/190884999.html> for a fine obituary of Mrs. King, who died in 2008) to Judge Petra Jimenez-Maes. Fearless child advocate Patty Jennings' daughter also presented the first annual Patty Jennings Citizen Advocacy Award to Angie Vachio, founder of Peanut Butter and Jelly Services for children and parents in Albuquerque (You can read about Patty Jennings [here](#)). The NMPS would like to thank our President-Elect Ben Hoffman, Karen Carson, John Ratmeyer and an anonymous donor for their generous sponsorship of a table of 10. Attending the event from the NMPS were Lance Chilton, Rob Miller, Amy Davis, Yadira Caraveo, Tina Petersen, Emily MacDonald and guests. Congratulations to all the nominees and winners!

CATCH CALL FOR PROPOSALS – November 2, 2009 - January 29, 2010

The Community Access to Child Health (CATCH) Program has announced a new cycle of CATCH Implementation Funds grants. CATCH supports pediatricians in the initial stage of developing and implementing a community-based child health initiative. Grants of up to \$12,000 are available on a competitive basis to pediatricians to address the local needs of children in their community. For more information, please go to <http://www.aap.org/catch/implementgrants.htm>. CATCH Resident Funds grants of up to \$3,000 are available for pediatric residents to work with local communities to ensure that all children, especially underserved children, have medical homes and access to any needed health care services. For more information, please go to <http://www.aap.org/catch/residentgrants.htm>

NMPS Fall Leadership Conference

Joanne M. Ray, DO

The members of the NMPS executive committee, joined by new Executive Director Anne Hanika-Ortiz, gathered in Las Cruces September 26 and 27 for a first-ever chapter Leadership Conference.

Held at the Ramada Palms de Las Cruces, the event featured training on the Balanced Scorecard on the afternoon of the 26th and personal leadership training the morning of the 27th. Those in attendance were Joanne Ray, president; Ben Hoffman, president-elect; John Ratmeyer, Steve Cohen and Amy Davis, members-at-large, and Vivian Herrero, UNMH resident representative. Amy and Vivian were welcomed as new members. Anne Hanika-Ortiz also was welcomed as the newly hired Executive Director.

The conference began at noon on the 26th with the September executive committee meeting.

After lunch, Chris Jenkins, Customer Services Director for the American Academy of Pediatrics, led sessions on the Balanced Scorecard, which is a tool used by many organizations, including the AAP. Adherence to a Balanced Scorecard helps keep an organization focused and moving steadily toward its strategic goals. The document lists organizational perspectives, strategic priorities, objectives to achieve the priorities and measurement tools. “Owners” (go-to persons) are identified and key initiatives are determined.

Chris led the committee in an overview of the Balanced Scorecard and then helped the committee flesh out the Pediatric Society’s Scorecard that was constructed last year. The executive committee has followed its perspectives during monthly meetings, but the document hadn’t been completed.

Five perspectives were identified: Child Health, Member/Customer, Financial, Internal Process and Education and Growth. All other parameters were determined, with the exception of Initiatives. The committee continues to determine important initiatives during its monthly meetings. One of the objectives was to “Achieve strategy execution excellence” by reviewing and updating the Scorecard quarterly.

Participants attended a wine and cheese party featuring wines of Southern New Mexico at Joanne’s house on Saturday evening.

Sunday morning, the Conference turned from organizational to personal training. Michael Egan, Ph.D., professional management consultant from the Doña Ana Community College (NMSU) Customized Training Institute, conducted nearly four hours of leadership training. Members discussed important leadership traits, determined their own leadership style, learned about applying their style to particular situations and briefly addressed conflict management.



NMPS President Elect Ben Hoffman at the 2009 Leadership Conference



Member-at-Large John Ratmeyer in Las Cruces



Members of the Executive Committee at the Leadership Conference

New Zealand Medical Adventure Part I: Acceptance

Don Blossom, MD

Ellie and I folded our knees into our chest, fastened our seatbelts, and prepared for 13 hours of torture and bad food with the folks who fly the “friendly skies” to Auckland, New Zealand. It was the first few days in January during the millennium change of 2000 and there was considerable speculation that our computerized world would be frozen in the electronic ice age of the 20th century. I had spent the last five years aimlessly wandering the US as a locum tenens pediatrician after 22 years of private practice in Los Alamos, NM.



Wainui Beach where we lived.

Ellie & I were both ready for an international adventure. Our youngest daughter, Julie, had just flown from the nest to start her college education at Colby College in Maine, altering our domestic priorities. We had

entered a window in life that allows (ir)responsibility and enterprise to merge with risk and promise. I had agreed to a one year sabbatical as a “Pediatric Consultant” to the New Zealand national healthcare system in Gisborne, NZ, predominantly a Maori community of 30,000 citizens, isolated and trapped by a mountain range against the Pacific Ocean on the east coast of the North Island. However, before I could begin my duties I was required to be scrutinized by the Health Minister in Wellington and subjected to a skin culture for MeRSA. (Methicillin resistant staph aureus was emerging in the medical literature and who more likely to be contaminated than an American physician?) While meeting the Minister of Health I wore a conservative blue suit with a sincere smile and suddenly all of the bureaucratic intricacies disappeared.

Ellie & I were off to Gisborne (pronounced “Gizbun” by the locals) with a begrudgingly approved NZ medical license (my experience with international licensing reveals that all countries, including the US and individual states, arrogantly cling to superior standards until there is a pressing need at which time they will license any warm body).

Our host, Dr. Danny Stevens, was the chairman of the pediatric department at the Tairāwhiti District Health & Gisborne Hospital. Danny and I had conversed in a long distance phone interview prior to my arrival and I was certain that I had impressed him with my sparkling credentials. (Actually, as I later discovered, he was desperate!) Danny was born and trained in the UK system in London and raised by a mother/physician equally as crude as Danny (I think she smoked cigars while consuming her whiskey). Danny was too bright to reason with, abrupt, rude, and profane. Otherwise, he was a very likeable “bloke”. I suspect he had some form of Asperger’s Syndrome or ADHD or else was completely self-absorbed and oblivious to the humanity that surrounded him, but this is pure speculation. He considered the UK system of medical training to be far superior to any of the universities on the “other side of the pond”, and as I alluded to before, he was “desperate” to leave Gisborne for a position at the medical school in Auckland. I represented his ticket out of town, but not before having to endure three months of profane rants and childish behavior.

After taxiing Ellie and me from the small Pacific Ocean airport, Danny promptly abandoned us at our medical billet on the grounds of the medical center. The entire complex was colonial English style from the 1800’s, rambling single story barracks, white cinderblock buildings with red metal roofs and plenty of green open space; nothing was modern but it was not unpleasant to the eye. Our quarters consisted of a one bedroom free-standing structure with a 1950ish “tin” kitchen, stove, and refrigerator. The walls were bare, the furniture Spartan (our

couch sported a sizeable pothole that was covered with a white sheet), and a lumpy double bed awaited restless nights. The floor was linoleum in parts with a well worn (and stained) potato chip thin carpet covering cement block foundation. It smelled of musty aspergillosis. It is likely that Ellie and I would have endured and adjusted to our new accommodations; we are troopers. However Ellie spotted a dead rat lying on the front porch and she immediately knew this was not her Shangri-La, nor did it remotely approach the standard of living to which I had promised her 37 years earlier before our marriage. The next morning we were “out of there”.

We headed for a highly recommended local restaurant resting on the banks of a small stream that coursed through the town, to “sup”, lick our wounds, and come up with “plan B”. Our waitress was a bubbly 19 year old, a walking definition of a party, and she overheard our tale of woe. Coincidentally, she and her boyfriend had just been refused occupancy at a beach bungalow on Wainui Beach only 15 minutes away. Apparently, the landlord had identified the couple as too young, too irresponsible, and too wild. She was very disappointed but she felt that we might qualify as suitable tenants. We gulped down our tasty meal, thanked her with a sizable tip, and made a quick exit, heading straight for Wainui beach (the hospital had left me with an old Australian Ford Falcon station wagon for transportation). The bungalow was wonderful; a small one bedroom rectangular house supported on stilts, open beam interior finish with a generous supply of wood and windows, and overlooking the most gorgeous beach on the planet. We asked ourselves, “Why suffer?” “Are we worthy of this enviroing?” Our answers; “We shouldn’t.” “Yes we are.” This was not a difficult decision.

Armed with a car, a beach home, and a much better attitude, I headed for the hospital on Monday morning. Ellie was headed for the beach. I introduced myself to the skeptical nursing staff on the pediatric ward and the newborn nursery and prepared to meet Linda, who was the administrative head of the pediatric department. Linda’s duties included: writing all the pay checks, staffing the wards, procuring any and all equipment, approving vacation time, and submitting quality reviews to the district administrator, including proficiency reports on each employee, which included all of the nurses and doctors. Linda had been a physiotherapist (one year training post high school) which in NZ is little more than a massage therapist. All policy was scrutinized and approved by Linda. I immediately understood that Linda and my futures were marching toward overwhelming conflict. Sound the bugle, beat the drums, I hunkered down for an uncomfortable year of administrative bloodletting. Applying my pediatric knowledge would be the easy task. However, maneuvering within the system for effective application of that knowledge was another story.

My duties were similar to those of an attending staff person at a US medical school hospital. I rounded in the mornings with my assigned “house surgeons” who were equivalent to 2nd and 3rd year family practice residents (though they refer to this training as “general practice”) and 2 to 3 medical students. My responsibilities were to oversee and approve of patient care and teaching of the house staff and students. In the afternoons I would see out-patients referred to me by private practicing general practitioners in Gisborne. I enjoyed morning teaching rounds, as well as the afternoon tutorials that were planned to discuss a subject in depth. In contrast to the American system, I was treated with professorial respect and my pronouncements were rarely challenged.

The respect I appreciated, but the lack of skepticism by the house surgeons was troubling. I finally was successful in encouraging “healthy skepticism” after I made a serious presentation of a bogus pediatric case riddled with errors and misinformation. They were bright students and house staff and they eventually realized the purpose of my errors. In the following weeks our tutorials and rounds

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Maori school girls learning traditional dance.





were peppered with insightful questions, educated speculations, and a “show me the evidence” attitude. We developed a warm bond within a rich learning atmosphere.

My approach was very different from the Kiwi pediatricians and the nursing staff was, initially, unwilling to accept my methods. I had been scrutinized at every new hospital where I had worked during my previous six years of locum tenens and, nearly always, it only took a week to “prove myself” to the staff. This was not so in New Zealand. The Kiwis are a self-reliant tough breed, hardworking, proud, and very capable. They are rarely animated and hesitate to pour out their life’s history. I am typical of most American pediatricians, that is, open, smiling, friendly, and

unabashed. The Kiwis (not the Maoris) view American behavior as “over the top” and often we are. Winning over the children on the wards and their Maori mothers was never difficult. But, it would take three months of effort on my part and a dramatic case to win over the confidence of the nursing staff and my two pediatric partners.

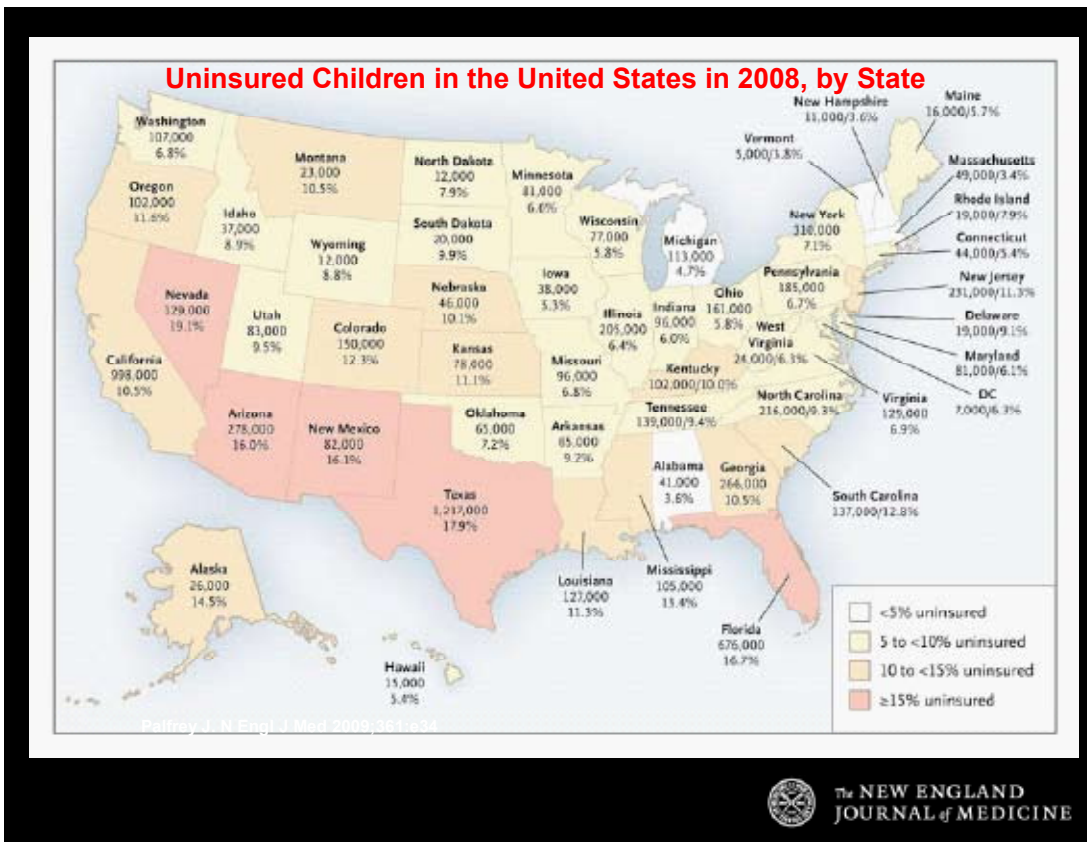
She was only 6 to 7 pounds at 5 months of age but a gritty petite Maori survivor. She was born grossly premature, spent her first month on life-support in the University Hospital NICU, and she had survived IRDS, Necrotizing Enterocolitis, and open heart surgery for a congenital lesion that I can no longer remember. She had been convalescing on our pediatric ward for the last two months, off all meds, feeding well and growing steadily. The nurses had become quite attached to her. Her extended Maori family was chomping at the bit to take her home and a rift had developed between the family and one of the Maori nurses. The conflict was worsening as the infant was improving and I had little justification for prolonging her discharge. The Maori nurse was angry with my decision but expressed no other concerns. Forty-eight hours after discharge she returned to our ER, DOA (dead on arrival)! I was stunned. The nursing staff was furious and in an uproar. Much of their emotional pain was leveled at me. In the ER she had been diagnosed as a SIDS (sudden infant death syndrome) but the nurses knew better. The Maori nurses knew the family very well and they understood Maori culture. They understood: historically, infanticide was not an uncommon method of birth control or problem solving, alcohol was a major problem in the family, and they were certain that this family would be unwilling to invest long term in the infant’s complex care. As a consequence of their knowledge, guilt, and lack of communications my decision to discharge had become their focus. I knew this was a pivotal circumstance in my effectiveness to remain on staff. I called for a ward meeting to include all nurses and physicians.

I began the meeting acknowledging full responsibility for a very poor decision and invited those nurses who were willing, to speak their piece. Within 30 minutes, all of the information that I could have used prior to discharge came pouring out. Without my saying a word they began to understand the importance of physician/nurse communications. I was careful to avoid any defense of my decision during the discussion and I was sensitive to their raw emotional circumstances and feelings of guilt. They then wanted to prosecute this family for premeditated infanticide based on nothing more than innuendo. I reminded them that there was little, if any, forensic distinction between the pathology found in SIDS and a smothered infant. Moreover, I pointed out that circulating rumors of suspected infanticide within the Maori community would alienate this dysfunctional family and contribute little toward healing their wounds. In the end, we all agreed there was nothing to be done other than a continuous follow up with social services and offering our support to the family. After this gut-wrenching conference, my relationship and communication with the nursing staff was vastly improved, and the pediatric staff began to treat me with greater warmth and respect. At last, three months into the sabbatical, I was accepted as a professional with equal status. There was a quantum improvement in my effectiveness for the remainder of the year.

To be continued ...

What about health reform?

No matter what your political beliefs, I suggest your reading American Academy of Pediatrics president Judy Palfrey's Perspective article in the October 22, 2009 New England Journal. The heavily-referenced article is entitled "How Health Care Reform Can Benefit Children and Adolescents", and is available free and only on-line at <http://content.nejm.org/cgi/content/full/361/17/e34>. This map shows why we New Mexican pediatricians should be especially concerned. ~ Lance



Legislative Report and Update

Larry Shandler, MD

In late October Governor Richardson called a special session of the New Mexico Legislature to deal with the \$450 million deficit in the current fiscal year. The Governor had hoped that the special session would last only one or two days but it took a week before the Legislature agreed on a revised budget. The Governor, in his "call" for the special session prohibited any attempts to raise revenues so the deficit needed to be closed by cuts in programs and services.

A great effort was made by many advocates and the Legislature to prevent cuts to Medicaid. Any cuts in the state's share to Medicaid would lead to even larger decreases in the federal share to Medicaid. Currently for every dollar of Medicaid funds, the state provides \$0.21 and the feds provide \$0.79.

The revised state budget is now on the Governor's desk. He has until November 12th to act. He has claimed that this revised budget will force him to cut Medicaid unless he makes even more severe cuts in all programs. It has become very confusing with the Governor and the Legislature claiming each has misinterpreted the exact wording of the bills passed. Even if Medicaid is "held harmless" we will see significant cuts in other state programs affecting children and their families.

No matter the outcome of this special session, the upcoming regular session in January will have to face even more difficult choices. The economic situation in New Mexico isn't improving and the federal stimulus monies that were used in the special session to help balance the budget will not be available for fiscal year 2011. However, there will be an opportunity to raise revenues, either by rolling back prior tax breaks and/or new "sin" taxes on tobacco, alcohol and sweetened drinks.

Pediatric Council Update



Karen Carson, MD

As always, our recent Pediatric Council meeting held in August was lively and full of discussion with the following highlights:

MENTAL HEALTH:

We started with Dr. Carol Larroque who presented information regarding the need for better mental health care access for children. Carol discussed problems with prior authorizations that many mental health care professionals are facing. Chris Stanley, the Medical Chief Officer of United Health Care discussed the need for continued work with Optum Health Care and offered his assistance as needed.

SYNAGIS®:

Synagis became our next topic of discussion with the new guidelines a hot area for everyone. It soon became apparent that the MCO's planned to follow the 2009 Red Book guidelines for Synagis administration. The Council re-worked the Synagis Prior Auth. Worksheet to follow the new guidelines; however it was made clear by all the MCO's that they would be open to appeals by providers. The Synagis form was finalized in mid-September and was released to all Saluds and BCBS. Additionally, United Health Care approved the Synagis Prior Auth form for use for their NM patients and providers.

DENTAL VARNISH:

No numbers were yet available from the pilot program in Chaves County. The Council reiterated its goal of dental varnish application covered by every Salud for children ages 6 months to 3 years. We will continue to work on dental varnish coverage. Remember, varnish is covered for patients in the Molina Salud! Program.

ASTHMA:

Asthma treatment in SE NM also is followed closely by the Council. A grant was applied for by the NM Pediatric Society to address some issues, but unfortunately was not approved. We discussed educational detailing by pulmonologists, but they are very busy with CMS clinics, etc. and this may be difficult. We will continue to pursue methods to aid Pediatricians to better treat Asthma especially in southeast New Mexico, where hospitalizations and ER visits for asthma are high.

MEDICAL HOME:

The state legislature's Medical Home Bill, HB710, was passed with a requirement that aid be given to physicians working to pursue certification as a medical home. The various Medicaid providers are working on program guidelines along with the New Mexico Medical Society. Grant money of various amounts depending on the Salud will be available to "bring the practice up" as a Medical Home. This money can be used in various ways – such as bringing on a social worker, helping with practice management, etc.

The Council will continue to liaison with the NMMS Medical Home Ad Hoc Committee for information regarding these plans. There is current information regarding the Medical Home funding on the NMMS webpage and through the Saluds themselves.

COUGH AND COLD MEDICINES:

The Council formally requested the deletion of coverage for cough and cold medicines for children less than 4

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years of age on all Salud and Insurance formularies.

NEWBORN CARE CODING:

We followed up on the decreases to reimbursement for newborn care after coding changes were initiated in January 2009. Lowell Gordon with Medicaid will look into the issue and we will plan specific appeals for these changes. It was noted that the payments were increased once again in May and June.

HEDIS MEASURES FOR OBESITY AND NUTRITION:

We discussed the various HEDIS measures used for obesity and nutrition tracking. It was felt that various V202 codes could be used for tracking purposes and the provider could also use an E&M code for billing purposes. There will be continued work on recommendations for coding to accurately track measures for HEDIS.

NON-PAYMENT FOR ER VISITS:

Finally, it was reported by Lovelace Salud MCO that they will no longer pay for non-emergency patient visits to the ER effective October 1, 2009. The patient will be triaged, but if the visit is deemed non-emergent by retrospective review, the patient will be responsible for payment of the ER visit. Letters explaining what is considered a “non-ER” visit will be sent to panel members and ERs. The Council did note concern for these patients and requested compassion for these retrospective evaluations of non-emergent visits, especially in rural communities, but also agreed there needs to be responsibility taken for non-emergent visits by patients.

As a corollary, Lovelace Salud will now be paying additional coding for clinic visits performed during “holiday” hours. This includes after-hours clinic visits by a patient. Please remember to code for “after-hour” work if your clinic sees patients during times the Saluds/Insurance Companies are not open. These codes include:

99050 – services provided in the office after regularly scheduled office hours

99051 – services provided during scheduled evening, weekend, or holiday hours

99053 – services provided between 10pm and 8am at a 24-hour facility (are you adding this to your middle-of-the-night c-section attendance?)

99056 – services provided out of the office at the request of a patient

99058, 99060 – services provided on an emergent basis in or out of the office when other scheduled office services are disrupted.

For example, if your office currently holds office hours on Saturdays you should be coding 99051 in addition to your E&M code. Remember, if the insurance companies are closed – it is a “non-office hours” time.

OTHER REVENUE:

Are you doing developmental screens? Those can bring in an additional \$18 per visit (ASQ, MCHAT). What about hearing and vision? An investment of \$5,000-10,000 for basic hearing (OAE) and vision (ie. pediavision or suresight) can increase your revenue during a well-child-check by \$60.00-80.00 and is a great preventive care service.

Our next Council meeting will be December 4, 2009. Please email me if you have questions or if the Council can assist you. (ksaltermd@msn.com)

Fixing Our 'Eyes on the Prize' in Tough Times

John Ratmeyer, M.D., FAAP

NMPS Executive Committee, Member-at-Large

As I write this piece, I'm returning from a few days meeting with the seminary board of trustees of which I've been a member for the past three years. I need only enjoy the blessing of gathering with these intelligent, generous people of strong, principled character to gather inspiration before returning to my more mundane day-to-day life of patient encounters! As a board, over the past year, we have struggled with tight finances in the wake of a devalued endowment, the prospect of decreased giving from donors, and searching our budget to 'trim the fat' (of which precious little remains!). Inevitably, our conversation turned back to the core of who we are and what we are called to do; to recall our mission and all the tasks we chart to accomplish that mission. Tough times ushered in by an economy in crisis have forced every organization, every family, and every individual to re-examine priorities.

As members of the New Mexico Pediatric Society (NMPS) and as pediatricians, we participate in that reflection. As we look forward to probable cuts in Medicaid — for many of us, our primary revenue stream — including cuts in payment rates, as the state struggles to balance its budget, we wonder how we can continue to serve our patients and their families, how we can continue to resource our practices and programs, and even how we can sustain our own livelihoods. We wonder how the national debate on health care reform will change what we do and how we serve families. As members of the NMPS, most of us also belong to our parent organization, the AAP. As we face tough times as practitioners, we would be wise to remember that the AAP's full title is the American Academy of Pediatrics and not pediatricians. We long ago recognized our principle mission to serve the children and families of our communities, whether local, national, or international. We most effectively advocate for our professions and ourselves as individual practitioners when we advocate meeting our patients' medical needs. Recalling that mission is not only the most effective method to frame all of our discussions with legislators and policy makers, but also to remember who we are at our cores. We are pediatric practitioners who safeguard the health and well-being of all our children. Our knowledge and expertise are to be sought after by those who would make policy on behalf of our families precisely because we know more about how to safeguard the health of our children.



In a letter to his shareholders several years ago, prophesying the tough times to come, Warren Buffet, the billionaire entrepreneur, wrote “at least when the tide goes out, you know who’s naked.” As the tide goes out on our economy, threatening the health of our patients and our effectiveness as child health advocates and practitioners, will our nakedness be exposed or will we be warmly clothed in our identities as those who would care for children, even more than we care about ourselves? Trust that fixing our eyes on the prize of healthy children best serves us all so that all will be served best.

John Ratmeyer is a long-time pediatrician at Gallup Indian Medical Center, and a member of our executive committee. John is a passionate advocate for Indian children and an expert in child abuse prevention and detection.

New Futures School

Toni Berg, RN

Do you worry about the teen parents in your practice, and whether they are in school? There is a great solution in Albuquerque: New Futures High School. This alternative secondary school provides all course work toward graduation, as well as hands-on learning about caring for babies.

New Futures provides State licensed child care for children of enrolled students . Having state-of-the-art child care available at no cost to the student is vital to improving the New Mexico graduation and drop-out prevention rates. Most student mothers take a two week maternity leave when the baby is born and then return to school. New Futures School uses a block schedule in which each nine week grading term is the equivalent of a semester. Missing any more time for maternity leave puts the student in danger of not earning credit for that term. Babies attending New Futures child care must be at least 2 weeks old.

Many health professionals think that child care involves huge rooms full of wild children dripping fluids from every orifice. Nothing could be further from the truth at New Futures. The child care center is composed of twelve age-divided rooms, each licensed for ten children with two care providers. With a 1:5 ratio of adult care providers to children, the care provided is excellent and designed to enhance each child's growth and development. There is a registered nurse in the school health office full time to care for the health needs of the students and their children. Immunization records are maintained as required by state law. Handwashing is taught and modeled by all the staff, both in the child care and in the classroom.

Breastfeeding is taught, encouraged and supported at New Futures School. The school nurse at New Futures is also a Board Certified Lactation Consultant (IBCLC) who can provide assistance for any breastfeeding difficulties. As the research is showing over and over, breastfeeding is the baby's first immunization and Nature's best protection during the early weeks after birth. New Futures has a breastfeeding initiation

rate of 80% or greater among enrolled students. Even very young babies are safer and healthier in any situation when they are breastfed. As the World Alliance for Breastfeeding Advocacy says, "Breastfed Babies Are Ready for Anything"!

Medical care providers who would like to learn more about New Futures School and the child care program are invited to call the school nurse, Toni Berg, at 883-5680, extension 5, to arrange a time to visit. Your calls and questions are welcome. Together we can help our parents be great parents AND be successful in school.

I have known and worked with Ms. Berg for many years. She is a valued colleague and is eager to work with other pediatricians in the Albuquerque area. ~ Lance



Happy
Thanksgiving

Correspondent's Corner

News of the North

Charlie Anderson, MD

It's always fun for me to write this column because I get to connect with my fellow Pediatricians in the North and maintain our friendships. This has been an unusual fall season for all of us because of the early occurrence of Influenza A and H1N1, as well as a host of other viruses. In my 45 years in the North I don't think I have ever seen flu epidemics start this early. October is generally a month to relax, close the office early, take vacation, and watch the leaves change color. This year it's overtime for everyone. Mike Nichols from Los Alamos says one of this town's football players went to a training camp in August and brought back H1N1 and shared the virus with the rest of the team, cheerleaders, and others. That kept them busy while the virus slowly made its way to the Española valley, and they are seeing that wave now. Mike Patterson from Camino Entrada in Santa Fe said he went to a very impressive lecture by Gary Overturf in which the state strategy was to get the vaccine to the schools and clinics early because they could see this coming. As of Oct 10 his clinic has not seen any vaccine from the state while we got ours two weeks ago. In Taos we are seeing allergy, asthma (chamisa has been a bumper crop), influenza A, H1N1, hand-foot-and-mouth disease, Fifth disease, croup, and Mycoplasma. This may be a long winter.

RAMBLINGS OF AN OLD TIMER

In the olden days (I can talk about this with authority) when we had true measles epidemics, the virus itself induced a temporary state of anergy. That means it weakened your immune status, and following measles the average child was seen in the office once a month for illness for the next six months. (Strep throat, flu, otitis, anything.) As an example of anergy, if a person was PPD positive, after rubeola his PPD sometimes became negative while his tuberculosis was activated. I've asked a number of younger pediatricians about this and none of them have ever heard of it. It was drummed into us in medical school. When measles vaccine first came out in the early '60s, we were all supposed to do a PPD before giving the vaccine. Using measles as an example, I think certain flu viruses create a state of relative anergy, and following this fall's epidemic I would not be surprised to see moderately sick kids returning to our office all winter long. Hope for a really cold winter with minus zero temperatures. That's when we see the least illness.

In Taos after a long delay we have finally broken ground on a new pediatric office building next door to the hospital. It will be modern, sterile, no trees and without charm. (Who needs charm?) Our current office has trees, shade, a lawn where kids play, and it is falling apart but it has charm. All the rooms have murals painted by local artists and the whole office has "Taos Funk". I will miss it. I will also miss the rental income. (Who needs income?)

MORE RAMBLINGS

In the office when I see a teenager for an annual exam I try and be complete and ask life style questions. The topic of sex is often awkward but sometimes I feel I have been helpful. Most of the time their parents have not discussed this topic at home. I surveyed my own children and asked them what they have discussed with their kids, two teen age boys and three girls). The girls all went on the pill at age 16 (to help regulate their periods) and the boys were all given condoms (in case they ever needed them). Discussion was minimal because the subject was taught at school. As I prepared for this column I started a survey of my fellow doctor friends as to what their parents told them when they were young. Most said, "Nothing". One friend's total sex education came as advice from his father (a minister) as he was about to go off to a dance at age 12. "If your thing becomes big when you are dancing, stop dancing!" (I love that one.) I had an interesting bit of discussion and advice from my step father

who broached the subject for the first time the day before I got married. I was 22 and had finished my first year of medical school. “Charlie, what are you going to do on your honeymoon?” “We plan to travel to the Coast and camp along the way.” I said. There was a long pause. “Don’t go camping! Women need water. I don’t know what they do with it but you find yourself hauling water up and back, up and back.” He reached into his wallet, pulled out a 50 dollar bill and said: “Find yourself a good motel. Don’t go camping!” I have remembered his advice. Now we have a small Winnebago and it has a 26 gallon water tank and even hot water. The water does not last very long (I don’t know where it goes), but we have fun and I am happy to haul water and fill the tank when it needs it. I guess I know all I need to know about sex.

ADDENDUM

After last spring’s Wylder lectures Joe Dean told me that he really liked the stories and case histories from the past that have been in News of the North, and he and others also have cases that they might like to tell. He thought it would be fun if we could share these with each other. I’d be happy to collect any such stories or cases and put them together in some form. Please all feel free to e-mail me or call and give me your ideas. E-mail: edyncwa@taosnet.com or phone: 575-758-9272.

Greetings from Roswell, everyone!

We’ve been busy with H1N1 – just like the rest of New Mexico, and it’s really affecting our practitioners and staff. We are used to the “winter” – RSV season in late December and January – finally letting up sometime in mid-February when we can take a come up for air. However, we’ve been under water now for a month and a half. The nurses assigned to phone triage during the day are reporting parents, worried about their child, wanting immediate appointments. Our inability to accommodate all these “same-day” visits has led to screamed curses at our staff, phone hang ups, and various threats. Most of these children don’t need to be seen – they were “exposed” to H1N1 at school, they “feel hot”, they have a runny nose and a cough.

This pandemic has led to lots of discussions within our practice. We’ve seen relatively mild illness in the majority of our patients. Yes, we’ve had our share of PICU transports and deaths, but these have not been numerically significant with regard to positive influenza cases that we’ve seen. I wonder, though – what if this virus were a more fatal strain? What if antigenic shift occurs and we start seeing large numbers of deaths in our community in a month or two? Will we stay open? Am I willing to risk my life and the life of my children by caring for these sick children and their families? The chaos in our clinic now would rise a thousand-fold. We would require police protection. I’ve joked that the clinic would close and I’d head for my ranch in the hills. It’s only a half-joke – I can’t tell you what I’d do, but I’m not sure I’d stick around. I think about the physicians of centuries ago – day in and day out caring for patients with highly contagious disease and no fancy antivirals, antibiotics or vaccinations. Just that funny looking outfit and the duck mask. It really brings us to the bone of the matter – medicine is a service profession – how far are we willing to serve?

For now, I’ll just keep on working, seeing those sick kids and reassuring the parents. We’ve had an emergency visit policy for many years – we will see any child under the age of 2 that same day. We’ll also work in a patient that the triage nurse feels needs to be seen. This has worked relatively well over the last few years, but is becoming a problem these last few weeks. There just aren’t enough visits in the day to accommodate everyone. What’s everyone else doing?

Let me finish with a funny case that was refreshing after a run of 7 H1N1 kids:

John, a 15 year-old Hispanic male, came in with a complaint of abdominal pain. The pain was periumbilical, usually increased after eating, and was intermittent. There was no fever, slight, non-bloody diarrhea “sometimes”, no URI symptoms, and no weight loss. He stared blankly when asked about bowel movements. His mother,

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ACIP Report

Lance Chilton, MD

I'm Baaack!...not just from the National Conference and Exhibition in Washington but also from the Centers for Disease Control's Advisory Committee on Immunization Practices (CDC ACIP) in Atlanta. It was great to see many New Mexicans in Washington (notably, UNM pediatric resident Oni Guha was there thanks to a Dyson Grant award for travel to present her data on her resident CATCH Grant). And it was great to see many friends among the folks at the ACIP meeting.

There were two long days of meetings in Atlanta, and "only" three hours were about influenza. I'm sure you're all seeing plenty of flu in your offices (we certainly are at Young Children's Health Center in Albuquerque!).

Most of what we had talked about during the summer at ACIP has proven to be true: the disease has remained about the same in severity (many people with symptoms, but not many terribly sick); the virus has remained unchanged, making the vaccine likely to be effective; a vaccine has been made and seems both safe and effective; there have been problems in predicting vaccine supply and getting it where it needs to be in a timely manner; vaccine demand has been affected by the public's access to minute-by-minute news reporting on the epidemic; supply problems have necessitated using prioritization and sub-prioritization decided upon by ACIP in July; and the virus remains almost (but not quite) uniformly sensitive to zanamivir (Relenza®) and oseltamivir (Tamiflu®) and resistant to amantadine and rimantidine.

You can't see the bars for the previous ten years, since there was virtually no flu in the state at this time of the year in any other year! And the last three weeks have more isolations than we see at the peak of seasonal flu in almost all years. Clearly, this is just the tip of the iceberg, as most of us are only testing kids who are very sick, unless we're one of the state's 22 "sentinel physicians."

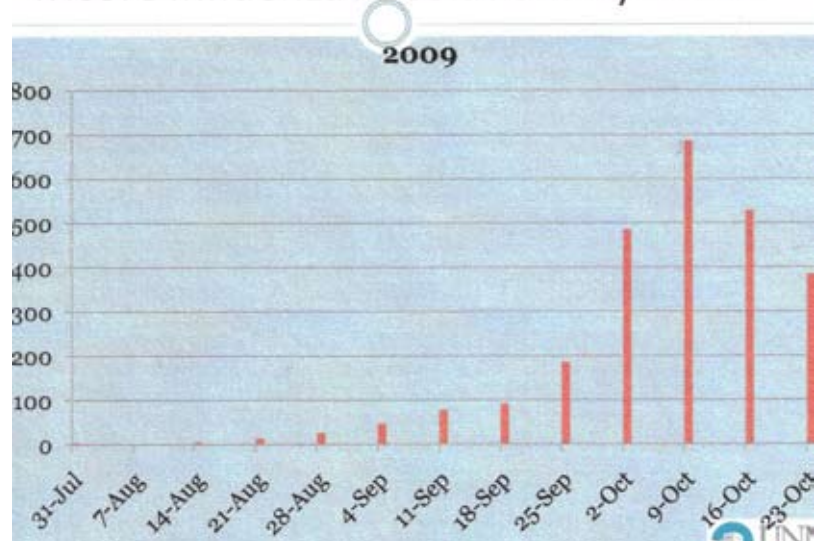
Vaccine for the H1N1 flu is making its way slowly out into the state. ACIP recommends flexibility in applying its recommendations for flu vaccine, but generally holding to the same priorities as set in July – see <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e0821a1.htm>

By the time this newsletter is online, there will probably be new successes and wrinkles. What won't change is the recommendation that all of us give all of our patients over 6 months of age seasonal influenza vaccine, and recommend it and the H1N1 vaccine especially to pregnant women.

There was a long discussion on human papillomavirus (HPV) vaccine, following FDA's actions to 1) approve Cervarix®, GSK's new HPV 16/18 vaccine, and 2) approve the use of Gardasil®, Merck's HPV 6/11/16/18 vaccine for males 9-26 years of age. ACIP pointedly refused to take a stand on Cervarix vs. Gardasil, pointing out only that Gardasil and Cervarix both protect against both of the HPV types that cause 70% of cervical cancer, while Gardasil is the only vaccine also protecting against genital warts. ACIP was presented with a great deal of economic analysis on use of Gardasil in males; it issued a "permissive recommendation," meaning that it can be safely used, but is not recommended for routine use. And also meaning, probably, that most insurances will not pay for it in males.

Jeanne Santoli gave her usual vaccine shortage update. Haemophilus influenza b, hepatitis A,

Tricore Influenza A Isolations By Week



Data from Tricore Labs in Albuquerque, courtesy of microbiologist Steve Young, are representative of the country's flu status ("widespread" in almost every state).

hepatitis B, Tdap, and Dtap-IPV all figure in her report, which is updated at least weekly, at www.cdc.gov/vaccines/vac-gen/shortages/default.htm. As of October 21, her conclusions were as follows:

1. Hib shortage resolving
2. HBV supply adequate for now to continue routine dosing
3. Intermittent outages in several vaccines continue (HBV, Tdap, DTaP, DTaP-IPV)
4. There is sufficient supply of these vaccines to maintain current recs, but providers may need to change formulations or brands.

A new pneumococcal vaccine, PCV13 (Pevnar13) is expected to be out soon, which should replace PCV7 and offer considerably better protection against invasive pneumococcal disease, pneumonia, otitis and probably other diseases, probably at a higher price.

Finally, some particularly good news: there's pretty solid evidence that rotavirus vaccine is working very well, with heavily damped annual epidemics the last two years. And more good news: the young child, older child, and adult immunization schedules for 2010 have no major changes. A new set of General Recommendations (a compendium of useful information about vaccines, summarizing a great many recommendations) will be out early in 2010. All CDC recs, including the General Recommendations, are on ACIP's part of the CDC website, at <http://www.cdc.gov/vaccines/recs/acip/default.htm>.

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Spanish-speaking-only, was extremely concerned about her son. They had travelled to Mexico about 9 months ago, but the abdominal pain was more recent – maybe for 2 or 3 weeks. He was the typical teenager with usual responses being “I dunno” and “maybe”. Mom had given her son a medication from Mexico used to treat “animales” (animals – worms usually) about 10 days ago. It was a single dose tablet and we guessed it was likely Vermox. It did not improve the pain. He is also taking a powdered anti-acid medication from Mexico. Mom worried the teen was “flaco” and “no tiene gusto” – basically, skinny and lethargic.

His exam showed a healthy-appearing male, no weight loss from a previous visit 6 months ago, normal abdominal exam. He pointed periumbilically as the source of his pain. Because of the overwhelming concern of the mother (I knew if I didn't do something, he'd end up in the ER), I ordered a CBC and an abdominal film. The CBC was negative. The film showed the patient FOS (Dr. Rose, UNM GI, knew this already). However, it also showed various small circular radiopaque items throughout the colon. Upon review with the patient and his mother there was no surprise. The teen stated he ate 45 “BB” pellets a few days ago. “Oh yes – he eats metal all the time” agreed his mother. She also stated that her entire family eats strange things – including her sister who drinks perfume, eats lipstick, and snacks regularly on pavement pieces. John couldn't say why he eats “stuff” – all kinds of metal usually, but sometimes other foreign objects. He just does.

His CBC showed no sign of anemia. A lead level (the BB's were steel) is pending. So are the psychiatric consult and the GI consult. He was started on Miralax and is supposed to come back in a month. We discussed the danger of eating objects that are not food. I haven't seen a case like this since my psychiatric rotation in medical school. “Floyd” liked to eat knives. So, if anyone else has a great idea – let me know.

And then I moved on to see some more flu. Good luck, y'all!

Karen Carson, our Roswell correspondent, may be tough enough (as head of our Pediatric Council, not with children) to chew nails, but not BBs. Karen is a valued member of our executive committee.

Autism Spectrum Disorder Coverage

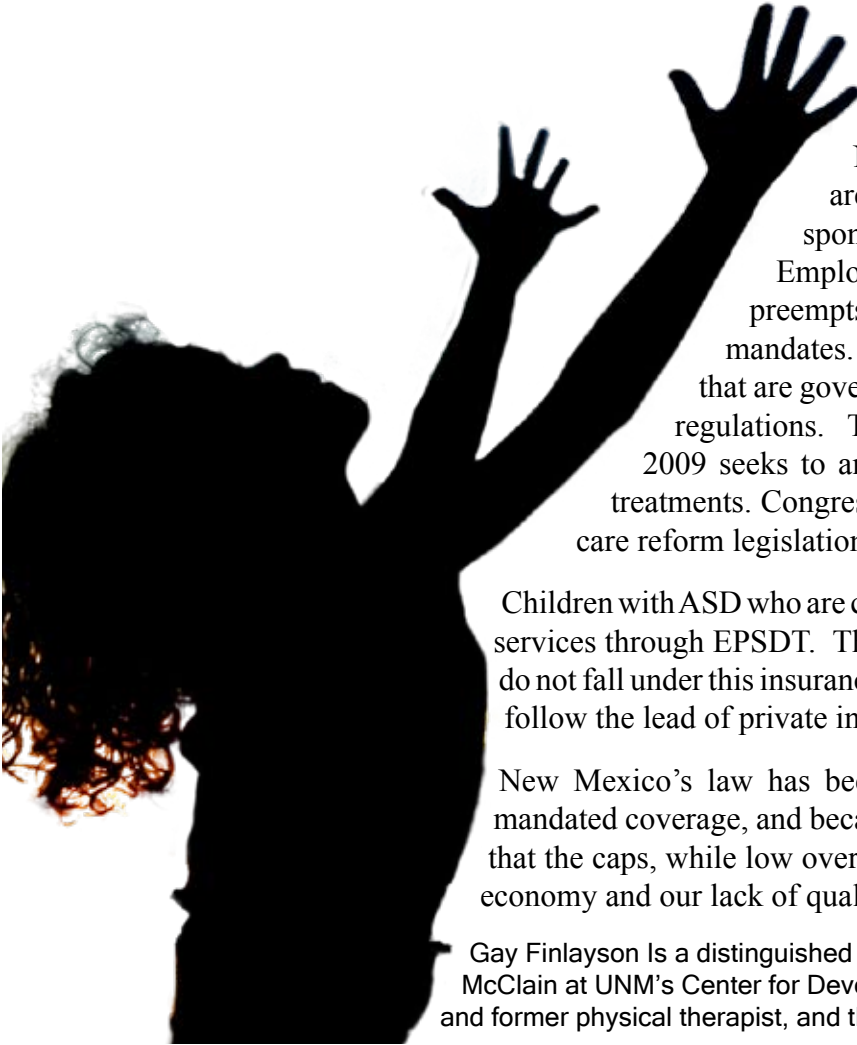
Private Health Insurance Coverage for Autism Spectrum Disorder

by Gay Finlayson and Cate McClain

New Mexico is now one of 14 states that has a law mandating private health insurance coverage for Autism Spectrum Disorders. SB 39 was introduced by Senator Clint Harden and received wide-spread support from the NM Legislature, which passed the bill during the 2009 regular session. Subsequently, the bill was signed into law by Governor Richardson and is now in effect.

The law mandates private health insurance plans in New Mexico cover the diagnosis and treatment of autism spectrum disorders for children to age 19 or through the age of 22, if they are still attending high school. Benefits are capped at \$36,000 a year, with a lifetime cap of \$200,000. The law also states that insurers can not terminate or restrict coverage based on a diagnosis of Autism Spectrum Disorder (ASD).

Covered under these benefits are diagnostic evaluation and treatment through speech therapy, occupational therapy, physical therapy, and Applied Behavioral Analysis. Coverage for services received in the schools through the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) are excluded. Treatment is limited to that prescribed by the treating physician and outlined in a treatment plan that includes the following: diagnosis, proposed treatment, proposed frequency and duration of treatment, treatment goals, and the frequency with which the treatment plan will be updated.



The new law doesn't apply to every child with autism in NM, nor to every child with ASD who has private health insurance. The majority of New Mexicans who have private health insurance are covered through large company or government sponsored self-insured plans. A federal law, the Employee Retirement Income Security Act (ERISA), preempts most state insurance regulation, including benefit mandates. ERISA allows companies to set up self-funded plans that are governed by federal law and exempt from state insurance regulations. The Autism Treatment Acceleration Act (ATAA) of 2009 seeks to amend ERISA law by requiring coverage of autism treatments. Congress is debating this section of ATAA as part of health care reform legislation.

Children with ASD who are covered by Medicaid receive diagnostic and treatment services through EPSDT. Their benefits are subject to Medicaid regulations and do not fall under this insurance mandate. Advocates are hopeful that Medicaid will follow the lead of private insurance and offer autism benefits to its members.

New Mexico's law has been criticized nationally, both for the low level of mandated coverage, and because it is not universal in scope. Advocates have felt that the caps, while low overall, are quite reasonable for New Mexico, given our economy and our lack of qualified providers, especially in rural communities.

Gay Finlayson is a distinguished alumna of James Madison University and works with Dr. McClain at UNM's Center for Development and Disability. Cate McClain is a pediatrician and former physical therapist, and the director of CDD.

Look who we caught getting ACTIVE!



Drs. Ben Hoffman and Alex Cvijanovich at the NCE.



Dr. Ray (second from left) joins other District VIII leaders in Calgary.



Drs. Vic Strasburger and Jane McGrath at the NCE.



Dr. George Bunch at the NCE.



Drs. Rene Ornelas and Erika Fernandez taking time out to visit Smithsonian Museum of American History during the 2009 NCE.

*Happy Holidays to all from the
New Mexico Pediatric Society*

New Mexico One of Eight Awardees Nationwide for Advocacy Training to Combat Childhood Obesity

Envision New Mexico: The Initiative for Child Healthcare Quality will lead a pilot project focusing on training NM healthcare professionals serving American Indian children and teens. In working partnership, Envision NM will collaborate statewide with pediatricians, American Indian health policy experts, and public health professionals. On October 9, 2009 The National Initiative for Children's Healthcare Quality (NICHQ) announced that eight organizations have received awards of \$15,000 each as part of the Mobilizing Healthcare Professionals as Community Leaders in the Fight Against Childhood Obesity program. The program is part of a \$3.25 million grant awarded to NICHQ from the Robert Wood Johnson Foundation (RWJF).

The goal of Mobilizing Healthcare Professionals as Community Leaders in the Fight Against Childhood Obesity, developed by NICHQ, in cooperation with the American Academy of Pediatrics (AAP), the California Medical Association Foundation (CMA-Foundation), and the Robert Wood Johnson Center to Prevent Childhood Obesity (CPCO), is to reverse the childhood obesity epidemic trend across the nation by training, supporting and providing technical assistance to healthcare professionals in becoming advocates for change within their communities.

The proposed project by Envision NM will include:

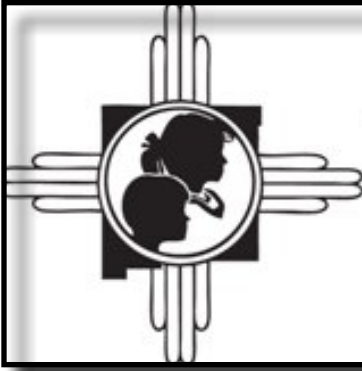
- Collaboration with project team members from NM Pediatric Society; Center for Native American Health (CNAH) at the University of New Mexico; RWJF Center for Native American Health Policy at UNM; Gallup Indian Medical Center; and Northern Navajo Medical Center. We welcome other interested partners as well.
- Formation of a prevention advocacy team of 20 or more healthcare professionals in NM. The team will be trained in advocacy, build consensus and collaboration, and develop an agenda to improve the prevention and treatment of childhood obesity within tribal communities. The healthcare professionals would include pediatricians, nurses, physician's assistants, nurse practitioners, health educators, Tribal Community Health Representatives (CHRs), Tribal Women, Infant, Children Programs (W.I.C.) and staff of school-based health centers who serve American Indian children and adolescents in NM.
- A network that supports and encourages NM healthcare professionals as influential advocates in the leadership role addressing childhood obesity prevention.

The other seven grants went to organizations in Alabama, Arkansas, Kentucky, Mississippi, North Carolina and Texas. "The awards will allow the recipients to conduct obesity-prevention advocacy training and provide implementation support to local healthcare providers" said Rachelle Mirkin, executive program director at NICHQ. "Healthcare professionals have an important voice in raising awareness and in helping communities and families find the tools they need to reverse obesity. I am especially pleased to see these grants awarded to organizations in many of the states with the highest rates of obesity." Joseph W. Thompson, MD, MPH, Director, CPCO.

"As a leader in fighting childhood obesity, we are thrilled to support other organizations that are making strides in erasing this epidemic," said Dr. Charles Homer, president and chief executive officer of NICHQ. "We look forward to working with the AAP, CMA-Foundation, RWJF and the awardees of this program to bring awareness to this critical issue facing children's health."

Awards were based on written applications and phone interviews. Successful applicants had detailed project plans, highly collaborative project teams and a history of working on sustainable advocacy and public health initiatives. In addition to the grant, NICHQ and its partners will provide the recipients with tools, training and technical assistance. The award period is from October 2009-May 2011.

For more information, contact Chenoa Bah Stilwell-Jensen, MS, Quality Improvement, Training, Consultation and Outreach Coordinator for Envision at (505) 925-7618 or cjensen@salud.unm.edu. Visit the website: www.envisionnm.org.



New Mexico Pediatric Society

NURTURING FUTURE GENERATIONS

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The NMPS has a new phone
and fax number!

Our *Enchanted Pediatrician* newsletter is developed quarterly and edited by Lance Chilton, MD, Janis Gonzales, MD and Anne Hanika-Ortiz, executive director. It is designed by CreativeWren Design.

We welcome all submissions for the *Enchanted Pediatrician*.

The next deadline is January 15, 2010. Please limit submissions to 500 words or less if possible.

The Editors reserve the right to edit submissions for clarity, spelling, punctuation and style to conform to the Associated Press style guidelines; and all submissions are published at the discretion of the Editors.

For questions contact Lance at lancekathy@yahoo.com.