



Minnesota www.mnaap.org Pediatrician

THE NEWSLETTER FOR THE MINNESOTA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

February 2010

MN-AAP
1043 Grand Ave. #544
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Join us for Peds Day at the Capitol Wednesday, March 3 from 12 - 4



Health care reform is front and center at the capitol.

Here's your chance to weigh in on important issues that affect your practice as well as your patients. Don't miss this opportunity to let your voice be heard!

(Continued on page 5)



President's Message Anne Edwards, MD

Every year as the legislative session approaches, I sense an urgency to be present, to be "in the mix", to advocate for those who do not have a vote at the capitol – children.

Given all the debates nationally regarding health care reform, this urgency looms even more for me this year. Wikipedia defines advocacy as "the pursuit of influencing outcomes — including public-policy and resource allocation decisions within political, economic, and social systems and institutions that directly affect people's current lives."

On some level, the definition might seem a bit overwhelming. Yet, for most pediatricians, advocacy is always at the core of what we do on a daily basis.

(Continued on page 3)

Minnesota

Pediatrician

*The official publication of the
Minnesota Chapter of the
American Academy of Pediatrics*

Minnesota Chapter-
American Academy of Pediatrics

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STATEMENT OF PURPOSE

Minnesota Pediatrician is dedicated to providing balanced, accurate and newsworthy information to Minnesota pediatricians about current issues in pediatrics and the actions of the Minnesota Chapter of the American Academy of Pediatrics.

Articles and notices cover organizational, economic, political, legislative, social, and other medical activities as they relate to the specialty of pediatrics. The content is written to challenge, motivate, and assist pediatricians in communicating with parents, colleagues, regulatory agencies, and the public.

ACCEPTABILITY OF ADVERTISING

All products and/or services to be considered for advertising must be related to pediatrics.

The Minnesota Chapter does not accept advertising or sponsorship dollars from pharmaceutical companies. The Chapter reserves the right to reject or cancel any advertising.

New 13-valent pneumococcal vaccine

The Food and Drug Administration (FDA) licensed a pediatric 7-valent pneumococcal conjugate vaccine (PCV-7) in February 2000.

It has been highly effective in young children in preventing invasive pneumococcal disease (IPD) caused by the 7 serotypes of pneumococcus covered by the vaccine.

Following PCV-7 introduction, overall rates of IPD among children <5 years old declined by 80%, with rates caused by serotypes included in PCV-7 declining by >99%. Since then, rates of IPD caused by other serotypes have increased, especially IPD due to serotype 19A, 7F, and 1.

In 2008, there were 76 cases of IPD in Minnesota in children under 5 years old, 48 of which occurred in children under 2 years. The FDA is expected to approve PCV-13 (which adds serotypes 19A, 1, 2, 5, 6A, and 7F to those included in PCV-7).

The Minnesota Department of Health (MDH) in collaboration with the Centers for Disease Control and Prevention's (CDC) Emerging Infections Program (EIP) is preparing to assess the effectiveness of the vaccine in children ages 2-59 months. This assessment will begin upon approval of PCV-13 by the FDA.

Children with IPD and children without disease who are of similar age will be enrolled. For children who do participate in the evaluation, MDH will be contacting their pediatric health care providers to ascertain their medical history including vaccines and chronic conditions.

MDH greatly appreciates your participation and would like to thank you ahead of time for your assistance in this important public health assessment.

If you have any questions regarding the vaccine evaluation, please call Corinne Holtzman at MDH at 651-201-5414.

Save the Date:
MN-AAP Annual Meeting

Friday, June 4, 2010

Topic: Health Care Reform
6 p.m.—9 p.m.

More details coming soon...

(President's Message continued from page 1)

It begins with personal relationships with patients and families, speaking out on your patients' behalf when working with schools, insurers, and other providers. It involves a guiding principle – improving the health and well-being of a child.

This individual advocacy easily extends to a larger community of children. Community advocacy relies on the formation of partnerships and coalitions to achieve improvement in child well-being. And this community advocacy can lead to state advocacy, involving multiple communities and many times evolving into legislative advocacy. The state legislature decides who has access to care —eligibility for public programs, public health policy, funding for early childhood education / public schools and what our health care system will look like in the future.

In considering MN-AAP's state legislative priorities, the board considered carefully all aspects of advocacy important to members— individual, community, state and national. Two priorities quickly rose to the top: access to care and obesity prevention.

Clearly with national health care reform debates, access to healthcare is on the minds of most families and providers alike. The MN-AAP supports efforts to ensure that every Minnesota child, adolescent, and pregnant woman has access to comprehensive medical care, mental health services, oral health care and access to an appropriate medical home.

Recognizing 70 percent of children and adolescents do not receive needed mental health services, the MN-AAP supports efforts to ensure that children in Minnesota have access to the mental health services they need to succeed.

Finally the MN-AAP supports efforts to address

workforce shortages and access to providers of care for infants, children and adolescents, including efforts which address a shortage of pediatric sub-specialists statewide and decreasing reimbursements for preventive health services, which jeopardize access to care in some portions of the state.

Given more than 15 percent of children ages 6 to 18 are obese, advocacy for obesity prevention and reduction efforts in the state is vital to improving the health of all children.

On March 3rd, pediatric providers will gather for the annual pediatric day at the capitol. I encourage you to join fellow child advocates. Legislators rely on personal stories provided by experts to guide their decision-making process – they welcome and request such input. The more voices present, the potential for more impact.

Most importantly, there are no children in the legislature; they rely on us as child advocates to promote the very future of their well-being.

Thank you in advance for advocating.



Anne Edwards, MD
President
MN-AAP

**Turn to page 5 for more information about
PEDS Day at the Capitol**

Sign up for legislative alerts!
*To receive regular updates about
MN-AAP's advocacy efforts at the
capitol, email debilzan@mnaap.org*

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Q&A With John Andrews, MD About Peds Day at the Capitol

1. Why did you decide to participate in past?

I participated because I was curious about how the legislative process worked. I also felt it was important to make the views of pediatricians known to legislators, who are subject to many other influences.

2. What made it worth your time?

The orientation to the issues made me feel confident talking with my legislators about them. It was also helpful to understand how my input might be viewed and to know that it would be valued.

3. What advice do you have for members who have never experienced PEDS Day?

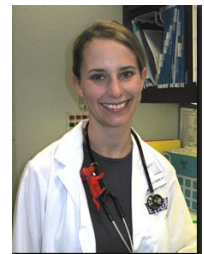
Come with an open mind and interest in advocating for child health. Trust your experience.

4. Anything else you'd like to add?

This is a really important event and a unique opportunity for the voice of pediatricians to be heard at the State Capitol.

“An important part of being a pediatrician is advocating for your patients.

By participating in PEDS Day every year, I have been able to engage our legislators and guide them in making important child health policy decisions.”



Megan Jennings, MD

Check out the MN-AAP website:

www.mnaap.org

Peds Day at the Capitol

Wednesday, March 3 from 12 - 4 p.m.

There are no children or pediatricians in the legislature. Yet the legislature passes so many laws that affect children -- from vaccine policy to newborn screening to access to health care.



We, as pediatricians, need to be sure to weigh in. MN-AAP will provide you with background information, talking points and other resources. Whether you're a first-timer or have been participating for years, we hope you'll join us!

Together, we can make an impact!

Agenda:

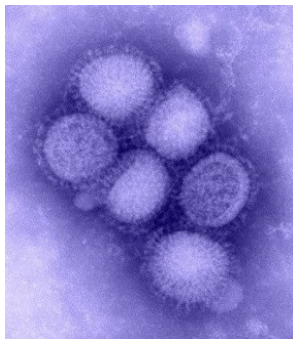
- 12:30 Registration, Capitol Room 118
- 1:00 MN-AAP issue overview
- 1:15 Advocacy 101: How to be an advocate for your practice
- 1:45 Discussion with key legislators
- 4:00 Debrief and follow up, Axels on Grand Ave. in Saint Paul.

Register by Feb. 24

To register or receive more information, send an email to:
debilzan@mnaap.org

Turn to page 8 to see MN-AAP's legislative priorities for 2010...

H1N1 Debrief: Q&A with State Epidemiologist Ruth Lynfield



Q: What are the current expert thoughts on the future of H1N1?

A: First, we think there's a possibility there will be a third wave, so we really encourage people to get vaccinated.

Second, we expect the virus to come back as seasonal influenza in the fall. This strain is going to be with us for a while. It will likely undergo some antigenic variation, so we will need to keep an eye on circulating strains.

Q: Is there any data yet on the vaccine's effectiveness?

A: Results from an NIH-sponsored trial to determine safety and dosing for the H1N1 vaccine, found similar immune responses in children to seasonal influenza. Thus far, what is in the H1N1 vaccine is very close antigenically to the H1N1 virus that is circulating, so we expect the vaccine to be working well. In the future, we hope to have some additional data. We, along with nine other states or areas in the U.S., are working with CDC on an H1N1 vaccine effectiveness study, evaluating cases with H1N1 influenza and controls.

Q: Will the H1N1 vaccine change for next year?

A: The determination for what will be in the seasonal influenza vaccine in the fall will be made over the next couple of months, based on circulating strains of influenza. The seasonal influenza vaccine has contained two influenza A subtypes (H1N1 and H3N2) and one influenza B. The identification of 2009 H1N1 pandemic influenza A occurred after the sea-

sonal vaccine production for the Northern Hemisphere had already started, but it has been included in this year's seasonal influenza vaccine for the Southern Hemisphere. As mentioned, to date, there hasn't been much antigenic change in 2009 H1N1, but it is likely at some point to have some antigenic changes (antigenic drift).

Q: How do you anticipate the distribution of the H1N1 vaccine changing for next year?

A: We don't anticipate a separate vaccine for H1N1 in the fall. It should be incorporated into the 2010-2011 seasonal vaccine.

Q: Will there be a new and improved flu vaccine in the future?

A: What you want is a vaccine that will give you protection against any influenza virus – a universal influenza vaccine – so you don't have to change it every year and make predictions on how the virus is going to change. There's a lot of research that's working on that right now, so we're hopeful that in the future there will be a better influenza vaccine.

Q: What were some lessons learned from the pandemic?

A: It is extremely useful to have had all this planning and to have worked with many partners because when we had this outbreak I think people had a sense of what they needed to do and who they needed to call. We needed to keep our eyes open. We needed to understand which populations it was affecting and what the severity was.

One thing that's frustrating is you cannot predict influenza. You don't know how severe the strain is going to be. We were very lucky that it was

(Continued on page 7)

not like the 1918 epidemic because we could have had many, many more hospitalizations and deaths.

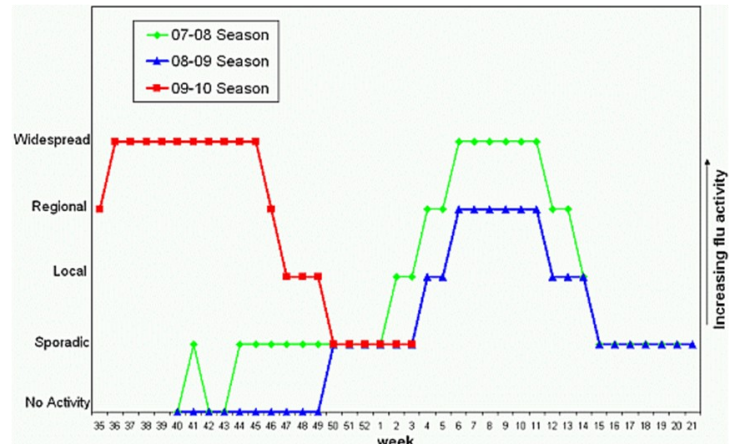
There are some challenges in that if you have a brand new influenza strain, your best tool—vaccine—takes a while to develop. I think it was very frustrating for everybody to not have vaccine in hand as quickly as we wanted. And yet, on the other hand, it's pretty amazing that this brand new virus, which was first detected in April, has a vaccine and that the first shipment arrived in October.

Q: What recommendations do you have for clinicians if the third wave hits, and what about seasonal influenza?

A: Again, it's very important to vaccinate. If we vaccinate right now that can impact the occurrence and the magnitude of a third wave of 2009 pandemic H1n1. And of course, if there is a third wave, encourage people to cover their coughs, wash their hands and stay home when they're sick, and follow guidelines for the use of antivirals.

The MDH continues to do careful surveillance on which strains are circulating and is asking hospitals to send swabs to MDH on anyone suspected of having influenza. Thus far the vast majority of circulating influenza viruses nationally have been 2009 pandemic H1N1, and there has been minimal seasonal influenza activity. Information on the MDH and the CDC website is updated on a frequent basis. Information about the use of anti-virals is also on these websites.

Lynfield is a MN-AAP member and a pediatrician.



Currently, influenza activity is classified as “sporadic” across the state of Minnesota (red line). The question is, will there be a third wave of H1N1, and when?

Minnesota H1N1 Statistics

- Spring wave: median age was 12; 260 hospitalizations.
- Fall wave: median age was 26; 1,549 hospitalizations.
- Approximately half of all hospitalization cases were people under 25.
- Nearly half of the children who were hospitalized had no known underlying conditions. 28 percent had asthma.
- 19 percent of those hospitalized ended up in the intensive care unit.
- 22 percent of adults who were hospitalized in the fall had obesity.
- 57 deaths were attributed to H1N1. Eight of them occurred in children under 18, two of whom had no known underlying conditions.

[Click here](#)

for the latest info on H1N1 from MDH

2010 Legislative Priorities

Access to Care

- **The MN-AAP supports efforts to ensure that every Minnesota child, adolescent, and pregnant woman has access to comprehensive medical care, mental health services, oral health care and access to a medical home.**

By ensuring access to health care, injury and disease can be prevented through early identification of disease, information on how to prevent injuries, and proper immunization. The MN-AAP strongly opposes efforts to remove children from programs that provide access to health care coverage or limit their access to critical benefits and care. Geographic, socio-economic and racial/ethnic disparities in access to care must be reduced.

- **The MN-AAP supports efforts to address workforce shortages and access to providers of care for infants, children and adolescents.**

A shortage of pediatric sub-specialists statewide and decreasing reimbursements for preventive health services is jeopardizing access to care in some portions of the state. Pediatric care should be delivered or directed by a well-trained primary care physician who is supported by the full range of medical and surgical specialties.

- **MN-AAP supports efforts to increase access to children's mental health services.**

It is estimated that 1 in 5 children and adolescents in the United States have a mental health disorder and that approximately 70 percent of those children and adolescents do not receive the needed mental health services.

The MN-AAP will support efforts to ensure that children in Minnesota have access to the mental health services they need to succeed.

- **MN-AAP supports efforts to ensure all children have access to an appropriate medical home.**

Medical home is a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The model, begun by the AAP and developed in collaboration from the American Academy of Family Physicians and American College of Physicians, is catching on as a way to provide higher quality care for patients with chronic disease in particular. The MN-AAP will monitor the development of the health care home model within Minnesota's health care reform efforts to ensure the model meets the unique needs of children.

Childhood Obesity Prevention and Reduction

- **MN-AAP supports efforts to increase daily exercise and building community environments that support regular physical activity.**

Almost 32 percent of school-age U.S. children and adolescents are at or above the 85th percentile of BMI for their age (JAMA. 2010). The MN-AAP will support efforts to promote physical activity and healthy food and beverage choices to prevent childhood obesity. The MN-AAP supports proposals such as Complete Streets, Play 60, maintaining SHIP funding and collaboration with local schools and public health to make lasting changes in the built environment that encourage physical activity.

In addition to these priorities, the Board endorses policies on a variety of legislative issues. These policies are continually updated on the website at www.mnaap.org

MN-AAP Childhood Obesity Task Force Needs Your Help

Are you aware of any helpful tools or resources to prevent or manage childhood obesity?

Examples include brochures, posters and other materials. Also, websites, software and other technologies.

This website link has a number of resources www.aap.org/obesity/whitehouse, including the template Rx for healthy living in English and Spanish.

Such tools and resources could be specifically for pediatricians or for children and parents.

Let us know if you have something to share! They will be reviewed for consideration to post on www.mnaap.org.

Email debilzan@mnaap.org

Rural Health Committee Meeting

Save the Date !

Thursday May 20

12:00 - 7pm

BayView Event Center
Excelsior, MN



Please come for all or even a portion of the day to engage in conversations about the future of rural pediatric practice. This forum provides a relaxed schedule with great discussion involving all participants and guest consultants. It's more important than ever for rural pediatricians to get together and discuss the ever-increasing challenges of delivering quality care medicine.

Dr. Michael Severson, Chairman, MNAAP Rural Health Committee, Chairman, District VI, American Pediatrics Board of Directors.

Watch your mail and the MN-AAP website for the agenda and registration information. Please contact the Children's of Minnesota outreach department with inquiries (612) 813-6633 or (888) 664-4542.

Stay up to date on
legislative activities

Go to <http://www.mnaap.org/legislativeupdate.htm>

If you would like to receive e-mail updates, email debilzan@mnaap.org

Find/Post Jobs at

www.mnaap.org/employmentopportunities.htm

For more information,
email cairns@mnaap.org

Minnesota's Vaccine for Children Program: Are Out-of-State Children Eligible?



By Patricia Segal Freeman, MDH

If you serve pediatric patients from Wisconsin, Iowa, North Dakota or South Dakota, you can provide MnVFC vaccine to those who are eligible according to Minnesota's eligibility screening form.

Any patient 18 years old and younger that receives medical care at a clinic in Minnesota can receive MnVFC vaccine if they meet the eligibility criteria.

These patients should be counted as part of your patient population and your vaccine needs would be calculated accordingly. For example, if you see 30 infants under 1 year of age from MN and 15 from another state, include both numbers (a total of 45 under age 1 year) when you report the number of children you see. This will assure that you receive adequate supply of MnVFC vaccine for all your patients.

So who is eligible for MnVFC vaccine?

Any patient served in your clinic, regardless of state residence, that is in any of the following categories can receive MnVFC vaccine:

- On medical assistance or a state insurance program – state doesn't matter
- Uninsured
- Insured but insurance does not cover the cost of vaccine
- Insured but has a cap that has been reached
- Insured but deductible is unmet

Questions?

Visit the Minnesota Department of Health's website at <http://www.health.state.mn.us/divs/idepc/immunize/mnvfc/index.html> or call the MnVFC program at 651-201-5522 or 1-800-657-3970.

Donate Online to the Minnesota Academy of Pediatrics at www.givemn.org

Currently the Foundation is participating in projects aimed at reducing childhood and teen obesity, increasing access to child and teen mental health experts and improving pediatric oral health. It is also supporting Reach out and Read, Family Voices and initiatives that promote universal health insurance for children, universal newborn screening, and universal immunizations for children.

[Click here to donate online](#)

Nominations Wanted for MN-AAP Awards:

Each year the MN-AAP recognizes a pediatrician for his or her outstanding efforts that contribute to the improvement of child health care.

In addition, MN-AAP chooses an individual from the community who goes above and beyond his or her everyday routine to advocate for the health and welfare of children in Minnesota.

Nominations are due May 1, 2010.
Click below for nomination forms.

[Distinguished Service Award](#) | [Child Advocacy Award](#)

Changes in School Immunization Law for Varicella Disease

By Patricia Segal Freeman, MDH

The Minnesota Department of Health (MDH) is asking for your help in implementing a change in how varicella disease history is reported under the school immunization law. This will make it easier for parents to document varicella disease so their children can go to school.



Photo Credit: James Gathany, Centers for Disease Control and Prevention

The Change

As of September 1, 2010, a parent's/guardian's signature *will no longer be accepted* to document history of a child's varicella disease in either kindergarten or seventh grade. Only the following will be legally acceptable to document a student's history of varicella disease:

- the signature of a provider along with the date of the child's varicella illness
- the signature of a provider along with a statement that the parent's or legal guardian's description of the child's varicella disease history is indicative of past varicella infection, or
- the signature of a provider or a representative of a public clinic along with laboratory evidence of the child's varicella immunity.

Why?

When the varicella immunization was added to Minnesota's School Immunization Law in the fall of 2004 (Minn. Rules, Chapter 4604.0900, subpart 3), a parent's/guardian's signature was allowed to document history of a child's varicella disease. *However, this was only temporary and it expires on August 31, 2010.*

This change was put into the law because as more children get their varicella shots, we have less chickenpox disease and more parents/guardians who have never seen a case of chickenpox and can't recognize it. The medical knowledge of a doctor is needed to make sure a child had the chickenpox – and not some other disease – so they are truly immune.

Here are some recommended ways that you can help with this change/process:

- Ensure that health care workers in your clinic document history of varicella disease in the patient's record. We strongly recommend that providers put this information into the State Immunization Registry (MIIC).
- Accept a parent's description of past or current varicella disease over the phone so they do not have to come into the office.
- Modify your clinic's immunization record to include information about varicella disease history.

Questions?

Contact Patricia Segal Freeman at MDH at 651-201-5503 or 800-657-3970 or e-mail at patricia.segal.freeman@state.mn.us

National Board Update



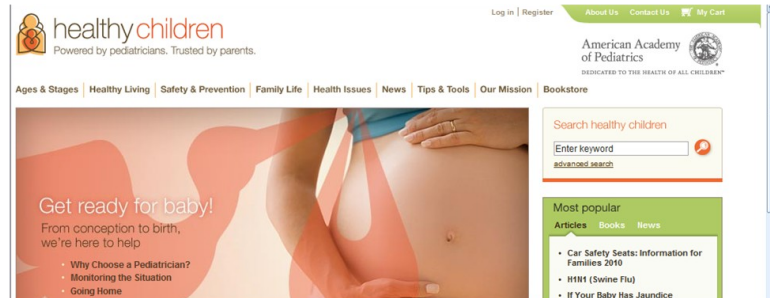
By Michael Severson, MD
National Board Member, District VI

I am writing this on my fourth day of the five-day AAP Board meeting. I wish I were skilled enough to fully translate the excitement, scope and breadth of Academy projects being presented this week. I will try to give you a little flavor of what the meeting was like.

We started with a financial report and I am happy to report that our CEO, Dr. Errol Alden, and our Chief Operating Officer, Mr. John Forbes, saw the economic downturn coming and developed a fiscal restraint program that has allowed us to continue to provide full services to members and the families we serve. Our dedicated staff made personal and financial sacrifices to accomplish this.

The Board divided into subgroups to work with staff to manage and plan AAP activities and obligations. I have oversight responsibility for information technology and participate on finance and membership advisory committees.

The most exciting IT issue has been the development of the [Healthy Children](http://HealthyChildren.org) website. This website is a comprehensive advice and education resource for parents and really for all who care for children. Please visit this site and then begin to recommend it to your families. You can also add it as a link if your practice has a website.



AAP Launches Website for Parents: HealthyChildren.org

The only Web site backed by 60,000 pediatricians, HealthyChildren.org offers trustworthy, up-to-the-minute health advice and guidance for parents and caregivers, along with interactive tools and personalized content.

The membership committee works tirelessly to provide value to you for membership commitment and dues. We want to be your accessible source for advocacy, continuing medical education, maintenance of certification and practice management as well as general advice and information.

Our meeting continued with a wonderful, expansive report from Dr. John Duby, chairman of the task force on Vision of Pediatrics 2020. Our own Anne Edwards, MD, served on this committee as well, so if you see her with a glazed look, it's from looking into the future for the last several months trying to predict megatrends, drivers, scenarios and transformations. I am sure we will hear about this from her at the annual meeting this year.

I conclude by thanking you for the opportunity to represent you and your needs at the Academy. Please don't hesitate to contact me with any concerns or comments. I can be reached by email at mseverson@AAP.org or my cell, 218 330-2216.

Early Screening + Care Coordination = School Readiness



Last February Dr. Betsy Murray, director of medical student education at the University of Minnesota, traveled to Denver, Colorado, to attend a national conference taking a closer look at the link between healthy child development and school readiness.

Currently, less than half of all children entering kindergarten are proficient across five learning domains, according to BUILD, a national initiative that helps state leaders prepare young children ages birth to five for school and conference host. Yet 94 percent of them have come in contact with a medical professional during their early childhood years.

“The number of young children who have been in contact with a medical professional vastly outpaces any other setting – including childcare or preschool,” said Murray, who was appointed by MN-AAP to be part of the MDH and BUILD team. “What that says is that pediatricians can have a critical impact in terms of identifying children who would benefit from early intervention and also promoting healthy early childhood development through their encounters with patients.”



- [BUILD](#)
- [Indicators and Strategies for Minnesota's Early Childhood System](#)
- [Healthy Tomorrows Project of MNCHIP](#)

As pediatricians begin to set up health care homes, they should be aware of this potential role.

“The reimbursement structure for the medical home model supports the kinds of screening and identification and care coordination that are necessary to identify and coordinate care for these kids that have risk factors in either health, education readiness or family support,” she said. “That often involves resources like social work and coordination across early childhood education special education environments.”

Lesson learned? The ABC's of school readiness start in the pediatrician's office for many kids.

AAP National Committee Members Needed

The AAP Board of Directors is soliciting nominations to fill 28 AAP National Committee member vacancies for terms beginning July 1, 2010.

For more information, please visit the AAP Member Center at:

<http://www.aap.org/moc/commnoms.htm>

Deadline for nominations is March 1, 2010.

Please contact caims@mnaap.org with any questions.

The Tools for Building a Health Care Home

October Conference a Success

In the midst of the H1N1 pandemic, about 200 physicians, nurses and other health care providers took time away from their busy schedules to talk about the importance of patient and family-centered care for primary care clinics.

The Building a Healthcare Home conference was held on October 29 and 30 at the Radisson Hotel and Conference Center in Plymouth.

Minnesota Department of Health Commissioner Dr. Sanne Magnan was one of many speakers who emphasized the importance of health care homes.

“Health care is going to change,” she said. “Health care homes are the way health care has to go. Whether or not there are rules around health care homes, whether or not there are payments for primary care coordination, policy makers are listening and there will be rewards for going in this direction. Even Medicare is looking at elements in health care homes.”

Beverly Johnson, BSN, president and CEO of the Institute for Family-Centered Care in Bethesda, Maryland, presented many tips on how to implement healthcare homes. There were many other speakers as well.

If you missed the conference, here were a few take-aways:

The Best Prescription for Non-Compliant Patients is to Engage Them

It’s difficult for some physicians to envision engaging and empowering patients to develop their own care plan. After all, physicians are the supposed to be the experts in medicine. What they fail to remember, however, is that patients are the experts on their own experiences and

goals. Studies show that when patients are engaged and allowed to help set their own goals, they’re much more likely to comply and follow through on their care.

“Some clinics drag their feet when it comes to health care homes because they’re afraid patients will say negative things and have unreasonable expectations,” Johnson said. “That will not happen. On the contrary, they energize you. They will give you great feedback on how to improve the quality of care.”

Develop a care plan *with* patients, not *for* patients.

Often the physician’s goals are different from the patient’s goals. For example, the physician’s goal for a chemically-dependent patient may be to keep that patient clean; however, the patient’s goal may be to stay out of the hospital. It’s important for physicians and patients to communicate their individual goals and merge them together.

“If you involve patients in the process, they become more compliant.”

-- Jeff Bangsberg

Changes don’t have to be expensive.

There are many ways to engage and empower patients. Beverly suggested a few:

- Post a welcome sign in different languages inside entrances.
- Call patients by their first names, rather than their last names.
- Provide nurses with a tent card to leave

(Continued on page 15)

with patients with their contact information, so they are familiar with each person they come in contact with.

- Turn your waiting room into an area of learning through relevant brochures, information and resources.
- Do a walk-about with patients to understand and appreciate their experience, from the parking lot to the waiting room to their physician's office.
- Select patients to form an advisory committee to provide suggestions on how to improve the quality of care.
- Select patients to teach seminars and workshops on managing their condition.

It's difficult, but not impossible to develop a health care home.

The best advice from presenters may have been to start small. They admit that it is a process, but it is well worth it.

Several providers as well as patients shared positive experiences with patient and family centered care. Currently there are more than a dozen providers in Minnesota working toward health care home certification. Over time, they are expecting to provide higher quality without higher costs.

Jeff Bangsburg, who is in a wheelchair due to a spinal cord injury, has set a goal to reduce the number of pain medications he is taking. Electronic medical records are helping him and all the specialists he sees to be on the same page.

Marge Turrin, who cares for her husband who has Parkinson's, helped to develop a comprehensive speciality center for people with Parkinson's and related disorders. Now she said she has

“perfect access” to everyone they need and don't have to wonder which doctor to call with questions.

Above all else, the underlying theme of the conference was to engage patients in order to achieve a win-win outcome for the patient, the provider and the community as a whole. As one physician put it, “We need to start referring to them as ‘participants’ as opposed to ‘patients.’”

“People say they don't have the time for this kind of collaboration. But without it, you'll be facing much more time and costs in the long run.”

-- Beverly Johnson

Upcoming Webinars on Health Care Homes

Wed., March 24

12 –1 p.m.

Health Care Home Payment Methodology

[More info / register](#)

Thurs., April 22

12—1 p.m.

Free and Low Cost Health Care Home Registry Resources

[More info / register](#)

For more information about health care homes, including past and future webinars, go to www.mnaap.org, click on projects, and then medical home.

Minnesota Pediatrician Voices Importance of Newborn Hearing Screening



Newborn hearing screening became mandatory in Minnesota in 2007. Before then, hospitals performed newborn hearing screening on a voluntary basis, and many hospitals didn't participate.

Concerned about the fact that a low number of kids were being referred for hearing screening, Dr. Lisa Schimmenti, associate professor of pediatrics at the University of Minnesota, sent letters to Governor Pawlenty and legislators, hoping to educate them on the issue. She also presented at hospitals around the state, emphasizing the importance of newborn screening.

Today every birth hospital does newborn hearing screening, and Dr. Schimmenti hopes the mandate will increase the number of children with early diagnosis and treatment for hearing loss.

"The thing I really want pediatricians to know is

that the likelihood that a child has hearing loss if they fail newborn screening is significant," she said. "When a child enters your practice, you need to go back and verify whether or not that child had been screened as a newborn and take the appropriate next steps.

"The other piece of the puzzle is sometimes babies pass newborn hearing screening and they still have hearing loss. So it's really important to know that just because they pass, it doesn't mean the story is over. There have been studies to show that not all hearing loss is present at birth. If there's any suspicion that a child has hearing loss, he or she should be sent for audiometric evaluation."

Hearing loss affects 1-3 babies per 1,000

[Click here for information for providers about newborn hearing screening](#)

Helping Haiti

Many of the children in Haiti are at increased risks for malnutrition and disease, trafficking, sexual exploitation and emotional trauma. You can help by making a donation. Below are some suggestions.

- [AAP Friends of Children Fund](#)
- [UNICEF](#)
- [Partners in Health](#)
- [Friends of the Orphans](#)

We're on Facebook and Twitter

As another way to stay connected with members (and the general public), MNAAP provides regular updates through Facebook and Twitter. Find us and become a fan.

FOLLOW US ON 

 Find us on **Facebook**

Woodbury Mom Donates Booster Seats to Coincide with New Law

When Betsy Horn walked out of King of Kings Church on June 6, 2009, she had an extra \$100 in her pocket. Betsy, who was one of MN-AAP's medical home parents, had been listening to her pastor talk about giving back to the community. He gave her and three others a simple mission: "Pay it forward."

At first, Betsy couldn't decide the best way to spend the money. All she knew was that she wanted to help children in her community somehow. After asking family and friends for ideas, she heard about a program through South Washington County that provides free car seats for children under age 2.

The program had plenty of free car seats to give away, but no booster seats for children over the age of 2. At about the same time, she found out that a new booster seat law was about to be passed, requiring children under age 8 and shorter than 4 feet 9 inches to be fastened in a

booster seat rather than a seat belt.

Betsy decided to use the money to purchase new booster seats for parents who couldn't otherwise afford them. She asked her family and friends to help as well. On October 8, 2009 she delivered 68



brand new booster seats to Washington County.

"There is a need out there," said Betsy, who has two boys ages 8 and 11. "There are people who need to choose between buying bread, milk and eggs for the week or a booster seat for their child. My family and I wanted to help by raising awareness that there was even a law and second of all that there are so many kids out there without car seats."



Since then, a handful of people have approached Betsy about donating additional car seats. It's been a great way to provide a boost to kids in the community – literally.

- Motor vehicle crashes are the leading cause of death for children ages 4–16 (American Academy of Pediatrics).
- 70 percent of Minnesota children ages 4–8 are riding either unbelted or not in a properly fitted booster seat (Wirthlin Worldwide Research Firm).
- For children 4–7 years old, booster seats reduce injury risk by 59 percent compared to seat belts alone (Children's Hospital of Philadelphia).

Did you know? The state has a limited number of free car seats and booster seats for hospitals, clinics and other organizations to provide to low-income patients. [Click here for more information](#) or contact Heather Darby, Office of Traffic Safety at (651) 201-7068 or Heather.Darby@state.mn.us

Welcome New Members

Joseph Arms

Barbara Bentz

Roxana Aguirre Castaneda

Laurel Cederberg

James Clark

Sloan D'Autremont

Hitesh Deshmukh

Adam Foss

Anjali Goel

Kelly Hill

James Laferriere

Robin Lloyd

Pamela Richards

Lisa Schimmenti

Andrea Singh

Kati Smentek

Hilary Stecklein

Heidi Stoltenberg

Joyce Warshawsky

Robert Zajac

Did you know?

- Sarah Jane Schwarzenberg, MD participated in the legislative Childhood Obesity Workgroup. This group includes legislators who are working to develop recommendations on state laws that can be created or changed to impact the rate of childhood obesity.
- Brooks Donald, MD is representing MN-AAP on the Minnesota Autism Spectrum Disorder Task Force created by 2009 legislation.
- Allison Golnik, MD and Michael Reiff, MD are serving on an Autism Steering Committee for a Clinical Learning Collaborative with the Departments of Health, Education, and Human Services.
- Peter Dehnel, MD received the Physician Communicator Award at the MMA annual meeting.

Dial in or Skype with MN-AAP

If you'd like to participate in advocacy meetings, or if you'd like to coordinate a regional workgroup on a specific issue, we'd be happy to facilitate it through a conference call or Skype connection.

For information on these options, contact cairns@mnaap.org

In Memoriam

Jane Van Roekel Deeb, MD passed away Dec. 27, 2009. Dr. Van Roekel was a founder of Dakota Pediatric Clinic and practiced pediatric medicine in Dakota County for over 30 years.

Renew Your Membership Online

Log onto <http://eweb.aap.org/myacctount> with your AAP ID# and password.

Or contact customer service at csc@aap.org or 866-843-2271 Monday—Friday from 7 a.m. to 5:30 p.m.

MN-AAP Communicates Primarily through Emails – Are You Receiving Them?

If you're not receiving bi-weekly e-mails from MN-AAP, please take the following steps to make sure you stay in the loop:



1. Check your spam/junk folder for messages from “MN-AAP.” If you find them, make sure you mark it “safe” or “not spam.”
2. If you don't find the email in your spam/junk folder, ask your IT department to white-list aap_minnesota@mail.vresp.com (note the underscore between aap and Minnesota)
3. Alternatively, provide us with a different email address.
4. Questions? Contact Melissa DeBilzan at debilzan@mnaap.org

Top 5 Ways to Get Involved with MN-AAP

1. **PEDS Day at the Capitol:** Join us March 3 (see page 5 for details)
2. **Primary Care Coordination:** If your practice has a number of children who have complex conditions and are on Minnesota Medical Assistance (Medicaid fee-for-service), MN-AAP pays \$500 per month for clinic participation and reports of progress. *Enroll by April 1, 2010.*
3. **Autism Medical Home:** If your practice has a group of children (birth to 8 years old) with or being evaluated for autism/ASD, you could be in a learning collaborative with other clinics for resources and partnerships. MN-AAP pays \$400 per month for clinic participation and reports of progress. *Enroll by February 28, 2010.*
4. **Pediatric Obesity Prevention:** Join a workgroup of the MN-AAP that is developing statewide initiatives.
5. **Pediatric Immunizations:** Join a workgroup of the MN-AAP that is looking at availability and access issues related to immunizations.
6. **Health Home Webinars/Conference Calls:** Scheduled monthly to help your practice become a medical home/health care home. Visit www.mnaap.org for details.

Email [Kathi Cairns](mailto:Kathi.Cairns@mnaap.org) for more information about any of these projects.