



Minnesota www.mnaap.org Pediatrician

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



Children's Health: Where do the Candidates for Governor Stand?

The November 2nd election is right around the corner and Mark Dayton (DFL party-endorsed), Tom Horner (Independent party-endorsed) and Tom Emmer (Republican party-endorsed) offer vastly different solutions to the health care dilemma. How would their proposed policies affect children and adolescents? What kind of changes can we expect to see in the next legislative session? Turn to page 4 to find out...and remember to vote!

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Mark Dayton, DFL



Tom Horner, IP



Tom Emmer, GOP

A Word from the President: Marilyn Peitso, MD



Pediatricians in the 21 clinics that participated in the Minnesota Medical Home Learning Collaborative, myself among them, have watched as medical home has been transformed from a model of how to provide care to children and youth with special health care needs to a process regulated by the state with terms to be negotiated with the insurance companies.

We may long just a little bit for the good old days when we had medical home all to ourselves as a project for our pediatric patients. Those days are gone, at least in Minnesota.

So, what's a snapshot of health care home today, and what may lie ahead?

To those certified health care homes, the state of Minnesota will pay patient coordination fees on a monthly basis. Providers will identify health care home patients using the tiering tool developed for Minnesota by the Department of Human Services and the Department of Health.

The tool ranks medical complexity from 1 to 4, with an additional payment per month increased by 15 percent for language barriers and/or serious mental health conditions in the

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1043 Grand Ave. #544
St. Paul, MN 55105
Phone: 651-402-2056
Fax: 651-699-7798
www.mnaap.org

Editor
Melissa DeBilzan
debilzan@mnaap.org

Editorial Committee
Anne Edwards, MD; Gordy Harvieux, MD; Elsa Keeler, MD; Rachel Lynch, MD; Mike Severson, MD

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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.

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Executive Director
Katherine Cairns
cairns@mnaap.org

Director of Communications
Melissa DeBilzan
debilzan@mnaap.org

Lobbyist
Eric Dick
edick@mnmed.org



Local CME Opportunities

October 29, 2010
Optimizing Shared Decision Making in Health Care
Neighborhood House at Wellstone Center, St. Paul, MN

October 29 - 30, 2010
A Taste of Tropical Medicine --
A Global Health Volunteerism Short Prep Course
Kahler Hotel, Rochester, MN

November 19, 2010
Minnesota Memorial Pediatric Orthopedic Symposium
Rochester, MN

December 3, 2010
Management of Musculoskeletal Conditions
in Children and Adolescents
The West Galleria, Edina

December 8-12, 2010
DB: PREP An Intensive Review of
Developmental-Behavioral Pediatrics
Chicago, Illinois

To register or for more information, visit
www.mnaap.org/calendar.htm

Correction: An article in the previous edition contained a typographical error. In "Preventing Youth Suicide: Strategies for Pediatricians," Table 1 illustrated the gender differences in suicide deaths and hospitalizations for non-fatal self-injury. The title for the table indicated that the data for suicide deaths by gender referred to all age groups. In fact, the table referred to suicide deaths by gender for youth ages 10-19. The correct graph is listed below.

Suicide Deaths by Gender, 2004-2008 (ages 10-19)

Gender	Count	Rate per 100,000
Male	167	9.0
Female	39	2.2

(Word from the President continued from page 1)

patients or caregivers. These increases are a first attempt, though imperfect, to take into account the added difficulty of coordinating care in the face of cultural and social barriers. We can expect that the tiering tool will change over time, hopefully to ever more accurately reflect the time and work that go into providing care coordination to our patients.

This summer the leadership of MN-AAP, Minnesota Academy of Family Physicians (MAFP), Minnesota Internists (MN-ACP) and Minnesota Medical Association (MMA) met with representatives from Minnesota health plans to gather information about how each plan will implement health care home payments to clinics “in a manner that is consistent with” the system developed by the state, as required by state law.

We posed a set of written questions to each plan, and the answers are posted on the home page of our website (www.mnaap.org) along with contact information if that was provided by the health plan. You can see some of the answers below.

You and your business manager/contract negotiator can call the insurance plan contact number listed to get started on the process of negotiating your clinic’s health care home

contract. Health plans have said they will not be contacting individual clinics/physicians regarding this.

The Minnesota Departments of Human Services and Health have applied for a Medicare demonstration project through Centers for Medicare/Medicaid. We should hear next month if Minnesota will be part of this large project to fund medical homes/health care homes for Medicare recipients. This will be good news for our adult medicine colleagues and should give even more momentum to health care home activity in our state as it becomes more financially feasible for primary care clinics to fund care coordinators.

I am always interested in hearing stories from you and your patients about your experiences in the health care home arena, positive or negative. It is by acting together that we can best advocate for our young patients and keep the medical home functioning in a way that works for all of us.

You can send me an email at peitsom@centracare.com with your comments.



Marilyn Peitsos, MD, FAAP
MN-AAP President

Health Plan Responses to Questions on Health Care Home Implementation				
	Preferred One	UCare	BCBS	HealthPartners
How does the health plan expect to meet the July 1, 2010 statutory requirement to “pay care coordination fees for their members...in a manner that is consistent with” the system developed by the state?	Preferred One is waiting for health care homes to become certified by the state. Once they are certified, PreferredOne will accept the codes and tiering tool as outlined by DHS.	UCare will follow a DHS model of tiered payment and will negotiate payment contracts individually with providers that become health care home certified or meet the NCQA certification process. UCare will not pay for services under the health care home until a contract is in place.	Blue Cross will use the state’s payment methodology as the basis for reimbursing network providers that become certified as health care homes and provide care coordination service to our members. However, we intend to adjust the state payment levels in a manner that will make them consistent with our existing provider contracts.	HealthPartners is currently using specific funding for care coordination payment methodologies. HealthPartners will meet the requirements for payment for health care homes and will be prepared to administer payments accordingly when the certifications are in place, if providers aren’t already under agreements for payment.
Will the plan recognize state health care home certification process for purposes of designating health care homes?	Yes.	Yes and will also recognize NCQA certifications for medical home. The DHS Health Care Home criteria will be considered. The contracts that are already in place with UCare for similar services that would be covered by health care homes criteria will also be considered.	Yes, for our Commercial and Public Programs business.	HealthPartners supports and has advanced payment reform to accelerate the development of health care homes (our own medical group is undergoing the MDH review for certification).
Health plan contact for health care home contracting information	To inquire about Health Care Home contracting, please call your Preferred One contract manager	HealthCareHome@ucare.org	To inquire about Health Care Home contracting, call your Blue Cross/Blue Shield contract manager	Chuck Abrahamson 952-967-6640 Charles.j.abrahamson@healthpartners.com
View the full set of questions and responses at www.mnaap.org/projects.htm				

Children's Health: Where do the Candidates Stand?

By Eric Dick, MN-AAP Lobbyist

It is my great pleasure to introduce myself as the newest member of MN-AAP's advocacy team. My name is Eric Dick and I am the new registered lobbyist for the Chapter. I will serve as the Chapter's "eyes and ears" and – when appropriate – the voice at the state Capitol during the upcoming legislative session.

By way of brief introduction, I come to MN-AAP most recently from the Minnesota State Senate, where I served as the Committee Administrator for the Senate Judiciary Committee and Senator Mee Moua. In addition to my work on the committee, I was the lead staff person for Senator Moua's chairmanship of the bi-partisan, bi-cameral Legislative Caucus on Children and Youth. Prior to my time at the Minnesota State Senate, I worked for a respected Twin Cities lobbying firm as well as U.S. Congressman Ron Kind in Wisconsin.

The 2011 legislative session promises to be very challenging as the state faces a budget deficit of upwards of \$6 billion. Given that almost three quarters of the state budget is devoted to K-12 education and health care, it is certain that the issues that the pediatric community cares about will be impacted.

Much will be determined by the November 2nd elections. Minnesotans will be electing a new governor and all 201 legislative seats are on the ballot. The major party candidates for governor offer starkly different plans for solving the budget crisis. The decisions made by the next governor and legislature will have dramatic effects on health care in Minnesota.

Legislators will also continue to work on the implementation of both the federal health care reforms (the Patient Protection and Affordable Care Act) as well as the 2008 Minnesota reform packages. A few months ago, the Minnesota

Department of Human Services announced the roll-out of the first health care homes, and many more are slated to soon follow. We will continue to monitor issues important to the Chapter, notably newborn screening, childhood obesity, vaccines, and tobacco.

“ Given that almost three quarters of the state budget is devoted to K-12 education and health care, it is certain that the issues that the pediatric community cares about will be impacted. ”

The next occupant of the Governor's mansion will also shape the direction of Minnesota's relationship to the federal government and federal health care reforms. Two of the three major party candidates have stated that they will accept the federal matching dollars in the form of "early Medicaid" adoption, and as we've seen over the last several months, many other federal grant opportunities may be available to Minnesota should the next governor choose to participate.

Election Day is November 2. Please do consider adding your voice! Midterm elections generally have very low turnout, so your vote will be vital. The 2011 legislative session holds both promise and pitfalls for MN-AAP. I look forward to serving as your representative at the Capitol and invite you to contact me with your thoughts or questions at any time.

Eric Dick can be reached at 612-362-3732 or edick@mnmed.org



Horner on Health Care

Horner has said he would support an expansion of Medical Assistance to include GAMC enrollees.

On his website, he calls for reforms of state programs without eliminating coverage for those in need. He notes that Minnesota will pay for the uninsured one way or the other. He says nursing homes should be fairly reimbursed, but that Minnesota also needs to find more community-based solutions for caring for the elderly.

In the area of personal responsibility, he says he supports holding people accountable for not having good health habits, and he'd support public policies that reduce tobacco consumption, such as increasing the tobacco tax. He'd also like to continue Minnesota's reform efforts that are underway to pay for outcomes not procedures and to improve care coordination in order to help patients better manage their expensive chronic conditions. Finally, he would support giving people greater ownership of their own health records so they can monitor their own progress and easily transport them from one doctor to the next.

Horner's budget proposal includes lowering the state sales tax by one percent, but also broadening it to include tax on clothing, personal services, alcohol and tobacco.

www.horner2010.com/issues/health-care/

On October 11, 2010 the three major candidates for governor took part in a spirited debate on issues relating to children's health and early education. The hour-long debate, referred to as the Minnesota Children's Forum, was sponsored by Children's Hospitals and Clinics of Minnesota, the Minnesota Early Learning Foundation and MinnPost.

They candidates addressed questions ranging from how they would increase the number of insured children in Minnesota to how they would fund early education programs to how they would promote better health and nutrition.

You can listen to their responses at www.minnesotachildrensforum.org

Dayton on Health Care

Dayton is an advocate for a national single-payer health care structure, noting on his campaign website that he hopes "to broaden Minnesota's health care into a 'single-payer' model for the nation – one that eliminates health insurance company profiteering."

Dayton would also seek to offer a public option to more Minnesotans by broadening Minnesota Care eligibility and increasing state subsidies of Minnesota Care premiums. Dayton also notes that he supports the Education Minnesota proposal to allow school districts to collectively negotiate for health insurance for their employees, thereby gaining bargaining power to obtain better coverage at lower costs.

Dayton is also a supporter of the 2008 Minnesota Health Reform Act which calls for the establishment of reporting measurements for the quality of care provided by hospitals and clinics, an expansion of the "health care homes" model of care for the chronically and terminally ill, and programs to reduce obesity and discourage Minnesotans from using tobacco.

In stark contrast to Emmer, Dayton supports moving GAMC recipients to Medicaid. The federal government is offering Minnesota \$1.4 billion in funding to do so, but the move would still cost Minnesota an estimated \$188 million.

Dayton plans to finance his health care initiatives primarily through increased taxes on those in Minnesota's wealthiest tax brackets.

www.markdayton.org/mainsite/issues/healthcare/

Emmer on Health Care

Emmer has been critical of the recently passed federal health care reform law, noting in a *Star Tribune* op-ed piece, that "getting the federal government out of our most personal health care choices is just a start." Should he be elected governor, Emmer plans to challenge the federal insurance mandate, slated to take effect in 2014, which requires all individuals to obtain health insurance coverage.

Another key element of Emmer's health care plan is the passage of the Health Care Freedom Act, a piece of legislation that Emmer sponsored as a state representative in September, 2009. There are three major parts to the health plan that Emmer is touting. According to Emmer's campaign website, tax deductions would be given to individuals to help them purchase health care coverage in the private sector. Second, insurance coverage mandates would be eliminated, and lastly, Minnesotans would be allowed to purchase health insurance across state lines.

Emmer has also proposed replacing Minnesota Care with vouchers to help individuals buy their own insurance coverage from the private sector. Minnesota Care is a publicly subsidized insurance program in which enrollees pay a sliding-scale fee based on family size and income. An estimated 100,000 Minnesotans use Minnesota Care each month according to the Minnesota Department of Human Services website.

Like Tim Pawlenty, the current governor, Emmer is also opposed to moving those who are currently utilizing General Assistance Medical Care (GAMC) to Medical Assistance.

Emmer would finance his proposals and deal with the budget deficit by cutting government programs and services while relying on market competition to drive health care costs down.

www.emmerforgovernor.com/issues/healthcare/

Working with Pediatric Home Care Agencies

By Amy Nelson, chair of the Council for Pediatric Home Care, MN HomeCare Association

Recent advances in medical technology have increased the number of pediatric patients now treated at home. Common home medical interventions include: infusion therapies with central and peripheral lines, lab draws, parenteral and enteral nutrition, sleep diagnostic testing, respiratory assistive devices such as ventilators, Bi-level, CPAP, oxygen monitoring, CO2 monitoring, airway clearance equipment and techniques.

The MN HomeCare Association's Council for Pediatric Home Care is the first of its kind among state home care associations. It is dedicated to act as a resource not only for physicians and health care agencies but also consumers. Its three-fold intent: offer optimal care approaches to meet specific client needs; provide trained and qualified nurses; prepare families to best care for their own children.

Local public health agencies previously provided some of these services in communities. However budget reductions have decreased the availability of these pediatric home care resources except for targeted populations of families and children.

Finding credible and reputable home care agencies to work with is a primary consideration for physicians. Examples of tools that pediatricians can use to access and implement home care:

- Pediatric Private Duty Nursing Qualification Assessment Tool -- determines a client's need for private duty nursing hours while accurately considering all conditions which require the intervention of a skilled nurse
- Acuity Tool -- determines reimbursement rates, anticipated outcomes, predictability of hospital re-admissions/ER visits and level of staffing skill/experience needed
- Annual Client Plan -- creates a detailed summary of all the factors involved in or influencing home care for the ensuing 12 months

Funding for pediatric home care is increasing as more people recognize its cost effectiveness. While the average tab for hospitalization can be \$5,000 per day -- and care for premature infants is often higher -- home care is reasonable by comparison, costing thousands less. Many insurance companies now cover extended hour nursing and care visits. A tracheotomy patient, for example, can be approved for 24 hours per day care for one month and then weaned onto family care.

Managed care companies such as Medica, Health Partners, UCare and Blue Cross/Blue Shield understand that home care for children is not only safe and efficient, but also from 5 -20 times less expensive than facility care. It also provides one-on-one care, which is very difficult to obtain at hospitals or group facilities.

Communication Tips for Physicians:

1. Talk to home care agencies to understand their array of services
2. Ask for their advice or perspective on certain types of patients
3. Be proactive in communicating about home care with families and nurses
4. Discuss discharge planning, including home care, at a patient's admission
5. Tell home care providers what you need to optimize patient care

Physicians should feel comfortable in trusting and delegating care duties to home care nurses.

"We have sent over 400 children home with trachs and vents and find home care to be a very good alternative with fewer infections and low readmission rates," says Dr. John McNamara, director of children's home care & hospice program at Children's Hospitals and Clinics of Minnesota "Even acute illnesses have been successfully cared for at home."

For a list of pediatric home care agencies, go to www.mnhomecare.org

Minnesota Fall Flu Guide Available Online

Starting this year, Minnesota's statewide "Flu Plan" will only be available online. MDH will not be mailing out hard copies.

In addition, the plan's name has been changed to Minnesota Fall Flu Guide 2010-11.

A link to the guide can be found at the bottom of MN-AAP's home page at www.mnaap.org

MOC Deadline Approaching for Some Pediatricians

Adapted from publications provided by AAP and ABP

Pediatricians with certificates expiring in 2010 will need to work fast to fulfill requirements for certification and submit supporting materials by Dec. 1, 2010.

The first step is to log on to the ABP Web site at www.abp.org and create or access your personal portfolio.

The MOC program consists of four parts:

Part One: Evidence of Professional Standing

Pediatricians must hold a valid, unrestricted medical license.

Part Two: Evidence of Lifelong Learning and Self-Assessment

Pediatricians assess and enhance knowledge in areas important to their practice using activities developed by the American Board of Pediatrics and other organizations such as the American Academy of Pediatrics (AAP).

Part Three: Evidence of Cognitive Expertise

Pediatricians pass a secure examination administered at testing centers worldwide.

Part Four: Evidence of Satisfactory Performance in Practice

Pediatricians participate in a range of ABP-approved quality improvement (QI) projects designed to assess and improve the quality of patient care:

- Patient Surveys
- Performance in Practice
- Web-based QI modules
- Credit for participation in ABP-approved QI projects

In October, *AAP News* posed the following questions to H. James Brown, M.D., FAAP, ABP, vice president of physician relations, regarding the MOC process.

How many pediatricians have certificates expiring in 2010?

We have more than 9,600 diplomates with a certificate expiring in 2010. A significant percentage of this cohort still needs to complete activities and/or enroll via the ABP Web site.

What is the cost and when is payment due?

Diplomates are required to pay \$1,030 at the time of online enrollment. Payable by Visa or MasterCard, this fee includes access to ABP-developed part 2 and part 4 activities, and includes the cost of one secure MOC examination every 10 years.

Can you estimate the time needed to complete a part 4 QI activity?

This is solely dependent upon the activity in which the diplomate chooses to participate. This can range from six weeks to nine months and beyond.

A diplomate can fully meet MOC Part 4 requirements by completing a Web-based activity such as an ABP Performance Improvement Module (PIM) or an EQIPP (Education in Quality Improvement for Pediatric Practice) module developed by the American Academy of Pediatrics.

Below are some of the Web-based programs that fulfill the Part 4 QI activity. For a complete list of QI programs, visit www.abp.org or aap.org/mocinfo

For Certificates Expiring in 2010	For Certificates Expiring in 2011	Requirements
By Dec. 15, 2010	By Dec. 15, 2011	<ul style="list-style-type: none"> • Fulfill requirements for current certification: <ul style="list-style-type: none"> • 1 Knowledge Self-Assessment • 1 Performance in Practice activity or project <p><i>Login to your ABP Portfolio to access these activities</i></p>
By Dec. 2010	By Dec. 2011	<ul style="list-style-type: none"> • Enroll in MOC • Submit license and pay fees
Jan. 2011- Dec. 2015	Jan. 2012 - Dec. 2016	<ul style="list-style-type: none"> • Accumulate 100 points: <ul style="list-style-type: none"> • Self-Assessment Activities: 40 points • Performance in Practice: 40 points • Electives: 20 points in either of the above • Complete 1 patient survey
Jan. - Dec. 2013	Jan. - Dec. 2014	<ul style="list-style-type: none"> • Pass secure exam (next exam is in 10 years)
By Dec. 2015	By Dec. 2016	<ul style="list-style-type: none"> • Re-enroll in a new 5-year MOC cycle

- Diagnosing and Managing Asthma in Pediatrics
- Give Your Immunization Rates a Shot in the Arm
- Differentiate and Manage: GER and GERD in Pediatrics
- EQIPP Nutritional Assessment of the Healthy and Chronically Ill Child

For more information about MOC requirements and deadlines, go to www.abp.org or www.aap.org/mocinfo

PROS Febrile Infant Study Completed

Office-based treatment and outcomes for febrile infants with clinically diagnosed bronchiolitis

As part of the Febrile Infant Study, investigators described (1) the frequency of sepsis evaluation and empiric antibiotic treatment, (2) clinical predictors of management, and (3) serious bacterial illness frequency for febrile infants seen in office settings with clinically diagnosed bronchiolitis.



Of the 3,066 infants seen during a national pediatric study, practitioners made an initial clinical diagnosis of bronchiolitis (before obtaining any test results) for 218 (7%), of which none had serious bacterial illness. Of these 218 patients, 182 (83.5%) had respiratory distress, chest-related findings or a cough, compared with 337 (12%) of 2,848 patients in the group without bronchiolitis.

Practitioners were less likely to perform a complete sepsis evaluation, urine testing, and cerebrospinal fluid culture and to administer parenteral antibiotic treatment for infants with bronchiolitis compared to those without. However, they were significantly more likely to be hospitalized (50% vs 34%) and received more follow-up visits (mean: 1.9 vs 1.7 visits).

Significant predictors of complete sepsis evaluation in infants with clinically diagnosed bronchiolitis included younger age, higher maximal temperature, and respiratory syncytial virus testing, while predictors of parenteral antibiotic use included initial ill appearance, age of <30 days, higher maximal temperature, and general signs of infant distress.

The findings suggest that serious bacterial illness in young febrile infants with clinically diagnosed bronchiolitis is uncommon in office settings. Limited testing for bacterial infections seems to be an appropriate management strategy.

www.aap.org/pros

What is PROS and why should you join?

PROS is a research network sponsored by the Academy with the mission statement focused on enhancing pediatric practice and improving child health. The PROS network was formed almost 25 years ago.

PROS practitioners just like you and me have completed 24 national studies that have resulted in over 65 published articles and 116 published abstracts. PROS studies have been cited in more than 1,000 publications. PROS is marching on with a new effort to study electronic health records. The initial mission remains to enhance processes in this evolving tool to improve pediatric practice and child health care. PROS and the contributions of PROS members have created new knowledge, changed public policy, and made me a better practitioner.

Well, that sounds nice, but I am just too busy to add one more thing to my day.

I know you are busy. You will not have to add something every day. You will not be participating in a study all of the time. Some studies can be completed in a week or two. Some may take a few months. When a study is set up by the network, you will get a notice about it. You will have an opportunity to review the study design and decide if you are interested. Next, you can look further to see if it fits your practice. If you have more questions, you can contact PROS and get more information. As one of the chapter coordinators, I can assure you each study is vetted so you can participate with minimal impact on your patients or practice.

What will my patients think if I am doing research?

My experience had been totally positive. In fact, I would say it is an asset. I commonly supplement a discussion with a parent or colleague by adding that I am a member of a national pediatric research network called PROS that has done a study on this topic. If I personally participated in the study, I add that information as well. To use a political term, it adds "gravitas" to my comments.

Hopefully my enthusiasm for PROS has added to your interest. I would be happy to discuss this further with you on a personal basis.

Let me also suggest that you learn more about PROS by reading a recently published article in the June Pediatric Annals titled "PROS: A Research Network to Enhance Practice and Improve Child Health."

If the journal isn't handy, you can go to www.Pediatric-SuperSite.com and just type PROS in the Google search window.

J. W. Hendricks, MD FAAP can be reached at DocJWH@aol.com

Ted Jewett, MD FAAP is the PROS representative in Minnesota. He can be reached at tjewett@slpeds.com or (952) 380-5164

Immunizations: Taskforce Update

The MN-AAP Immunization Task Force is composed of statewide pediatricians who are interested in:

- Increasing Minnesota's infant, child and teen immunization rates; and
- Decreasing obstacles for clinics to provide CDC recommended vaccines and reimbursement.

Over the past several months, the Task Force has partnered with the Minnesota Department of Health in surveying states with a universal vaccine purchase program, updated health plans on findings, identified pediatric practices not participating in the Minnesota Vaccines for Children Program (MnVFC) and Minnesota Immunization Information Connection (MIIC), participated in a statewide immunization conference, worked with health system purchasing staff to compare federal vaccine purchase prices to what system/private clinics pay, and worked with a U of M School of Public Health student (Steven Haasken, MD) who is working with the Task Force.

What have we learned?

- Federal vaccine purchase prices are generally at least 20% cheaper than what large private clinics currently pay. You can compare your clinic's purchase price to the federal rates at:
www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm

- A universal vaccine purchase program would pool dollars from state vaccine purchase programs (MnVFC, Medicaid) with dollars paid for vaccines to clinics by health plans/ insurance companies for their covered children. This pool of vaccine dollars would be used by either a state agency or new non-profit (it has been done both ways by different states) to purchase all of the vaccines for all children in the state. It would eliminate the need for separate refrigeration systems/documentation systems in each clinic. It would eliminate the need for clinics to purchase vaccine and conserve clinic cash. Clinics would not bill payers for vaccine, but only for the vaccine administration charge, for their infant, children and teens.

- A vaccine purchase program would offer large health system discounts for vaccines to smaller clinics that participate through an affiliated purchasing agreement. The smaller clinics may save 10-15% on vaccine costs by partnering

with larger clinic systems. Clinics would still need to pay for their vaccine and would still bill payers for vaccines and for vaccine administration.

- Comments from some clinics indicate that they are concerned about the increasing costs of vaccines, the difficulties their families have in affording health care when they have high co-pays, and the inequities in vaccine costs among clinics.

- Pediatricians remain concerned about the very low vaccine administration reimbursement for children covered by Medicaid and see this as a priority to be addressed. The recent AAP report (http://pediatrics.aappublications.org/cgi/content/full/124/Supplement_5/S451) proposes to add the administration charge to the VFC program and be funded by the federal government. The new federal health reform legislation will increase Medicaid payment rates to the Medicare levels -nearly double the vaccine administration payment- in 2013.

How can you help?

- Participate in the Immunization monthly lunchtime conference calls for updates.

- Let the Immunization Task Force know what you think about the universal vaccine purchase proposal and the impact on your clinic- a brief survey will be sent by email to all members in November.

- MN-AAP sent AAP childhood immunization public service announcements to radio stations statewide. Consider joining the Immunization Task Force and serving as a local media and/or parent resource.

If you are interested in participating in the next immunization conference call, please contact cairns@mnaap.org



Results of the latest National Immunization Survey (NIS) show that the overall rate among Minnesota children age 19-35 months is 71.6 percent for the series of four DTP/DTPaP, three IPV, one MMR, three hepatitis B, one varicella, and four pneumococcal (this doesn't include Hib). This is slightly higher than the national rate of 70.5 percent and ranks Minnesota 17th in the nation.

A November lunchtime webinar on Minnesota vaccine purchasing options will be announced at www.mnaap.org

Pediatric Obesity: Taskforce Update

Which labs should be done on a patient with a BMI greater than the 95th percentile? What are the pharmacological treatment recommendations for obesity or hyperlipidemia? What does an exercise prescription look like for an obese child? What does a diet prescription look like?

In an effort to address these and other questions, MN-AAP is developing a series of webinars to highlight best practices for evaluating, treating and preventing childhood obesity. In addition, these webinars are a way to share best practices among members as well as specific concerns and questions.



Past Webinars

Childhood Obesity in Minnesota – An Overview

What is MN-AAP's pediatric obesity taskforce doing to help pediatricians assess, treat and prevent this epidemic in Minnesota? In this hour-long webinar, Dr. Sarah Jane Schwarzenberg, co-chair of the taskforce and director of the pediatric weight management program at the University of Minnesota, shares tools, strategies and success stories that physicians can take back to their practice as well as their community, including BMI and diagnosis, strategies for communicating with parents and the 5-2-1-0 approach to treatment.

Download the podcast or a copy of the webinar at www.mnaap.org/obesity.htm

Future Webinars

A November webinar on obesity screening or motivational interviewing will be announced soon.

In addition to webinars, the taskforce is continually adding physician and patient resources to the MN-AAP website at www.mnaap.org/obesity.htm

If you are interested in participating on the obesity taskforce, please contact debilzan@mnaap.org



Childhood Obesity Prevention Resources in MN

Duluth: A nonprofit organization called Fit City Duluth has put together a searchable database of dozens of local physical activities that can be done in every season in addition to health and wellness tips. A great resource for kids. Dr. Nancy Beery, an MN-AAP member, is a board member of this organization. www.fitcityduluth.com

Central Minnesota: BLEND, which stands for Better Living: Exercise and Nutrition Daily, is a non-profit that coordinates large, community-based events to teach families about healthy eating and physical nutrition. In addition, it works with the medical community to encourage BMI tracking and provide materials to physicians. www.blendcentralmn.org

University of Minnesota: With a \$7 million federal grant, the University of Minnesota recently created a childhood obesity center with the goal of transforming the exercise and eating habits of as many as 530 Minnesota families. The center will connect families with health advocates in medical clinics, enroll them in classes about healthy foods and active lifestyles, and improve their access to healthful foods and recreation opportunities. www.ahc.umn.edu/opc

Minneapolis: HCMC has launched a program called Taking Steps Together, which teaches children and their families all about nutrition, cooking and healthy lifestyle practices. Programs are held once a week for 16 weeks. Call Rachel at (612) 873-6839 for more information.



Timothy Culbert, MD, an MN-AAP member, co-authored a new book on self-care skills for kids with weight challenges called *Be Fit Be Strong Be You*.

He is a pediatrician at Children's Hospital in Minneapolis.

Patient-Centered Care Index Being Piloted in 7 Clinics

Family Voices of Minnesota is working in collaboration with the Minnesota Academy of Pediatrics and the Minnesota Department of Human Services on a project focused on primary care clinics.

As part of this project, Family Voices is developing and piloting a Patient/Family-Centered Care Index (PFCC) to measure and track the implementation of patient- and family-centered care in clinics.

Several primary care providers, other clinic staff and patient/parent advisors have given their expert input into this measurement tool. Over the next few months, the PFCC Index will be piloted in 7 primary care pediatric and family practice clinics.

The PFCC Index is part of a comprehensive package of services provided by Family Voices of Minnesota that includes:

- Technical assistance to develop a quality improvement action plan that sets goals and steps for change
- Follow-up assistance and training on patient-family-centered-care principles and practices for clinic staff
- Preparing patient/parent partners to serve on advisory committees.

Please visit the Family Voices of Minnesota website at www.familyvoicesofminnesota.org for the latest information on health care reform and other great tools to assist in the care of children and youth with special health care needs.

Did you know?

20 percent of all Minnesota families with children have at least one child with special health care needs.

Resource for Adolescents with Sexual Health Questions

Adolescents who have sexual health questions can now text them to 36269 or chat with a health educator online at www.sexualhealthmn.org. This in addition to the toll-free hotline 1-800-78-FACTS.

Established in 1978, the Minnesota Family Planning & STD Hotline provides reliable, medically-accurate, and confidential information about family planning and sexual health, as well as referrals to low-cost and free clinics.

It is sponsored by the Minnesota Department of Health

and operated by Family Tree Clinic in St. Paul. The hotline serves the entire state of Minnesota.

Physicians and clinics can order free promotional materials to share with adolescent patients (pens, magnets, etc.) by visiting www.sexualhealthmn.org and clicking on "About the Hotline."

Did you know?

Of the 18.9 million new cases of STIs each year, 48 percent occur among 15 - 24-year-olds.



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Free Online CME:

Recognizing Early Motor Delays

AAP and Pathways Awareness, a non-profit committed to early motor delay detection, have developed a new online continuing medical education (CME) course: Recognizing Early Motor Delays at the 2-month Pediatric Well Visit.

This 20-minute course is being offered free for all pediatricians by entering the code PATHWAYS at checkout.

To take the course, visit <http://www.pedialink.org/cme/htemd>

Community of Pediatricians: Member Profile



Vijay Chawla, MD
Pediatrician
Austin Medical Center —
Mayo Health System

What do you like best about your job?

The best part about my job is being able to work with many different families, getting to know them personally, and to share their lives with them as their children grow. I've even been invited to some of my patients' birthday parties and that means a lot to know I'm thought of as a part of their family.

What are your areas of special interest?

Preventive care and infectious diseases are of special interest to me. I am in a leadership role for immunizations, infection control, and preventive care at Austin Medical Center, as well as am involved in many continuous improvement projects in these areas.

What is your greatest professional accomplishment?

I think my greatest accomplishment is becoming a physician. I came to the United States from India and got my start at the Mayo Graduate School of Medicine in Rochester, so being a part of the medical community, and with Mayo Clinic, is a great honor.

What are some of the biggest challenges you face in your practice?

One of the biggest challenges in today's world is technology. I didn't grow up with any computer background, and still today have a constant learning process with the continually changing technology. The other major challenge in today's health care is dealing with insurance carriers — often times they try to tell us (physicians) what you should and should not use to treat patients and that may not always be in the best interest of my patients. I would like to be able to provide the best, cost-effective care to every child, all the time.

If you weren't a pediatrician, what would you be, and why?

I always wanted to be a doctor. When I did my first rotation as a medical student in pediatrics, I knew that being a pediatrician is what I wanted to do for the rest of my life. I am so thankful to be able to have achieved my goal of becoming a physician and ultimately support my family. I've also enjoyed teaching and I feel I do that in my day-to-day work in pediatrics, so that is great. You'll likely laugh when I tell you that I wanted to pursue a career in professional classical Indian dancing prior to becoming a physician. I was actually very good at it and I enjoyed it a lot.

How is pediatrics different today than when you started?

When I first started I had autonomy to do what I thought was in the best interest of each patient and we never looked at the bottom line. Now health care is more like a business model. Some changes are positive and others are not so conducive to a positive patient-provider relationship. With that said, preventive care was not at the forefront in patient care as it is today, so that is a huge plus. Today we can educate and help prevent multiple injuries and illnesses and likely save hundreds if not thousands of lives each day because of it.

“ *When I first started I had autonomy to do what I thought was in the best interest of each patient and we never looked at the bottom line. Now health care is more like a business model.* ”

What advice do you have for younger pediatricians?

I would tell young physicians that primary care can be very satisfying. The relationships you build with patients and their families are priceless. I think pediatricians contribute significantly to the lives of our patients. It's a wonderful job.

To read about or contact other MN-AAP members, go to www.mnaap.org and click on Community of Pediatricians.

Statistics on Children's Health in the U.S. and MN

In the United States

Each year the Federal Interagency Forum on Child and Family Statistics publishes a report on the well-being of children and families. Its 2010 report is now available. Below are some highlights from data collected in 2009:

- About 70 percent of children under age 18 lived with two parents, 26 percent lived with one parent and 4 percent lived with neither parent.
- About 22 percent of children lived in food-insecure households in 2008, up from 17 percent in 2007 and the highest recorded percentage.
- The percentage of children ages 5-11 with untreated dental cavities declined from 27 percent in 1999-2004 to 20 percent in 2005-2008.
- The percentage of infants born pre-term declined for the second straight year, from 12.8 percent in 2006 to 12.7 percent in 2007 and to 12.3 percent in 2008.
- 19 percent of children ages 6–17 were obese in 2007-2008, compared to 6% in 1976-1980, but unchanged from 2005-2006.
- 9 percent of all youth ages 16-19 were neither enrolled in school nor working in an average work week in 2009, up from 8 percent in 2008.
- 7 percent of black, non-Hispanic children ages 1-5 had blood levels at or above 5 ug/dL in 2005-2008, the highest levels among racial and ethnic groups.

View the full report at www.childstats.gov

In Minnesota

Last year the Children's Defense Fund released fact sheets on poverty, health, hunger, child welfare, early childhood development, education and youth at risk for children in each state. Below are some statistics specific to Minnesota:

- In 2008, 7.1 percent of all children in Minnesota were uninsured.
- Half of those enrolled in Medicaid are children, yet only 23.4 percent of Medicaid expenditures are directed toward children.
- 19.5 percent of two-year-olds are not fully immunized.
- In Minnesota, a child is born into poverty every 53 minutes.
- A child is abused or neglected every one hour.
- A child dies before his or her first birthday every 1 day.
- A child or teen is killed by gunfire every 10 days.
- Minnesota is 3rd among states in its infant mortality rate.
- Minnesota is 6th among states in percent of babies born at low birth weight.
- 63 percent of public school fourth graders are reading below grade level.
- Minnesota is 24th among states in per pupil expenditures.

View the full report at www.childrensdefense.org/

Recent Census Bureau information shows the number of children without health insurance coverage declined in all but two states last year. **Minnesota was one of two states with increasing rates of uninsured children in 2009.**



You Spoke, We're Listening: 2010 Member Survey Results

As of early mid-October, 93 members responded to MN-AAP's annual membership survey. Their responses will help guide MN-AAP's legislative priorities, educational programs, and communication efforts in 2011. Below are some of the highlights. If you have not yet participated, you may still do so at www.mnaap.org

Please choose 3 legislative priority issues that should be part of MN-AAP's 2011 legislative agenda.

Universal access to health care for children	60%
Obesity prevention	46%
Decrease health disparities	37%
Mental health screening/resources for children	26%
Newborn screening preservation	26%
Medical home for children with chronic conditions	26%
Preserve child health benefits in state programs	22%
Increase oral health access for children	21%
State/health plan universal vaccine purchase	19%
Child abuse prevention	18%
Coverage of habilitative therapy	17%
Expand early childhood screening, education	16%
Increased taxes dedicated to pediatric access	15%
Support EMR implementation	13%
Anti-smoking legislation	12%
Foster care	11%
Reimbursement for vaccine administration	9%
Expanded service mandates for kids with autism	9%

Other suggestions: Comprehensive sexuality education, infant and early childhood mental health, pediatric workforce issues, circumcision coverage, and bike helmet law for children.

The public policy committee will monitor these key issues identified on the member survey. Priorities will be set by the board prior to the legislative session based on recommendations from the policy committee, which considers these survey results as well as anticipated key issues during the upcoming legislative session.

Which methods of communication do you prefer?

Email	96%
Web page	15%
Traditional mail	12%

To receive bi-weekly email updates or an electronic newsletter only, email debilzan@mnaap.org

Which activities and services are you most likely to participate in during 2011? Check all that apply.

Read newsletter	65%
Attend the annual meeting	44%
Use the website www.mnaap.org	43%
Attend CME opportunities	43%
Receive email updates	34%
Participate in MOC 4 programs	28%
Attend webinars	20%
Participate in Peds Day at the Capitol	18%
Participate in quality improvement programs	16%
Participate in Internet-based forums	14%
Serve on a committee	14%
Participate in health care home training	12%
Serve on pediatric council	11%
Participate in PROS	9%
Participate in CATCH grant opportunity	3%
Other	4%

For more information about any of these activities or services, contact caims@mnaap.org.

Which information are you most interested in receiving from MN-AAP? Check all that apply.

Local programs/resources affecting pediatricians	71%
CME opportunities	65%
Legislative updates	60%
Upcoming events	57%
News about my colleagues	40%
Committee/board updates	39%

Watch for more information about these issues in MN-AAP's quarterly newsletters, bi-weekly email updates and website at www.mnaap.org. If you are not receiving bi-weekly email updates, please contact debilzan@mnaap.org.

If MN-AAP were to offer ongoing, continuous quality improvement projects that could satisfy MOC 4 requirements, in which ones would you be most likely to participate?

Asthma management	36%
Obesity prevention/reduction	36%
Developmental and behavioral health screening	35%
Pediatric immunizations	26%
Hospital-based improvement	24%
Autism	23%
Health care home implementation	23%
None	16%
Oral health	10%

Other suggestions: smoking cessation in parents, adolescent preventative care improvement, lactation support, effective parenting for very challenging children, acute care pediatrics/emergency medicine, injury prevention, substance abuse and child abuse.

MN-AAP is applying to become a MOC 4 provider for programs in developmental/behavioral health screening, obesity prevention/reduction and health care home/medical home implementation. Additional ideas may be considered in the future. Contact caims@mnaap.org for more information and suggestions.

Are you interested in communicating with other members? If yes, how? Check all that apply.

List of members and their contact information	46%
Email listserve	36%
Networking events	26%
Educational webinars	19%
Online forum/discussion board on website	19%
Mentoring college students interested in peds	14%
Family friendly events (with or without CME)	12%
Pediatric resident statewide networking	9%

MN-AAP has made it easier to view a list of members and their contact information. Simply go to www.mnaap.org and click on Community of Pediatricians. Enter your username (AAP ID number) and your password (last name). If you have problems, email debilzan@mnaap.org. In addition, MN-AAP is exploring the idea of an email listserve as well as additional member-only events and webinars. You can also follow MN-AAP on Facebook and Twitter.

Job Opportunities Posted on www.mnaap.org

Minneapolis, MN
Pediatrician, Park Nicollet Clinic

Virginia, MN
Pediatrician, Duluth Clinic

St. Cloud, MN
Pediatrician, HealthPartners
Central Minnesota Clinics

For details, go to www.mnaap.org and click on employment opportunities.

To post an opportunity at your clinic, email caims@mnaap.org

Peds Day at the Park: Bringing Pediatricians and Pediatric Residents Together



Sixty pediatric residents from the U of M and Mayo, pediatricians and their families attended a Minnesota Twins game on September 4, 2010.

At the 7th inning stretch they heard from MNAAP President Marilyn Peitso about the need for pediatricians in primary care, rural health opportunities, loan forgiveness programs and MN Health Care Home. Past-president Anne Edwards provided an update on public policy initiatives.





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Remember to VOTE on Nov. 2

Turn to pages 4-5 for more information about the candidates for governor.



Consider Giving to MN-AAP's Foundation on Nov. 16

GiveMN has declared Tuesday, November 16 as "Give to the Max Day" and is offering incentives to inspire nonprofit and donor participation on that day.

Consider making a donation to the Minnesota Academy of Pediatrics on this day. Your donation will support projects aimed at reducing childhood and teen obesity, increasing access to child and teen mental health experts, improving pediatric oral health, and promoting universal health insurance, newborn screening and immunizations for children.

To contribute or for more information, go to www.mnaap.org

AAP Launching Membership Drive in November

AAP is kicking off a membership campaign on November 1 with a goal of bringing in 1,000 new or reinstated members by Jan. 31, 2011.

Members will be provided with all the resources they need to recruit their colleagues, including an online search tool to find lapsed members in their community.

Contest rules and recruiter resources will be posted on the Member Center home page, www.aap.org/moc on November 1st.

