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Word from the President: Robert M. Jacobson, MD, FAAP
Celebrating the Large Chapter of the Year Award

In case you haven’t heard, MNAAP received the 2014 Outstanding Large Chapter of the Year award in March at AAP’s Annual Leadership Forum. AAP has been awarding chapters for their performance since 1964. Of its 66 chapters, 18 are defined as large. Minnesota is among those 18. We’ve won the award twice before, most recently in 2010 under the leadership of Anne Edwards, MD.

What made MNAAP stand out from other chapters?

I would argue that the infrastructure, relationships, and membership efforts that won us the award in 2009 led to our recognition again in 2013. Frankly, we have not changed our approach to chapter leadership and activity since then. Perhaps we have matured some processes. Of course we would hope so, but what appear to be critical factors in our success remain unchanged.

By infrastructure, we mean our organization with contract staff, committees, and work groups. Our work groups are key to driving advocacy, education, and outreach as well as our ability to address collaborations and membership. We aim for 3 or 4 work groups whose work is based on our annual member surveys that drive our strategic planning. Our work groups thus come and go--forming, transforming, and dissolving, depending on the issues we pursue with our strategic plans.

Our next round of strategic planning takes place this summer under the leadership of incoming President Sue Berry, MD. As a result we will have a different set of work groups for the coming 2 years. The strategic planning gives us the flexibility to maximize our limited resources.

By collaboration, we mean our continued efforts to work closely with allies for children’s health around the state, including not-for-profit organizations, parent groups, and professional organizations as well as state government offices and agencies. We also pursue support from our own national AAP as well as other national resources that can support our work.

MNAAP’s legislative priority this year has been the restoration of the Minnesota’s newborn screening program. We have put the lion’s share of our resources in leading and shepherding legislation to restore the program. As a result of this focus, we have had to rely on our collaborators to take the lead with other issues this year.

But our work with collaborators extends far beyond legislative advocacy. We pursue grants with them, we invite them to participate in our work groups, and we execute educational efforts with them.

Continued on page 3...
Upcoming Local CME Opportunities

Mon, May 5 - Wed, May 7
Moving Forward in the Treatment of Pediatric Neurological Disorders
Minneapolis Convention Center
Hosted by Gillette Children’s Specialty Healthcare

Thurs, May 6
Perinatal Hospital Leadership Summit: Implementing Best Practice Mother-Baby Care
Hosted by the Minnesota Breastfeeding Coalition

Thurs, May 8
Spring Pediatric Update
Bullying Risks and Response: A Primary Care Approach
Hosted by Children’s Hospitals and Clinics of Minnesota

Sat, May 17
Changing Psychiatric Practice in 2014: What You Need to Know
The American Swedish Institute
Hosted by the Minnesota Psychiatric Society

Thurs, May 22
Rural Pediatrics Conference
Crow River Winery and Event Center
Hosted by MNAAP and Children’s Hospitals and Clinics of Minnesota

Thurs, May 29 - Fri, May 30
Topics and Advances in Pediatrics
Courtyard by Marriott Mpls
Hosted by U of M

Sat, June 7 - Fri, June 13
Pediatric Pain Master Class
Hosted by Children’s Hospitals and Clinics of Minnesota

Thurs, June 12
Child & Teen Checkups: The Adolescent Health Encounter
Rochester
Hosted by MDH and the U of M

Fri, June 13
Hot Topics in Pediatrics Conference & Annual Meeting
- Practical Approaches to Managing and Preventing Pediatric Obesity
- HPV training
- HCH collaborative
- Eliminating Health Disparities
- MNAAP Annual Dinner

The Hilton, Bloomington
Hosted by MNAAP

Thurs, Sept. 11 - Sat, Sept. 13
NPHTI Pediatric Clinical Hypnosis
Oak Ridge Hotel and Conference Center, Chaska
Hosted by U of M

Thurs, Sept. 18 - Fri, Sept. 19
Practical Pediatrics for the Primary Care Physician
Hosted by Children’s Hospitals and Clinics of Minnesota Minnesota

Thurs, September 25
Sixth Annual Minnesota Childhood Injury Summit
Vadnais Heights Commons
Co-hosted by Safe Kids Minnesota, MDH and the Minnesota Safety Council

Mon, Sept. 29 - Tues, Sept. 30
Pediatric Days 2014
Chicago, IL
Hosted by Mayo Clinic

To register or for more information, visit www.mnaap.org/calendar.htm
Without their collaboration, we would be a smaller, less successful, less productive chapter.

By membership efforts, we mean our focus on the inclusiveness of our organization. We strive to represent all pediatricians across the state. To do that, ideally, all pediatricians should belong to our chapter. We work to keep our dues affordable and include at no charge trainees as well as retirees.

Our focus on trainees is driven by our need to prepare for the future and to utilize the energy they can bring now. Our focus on retirees is driven by our respect for what they have already contributed as well as what their acquired experience and wisdom can now teach us.

And we regularly reach out to non-members. We hold events that are open to members and non-members alike. We strive to be useful and accessible.

But, for us, membership is not about reaching a certain number. It’s about including, supporting and engaging as many pediatricians as possible. Winning such an award is a great honor, but we cannot relax. We have to ask how we are going to stay relevant, focused, and solvent. I’d argue that we maintain our current infrastructure, cultivate our collaborations, and continue to reach out for new members and work to deserve the ones we have.

Our work, of course, requires member input as well as participation. Our success depends on it. It always has and it always will.

Robert M. Jacobson, MD, FAAP
MNAAP President
jacobson.robert@mayo.edu

Receiving the 2014 Outstanding Large Chapter of the Year Award on behalf of MNAAP (left to right) were Katherine Cairns, Executive Director; Pam Shaw, MD, District VI chair; Susan Berry, MD, president elect; Robert Jacobson, MD; president; and Chuck Oberg, MD, District VI vice chair.
8:00 a.m. - 12:00 p.m.

**Practical Approaches for Managing and Preventing Pediatric Obesity**

Co-hosted with the Minnesota Pediatric Obesity Consortium

Discuss evidence-based practices with a special focus on co-morbidities and underserved populations. Presentations take a closer look at food insecurity; fatty liver disease; dyslipidemia and multi-cultural approaches to discussing healthy weight with families.

1:00 p.m. - 5:00 p.m.

**Eliminating Health Disparities: Pediatric Challenges and Successes**

Minnesota has one of the largest gaps in health disparities in the country. This session will focus on persistent disparities in health outcomes for minority children in Minnesota, including rates of immunization, obesity and infant mortality. Gain practical resources you can share with families to get them connected to the care and services they need.

5:00 - 6:00 p.m.

**Medical Student/Pediatric Resident Abstract Competition**

See and hear pediatric clinical case studies, quality improvement and research projects presented by Minnesota medical students and pediatric residents. Community pediatrician judges are welcome to assist.

6:00 p.m. - 9:00 p.m.

**MNAAP Annual Meeting Dinner: Breaking the Impact of Poverty on Child Health**

More than 11 percent of all MN children live in poverty. What can individual pediatricians do about this statistic and its impact on child health? Following our keynote by Renée Jenkins, MD, past president of AAP, hear a brief overview of newborn screening and other hot topics. This is a great opportunity to connect with colleagues and learn from those who are leading the way to protect and enhance the health of Minnesota’s children.

Speakers for the day include: Ed Ehlinger, MD, PhD, commissioner of MDH; Renée Jenkins, MD, past president of AAP and Professor of Pediatrics at Howard University College of Medicine; Diana Cutts, MD, HCMC; Nissa Erickson, MD, Minnesota Gastroenterology, P.A.; Julia Steinberger, MD, Amplatz; Muna Sunni, MD, FAAP, University of Minnesota; Julie Boman, MD, FAAP, Children’s Hospitals and Clinics; Damon Dixon, MD, Amplatz; Weining Hu, MD, CentraCare Clinic; Dawn Martin, MD, MPH; HCMC; Abe Jacob, MD, MHA, Amplatz; Amy Burt, DO, Medica; Robert Payne, MD, Children’s Hospitals and Clinics; Charles Oberg, MD, MPH, AAP District VI Vice-Chair; Jeff Schiff, MD, MBA, FAAP, DHS; Lauren Gilchrist, Office of Governor Mark Dayton; Peggy Flanagan, Children’s Defense Fund of Minnesota; Marilyn Peitso, MD, FAAP, CentraCare; Nathan T. Chomilo, MD, Reach Out and Read-MN. Additional speakers to be announced soon.
Register below or online at [www.mnaap.org](http://www.mnaap.org)

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Please select the sessions you plan to attend:

- Practical Approaches for Managing and Preventing Pediatric Obesity
- HPV - Skill Building for Strong Provider Recommendation
- HCH Learning Collaborative for Clinics-Hospitals-Health Plan
- Eliminating Health Disparities: Pediatric Challenges and Successes
- MNAAP Annual Meeting and Dinner: Breaking the Impact of Poverty on Child Health

**Keynote:** Renée Jenkins, MD, FAAP, past president of AAP

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**EXHIBITING OPPORTUNITIES**

Companies and non-profits that provide valuable pediatric tools and resources are encouraged to exhibit.

Email debilzan@mnaap.org for details.

**MAIL COMPLETED FORMS WITH PAYMENT TO:**

MNAAP
1043 Grand Ave. #544
St. Paul, MN 55105
Or Fax to: 651-699-7798

**QUESTIONS? CONTACT**

Melissa De Bilzan
651-338-1823
debilzan@mnaap.org

DON’T MISS OUT! REGISTER NOW!

2014 HOT TOPICS IN PEDIATRICS CONFERENCE

Friday, June 13, 2014

Total Enclosed: $ _______________

- MasterCard  - VISA  - Check (payable to MNAAP)

- I cannot attend MNAAP’s annual meeting/dinner. Please donate my meal ticket to a resident/medical student.

Address        City    State    Zip            Phone

Credit Card Number        Exp. Date        CSV Code        Billing Zip

Print Name as it appears on Card
Over 100 pediatricians and trainees gathered at the State Capitol on March 26 for the chapter’s annual Pediatricians Day at the Capitol. A day of advocacy and action, the discussion focused upon the chapter’s key legislative priorities for 2014: restoring Minnesota’s newborn screening program to its former nation-leading status and making schools safer with a robust, comprehensive anti-bullying policy.

Following an introduction by Anne Edwards, MD, chair of the MNAAP Policy Committee and Robert Jacobson, MD, president of the MNAAP, attendees heard updates on the state of the legislative session and the status of key goals for the chapter. Senator Scott Dibble (DFL - Minneapolis) visited with the group and provided an update on his Safe Schools for All proposal, an effort to combat bullying. The group also heard from Rep. Nick Zerwas (GOP - Elk River), a key newborn screening supporter in the House of Representatives. Rep. Zerwas also shared with the group the tales of his multiple pediatric heart surgeries, and offered his thanks for the work of pediatricians.

Following the formal program, pediatricians fanned out across the Capitol to meet with their individual elected officials. Much of the group reconvened at a St. Paul restaurant to debrief about the day’s advocacy work. The group was joined by a surprise guest: Minnesota Department of Health Commissioner, Ed Ehlinger, MD, a pediatrician himself.
Bill to Restore Newborn Screening Signed into Law!

May 6 was a great day for children and their families! Governor Dayton signed a bill that would remove the 71-day and 2-year time limits for saving newborn blood spots, data, and test results generated from those blood spots. Backed by the MNAAP, the MMA, and other medical and parent organizations, including the March of Dimes, the bill passed the House 69-58 and the Senate 36-20.

Under the new law, children, their families, and their clinicians will be able to access the blood spots, data, and results generated indefinitely so that it is available to parents and clinicians in cases of missed, delayed or false diagnoses. Furthermore, the stores of blood spots and data will serve to support quality improvement and screening test development.

In essence, the law positions Minnesota to save as many lives as possible while recognizing the rights of an individual to refuse testing, request destruction of test results, or both. The Minnesota Department of Health soon will announce plans to implement the new law.

MNAAP has been leading the effort to preserve newborn screening data to ensure it remains available to parents and physicians in cases of missed, delayed, or incorrect diagnoses. Long-term storage is also critical to new test development.

The bill garnered broad support from many parent and medical groups. In addition to several hospitals, it was backed by the Minnesota Hospital Association, the Minnesota Medical Association, the Minnesota Chapters of the March of Dimes and American Heart Association as well as the Save Babies through Screening Foundation.

Many MNAAP members sent emails to their legislators, encouraging their support of the bill. Others sent letters to the editors of their local papers. Thank you, members, for advocating on behalf of Minnesota’s children.

Newborn screening saves lives!

Anti-Bullying Bill Signed Into Law

In a sun-soaked ceremony on the front steps of the Capitol, Governor Dayton signed into law the Safe and Supportive Schools Act, a comprehensive anti-bullying bill that has been considered by the Legislature for more than a year.

Minnesota’s anti-bullying statute has been widely dubbed among the nation’s weakest. Under the bill, school districts are required to establish comprehensive anti-bullying policies that contain key protections for students. The bill also includes requirements for reporting of bullying incidences, as well as resources for students, teachers, and education administrators.

The bill had long been a key priority of the MNAAP.

MNAAP Board Election: Cast Your Ballots Online

MNAAP has 5 openings for member pediatricians and specialists interested in supporting its mission of protecting and improving the health of all Minnesota children and teens. At least one of the vacancies is for a pediatrician/pediatric specialist in greater Minnesota. Terms begin July 1, 2014 and run through June 30, 2016. Please take a moment to vote for the candidates you feel would best represent the chapter. Visit www.mnaap.org to view candidate bios, submit your online ballot and/or see a list of current board members. Submit your ballot by Thursday, June 12!
Is Breastfeeding Still Best? MN Hospitals Make Changes to Support it

By Pamela Heggie, MD, FAAP, IBCLC, Fairview Children’s Clinic, Minneapolis and Robert M. Jacobson, MD, FAAP, Mayo Clinic, Rochester and MNAAP President

A recent article published in the journal Social Science and Medicine made headlines and was widely quoted in blogs, email listserves and Facebook: “Is Breast Truly Best? Estimating the Effects of Breastfeeding on Long-term Child Health and Wellbeing in the United States Using Sibling Comparisons” (Colen, 2014). This article raised questions about the long-term benefits of breastfeeding on health outcomes for children.

The investigators reviewed infant feeding histories within families and compared the long-term health outcomes of siblings within the same family. In particular they focused on families with siblings who had discordant feeding types where one sibling was breastfed and the other bottle-fed. The investigators compared the outcomes of these siblings over time, looking at 11 variables, including body mass index, asthma, obesity, and additional behavioral and academic outcomes. The study found that overall the breastfed children scored better than the bottle-fed children in 10 out of 11 health outcomes when all children were combined.

Yet when the investigators compared siblings in the same family—one breastfed and the other not, they found no statistically significant differences. They suggest that it is familial factors such as home environment, socio-economic status, race, and work status of mother that influence health outcome more than infant feeding type. The investigators conclude that breastfeeding has no long-term benefits.

However, the study is deeply flawed. When looking at the methods and the way the study was conducted, we note that the investigators fail to consider the duration of breastfeeding. The investigators included children in the breastfed group who may have received any amount of breastfeeding. Even breastfeeding prior to discharge from the hospital following delivery would have sufficed. The AAP recommends breastfeeding over formula feeding when possible and exclusive breastfeeding for six months before the introduction of solids. The study did not compare infants fed exclusively with breastmilk for six months with infants fed exclusively with formula for six months. The reader is left wondering how many of the discordant siblings were both basically formula-fed the entirety of their infancy.

This shortcoming of the study ignores the robust body of literature demonstrating a dose response relationship between breastmilk and health outcome. Multiple studies reported by the Agency for Healthcare Research and Quality (AHRQ) and noted in the 2011 Surgeon General’s Call to Action to Support Breastfeeding show that exclusive breastfeeding and a longer duration of breastfeeding improve health in a number of areas, including reduced risk for obesity, diabetes, infection, sudden infant death syndrome, necrotizing enterocolitis, and other health outcomes.

In addition, the investigators do not define “bottle-feeding.” The investigators appear to assume that a bottle-fed infant was given formula, but many mothers who choose not to nurse give breastmilk to their baby by bottle. By including babies who received breastmilk in the bottle-fed group, differences due to breastmilk versus formula would be lost.

Another limitation of this study is that it only addresses long-term effects (4-14 years) when looking at potential benefits of breastfeeding versus bottle feeding. It ignores the early short-term benefits of breastfeeding so important in preventing illness in a baby’s first year of life, including reduction in sudden infant death syndrome, necrotizing enterocolitis, pneumonia, otitis media, and diarrhea.

Finally, the investigators disregard the benefits of breastfeeding on maternal health. Women who breastfeed have much lower rates of obesity, heart disease, and cancer and these effects last a lifetime for the mother. In addition, breastfeeding mothers often note the cost and time savings of breastfeeding.

The authors claim their results show that the benefits of breastfeeding are “overstated.” We disagree, given the many limitations of this study. Often the headlines from controversial studies like this one are confusing for families in our practices. So what shall we tell parents about breastfeeding?

The AAP 2012 Statement on Breastfeeding and the Use of Human Milk gives clear guidance to us and to the families we provide care for: Pediatricians should recommend exclusive breastfeeding for about 6 months, followed by continued breastfeeding to at least 1 year as complementary foods are introduced. The AAP statement goes on to say that “Given the documented short- and long-term medical and neurodevelopmental advantages of breastfeeding, infant nutrition should be considered a public health issue and not only a lifestyle choice.”

Minnesota Hospitals Act to Support Breastfeeding

Many hospitals throughout Minnesota are focusing on ways to improve breastfeeding rates and support infant feeding choice so that all families can reach their infant feeding goals. Some hospitals have chosen to pursue the Baby-Friendly Hospital Initiative as a way to help families get off to the right start with breastfeeding. The Baby-Friendly Hospital Initiative not only helps to increase overall rates
The 10 Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.

2. Train all health care staff in skills necessary to implement this policy.

3. Inform all pregnant women about the benefits and management of breastfeeding.

4. Help mothers initiate breastfeeding within 1 hour of birth.

5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.

6. Give newborn infants no food or drink other than breast milk, unless medically indicated.

7. Practice rooming-in—allow mothers and infants to remain together—24 hours a day.

8. Encourage breastfeeding on demand.

9. Give no artificial nipples or pacifiers to breastfeeding infants.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

In 2009, Baby-Friendly hospitals provide care that emphasizes best practice in infant feeding, while helping ALL families reach their infant feeding goals. Hospitals provide breastfeeding support for mothers who plan to breastfeed and instruction about safe formula feeding for mothers who choose to formula feed their babies. No mother is ever “forced” to breastfeed.

There are currently 20,000 Baby-Friendly hospitals and birthing centers worldwide in 150 countries, but as of 2013, only 6.9% of US birth hospitals were certified Baby-Friendly. In Minnesota, two hospitals are Baby-Friendly: the University of Minnesota Amplatz Children’s Hospital and Austin Medical Center (Mayo Clinic Health System). Regions Hospital in St. Paul and Hennepin County Medical Center (HCMC) in Minneapolis are participating in a grant program from the Centers for Disease Control and Prevention called Best Fed Beginnings, which is designed to increase the number of Baby-Friendly hospitals in the country. Regions and HCMC joined 88 other hospitals throughout the country on a fast track Baby-Friendly journey as part of this grant program.

As of January 2014, 16 out of 97 Minnesota maternity care hospitals have declared intention to work on becoming Baby-Friendly hospitals. Despite this progress, 73.5 percent of women giving birth in Minnesota start out breastfeeding but less than half are still breastfeeding at 6 months and only 23.5 percent are exclusively breastfeeding (CDC, 2013), falling short of the AAP’s recommendation to exclusively breastfeed for 6 months. Also, according to recent data from the Minnesota Women, Infant and Children’s nutrition program (WIC), significant racial and ethnic disparities persist in breastfeeding rates throughout Minnesota (WIC, 2012).

The Baby-Friendly Hospital Initiative helps to create health equity in infant feeding, emphasizing cultural competence and equal access to best practice maternity care and lactation support regardless of race, ethnicity, income, family structure or language.

Be on the look-out for more Baby-Friendly hospitals in Minnesota! Maybe you can take the lead at your hospital to improve health equity in Minnesota for mothers and babies!

Check out the online toolkit for pediatricians and families from the MN Breastfeeding Coalition at http://mnbreastfeedingcoalition.org/pediatrictoolkit/

14th Annual Committee on Rural Health Education
Thurs, May 22 | 12 – 6 p.m.
Crow River Event Center | Hutchinson

Hosted by MNAAP and Children’s Hospitals and Clinics of Minnesota. Roundtable discussions include:

- **Epilepsy:** Dimitrios Arkilo, MD, Minnesota Epilepsy Group, P.A.
- **Pediatric psychiatry:** David Einzig, MD, Children’s Hospitals and Clinics of Minnesota
- **Pediatric gynecology:** Anne-Marie Priebe, DO, Children’s Hospitals and Clinics of Minnesota

Register at [www.mnaap.org/calendar.htm](http://www.mnaap.org/calendar.htm)
Hearing screeners in Minnesota have a valuable new resource in the Guidelines for Hearing Screening after the Newborn Period to Kindergarten Age, recently approved by the Minnesota Newborn Hearing Screening Advisory Committee.

The new guidelines provide Minnesota-specific information and resources, including details on screening equipment, protocols, and pass/refer criteria, as well as Individuals with Disabilities Education Act (IDEA) Part C and Part B referral and evaluation. They also clarify documentation and reporting requirements.

The biggest impact of these guidelines on the primary care provider’s practice is the definitive direction given to screeners thereby streamlining their decision making and referral process, which in turn assists providers in the timely identification of children most at risk for permanent hearing loss. The guidelines provide different referral recommendations and timelines for at-risk children, which separates them from those who have transient or fluctuating hearing loss due to otitis media with effusion.

Consistent with American Academy of Pediatrics (AAP) and Joint Commission on Infant Hearing 2007 recommendations, children who pass their newborn hearing screening but have a risk factor for hearing loss should be referred to an audiologist by 24-30 months of age. The guidelines clarify that this should occur as soon as a concern is identified.

Screening algorithm for OAE and tympanometry: www.improveehdi.org/mn/library/files/oaetympflowchart.pdf

Children with hearing loss that are identified and provided access to language BEFORE six months of age are able to learn language at the same rate as their hearing peers.

The guidelines give specific direction regarding the appropriate use of otoacoustic emissions (OAE) screening for children after the newborn stage through three years of age, or when developmentally necessary in older children, and the use of tympanometry in identifying the absence of middle ear effusion. The screening algorithm for OAE and tympanometry calls for a waiting period of 14-21 days if a child has a REFER on both OAE screening and tympanometry, but primary care providers can proceed directly to the step of middle ear evaluation—saving valuable time for the family and potentially reaching a diagnosis more quickly.

Pure tone audiometry is recommended for screening children age three and older, with tympanometry used as indicated by the guidelines as a second stage screen for children with a pure tone screening REFER. For children who REFER on pure tone audiometry screening at a primary care visit, the provider may proceed directly to the step of middle ear evaluation.

Hearing screening in early childhood plays a critical role in the EHDI process by identifying children with permanent and longstanding fluctuating childhood hearing loss that may affect health, communication, learning and development. With prompt referral and follow-up, Minnesota children have an opportunity to receive appropriate and timely care and services which lead to better health and educational outcomes. For more information, please contact the Minnesota EHDI program at ehdi@state.mn.us or call (651) 201-3650 or visit www.improveehdi.org/mn/index.cfm Find the guidelines online at: www.improveehdi.org/mn/library/files/afternewbornperiodguidelines.pdf

WIC Requiring Medical Documentation for Some Reformulated Infant Formulas

The caloric density of some Similac specialty formulas has been reduced below federal WIC guidelines. As a result, parents may need to obtain medical documentation from a physician to continue to receive them from WIC.

For more information, contact MDH at 651-231-2155.

Note: Neither pediatricians nor parents should assume newer or more expensive formulas offer any health benefits, according to March 28 article in AAP News titled "What Pediatricians Need to Know About Low Calorie/ Low Protein Formulas."

In 2012, Minnesota screened 66,784 (98.7%) newborns for hearing loss
Poverty, Toxic Stress and Health Disparities

By Charles N. Oberg, MD, FAAP, Program Director of Maternal and Child Health at the University of Minnesota’s School of Public Health; pediatrician at Hennepin County Medical Center; District VI Vice Chair for the American Academy of Pediatrics.

In 2013 the AAP added poverty and child health to its strategic plan as a key priority calling for further investigation as well as action. Its agenda reads in part, “When families can’t afford the basics in life, it negatively affects their health. Poverty can inhibit children’s ability to learn and contribute to social, emotional, and behavioral problems. Furthermore, poverty is a contributing factor to toxic stress, which has been shown to disrupt the developing brains of infants and children and influence behavioral, educational, economic and health outcomes for years.” As poverty affects children from minority communities at higher rates, the resulting disparity in toxic stress results in disparities of health.

At the start of the Millennium, the overall poverty rate in the United States was at 11.3 percent as compared to the higher rate of 16.2 percent for children. By 2012, the overall poverty rate had increased to 15 percent and 21.3 percent for children, representing a significant increase over the first decade of the 21st Century.

The poverty rate among minority children is especially concerning. An estimated 37.9 percent of black children and 33.8 percent of children of Hispanic descent lived below the poverty threshold in 2012 compared to 12.3 percent of white, non-Hispanic children. Minnesota’s income disparity between children of Caucasian descent and those of color is even more striking and of major concern. The overall child poverty rate for the state was 14.6 percent, significantly less than the overall United States. But the poverty rate for white children was 8.2 percent contrasted to 30.4 percent for Hispanic children and to an alarming 46.1 percent for our African American children.

How does poverty contribute to persistent health disparities? It is not just through the lack of access to health care. The AAP in 2012 released a policy statement entitled Early Childhood Adversity, Toxic Stress, and the role of the Pediatrician: Translating Developmental Science into Lifelong Health. It documents how intense, frequent, and prolonged activation of the physiological stress-response systems has a lasting impact on the developing physiological endocrine, immunological, inflammatory, and neurological functioning regulatory systems. In turn, these disruptions place the child at risk for a myriad of health and mental health problems over the lifespan, such as atopic conditions (e.g., asthma; allergies), hypertension, chronic infections, and emotional and behaviors problems. Hence, persistent health disparities linked to poverty and toxic stress contribute to the manifestation of a variety of childhood health problems and persistent health disparities.

Please join us on Friday, June 13 for the 2014 Hot Topics in Pediatrics Conference with the afternoon session focused on “Eliminating Health Disparities: Pediatric Challenges and Successes.” During the afternoon session, the keynote speaker will be Minnesota Department of Health (MDH) Commissioner Edward Ehlinger, MD, who will discuss the department’s recent report on advancing health equity in Minnesota. Remain for our annual dinner to hear former national AAP president Dr. Renee Jenkins, a renowned adolescent health expert from Howard University and a member of the newly formed AAP Task Force on Poverty and Children’s Health, discuss what pediatricians can do about the link between child poverty and health.
Recent media attention has some adolescents and parents wondering whether the human papillomavirus (HPV) vaccine is safe and effective. The discussions that have prompted all of this chatter are not based on available evidence. Unfortunately, a lack of validity does not prevent rapid transmission of rumors and innuendo, especially on television and the Internet.

Pediatricians can allay fears of patients and families and improve HPV vaccination rates if they are aware of the evidence and respond effectively to patient and parental questions. They also need to be as committed to HPV immunization as they are to all of the other AAP-recommended vaccines.

Following are some talking points that pediatricians can use to answer questions about effectiveness and safety of HPV vaccine.

**Effectiveness**

Clinical trials performed to achieve Food and Drug Administration approval showed the following:

- HPV 16/18-related cervical intraepithelial neoplasia grade 2/3 or adenocarcinoma in situ were reduced by 100 percent.
- Genital warts in females were reduced by 97 percent.
- Genital warts in males were reduced by 89 percent after three doses and 67 percent after one dose.

**Post-marketing surveillance in “real world” settings showed dramatic benefit:**

- 56 percent reduction in prevalence of HPV strains 6, 11, 16 and 18 in adolescent girls in the United States (National Health and Nutrition Examination Survey) despite the fact that only 33 percent of girls received three doses.
- 77 percent reduction in prevalence of HPV strains 6, 11, 16 and 18 in adolescent girls in Australia within three years of vaccine introduction (three-dose immunization rates of 70 percent).
- 75 percent reduction in low-grade cervical abnormalities in Australian girls younger than 18 years of age within three years of vaccine introduction.
- 45 percent reduction in genital warts in girls 16-17 years of age in Denmark.
- 36 percent reduction in genital warts in U.S. girls 15-19 years of age despite low HPV immunization rates.
- 88 percent reduction in genital warts in Australian females younger than 21 years of age.
- Data on cervical cancer reduction will take longer to obtain due to the time between HPV infection and development of cancer. But data on prevention of precancerous lesions make it clear that the HPV vaccine is having its desired effect.

While it is important to administer the HPV vaccine prior to sexual debut, there is an additional advantage to providing HPV vaccine at the recommended age of 11 to 12 years. The antibody response is more robust, with higher levels of antibodies achieved when given at 11 to 12 years compared to after age 16 years. Data on persistence of antibody are optimistic, with high antibody levels maintained beyond seven years post-immunization. Continued follow-up is needed to determine how long the antibody persists at “protective” levels. However, it doesn’t appear that a booster will be needed.

**Safety**

- Nearly 60 million doses of HPV vaccine have been given in the United States through 2013.
- Post-marketing surveillance has not identified any new safety concerns in female or male HPV vaccine recipients.
- Injection site discomfort is the most common adverse event.
- Syncope is the most common safety concern. Adherence to a 15-minute observation period after vaccination should prevent significant adverse consequences due to syncope.
- Reports to the Vaccine Adverse Event Reporting System have declined dramatically since 2008 with no serious adverse events reported in 2013.
- Post-marketing surveillance has not shown any increased risk following HPV vaccine for the following conditions: Guillain-Barré syndrome, seizures, stroke, venous thromboembolism, appendicitis, anaphylaxis or other allergic reactions.
- While not approved to be given during pregnancy, no safety concerns have been identified in the HPV pregnancy registry, which includes reports of girls who have been immunized with HPV vaccine while pregnant.
New School and Daycare Immunization Rules in Effect this September

By Dawn Martin, MD, MPH, Pediatric Staff Physician, Hennepin County Medical Center, Assistant Professor of Pediatrics, University of Minnesota

Long waited changes to Minnesota’s Immunization law will go into effect in September 2014. Minnesota’s immunization law has not been updated for over 10 years and current law did not reflect national standards to protect children from vaccine-preventable disease. The Minnesota Department of Health (MDH) started a process almost two years ago to update Minnesota school and daycare requirements to reflect national immunization standards as set by the Advisory Committee on Immunization Practice (ACIP). Drs. Robert Jacobson, Dawn Martin and Michael Garvis were participants in the Immunization Rulemaking Advisory Committee for this process and Drs. Robert Jacobson and Mark Schleiss testified at a public hearing in June 2013 in support of these changes. MDH also involved other stakeholders in the process, including schools, parents, child care providers and early childhood programs. The new immunization requirements for children in Minnesota child care, early childhood programs and schools apply to children enrolling in programs beginning September 1, 2014.

Weaker school and daycare rules have been proven to result in lower rates of vaccination and higher rates of vaccine-preventable disease. School and daycare immunization rules not only protect the individual children who are vaccinated, but those who cannot get the vaccines because of specific underlying diseases, those who do not respond to the vaccines, and those too young to get the vaccines. They also protect those who care for these children and the families of the children who attend school and daycare facilities. These new rules do not change the medical exemption or option for parents to decline any or all vaccines for conscientious reasons.

The new immunization rules support and strengthen our work as pediatricians to protect children from vaccine-preventable diseases and keep Minnesota children and families healthy.

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New Vaccine Requirements

- **Hepatitis A and B** – for all children over 2 months old in child care or an early childhood program
- **Tdap** – for all students entering seventh grade. Students in eighth through 12th grade must show documentation if the school requests it. This replaces theTd immunization requirement.
- **Meningitis** (meningococcal) – for all students entering seventh grade. Students in eighth through 12th grade must show documentation if the school requests it.
- Kindergarten children must have their final dose of DTaP and polio on or after their fourth birthday.

Early childhood programs now included

Also under Minnesota’s new Immunization Law are early childhood programs, which include programs that provide instructional or other services to support children’s learning and development, serve children from birth to kindergarten and meet at least once a week for at least six weeks or more during the year. These children must provide proof of immunization for DTaP, Polio, Hib, Pneumococcal, MMR, Varicella, Hepatitis A and Hepatitis B.

A document explaining the need and reasonableness of these changes from MDH is at: [www.health.state.mn.us/divs/idepc/immunize/immrule/sonar.pdf](http://www.health.state.mn.us/divs/idepc/immunize/immrule/sonar.pdf)

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HPV vaccine, continued from page 11...

- There is no evidence to suggest that HPV vaccine is responsible for ovarian failure. Genetic, infectious, inflammatory, autoimmune and toxin-related conditions are most likely responsible for ovarian failure in adolescent girls who have received HPV vaccine. (The relationship between ovarian failure and HPV vaccine is temporal but not causal.)

- As of June 2013, 85 deaths had been reported to the Vaccine Adverse Event Reporting System in individuals who have received HPV vaccine. A majority of these deaths have been reviewed by the Centers for Disease Control and Prevention, which found:
  - There is no diagnosis at death that would suggest the HPV vaccine caused the death.
  - There is no pattern of death occurring with respect to time after vaccination.
  - There is no consistent vaccine dose number or combination of vaccines given and death.

The HPV vaccine has the potential to prevent tens of thousands of cases of cervical cancer. It truly is a cancer vaccine. Initial information strongly suggests efficacy and good safety. Acceptance of HPV vaccination can be enhanced by a strong recommendation from the health care professional.

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Member Profile: Andrew Kiragu, MD, FAAP
Assistant Chief of Pediatrics and PICU Medical Director at HCMC

What made you decide to go into pediatrics?
I was born and raised in Kenya. Both my parents were in healthcare. My father was a physician and my mother is a nurse. Growing up, I really admired the way my parents cared for their patients and the impact they had on the lives of others. I remember one elderly gentleman who had driven over an hour to see my dad, but when he heard that he was out of town, he refused to see anyone else. I wanted to be the kind of physician my dad was. Unfortunately my father passed away during my residency, but I like to believe I'm making him proud.

After high school in Kenya, I joined Dalhousie University in Nova Scotia, Canada followed by medical school at Howard University in Washington, DC. I then came to Minnesota where I completed my residency training in internal medicine and pediatrics and subsequently a fellowship in Pediatric Critical Care. Why pediatrics? I have always enjoyed being around kids. They are energetic, curious, funny, loving human beings. They are also quite resilient and most, including some of the sickest patients in the PICU, are able to bounce back to health.

Describe your role at HCMC. What are some of the biggest challenges you face as an urban practitioner?
At HCMC, I wear a number of hats. In addition, I serve on a number of hospital committees including the hospital's peer review committee, which I currently chair. These roles take me beyond my usual clinical duties as a critical care physician and this can be demanding at times. HCMC is a safety net hospital that strives to provide exceptional care without exception. This means that sometimes my colleagues and I care for children who come from families that are facing multiple stressors, including financial, housing and other psychosocial problems that are compounded by the child's illness.

Helping these families navigate the healthcare system can be quite difficult and challenging but is ultimately rewarding.

You are an active member of MNAAP and the chapter's next president elect. Why are you actively involved in this coalition of pediatricians?
I want to be able to make a difference. With MNAAP, I have joined a similar-minded group of pediatricians who are working together to improve the lives of Minnesota’s children. There are significant challenges that kids face, including access (which hopefully will improve with the Affordable Care Act), unintentional and intentional injuries, hunger, health disparities, obesity and newborn screening. I want to be a part of the team that stands in the gap for Minnesota’s kids.

When you're not taking care of sick babies and children, what do you enjoy doing in your spare time?
I enjoy spending time with family and friends. I love to travel. I love to read. Science fiction and fantasy works as well as African and African American literature are the main genres I enjoy. I also like certain non-fiction authors. I recently got done reading Malcolm Gladwell's “David and Goliath,” which was an intriguing look at how we interpret obstacles and perceived disadvantage. I also enjoy listening to music. Although I have lived in Minnesota for almost 20 years, I have never quite gotten into winter sports. Given this past winter, I wonder if I should reconsider my stance on winter sports. This summer I am taking up a friend’s challenge and getting introduced to golf.

People say you always have a smile on your face. What's your secret to being a happy pediatrician?
The smile is a blessing from God and my parents. I think the secret to being a happy pediatrician is finding a balance between work and personal life, which for me, is easier said than done. Fortunately, I have a very patient spouse. It also helps that we as pediatricians we have the coolest patients. Once you have made a connection with a child and their family, the natural joy that kids have just comes out and is very infectious.

Anything else you'd like to share? Anything people would be surprised to know about you?
My family is Kikuyu. The Kikuyu are the largest ethnic community in Kenya. I think what folks may be surprised to know about me, is that my surname “Kiragu” is derived from the Kikuyu words “mundū muragū” or “muragūri,” which mean “medicine man.”

I guess you can just call me Dr. Doctor.
Congratulations Graduating Residents and Fellows!

**U OF M RESIDENTS**

**Kristen Aggerbeck, MD**  
Fellowship | DBP | U of M

**Danielle Brueck, MD**  
Fellowship | Rheum | U of M

**Nathan Chomilo, MD**  
Med-Peds | Park Nicollet

**Sansanee Craig, MD**  
Locum Tenems

**Danielle Dhaliwal, MD**  
Fellowship | PICU | U of M

**Elissa Downs, MD**  
Fellowship | Gastro | MUSC

**Brennan Forward, MD**  
General Peds | Fargo

**Emily Hall, MD**  
Puyallup Indian Reservation | Washington State

**Laura Hagemeyer, MD**  
Chief Resident

**Natalie Lechault, MD**  
South Lake Pediatrics

**Sarah Mitchell, MD**  
Fellowship | Pediatric  
HemOnc | Emory University

**Abby Montague, MD**  
Chief Resident

**Dana Mueller, MD**  
Fellowship | Pediatric Critical Care | Children’s Hospital of Los Angeles

**Katie Satrom, MD**  
Fellowship | Neonatology | U of M

**Luke Schroeder, MD**  
Fellowship | Pediatric Cardiology | MUSC

**Michael Taylor, MD**  
Fellowship | Pediatric Global Health | UMass

**Yossi Wexler, MD**  
Fellowship | Sleep medicine | Twin Cities

**Jade Wulff, MD**  
Fellowship | Pediatric HemOnc | Texas Children’s

**Samuel Wong, MD**  
Fellowship | Neonatology | IUPUI

**Judy Wiltse, MD**  
Chief Resident

**Jason Young, MD**  
South Lake Pediatrics

**MAYO CLINIC RESIDENTS**

**Jason Anderson, MD**  
Fellowship | Pediatric Cardiology | Mayo Clinic

**Katelyn Anderson, MD**  
Dermatology Residency | Mayo Clinic

**Meagan Cain, MD**  
Fellowship | Pediatric Emergency Medicine | Children’s Hospitals of MN

**Melinda Chen, MD**  
Fellowship | Pediatric Endocrinology | Riley Children’s Hospital

**Rachel Chevalier, MD**  
Fellowship | Pediatric GI | UCSF

**Kelsey Claas, MD**  
Chief Resident

**Robert Loar, MD**  
Fellowship | Pediatric Cardiology | Texas Children’s

**Jeffrey Robinson, MD**  
Fellowship | Pediatric Cardiology | Rainbow Babies & Children’s Hospital

**Andrew Schneider, MD**  
Fellowship | Pediatric Cardiology | Mayo Clinic

**Timothy Ulrich, MD**  
Fellowship | Neonatology | Children’s Mercy Hospital

**Lindsey Yock, MD**  
Chief Resident

**U OF M FELLOWS**

**Colleen Correll, MD**  
Asst Prof Rheumatology | U of M

**Damon Dixon, MD**  
Cardiology | Phoenix Children’s

**Benjamin Hanisch, MD**  
Pending (ID)

**Updiner Jodkha, MD**  
Cardiology | UCSF-Fresno

**Michael Kent, MD**  
HemOnc/BMT | Yale-New Haven Medical Center

**Luiz Mantovani, MD**  
HemOnc | U of Sao Paulo

**Ewa Oberdorfer, MD**  
Pending (Endo)

**Jennifer Orozco, MD**  
Pending

**Mary Skrypek, MD**  
Pending

**Tara Zamora**  
NICU | St. Paul Children’s

**MAYO CLINIC FELLOWS**

**Asma Javed, MBBS**  
Pending

**Preethi Reddy Marri, MBBS**  
Pending

**Daniel Anthony Mauriello, MD,**  
Pediatric Cardiology | All Children’s Hospital

**Beth Ann Medford, MD**  
Pediatric Cardiology | Prevea Health

**Muhammad Yasir Qureshi, MBBS**  
Advanced Pediatric & Congenital Cardiac Imaging | Mayo Clinic

**Employment Opportunities**

- Pediatrician, Marshall Avera Medical Group
- Pediatrician, Willmar ACMC
- DB Pediatrician, Mpls, HealthPartners
- BE/BC Pediatrician, Sartell, Lakeview Clinic

For details visit [www.mnaap.org](http://www.mnaap.org)

**Congratulations, Members!**

**Anne Edwards, MD,** a Minneapolis pediatrician, was reappointed as chair of AAP’s Committee on State Government Affairs.

**Kerri Ann Mahon, MD,** a Willmar pediatrician, applied for and received a federal grant to improve access to oral health services for disadvantaged populations at Rice Memorial Hospital in Willmar.
Thank you to MNAAP's 2013-2014 sponsors

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