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President's Preface

The Iowa AAP Identity Crisis

2004 Strategic Planning Initiatives

Rizwan Shah, MD

On Dec. 10th, the Iowa Chapter leadership held the 2004 Strategic Planning Meeting, and identified the following goals to be accomplished in the next three years:

1. Development of links with State Agencies, Legislators, Governor's office, other medical organizations and the media.
2. Build Chapter's infrastructure support, increase member value and increase Iowa AAP visibility across the state.
3. The Chapter will pursue means to involve Chapter in determining direction of State Child Health Policies.

To meet these goals, the Chapter leadership needs active participation by its membership. We are an organization of 385 pediatricians, each striving for the optimal health, safety, and well-being of Iowa's children. Yes, individually, we are all dedicated child advocates; but as an organized group, we remain invisible to key state players. Though many members are listed on chapter committees, they are better known as individuals than as Iowa Chapter representatives.

To combat our anonymity, members should proudly identify themselves as Iowa AAP representatives. To accomplish this feat, we are developing chapter identity cards for use during advocacy efforts, and hope to have them available soon.

I would like to urge current chap-

ter members to persuade any colleagues who are not members to join the Iowa AAP, and help shape child health policies in Iowa. Every member should be active in the organization, not for the potential of personal rewards, but because of your commitment to children.

In August, Dr. Murph and I will attend the National AAP Forum. Let us know about child health issues you want presented at the Forum. Send an e-mail about your innovative solutions to improve children's access to health care. And please join others for membership meetings, and share thoughts, exchange ideas, and benefit from your chapter colleagues.

Your Iowa AAP Board of Directors is committed to identifying pediatric leaders who will share their expertise in all child health and safety discussion forums, but we can't do this without your help. Become an active member of *your* Iowa Chapter of the American Academy of Pediatrics.

Help the chapter make an impact on children's health policy in Iowa. We need the strength of all of our voices. Your pediatric expertise touches each child in your care. Now, the chapter wants to bring that expertise to bear on the entire class of children in this state. Join us as we collectively make a difference!

Special thanks to our guest facilitator, Suzanne

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™



Iowa Chapter

District Highlights **Notes from the Advisory Committee and BOD Meetings**

Kathryn Nichol, MD

Ongoing initiatives

Task Force on Obesity Update (TFOO)

The TFOO identified 3 priority development objectives, including implementation of (1) a physician obesity kit, (2) reimbursement resources, and (3) a community advocacy kit. In addition, there were as many as 7 obesity sessions sponsored by the TFOO and the Peds-21 Steering Committee at the 2004 NCE. A popular session entitled "Fact, Fiction, or the Future of Pediatric Obesity" consisted of presentations on primary prevention, pathophysiology of obesity, physical activity basics, non-family environmental issues, office-based treatment, and alternative therapies/fad diets.

Mental Health Task Force

Their first meeting's (Dec. 10-11, 2004) agenda included the following: (1) a review of the task force directives, (2) mental health issues paper, (3) the periodic survey results, (4) Bright Futures and mental health commonalities, (5) issue of assisting AAP Chapters, and (6) the development of a mental health tool kit, intended to outline patient engagement strategies, clinician decision support, information systems/tracking support, and organization/financing of care.

Medicaid and SCHIP

The President's proposed budget will likely include a sizable cut to Medicaid, perhaps coupled with changes to the existing Medicaid financing structure, including capping federal financing for the states. Because Medicaid proves a hefty expense for many states, several consider waiver proposals dictating a cap as an attractive option. The AAP supports the following:

- Maintain the individual entitlement to Medicaid
- Ensure appropriate/adequate physician payment under Medicaid
- Protect the Medicaid benefits, critical for children (e.g., EPSDT)

- Protect the SCHIP program and its' funding
- Do not substitute tax credits for the Medicaid program

The National Governors Association (NGA) does not want Medicaid reform to include shifts from the federal government to the states, nor do they feel such reform should be part of a federal budget reduction and reconciliation process. The AAP sent a sample letter to chapter presidents encouraging them to write their governor, advocating for the Academy's position on Medicaid. We need to continually point out that children, while making up over 50% of the Medicaid population, account for less than 25% of the cost of the program.

On another Medicaid-related topic, the AAP continues advocating for the establishment of a Medicaid Payment Advisory Commission that would advise CMS and Congress on physician coding and payment policies related to state Medicaid programs, in a similar fashion to the Medicare Payment Advisory Commission with respect to Medicare payment policies.

There was an extensive discussion on **Newborn Screening** (NBS). Each year, more than 1,000 newborns go undetected because states do not screen for identifiable conditions. The AAP, among other agencies, is reviewing a report by the American College of Genetics (ACMG). The Academy's will likely recommend the following:

- Mandate screening for all core panel conditions (29). These are conditions for which there are known treatments.
- Mandate reporting of any clinically significant conditions identified while screening for core conditions (25). These are conditions which do not have known treatments at this time, but have genetic patterns of inheritance of importance in decision making for

parents and families.

- Maximize use of multiplex technologies and 2nd tier tests
- Recognize that the range of benefits from NBS go beyond infant mortality and morbidity.

More information will follow should the Academy choose to endorse this re-



port.

The BOD heard a summary of market research findings concerning AAP member attitudes, awareness, and usage. Results affirmed that members view the AAP image as a respected organization, involved in both child advocacy and advancement of pediatric science. The AAP must maintain this image. After all, members not only seek value in their membership, they also appreciate feeling valued as a member, both within their community and in the Academy.

Jan Berger, the chair of the Committee Management Committee, gave an outstanding presentation on consumer driven health plans (CDH), currently a media hot topic. CDH is presently offered by Kaiser Permanente, Humana, and United Health Care, among others, but predictions indicate by 2007, 70% of employers will offer CDH. Physicians need to understand the types of models, develop marketing expertise, and have knowledge of cost of services and goods, as well as good billing and liability systems. The AAP remains committed to developing materials and education that help pediatricians negotiate this new territory.

Lastly, the Academy is developing a more comprehensive quality initiative. It will be cross-departmental, including areas the AAP is already working on such as the electronic health record, PROS

Editorial



Vote for Whom?

Robert F. Anderson, MD



Many nominees are asked to serve simply to have warm bodies on a committee or to fill a slate. This spring you will be asked to vote in Chapter, District, and National AAP elections. Our Chapter will elect a trustee—all have 2 year terms, but can be eligible for another term. The District will elect a person to replace Tom Herr on the National Nominating Committee (NNC); the Academy will vote on the president elect for 2005-2006.

These are important elections, because the elected individual represents you. Our trustees align strategic goals of the Chapter with your needs as pediatricians and your patient needs; they are your spokespersons for the public agenda. The NNC chooses two individuals from a very qualified field to be the spokes-

person for all Pediatricians in the AAP. The NNC is composed of representatives from each District, aligning regional concerns with the best candidates who address those needs. In one sense, the committee cannot go “wrong” due to the qualifications of the candidates. But as with any choice, the voter and the candidate have agendas, which may or may not be the right fit for your Academy at the time of their tenure.

You may be familiar with the candidate for trustee of our Chapter, Dr. Jeff Lobas. The NNC nominees are perhaps unknown to you. Dr. Jane Carnazzo is a pediatrician in private practice from Omaha, Nebraska, who just completed serving the 3-year term as president of the Nebraska Chapter. She was also a contemporary of mine, through

spring of 2004, at District meetings and Chapter Forums, and serves as a member of the Section on Administration and Practice Management. Dr. Terry Hatch is an academic pediatrician practicing pediatric gastroenterology at Champaign-Urbana, Illinois. He is past president of the Illinois Chapter, and has been active in legislation as a key contact and a member of the Section on Gastroenterology and Nutrition. The elected nominee will serve for 3 years, helping to decide the annual candidate for the President-elect. Drs. Jay Berkelhamer and Charlie Linder are 2005 President-elect candidates, and have been well publicized in AAP News as candidates for President-elect. Both hail from the state of Georgia.

Child Health Specialty Clinics

Title V Program for Children with Special Healthcare Needs

Child Health Specialty Clinics is Iowa’s Title V Program for children with special health care needs. CHSC is a public health program and is authorized by Title V of the Social Security Act of 1935. CHSC has addressed pediatric chronic illness from the early days of orthopedic problems to the current landscape of behavioral problems, developmental issues, and early childhood drug exposure. As a comprehensive service provider, CHSC offers direct clinical care, care coordination, and core public health functions to help build high quality service systems.

CHSC has, over thirty years, developed a statewide community-based public health infrastructure located in 13 regional centers. This infrastructure has facilitated CHSC’s leadership and participation in several important system development efforts including: the Iowa Medical Home Initiative; the Magellan Behavioral Health Program; the Assuring Better Child Health and

Development Project; and the Early ACCESS Early Intervention Program.

CHSC receives primary support from federal and state funds, supplemented by external grants and contracts. Unfortunately, the federal Title V Block Grant appropriation has decreased by 7.6% since 1994 and the state appropriation has decreased by 57% since 2001 – all while service demand and personnel costs have increased. To adjust to the decreases, CHSC’s mobile specialty clinics and nutrition consultation service have been discontinued; the Waterloo regional center has been closed; and the Council Bluffs, Dubuque, Mason City, and Sioux City regional centers have decreased hours by 20-percent.

Without some improvement in available resources, CHSC will close its centers in Burlington, Sioux City, and Council Bluffs. This valuable resource for the state of Iowa and its children is in danger of being

lost. CHSC staff and families using CHSC services are educating Iowa’s executive and legislative branches about the value of its services. Further deterioration of the CHSC infrastructure will diminish families’ access to pediatric specialty services. It will also diminish involvement in service system improvement efforts.



*As of this article, the Governor hopes to increase state support for CHSC through the Healthy Communities Initiative funded by an increased cigarette tax.

Camp Hertko Hollow: helping children live with diabetes

Michael Tansey, MD

Camp Hertko Hollow is a summer camp for children with diabetes. The camp was started 35 years ago by Dr. Ed Hertko, an endocrinologist from Des Moines. Dr. Hertko continues to be actively involved with the camp, and has set up a foundation to help fund children with diabetes to attend the camp. For the past 32 years Camp Hertko Hollow has been held at the Des Moines YMCA Camp site north of Boone, Iowa, located along the Des Moines River

Camp Hertko Hollow is a week long camp for children ages 6 to 18 who happen to have diabetes. Most children have type 1 diabetes, but we are seeing more children with type 2 diabetes and they are enjoying the camp experience as well. At camp they learn how to cope with this chronic disease and how to perform the daily tasks. Having diabetes usually involves taking 2-4 shots of insu-

lin, counting grams of carbohydrate of all foods eaten at meals and snacks, and doing 4-6 finger pricks to check blood sugar levels every day. In addition, adjustments must be made for illness, schedule changes, and exercise. Emergency situations such as hypoglycemic reactions or coma can result without diligent monitoring. This is a difficult regiment even for the most responsible adult, much less a growing and ever changing child. At camp, our mission is to provide the child with the skills necessary to manage their disease, to instill a positive attitude and motivation that they can handle the many challenges they are faced with and to realize that they are not alone. By learning how to control blood sugars, long term complications such as blindness, kidney failure, heart disease, neuropathy, and amputations can be minimized, according to the DCCT 10 year study by the National

Institute of Health.

The Y Camp provides a safe place for campers to learn about life in the outdoors and make lifelong friendships. The values of caring, respect, responsibility, honesty and health are emphasized during the week at camp. Children with diabetes are able to learn more about diabetes, and to spend time with other children with the same disease. If you would like information about Camp Hertko Hollow for a patient, or if you are interested in volunteering at camp, please visit the camp website at: www.camphertkohollow.com or contact me directly.

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IMIS

IOWA MEDICAL SOCIETY

Working for Iowa physicians and their patients

Iowa Medical Society, together with Iowa's Health Initiative, supports a \$1.00 per pack increase in Iowa's cigarette tax. Increasing tobacco excise taxes is the single most effective strategy in reducing tobacco use, particularly among minor children. Further, it is a major component to create additional revenue to support health care programs and services for Iowans.

A \$1.00 per pack increase will:

•**Reduce the number of Iowans who smoke.** Nearly 25% of all Iowa households are compromised of one or more adults who smoke. Research shows high tax on cigarettes reduces the number of people who choose to smoke, thus reducing the incidence of tobacco-related death and disease. Experts suggest nearly 28,000 Iowa adults would stop smoking if the tax were increased by \$1.00 per pack.

Tobacco Tax Increase

From the Iowa Medical Society

- Lower health care costs.** The current average retail price per pack of cigarettes is \$3.50. For each and every pack of cigarettes sold in Iowa, smoking-related medical expenses costs Iowa citizens \$6.40.
- Aid in the reduction of youth smokers.** More than 27% of high school students in Iowa smoke. Research has shown youth smoking rates are exceptionally sensitive to price increases. Raising the cigarette tax by only \$1.00 per pack is projected to reduce youth smoking by 19.5%
- Create additional revenue to support health care programs for Iowans.** Smoking-related diseases and illnesses cost the state approximately \$235 million annually. An increase in the tobacco tax will lower smoking-related medical costs and establish an additional revenue stream of an estimated \$135 million, which will aid the state with the impending Medicaid funding crisis.
- Ensure Iowa's financial future.** Governor Vilsack strongly supports the cigarette tax increase as a vehicle to ensure Iowa's financial future. In his recent budget proposal for Fiscal Year 2006, Gov. Vilsack based supplement funding for Medicaid and a 3% increase in provider reimbursement around the higher tobacco tax. Without this increase, Iowa's Medicaid program is headed for catastrophe.
- Help Iowa move towards the head of the class.** Iowa's 36-cent tobacco tax has not been increased since 1991. Iowa currently ranks 42nd among the states – a disheartening fact for a non-tobacco state which prides itself on its commitment to public health.
- Produce long-term healthcare savings for the state.** Experts project long-term health care savings of more than \$790 million by a \$1.00 per pack increase in the cigarette tax.

Medical Home Initiative

Medical Home: a Partner Practice

Robert F. Anderson, MD

For over one year, our pediatric practice in Bettendorf has aligned with the Iowa Medical Home Initiative (IMHI) as a partner practice. That means we have committed to the principles of a practice that is accessible and provides family centered, coordinated, comprehensive, culturally competent, and of course, compassionate care. Certainly, every primary care practitioner says their practice tries their best to be a Medical Home; but the downfall comes in actually assessing the practice, looking into the mirror, and moving forward to change the inefficient areas of delivery, or those that act as a barrier to excellent patient care. So enters the learning collaboration with IMHI. The Vision of IMHI ensures that **Iowa's families, providers, communities, including payers and policymakers, will support the medical home model as a system of care that is sustainable, cost effective and equitable. This system will be an evidence based, continuous quality improvement model providing safe healthcare for children with special health-care needs or chronic conditions. Care will be accessible, family**

centered, continuous, comprehensive, coordinated compassionate and culturally effective.

After using the medical home index as a tool, our practice decided, with the help of IMHI facilitators, to develop a registry of children with special health care needs (CHSCN). We started identifying children with serious health impairments. Our phone nurse identified CHSCN in the patient database. The front office then stamped a smiley face on the chart. The registry by itself means little. On the other hand, it became apparent the registry served as a basis for systematic change towards more efficient care. The special needs for the office visit were identified: a longer appointment time, nursing interventions before the physician saw the patient, recognizing the special visit needs (back door entry for the immunosuppressed, autistic children's preferences, etc.) of the patient, and a separate intake form identifying current community and healthcare involvement and those needs that have not been met.

Changes do not occur easily. How about parent advisors brain-

storming with you to enhance patient flow (throughput)? Or reminding you what the patients are really looking for? Or care coordination and communication with Early Access and Schools? Or efficient communication with consultants?

Practices must define the goal and the plan. What are the expected outcomes? The barriers? How are they measured? Our traditional training does not provide formal tools for effective change in our practices. Old habits are hard to change, new habits are hard to make efficient, leaving the value questionable. In order to meet the rationale for IMHI learning, practices must be able to formally, systematically address these questions. It's the best way to



achieve the Medical Homes we want.

For more information about partnering with IMH, email Dr. Anderson:

Contact Your State Legislator

Phone

Iowa Senate: (515) 281-3371

Iowa House: (515) 281-3221

Mail

c/o State Capitol Bldg.
Des Moines, IA 50319

Email

You can access email addresses at <http://www.state.ia.us> (click "Government," then "Government Telephone Listings," then "Legislative Email Directory")

On the Web

www.legis.state.ia.us
Find information about legislators, committees, and the legislative calendar. You can also search for legislation by file number and listen to live floor debate.

NIDCD Fact Sheet

Increasing Number of Children Lost to Follow Up

Early Hearing Detection and Intervention (EHDI) Program

The National Institute on Deafness and other Communication Disorders (NIDCD) has developed a fact sheet, "When A Newborn Doesn't Pass a Hearing Screening: How Medical and Other Health Professionals Can Help Increase the Number of Infants Who Return for a Follow-Up Evaluation."

This comprehensive fact sheet includes information regarding why parents do not return for a follow up examination, what parents need to know before they leave the hospital, and a list of publications and resources for families on this topic. Consider using this as a hand-

out in EHDI presentations to pediatric primary care providers to assist them in better understanding issues related to "lost to follow up." You may download this document at: <http://www.medicalhomeinfo.org/screening/Screen%20Materials/NIDCD%20Fact%20Sheet%20How%20Medical%20and%20Other%20Professionals.pdf>.

For additional information on hearing screening, visit the following link: <http://www.medicalhomeinfo.org/screening/hearing.html>. You may also contact Michelle Esquivel with the AAP EDHI program at mzesquivel@yahoo.com or (847) 608-6550.

Medicaid & SCHIP

Medicaid and SCHIP Updates

AAP Research: Medicaid/SCHIP Keep Children Insured While Private Coverage Continues Decline

A new report from the AAP's Division of Health Policy Research indicates that the number of uninsured children in America did not increase in 2003, thanks almost entirely to coverage via the Medicaid and SCHIP programs. While 1.2 million more children lost private employer-based coverage between 2002 and 2003, Medicaid and SCHIP eligibility kept these children from becoming uninsured. This report analyzes 2001-2004 Current Population Survey (CPS) data, and finds that the trend of children losing private employer-based coverage has continued from 2000. In 2000, there were 50.5 million children with employer-based coverage; by 2003 that number had dropped to 47.3 million. The number of uninsured children stayed relatively stable over that time frame at approximately 9.0 million, while Medicaid/SCHIP coverage grew by 5.2 million. This report highlights the importance of maintaining the Medicaid and SCHIP programs for children, and can be found online at: www.aap.org/research/2004cps.pdf



State Budget Reports: Widespread Improvement but Medicaid Becomes Largest Budget Item

Three recent reports examine the health of state budgets and the growth of Medicaid:

The Nelson A. Rockefeller Institute of Government released

state tax revenue data for the July-September 2004 quarter. The report indicates that, once again, states experienced growth in state tax revenues over this quarter. Adjusted for inflation, state tax revenue grew by 4.5%. The strongest growth was seen in the Southwest (7.6% growth), while the weakest was seen in the Rocky Mountain region (0.5% growth). This is the fourth straight quarter that all regions had real tax revenue growth, and the ninth straight quarter of state tax revenue growth overall. States still have far to go, however, in terms of real per-capita state tax revenue, and are still well behind pre-recession levels in this measure. This report can be found online at: http://stateandlocalgateway.rockinst.org/fiscal_pub/state_news/sn_reports/SFNV4N8.pdf

A November 2004 *State Budget Update* from the National Conference of State Legislatures (NCSL) has found that only 3 states report budget gaps since the beginning of the fiscal year that started July 1, 2004 in most states. The cumulative budget gap is currently \$568.1 million, compared to \$2.8 billion last year and \$17.5 billion two years ago. Despite these improvements, Medicaid continues to be the most commonly cited budget overrun, exceeding appropriations in 16 states so far in FY 2005. States will continue to examine Medicaid spending in FY 2005 as the budget year progresses and the legislative year begins. The NCSL November 2004 *State Budget Update* can be found online at: www.ncsl.org/print/fiscal/sbu2005-0411.pdf

Finally, the National Governors Association (NGA) and National Association of State Budget Officers (NASBO) have just released an updated *The Fiscal Survey of States*, which has found that revenue collections are narrowly exceeding budgeted estimates in nearly all states

this fiscal year. However, the report estimates that Medicaid will grow by as much as 12.1% in FY 2005, due in part to expiring federal relief. Moreover, Medicaid spending is expected to continue to grow, and is now a larger component of total state spending than elementary and secondary education combined, exceeding education spending by 0.5%. The NGA/NASBO *The Fiscal Survey of the States* can be found online at: www.nga.org/cda/files/FSS0412.pdf

NCSL Releases Policy Report on Quality in Children's Health Care

The National Conference of State Legislatures (NCSL) Forum for State Health Policy Leadership has released a policy report entitled "Quality in Children's Health Care," specifically focusing on the Medicaid and SCHIP programs. The report examines why quality measurement is important for children in Medicaid and SCHIP, the different dimensions of quality that are measured, as well as the role of state legislatures in this process. The report provides a number of quality measurements that exist for children, such as the Health Plan Employer Data Information Set (HEDIS), the Consumer Assessment of Health Plans (CAHPS) and other existing measurement sets, including the AAP's SCHIP Evaluation Tool. Federal Medicaid Managed Care regulations require states to have a written quality assessment and improvement strategy, and most states require managed care plans to use HEDIS measures as well as other state-designed measures. The report also provides details of quality measurement tools in place in state non-Medicaid SCHIP programs as of September 2001, examines problems measuring quality for children with special health care needs, and discusses issues surrounding cultural diversity. This report can be found online at: <http://www.ncsl.org/programs/health/forum/qualitychildrenhealthcare.htm>

ABCD II: IOWA'S NEW INITIATIVE TO PROMOTE THE HEALTHY MENTAL DEVELOPMENT OF YOUNG CHILDREN

Background

Early identification of children with or at risk of developmental, behavioral, or social-emotional problems is important in the primary care setting so that appropriate intervention can be instituted. According to recent estimates, 12% to 16% of American children have developmental or behavioral problems. Parents now expect their primary care provider to give them guidance on behavior and development during routine office visits. The American Academy of Pediatrics policy statement on Developmental Surveillance and Screening of Infants and Young Children acknowledges that child development is a dynamic process and that a single test at one point in time only gives a snapshot of this dynamic process, making periodic screening necessary to detect emerging disabilities as the child grows. Based on this, the Academy now recommends that practices develop a strategy to provide periodic screening in the context of office-based primary care. The Academy statement also acknowledges that children and families are best served when provider screening efforts are coordinated with tracking and intervention services available in the community.

ABCD II Overview and Purpose

Iowa was one of five states awarded an ABCD II Healthy Mental Development Grant from the Commonwealth Fund and the National Association for State Health Policy. Through this grant, Iowa plans to move toward the development and infusion of healthy mental development services into our current Medicaid EPSDT system.

The three-year ABCD II grant was awarded to Iowa Medicaid who is partnering with the Iowa Department of Public Health, Prevention of Disabilities Policy Council, Child Health Specialty Clinics, and the UIHC Center for Disabilities and Development to implement the grant.

In the first grant year, beginning in January of 2004, ABCD II partners convened a Clinical Panel to propose standards and processes for the screening, assessment, referral and intervention for infants and young children with or at risk for developmental, behavioral, and/or social-emotional problems. The Iowa EPSDT Collaborative Board has worked with the Panel to identify and address Medicaid barriers to implementation of the standards and processes.

In the second grant year, ABCD II partners intend to establish two demonstration projects to test the proposed system standards and processes. In the final project year, data from the demonstration sites will be assessed and recommendations will be made for a statewide system of healthy mental development; care for Iowa's young children.

What ABCD II Demonstration Sites Receive

ABCD II will . . .

1. Provide a facilitation team to assist practices with implementing the standards and processes and for the screening, assessment, referral and intervention for infants and young children with or at risk for developmental, behavioral, and/or social-emotional problems. At a minimum, the facilitation team will include a physician advisory (pediatrician or family physician), nurse advisor, and a community health consultant with expertise in the development of community-based referral and intervention systems.
2. Provide an evaluation team to work with practices in gathering data and to conduct analysis of the collected data. Compensation for an individual within the practice to coordinate the processes and data collection will be paid to the practice at a rate of \$25/hour up to a maximum of \$2,700.
3. Pay practices \$15.00 in addition to the regular well-child visit rate for completing the ABCD II Health Maintenance

Clinical Notes forms according to the recommended standards.

4. Organize and conduct at least one in person facilitation session each quarter. Compensation for in-person facilitation sessions will be paid to the practice at a rate of \$200/hour up to a maximum of \$400 per session.
5. Supplement the facilitation experience with telephone consultation, material resource sharing, and linkage to health-related community services on an as needed individualized basis.
6. Provide training to practices on skills needed to implement the system standards and processes (if desired).
7. Broker relationships with local public child health agencies, Early ACCESS, and other community resources to facilitate the referral and treatment of young children with or at risk of developmental, behavioral, and/or social-emotional problems.
8. Provide a Medicaid consultant to work with the practice on billing for needed screening, assessment, referral and intervention services

What ABCD II Demonstration Sites Are Expected to Do

ABCDII demonstration sites will be expected to . . .

1. Provide at least one physician and one management-level office staff member to lead practice participation in all aspects of implementing ABCD II proposed standards and processes. Other practice professional and support staff may participate as needed.
2. Utilize the ABCD II Health Maintenance Clinical Notes to screen young children according to the proposed standards.
3. Collect data for the project and forward it to the UIHC CDD for analysis.
4. Provide regular feedback about the standards and processes to the ABCD II facilitation team and work with the team to make necessary adjustments to processes.

A Toolkit on Child Development: Learn the Signs. Act Early.

From the Centers for Disease Control

The Centers for Disease Control and Prevention (CDC) has launched an awareness campaign to educate parents about childhood development, including early warning signs of autism and other developmental disorders. The earlier a child with a developmental delay receives appropriate assessment and intervention, the better the developmental outcome can be.

To help prepare the health care community for the anticipated increase in questions and requests for information from parents, CDC has developed a **Provider Resource Kit**. This kit contains materials designed to help you communicate with parents about childhood development, what parents should be concerned about, and the warning signs of autism and other delays.

In this kit, you will find:

- A small poster (11" by 17") designed for areas such as an examination room.
- A series of fact sheets on childhood development and developmental screening, developmental disorders (including autism spectrum disorders, cerebral palsy, mental retardation,

ADHD, vision loss and hearing loss), and age-specific milestones.

- Informational cards that provide parents with a few milestones by age and a series of questions to discuss with you and your staff, as their child's key health care professional. This card is designed to assist them in talking to you about their observations of their child's development and to give them realistic guidelines based on AAP standards.

*The materials in this kit are printed in Spanish on the reverse side.

This small quantity of materials is a "starter kit" for your practice or clinic. More cards, fact sheets, or entire kits are available to you at no cost. Also available are larger posters (24" by 36") designed for display in high-traffic areas, such as your office lobby, or main waiting room.

The campaign is a collaborative effort of the U.S. Department of Health and Human Services (HHS) and CDC, the Autism Coalition, Autism Society of America (ASA), Cure Autism Now (CAN), First Signs, Organization for Autism Research (OAR), the National Alliance for Au-

tism Research (NAAR), and the American Academy of Pediatrics (AAP).

The "Learn the Signs. Act Early." Campaign seeks to increase awareness about the importance of early childhood development and encourage early detection and intervention. Its success depends on health care professionals, like you, using these materials to talk to parents about their child's overall development and sharing these materials with your colleagues.



To request or download PDFs of these materials in English and/or Spanish, please visit www.cdc.gov/actearly or call toll-free 1-800-CDC-INFO.

Have you ever said these?

- * "Parents worry too much."
- * "Every child is different."
- * "Boys are slower. He'll catch up."
- * "We'll watch and check again in 6 months."

Instead, try these!

- * "I understand you're worried. Tell me more."
- * "Children are different, but let's check to be sure."
- * "Boys can be slower. But let's see if therapy can help."
- * "The nurse will give you the information for a referral today."

Learn the Signs. Act Early

News from the Children’s Center at Mercy Medical Center

The **Mercy Pediatric Subspecialty Clinic** has relocated to 330 Laurel Street, Suite 1200, Des Moines, Iowa, 50314. Clinic doctors include:

H. George Nobel, MD
Pediatric Surgeon

W. Dale Franks, MD
Director/Craniofacial Surgeon
Center for Craniofacial Reconstructive Surgery

Martin I. Sachs, PhD, DO
Allergist/Immunologist

Eytan Young, MD
Pediatric Otolaryngologist
ENT Clinic of Iowa

Catherine Berry, MD, a graduate of Saint Louis University School of Medicine, has joined the ER staff at Children’s Center at Mercy.

Mercy Clinics New Locations

Greater Des Moines

Mercy Clinics, Inc. has been busy cutting ribbons and holding open houses for their pediatrics expansion in the greater Des Moines, Iowa market. The opening of Mercy East Pediatrics (5900 East University Avenue in Pleasant Hill) and Mercy North Pediatrics (800 East First Street in Ankeny) will add space and accessibility to Mercy Clinics’ growing pediatrics populations.

Positioned in high-growth areas of the metro, Mercy East and Mercy North Pediatrics bring community pediatrics closer to home. Physicians can now be more active and involved in prevention activities with local schools and health agencies. For example, Mercy Clinic physicians decorated their clinic walls with artwork from local students. The theme was “The Art of Health.” This venture proved popular not only

to patients, but to the schools, community, and media alike.

Mercy Clinics, Incorporated is comprised of 27 clinics and five physical therapy sites throughout the Des Moines metro area. This multi-specialty clinic system is comprised of primary care clinics, specialty clinics, physical therapy and diagnostic testing sites. Mercy Clinics has five pediatric sites located throughout the metro:

- Mercy Central Pediatrics: 330 Laurel Street, Suite 2100 – Des Moines
- Mercy East Pediatrics: 5900 E. University Ave. – Pleasant Hill
- Mercy Johnston Pediatrics – 5615 NW 86th Street - Johnston
- Mercy North Pediatrics) 800 E. First St. - Ankeny
- Mercy West Pediatrics – 1601 NW 114th Street, Suite 345 - Clive

**Children’s Center at Mercy
Community Childhood Obesity Programs**

The Children’s Center at Mercy has been collaborating with many community partners in order to help prevent obesity, or provide intervention programs.

WALK ACROSS IOWA

A fitness/nutrition program that was offered this past fall to Moulton Extended Learning Center, and Harding Middle School in Des Moines. This program was lead by Marty Driessnack, a pediatric nurse practitioner. The students and faculty at these schools were issued pedometers, and kept track of the miles they walked. These were added together, as the students “walked across Iowa”. In addition, weekly lessons were taught on nutrition and exercise.

TRIM KIDS

A collaborative program sponsored by the Children’s Center at Mercy, Blank Children’s Hospital, and the Riverfront YMCA. Dr. Janet Graeve

from Mercy, and Dr. Cheri Standing from Blank have taken the leadership to develop this program for overweight children. The program was offered last fall, and 26 children completed the program, losing 200 pounds collaboratively. With the YMCA as a new partner, and after receiving some grant money from the Mid-Iowa Health Foundation, the program will be offered 3 more times in 2005.

The Children’s Center at Mercy is also collaborating with Des Moines Public Schools in a nutrition program funded by a BASICS grant. This program provides nutrition education to Des Moines elementary students, and is taught by a Mercy dietitian.

For additional information on any of these programs please contact Ron Askland at raskland@mercydesmoines.org.

Teachers of the Year

University of Iowa Carver
College of Medicine

I am pleased to announce the recipients of the "Teacher of the Year" awards:

- PL-2, Oleg Shchelochkov**
- PL-3, Kaye Wagner**

Congratulations Oleg and Kaye!

These two individuals have been identified as the best teachers in their respective resident groups by their fellow residents. In recognition of this honor, all expense paid attendance at the annual Pediatric Academic Societies meeting in Washington DC this spring is provided by the Department of Pediatrics.

For the first time, a run off had to be held in both classes; this reflects the significant teaching that *all* of our residents do, of their peers and of medical students in the CCOM. Residents – thank you for participating in this important role you have as teachers.

MARK YOUR CALENDAR

March 29-30, 2005

Public Health Conference
Iowa State University, Ames

April 15-17, 2005

Iowa Medical Society Annual Meeting, Des Moines

April 28-29, 2005

Blank Hospital Spring Meeting, Des Moines

Annual Chapter Meeting, Iowa AAP

- April 28th, 2005
- 12:00 to 5:00 p.m.
- Virginia Thompson Auditorium
IHS Research Bldg
Des Moines, Iowa
- Guest Speaker: **Carol Berkowitz, MD**, President of the American Academy of Pediatrics

Please try to attend this special membership meeting. Topics will include improving chapter visibility within the state and the Academy, as well as current and future projects for our chapter. Every member's participation and input is greatly appreciated.

For more information or to register, contact Rusty with the Pediatric Education Office at (515) 241-4497.

MORE INFORMATION

Iowa Chapter Website

<http://www.uihealthcare.com/depts/med/pediatrics/AAP>

National Academy Website

<http://www.aap.org>

Change of Address

Please send updates to:

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American Academy of Pediatrics
141 NW Point Blvd, PO Box 927
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Phone: (800) 433-9016

Newsletter Information

Please send information and articles for future newsletters to Robert Anderson, MD, at rfamd@mchsi.com, or Jason Mitchell at jsmitchell@aap.org.

- * For further information regarding articles published in this issue, please contact the author directly. If no one is listed, you may email Jason Mitchell at jsmitchell@aap.org.



42nd Annual/Final Course
INTENSIVE COURSE IN PEDIATRIC NUTRITION
May 9-13, 2005

Iowa Memorial Union, University of Iowa
Iowa City, Iowa

The purpose of the Intensive Course in Pediatric Nutrition is to offer to local, state, national and international health care professionals (dietitians, nutritionists, pediatricians, family physicians and nurses) a continuing education and development course that provides the most current, evidence-based information and recommendations for the nutritional management of normal and ill infants and children. Health care professionals need this course so they can effectively manage the nutritional aspects of their patients.

Sponsored by:

University of Iowa Health Care, Department of Pediatrics
University of Iowa Roy J. and Lucille A. Carver College of Medicine

Supported in part by the Federal Maternal and Child Health Bureau,
Health Resources and Service Administration

The University of Iowa College of Medicine designates this continuing medical education activity for 33.5 hours in Category 1 of the Physician's Award of the American Medical Association and 29 hours prescribed hours by the American Academy of Family Physicians.

Non-refundable course fee: \$300.00 (or \$200 with documented affiliation with Maternal & Child Health Bureau)

For application and information

Ekhard E. Ziegler, MD, Professor and Director, Department of Pediatrics, Division of Nutrition, W136 General Hospital, University of Iowa Hospitals & Clinics, Iowa City, IA 52242-1083. 319-356-3636 or FAX 319-356-8669

On-line registration: www.medicine.uiowa.edu/PediatricNutrition

American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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