

WISCONSIN WHISPER

November 2000

FROM THE PRESIDENT

Joanne A. Selkurt, MD, FAAP

The WIAAP has its work cut out for it in 2000-01 and you are invited to become a participant as we work for the kids of Wisconsin and their pediatricians.

Legislative goals are; 1) Get the bike helmet legislation passed (Kathy Barkow - tentsu@aol.com and Murray Katcher - mkatcher@facstaff.wisc.edu); 2) Support the efforts to increase \$'s for the expansion of POCAN - Home Visiting for First Time Parents- so that we can have a statewide system of home visitation in Wisconsin, (Grace Heitsch -Gheitsch@smdc.org); 3) Support in every way possible, passage of the Varicella requirement for school and daycare entry Administrative Rule #144 change, now winding its way through the bureaucratic mine field, so that a summer start up date of 2001 is realized. This will include a practitioner education and advocacy component that will need to be in place by the start of the year 2001. (Tom Saari - tsaari@facstaff.wisc.edu.) These goals will be worked on also by the newly energized Legislative Committee. Look for the call to "Act now!"

The second area of goals is in the general heading of "Health and Safety of Kids;" 1) Actively support the WARN project to change physician practices of antibiotic overuse; 2) To get a pediatrician involved in as many of the 72 Public Health Departments as there are that have a pediatrician living or working in that geographical area, (Dick Aronson - aronsra@dhfs.state.wi.us); 3) Educate pediatricians about the correct use of child safety seats, (Murray Katcher - mkatcher@facstaff.wisc.edu); 4) Contribute to the efforts to reduce the morbidity and mortality associated with asthma in the state, (John Meurer - jmurer@mcw.edu); 5) Continue to support the efforts being made in the promotion of the Universal Newborn Hearing Program in the state, (Sharon Fleischfresser - @dhfs.state.wi.us); 6) Support efforts at obesity prevention (Dave Bernhardt - dbermj@facstaff.wisc.

edu); 7) Have a pediatrician involved in all school districts where a pediatrician lives or works (Jeff Lamont - lamontj@mfldclin.edu).

So, does it look like the WIAAP is the place where the action can be? You bet! But, we can only do it if we all work together. If each of us does our own little part, in our own community (especially #'s 2, 3, 6, and 7) where our thoughts and opinions are valued, and contact our own legislators on the legislative issues when the time is appropriate, the impact on the health and safety of Wisconsin's children would be "awesome."

Pediatricians Urged to Distribute New 2000-2001 Healthy Start Brochures

The Division of Public Health's new Healthy Start brochures, reflecting more generous 2000 income guidelines for pregnant women and children, are now available. Pediatrician's distribution of this brochure has helped program enrollment increase by more than 20 percent since last June, to more than 101,000. Of that total, about 85,000 children receive the comprehensive Medicaid coverage. Previous year's brochures are now outdated, so pediatricians should consider ordering the newer brochures by calling Kevin Wymore at the State Division of Public Health, (608) 267-9188.

**Mark Your Calendar Now!
Wisconsin Chapter Annual
CME Meeting
Saturday, April 7, 2001
The Abbey Resort
Lake Geneva, Wisconsin**

WIAAP Chapter Elections: Positions Open 2001 - 2004 Board of Directors

Nominations are being taken for two positions opening on the Wisconsin Chapter AAP Board of Directors with terms running from July 1, 2001 through June 30, 2004. Currently holding these positions are Drs. Wm. Perloff and Karen Pletta. Both are eligible for re-election and have indicated a willingness to serve a second term.

Duties include attendance at three WIAAP Board Meetings, two of which are held in Madison, the third at the site of the Annual CME Meeting. Meetings are normally scheduled for Fridays from 10:00 am to 3:00 PM. The Board of Directors is responsible for planning and conducting all of the business of the Chapter.

Secretary/Treasurer

The position of Secretary/Treasurer is a three year term beginning July 1, 2001 and running through June 30, 2004. This position also includes serving as Treasurer for the Wisconsin Academy of Pediatrics Foundation. Duties include attendance at all Chapter and Foundation Board meetings, preparation of budgets and maintaining financial records for both organizations, filing all Federal and State tax reports as well as organizational reports to the State and Federal government, and keeping the official minutes of all meetings. Dr. Donald Burandt, currently holding this position, is eligible for re-election, and has indicated his willingness to serve a second term.

All nominations should be addressed to: WIAAP Nominating Committee, % of the Chapter Office. Nominations may be mailed, faxed or e-mailed. Please include the nominee's name, address and a brief professional background statement.

AAP Fellows and Senior Fellows are eligible to vote and hold elective office.

For further specifics regarding these positions you may contact Carolyn Evenstad, Executive Director at the Chapter office.

Officers:

President: Joanne Selkurt, MD 715.538.4355
 Vice President: Carl Eisenberg, MD 414.352.3100
 Secretary/Treas. Donald Burandt, MD 608.364.2420

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 Halim Hennes, MD 414.266.2629
 Murray Katcher, MD 608.262.8416
 William Perloff, MD 920.839.9282
 Karen Pletta, MD 608.877.2660
 Thomas Saari, MD 608.263.9733

State Committees:

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 Bioethics: Steve Leuthner, MD 414.266.6706
 Breastfeeding: Grace Heitsch, MD 715.685.7582
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 CATCH Coord., Substance Abuse:
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 Child Abuse & Neglect:
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 CPT: Ken Johnson, MD 414.351.5583
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 School Health: Jeff Lamont, MD 715.847.3000
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 Sports Medicine: William Bartlett, MD
 608.252.8181
 David Bernhardt, MD 608.263.8557
 Tobacco Free Coordinator: Warren Post, MD
 414.923.7400
 UW, Chairman - Department of Pediatrics:
 Aaron Friedman, MD 608.263.8558
 Young Pediatricians: Lorelle Manion, MD
 414.547.7979

National Committees:

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 "Pediatrics" Editorial Board: Richard Aronson, MD
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 Sports Medicine: David Bernhardt, MD

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Wisconsin Update on Child Health Financing

John Meurer, MD, FAAP

Children's health insurance in Wisconsin. About 114,000 or 8% of children in Wisconsin still do not have health insurance. Wisconsin expanded Medicaid coverage under BadgerCare with Title XXI funds to children through age 18 up to 185% federal poverty level. Over one-third (38%) of all uninsured children in Wisconsin are eligible for Medicaid or BadgerCare but are not enrolled. In Wisconsin, Medicaid can insure four children for less than what it costs to insure one adult. Average annual expenditures per Wisconsin Medicaid participant in 1998 were \$1,582 for children and \$7,271 for adults. Providing health care to children is affordable. More information about health insurance is found in the Advocacy/State Govt. Affairs section of the AAP web site, www.aap.org. A new report of Wisconsin health insurance coverage based on the 1999 Family Health Survey is available from cautlek@dhfs.state.wi.us.

Serving children in Medicaid and SCHIP. Nationally pediatrician participation in Medicaid increased by 20 percentage points between 1993 and 2000. More than one third of pediatricians' patients are enrolled in Medicaid and the State Children's Health Insurance Program. Low reimbursement, paperwork concerns, and unpredictable payments are the three most important reasons pediatricians cite for limiting their participation in Medicaid. States with the lowest pediatrician participation have the lowest reimbursement and the highest concerns about paperwork.

Task Force on Reimbursement Recommendations. Key recommendations of the AAP Task Force on Reimbursement Activities include:

- Address inequities and inconsistencies in coding and the use of the resource-based relative value scale
- Promote the value of the pediatrician to purchasers and payers
- Address inadequate reimbursement in Medicaid and SCHIP
- Provide practice management and coding assistance and training to enable pediatricians to maximize reimbursement and quality

The Task Force's full report is expected in December. See www.aap.org/moc/reimburse for strategies for increasing Medicaid reimbursement.

Presidential candidate's child health insurance proposals. Al Gore proposes incrementally expanding eligibility for SCHIP to children of families up to 250% of the poverty level and allowing all families to buy into the program. His proposal won't achieve universal coverage for all children. George W. Bush proposes a \$2,000 per-family health credit for uninsured, low-income Americans and giving states more flexibility. His proposal would allow catastrophic coverage but won't include comprehensive benefits recommended by the AAP. Gov. Bush also proposes \$3.6 billion to build 1,200 new Community and Migrant Health Centers in medically under-served areas.

Patient's bill of rights. The AAP supports the Bipartisan Consensus Managed Care Improvement Act of 1999 (HR 2723) sponsored by Representatives Norwood (R-GA) and Dingell (D-MI). The AAP wants to ensure access to pediatricians in the bill. A compromise bill will likely pass before the election.

COCHF policy statements. The AAP Committee on Child Health Financing recently drafted or revised three policy statements: implementation principles and strategies for SCHIP, principles for ensuring children have access to new vaccines, and financing substance abuse treatment for children and adolescents. For more information, contact John Meurer at jmeurer@mcw.edu or 414-456-4116.

Eligible Pediatricians Urged to Claim Major Medicaid Reimbursement Bonuses

Kevin Wymore, State Division of Public Health

Example: Claiming HPSA Bonus Usually Earns Extra 20% Over MA Maximums

Pediatricians and other primary care physicians are urged to code properly to claim bonuses of 20 percent for serving the Medicaid Health Professional Shortage Areas (HPSA) near them. Pediatricians **practicing in a HPSA zip code, or providing services to Medicaid, Healthy Start or BadgerCare recipients living in HPSA zip codes**, are eligible for the extra payments.

Eligible pediatricians, family physicians, obstetricians, internists, and emergency physicians can receive the 50 percent bonus for selected obstetrical and gynecological procedures, including routine deliveries. However, most HPSA-eligible procedure codes performed by pediatricians earn a 20 percent bonus. Eligible family physicians, internists, and pediatricians receive a 20 percent bonus for HPSA-eligible procedures listed in Appendix 28 of the MA Physician Services Handbook.

Numerous immunization, evaluation and management, and preventive medicine CPT codes qualify for the bonus. The entire Appendix 28 of qualifying HPSA zip codes and CPT codes can be found in the state's Medicaid website by clicking on Appendix 28 at: www.dhfs.state.wi.us/Medicid2/handbooks/physician/pdf/appendix_list.htm

Medicaid recipients living in much of the city of Milwaukee, as well as these larger Wisconsin cities or urban areas, are designated as HPSA recipients:

- Kenosha zip codes 53140, 53142, 53143, and 53144
 - Wausau zip codes 54401, 54403
 - Beloit zip code 53511
 - Brown County zip code 54162
- Milwaukee HPSA zip codes are: 53203, 53206, 53212, 53205, 53208, 53209, 53210, 53216, 53218, 53215, 53204, and 53233.

In other words, either pediatricians practicing in these zip codes, or services rendered to patients living in these zip codes, are eligible for the bonuses. Overall, for example, 74 percent of Milwaukee Public School students live in households

with incomes qualifying for BadgerCare, Healthy Start or Medicaid.

To claim the HPSA bonus on claim forms, the physician's office must add the proper modifier upon treatment of eligible MA, Healthy Start or BadgerCare recipients. The relevant modifiers are: HP for eligible adult patients over 18, and HK for eligible pediatric services for patients 18 and under. **MA HMOs must pass on these substantial bonuses to physicians.** HPSA billing instructions are in the MA provider handbook. For more information on HPSA bonuses, or to request the new 2000-2001 Healthy Start or BadgerCare brochures, call Kevin Wymore, state Division of Public Health, (608) 267-9188.

Medical College of Wisconsin Medical Students Describe Summer Externship Experiences Funded by WAPF

Emarcia P. Peete - After completing my first year at the Medical College of Wisconsin I had the opportunity to participate in the Pediatric Externship Program. My expectations for the program were three-fold. First, I had hoped that participation in the Externship would allow me to apply book knowledge to actual everyday cases. While working in July at the Endocrine Clinic at children's Hospital of Wisconsin I was able to observe many adolescents with short stature. It was imperative that their bone ages rather than the chronological age be determined. This information would allow the physician to ascertain how long Growth Hormone therapy would be effective. Early that year in Physiology, I learned that during puberty the presence of testosterone, or estrogen limits the time an adolescent has to grow. So when the physician receives the results of the bone age they are able to measure the puberty development and therefore remaining time left for growth.

One of my biggest expectations for the summer was to immerse myself in as many programs involving children and adolescents as possible. I was able to experience this during the month of June while working at the Downtown Health Clinic. First I was able to participate in a nurse's home visit. I also went with the public health social worker investigating high lead level in children's homes. I was taught how to inspect and what to look for when high lead levels are reported at that site. I then took a "field trip" to the Milwaukee Bureau of Child Welfare and Protective Services. I spent some time at the Child Protective Center. Lastly I went to the Milwaukee County Adolescent Detention Center. All of these off site experiences allowed me to participate in different medical areas involving children and adolescents.

My final expectation for the summer was to witness how qualified medical personnel deal with various situations that occur during an average workday. Some of the issues the children had were vaccinations, asthma attack follow-ups, fever in infants, well baby checkups and general physicals.

The Externship allowed me the opportunity to learn and grow. All my expectations prior to starting the program were met. It was time well spent and I am thankful to have had the experience.

Sarah Teresinski - Hear one, see one, do one; an approach that encompasses the process of learning. This triad was reinforced by my participation in the Pediatric Externship during June and July. I not only learned about various diseases and the practice of medicine from a pediatrician's standpoint, but I also learned how to approach the learning process as I continue through medical school. The various locations that I was placed at for the Externship, the Forest View Pediatric Clinic in Hales Corners, the Downtown Health Clinic, and the Children's Hospital, allowed me to also compare the different settings in which a general pediatrician may practice.

During the month of June I worked at Forest View Pediatrics where I primarily followed Dr. Lautz. I also had several opportunities to observe each of the five other pediatricians at this clinic, allowing me to compare their individual styles and techniques. This was a great place for me to begin the externship. This one short month taught me skills that will last a lifetime.

(continued on page 4)

Antimicrobial Resistance: What You Can Do

By Edward Belongia, MD, Principal Investigator
Wisconsin Antibiotic Resistance Network

Antimicrobial resistance is a serious public health issue of the 20th and 21st centuries. In 1999, 10% of invasive *Streptococcus pneumoniae* isolates in Wisconsin were fully resistant to penicillin. At the national level, the percentage of fully resistant invasive pneumococcal isolates increased from 3.5% in 1994 to 16.4% in 1999—a five-fold increase!

In June 2000, the World Health Organization (WHO) issued an annual report on infectious diseases titled “Overcoming Antimicrobial Resistance.” The report described how almost all major infectious diseases are slowly, but surely, becoming resistant to existing medicines. As Dr. Gro Harlem Brundtland, WHO Director-General said, “We risk losing these valuable drugs, and our opportunity to eventually control many infectious diseases, because of increasing antimicrobial resistance.” To offset this perilous course, the challenge is to get the right treatment to the patient, each and every time.

How can you get the right treatment to the patient, each and every time, and avoid unnecessary antibiotic therapy?

- Encourage active management of the illness. Reassure the patient and prescribe treatments to alleviate symptoms. Explain that “treatment” doesn’t always come in the form of an antibiotic. For example, consider treating mild or equivocal otitis media with pain relievers and close follow-up.
- Explain the illness and answer questions. Patient satisfaction is correlated with the patient’s understanding of the illness and whether the doctor spent enough time answering questions. It is not associated with receiving an antibiotic.
- Explain that unnecessary antibiotics can be harmful to the patient and the community, and can lead to antibiotic-resistant bacteria.
- Talk about appropriate antibiotic use at 4- and 12-month well child visits.
- Start the educational process in the waiting room with educational brochures and posters on appropriate antibiotic use and antibiotic resistance.
- Consider implementing a protocol in your office that directs office staff members to call patients (diagnosed with viral infections) 2-3 days after the visit to see if symptoms have improved.
- Assure all otoscopes are set up for pneumatic otoscopy with an appropriately cuffed speculum.
- Avoid over-the-phone prescribing for patients that have not been clinically evaluated and examined. Accurate diagnosis of bacterial infections requires a careful history supported by physical exam findings.

The Wisconsin Antibiotic Resistance Network (WARN) is a statewide, CDC-funded, health education campaign to promote appropriate antibiotic use. WARN has developed a variety of *free* resources to help you implement these strategies. These include educational brochures for parents and adults, stickers and coloring sheets for children, handouts for parents, and more! Please visit www.wismed.org for more information.

Join the many health care providers throughout Wisconsin who are already utilizing these materials to promote careful antibiotic use. By implementing these strategies, you can positively effect change, influence future patient behavior, decrease the demand for antibiotics, and contribute to healthier communities for generations to come.

WARN partners: State Medical Society of Wisconsin, Marshfield Medical Research Foundation, and the Wisconsin Division of Public Health. Funding: U.S. Centers for Disease Control and Prevention

Wisconsin Chapter Endorses WARN 5 Year

Following an April 2000 Wisconsin Antibiotic Resistance Network (WARN) presentation to the WIAAP Executive Board by the WARN project director, Dr. Ed Belongia, the Board unanimously endorsed the WARN 5 year mission to educate both the public and practitioners in the appropriate use of antimicrobials. WARN is a CDC sponsored effort to reduce by 25%, 1) patient demand for antibiotics, 2) the number of antibiotic prescriptions written and, 3) the incidence of antibiotic resistant pneumococci in circulation in the community when compared to pre-1999 figures.

—Tom Saari, MD, FAAP
WIAAP Chair, Infectious Disease
Immunization Committee

BADGERCARE/MEDICAID MEETING SCHEDULED

Carl Eisenberg, MD, FAAP

Leaders of the WIAAP’s ACCESS committee will meet with representatives from the State, and the State Medical Society on Friday, December 1, 2000 at the State Medical Society to initiate a new level of involvement of the Chapter in the BadgerCare/Medicaid arena. There are new individuals in each organization who need to meet one another.

Please feel free to contact the following Chapter participants with any suggestions regarding agenda items, or any questions that you might have: Drs. LuAnne Moraski, John Meurer, Tim Corden, or Don Burandt.

Carolyn Evenstad, Chapter Executive Director at the Chapter office, can assist you in contacting these leaders.

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IMMUNIZATION and INFECTIOUS DISEASE NEWS

November 2000

Tom Saari, MD, FAAP

Pneumococcal Conjugate Vaccine Follow Up:

The CDC Advisory Committee for Immunization Practices (ACIP) has finally published their recommendations in the MMWR (Oct. 6) which gives official sanction for the use of PCV7 vaccine in the public health system. ACIP recommendations parallel that of the AAP-COVID and could be interpreted as perhaps more liberal for use in children aged 23 to 59 months of age. ACIP approval was needed before PCV7 could be included in the Vaccines For Children (VFC) program. Consequently, the Wisconsin State Immunization Program now includes PCV7 (pneumococcal conjugate vaccine) in the Wisconsin VFC formulary of vaccines available to those of you who are participating in the VFC program. Local Health Departments will also begin providing PCV7 in the public immunization clinics soon if not doing so already.

I have received numerous calls from you regarding the use of this vaccine in children over 5 years of age who have health conditions that are considered high risk. The FDA has given provisional approval for use in patients up through 9 years of age who fall in the high risk categories. Those patients immunization histories are usually quite complex with many of them having already received the old PS23 polysaccharide vaccine as the only pneumococcal vaccine then available. Table 3 in the AAP statement on PCV7 recommendations found in

< www.aap.org > and in the August 2000 Pediatrics article will provide guidance in the dosing schedule. I would apply that schedule through age 9 in the highest risk only. E-mail < tsaari@facstaff.wisc.edu > or give me a call (1-608-263-9733) for clarification if you need it.

The UW Health / Physicians Plus system began widespread use of PCV 7 in the middle of this summer and many of the infants are now receiving their second dose. There is little question that there are more febrile reactions prompting more middle of the night phone calls from parents of those infants receiving dose #2, as predicted. Some increase of local redness and swelling following dose #2 is also being reported. All of these reactions are short lived (24-48 hours) and if parents are informed beforehand, it might help your sleep. Having parents prepared to use acetaminophen or ibuprofen is a good idea. PCV7 vaccine clinical trial reports suggest no increase in febrile/local reaction incidence for doses #3 and #4 above that normally seen as background from the other concurrent vaccines given at those visits.

As a point of interest, the designation or identifier for the current seven component pneumococcal conjugate vaccine has not been settled on yet. The PCV7 nomenclature is the AAP's and not internationally recognized. Because vaccines containing 9 and 11 serotypes are currently in trials, a way to differentiate future pneumococcal conjugates is being discussed. PCV9 and PCV11 would make sense but sense doesn't always prevail in the vaccine world.

DTaP 4th and 5th Dosing: Aventis (Formerly Pastuer Merieux) has gained FDA approval for giving 5 consecutive doses of

Tripedia DTaP in the same patient. It joins Wyeth Lederle's Acel-Imune as the only two DTaP's with that distinction. This means that if you gave Tripedia for the first 3 or 4 doses, it will no longer be off-label use to give a 5th dose. Those of you who have been using SmithKline's Infanrix in infants from when it was released in the end of January, 1997 can expect FDA approval for 5 consecutive doses early next year. ACIP has been very clear that it is permissible to give any DTaP as a 5th dose, particularly if your patient received a different DTaP primer series than the DTaP you are stocking now. There is no indication that using a DTaP approved for a 5 consecutive dosing schedule is any better or safer than any other DTaP when given as a 5th dose to a child who had a different DTaP used for the first 3 or 4 doses. It is better to give any DTaP for a 4th or 5th dose than no DTaP at all. These are all very good DTaP vaccines and recent studies have shown a significant reduction in adverse vaccine events across the board attributable to DTaP since it was introduced for widespread use in 1996.

I have to acknowledge the first true Entire Thigh Swelling (ETS) case that I have encountered since reports of this phenomenon were made known last winter. This 18 month old patient had a significant febrile component (104⁰F) and significant irritability in addition to ETS within 48 hours of a 4th DTaP dose. A very impressive reaction to say the least but benign, by definition, because it completely resolves without residua. For that reason, ETS is not listed as a contra-indication for giving subsequent DTaP doses if they are due.

Varicella Immunity Requirements for Daycare and School:

Twenty three states now have a varicella immunity requirement for daycare and/or school entry, an increase of 10 over the previous year. Progress continues to be made in incorporating proof of varicella immunity for daycare, kindergarten and middle school entry into Wisconsin Administrative Rule 144. Public hearings are tentatively scheduled in November and we are working to meet an anticipated enactment in time for the start of the 2001 school year. The implementation schedule would look like this:

Mid-2001	DC / K
2002	DC / K / 1 st grade
2003	DC / K / 1 st / 2 nd grade
2004	DC / K thru 8 th grade
2005	DC / K thru 12 th grade

DC =Daycare K = Kindergarten

In anticipation of next year's requirement, several local immunization coalitions have started public information campaigns ("Stop the Pox") including Milwaukee and Madison. A recent report on a 1998 National Immunization Survey (NIS) showed that 37.5% of susceptible Milwaukee children up to age 3 years had received varicella vaccine while only 31.3% of the rest of Wisconsin 3 year olds had gotten their varicella shot. The national average in 1998 was 43.2% of susceptible 3 year olds had gotten varicella protection. Preliminary numbers for 1999 showed a jump to 59% coverage of 3 year olds nationally and Milwaukee pediatricians continue to lead the effort in our state. It makes sense to immunize as many Wisconsin children as possible now to avoid the rush later. The incidence of varicella disease continues to fall making it less likely your patient will contract natural chicken pox at an early age if that is what you and your families are waiting for. I consulted on 6 cases of

children hospitalized with chicken pox complications in the first 6 months of the Year 2000, 2 of whom escaped their PICU experiences within an inch of their lives. It will take only one experience like this to make a physician or a parent a believer in varicella prevention.

Hepatitis B Birthdosing: A major national campaign is unfolding to encourage a resumption of hepatitis B birthdosing before infants are discharged home from hospitals. A tragic, preventable death of a 3 month old Michigan infant who succumbed to acute hepatitis B liver failure occurred last December. The hospital had suspended HBV birthdosing during the thimerosal alert and elected not to resume routine immunization of all infants when thimerosal – free vaccine became available the end of September, 1999. The infant was born in October to a mother who was known by her physician to be a hepatitis B surface antigen carrier. Her lab report sent to the hospital was erroneously reported as negative and the state health department was not informed of her HB Sag (+) status as required by law.

WCIP (Wisconsin Council for Immunization Practices) followed up on the survey it conducted last Spring (the results of which are expected to be published as a MMWR summary soon). Letters were sent to every birthing hospital in the state either congratulating them on resumption of their birthdose program (48 hospitals) or urging them to resume a birthdosing program that, at the very least, provides for standing orders to immunize infants born to mothers with HB Sag (+) or UNKNOWN surface antigen status. As can be seen in the above fatal case, doing the bare minimum would not have saved this infant from a bureaucratic snafu. The most compliant hospital in our state has a HBV maternal testing batting average of 94%, ie: 6 out of every 100 women admitted for delivery have no record of a maternal hepatitis B test being done. Most hospitals range from 80-90% of mothers with HBV test results known at delivery. There are plenty of opportunities for infants to slip through the cracks in Wisconsin. As opposed to the rapid demise of the Michigan infant, most infants who acquire hepatitis B perinatally in Wisconsin are silently infected and 25% of them will succumb from cirrhosis or hepatocellular carcinoma 20 to 30 years from the time of their exposure. We have good data that predicts between 200 and 250 Wisconsin infants are born to HB surface antigen (+) mothers every year, most of whom live in the southeastern part of the state where HB birthdosing practices have fallen on hard times the most severely since the thimerosal alert.

The Wisconsin DHFS has gone the extra mile to make hepatitis B vaccine FREE to any Wisconsin birthing hospital who wishes to sign up through the VFC program and give hepatitis B vaccine to all their infants before discharge. This means that every infant, regardless of their insurance or HMO status, can receive hepatitis B vaccine prior to discharge at no cost to anyone but the DHFS. Several hospitals have already availed themselves of this offer but it takes pediatricians on hospital staffs to encourage their hospital administrators to look a gift horse in the mouth. If your use of combination vaccines has turned you away from birthdosing, there is no contra-indication to giving a HBV birthdose and still complete your usual immunization schedule with the combo.

WIR Progress: The Wisconsin Immunization Registry (WIR)

is up and running with most local health departments already plugged in. Demos for private sector provider groups are underway and a real push to sign up as many clinics as possible will go into next year. A demonstration was performed for WCIP and the Wisconsin Chapter AAP Executive Board recently and WIR is truly a marvel. This web based system is one of the most advanced and adaptable in the country. The CDC recently honored the developers of WIR for creating a tool that was innovative and responsive to the needs of the practitioners expected to use it. The WIR will blend in databases from Marshfield's RECI system and other large HMOs to seamlessly integrate existing systems. Keep tuned to: www.dhfs.state.wi.us/immunization/index.htm

WCIP News: Most WCIP activity in the past 2 months has centered around planning for the upcoming influenza season. Vaccine production delays and resulting shortages have complicated the picture considerably. WCIP has come up with an Influenza Contingency Plan that focuses on high risk patients as the primary recipients of limited quantities during early vaccine distribution. Of most concern are those over 65 years of age and those 6 months and older who have chronic disease conditions that increase morbidity and mortality outcomes during influenza encounters. As vaccine supplies increase in late November and into December, target populations will expand in scope. Because of production problems, the USA was projected to be 9 million doses short of the amount of vaccine distributed last year. A late production contract for an additional 9 million doses was let to Aventis in September in hopes of making up for the short fall by the start of the New Year. (It takes about a 100 days to produce a batch of influenza vaccine). This late vaccine is primarily earmarked for high risk patients. If influenza appears earlier than usual this year, this gamble will not pay off. So make every effort to get your high risk pediatric patients immunized as quickly as possible, especially if they are under age 9 years and is their first flu vaccine encounter. Those children will need two doses of vaccine one month apart as a primer series.

Any of you who received shipments of Medeva influenza vaccine need to know that the FDA has not approved that vaccine for children under age 4 years old. The company was unable to supply sufficient documentation for safety and efficacy in that age group. If Medeva is all you have, swap it with any other influenza vaccine source in your community. View the Wisconsin Influenza Contingency Plan on : www.dhfs.state.wi.us/immunization/index.htm

Wisconsin Chapter AAP Mission Statement
The Wisconsin Chapter of the American Academy of Pediatrics works to, 1) assure optimal health and safety for Wisconsin's children and their families through advocacy and collaboration with other child interest groups, 2) give support to Wisconsin pediatricians that enables them to continue to be the most effective provider of health care to children.

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2000

*BadgerCare/Medicaid Meeting
State Medical Society
Friday, December 1, 2000

*WI Chapter Board of Directors
Executive Committee
Joint Meeting with Illinois Chapter
Friday, January 26, 2001
(Joint Meeting to Begin at 1:00 PM)
Saturday, January 27, 2001
WIAAP Ex. Committee/Board
(8:00 AM - Noon)
Elk Grove Sheraton Hotel
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2001

*District VI Meeting
March 29, 2001
Sanibel Island, FL

*WI Chapter Annual CME Meeting
Saturday, April 7, 2001
The Abbey Resort
Lake Geneva, WI

*******On the Inside*******

*President's Report

*Chapter Positions Opening
Nominations Solicited

*Wisconsin Update on Child Health
Financing

*Medicaid Reimbursement Bonuses

*Summer Externships

*MCW Medical Students Reports

*Breastfeeding: Tools For Assessing the
First Week

*Wisconsin Antibiotic Resistance Network
Antimicrobial Resistance: What You Can Do

*Immunization and Infectious Disease News