

The Wisper

July 2002

FROM THE PRESIDENT

Joanne A. Selkurt, MD, FAAP

As my tenure as the WI AAP Chapter President comes to an end, I decided to look back and review some of the things that the Chapter has accomplished. The Chapter's first Legislative Day was held in February 1996 when we visited the legislators with our concerns on W2. Also during that year, thanks to Dick Aronson and Earnestine Willis, the first "Data and Dialogue" slide set was developed. These slides depicted county by county how each fared on 17 different criteria relating to children's health. This information was distributed to each Public Health Regional Office. The Sports Medicine Committee co-chaired by Bill Bartlett and Dave Bernhardt produced the "Youth Fitness" brochure that was distributed to middle and high schools across the state.

In 1996-97 legislative efforts surrounded the "Home Visiting for First Time Families" spearheaded by Grace Heitsch. Thanks to Carl Eisenberg, WI AAP was one of the first chapters to develop an email distribution list to expedite the spread of information. This was undoubtedly one of the best things that allowed the Chapter to move forward. Also during this year, over 100 pediatricians were given trigger locks to educate families, with the purpose of curbing gun violence. With the urging of Bill Bartlett, pediatricians also became involved in the planning of "Safe Nights." This was the year that the summer pediatric externship for medical students was first supported. The Chapter moved into the international scene with its linkage to the Sociedad de Nicaraguense, and Marshall Cusic presented at their congress in Managua. Grace Heitsch and Karen Pletta, as the Chapter Breastfeeding Coordinators, conducted a survey of the members on this topic that has resulted in a continuing education program for Chapter members. The first strategic planning meeting was held which has shaped the current structure of the

Chapter. For these, and other efforts, the Chapter was awarded the AAP's "Outstanding Chapter Award" for middle size chapters along with a \$2,000 prize.

1997-98 highlights included the October Child Health Month's distribution of "This is a Smoke Free House" window stickers to all pediatricians for their smoke free families. Warren Post secured a grant for this project. Legislative efforts were centered around how to use SCHIP funds in the "Badger Care" program which would also cover adults. And, Jeff Lamont, School Health Committee Chair, began his campaign to get pediatricians involved as medical advisors in their local school districts.

In 1998-99 Bob Perelman moved to the AAP, Carl Eisenberg became Vice President and Don Burandt, Secretary/Treasurer. The Chapter sent supplies to help the Children's Hospital in Managua after Hurricane Mitch. Murray Katcher was instrumental in formulating the Graduated Driver's License Bill that eventually was passed into law. Sharon Fleischfresser spearheaded the state's effort to get the Universal Newborn Hearing Screening Program functional. Don Burandt got the Chapter into compliance as a 501(c)6. He was also the driving force along with Chuck Lobeck in the formation of the Wisconsin Chapter Academy of Pediatrics Foundation (a 501(c)3). Medical student membership was approved.

1999-2000: Tom Saari continued his work as Chair of the Committee on Infectious Disease and worked to get varicella vaccine mandated for all children on entry to daycare or school. Information on nutritional supplements for athletes and parents prepared by Dave Bernhardt was distributed in a patient education form for Child Health Month. Lorelle Manion continued to work with young pediatricians and Chuck Lobeck with seniors.

(Continued on Page 10)

Pediatrician of the Year

Chapter Pediatrician of the Year
Award

Peter Havens, MD, FAAP

Dr. Peter Havens, Director of the nationally recognized Wisconsin HIV Primary Support Network of the Children's Hospital of Wisconsin, addresses Annual Meeting luncheon guests following his acceptance of the Chapter Pediatrician of the Year Award from Dr. Thomas Saari.

The Children's Hospital HIV program provides assistance to Wisconsin pediatricians and family practitioners who choose to care for their pediatric patients with HIV/AIDS in their own communities.

A long time Wisconsin Chapter member, Dr. Havens is Chair of the Pediatric Aids Committee and was recently chosen to serve on the AAP Committee for HIV/AIDS.

The Wisper

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Please visit the Wisconsin

Chapter online at:

<http://www.wisaap.org/>

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**WI Chapter Thanks Dr. Richard Aronson,
 Chief Medical Officer for MCH, WI Division of Public Health
 Murray Katcher, MD, FAAP**

Dr. Aronson returns to New England

It is an honor for me to write this brief article wishing my friend and colleague, Dick Aronson, the best for his family and for himself as he moves back to New England where his family roots are. I first met Dick in 1987 when he was interviewing for the job that brought him to Wisconsin from Vermont. I had heard of his excellent reputation throughout New England as a dedicated and passionate physician who worked tirelessly for the betterment of the lives of children. Dick was chosen for the position of Medical Consultant in the Maternal and Child Health unit of the Wisconsin Division of Health. In 1991, he became the Chief Medical Officer for Maternal and Child Health (MCH) and State MCH Director, Wisconsin Division of Public Health, the position he held until his departure on July 1 to take a similar position in the Maine Department of Health.

Dick is a Board-Certified pediatrician who received his MD with Distinction in Research from the University of Rochester School of Medicine (1974). He obtained his Masters in Public Health degree from the Department of MCH, University of North Carolina at Chapel Hill School of Public Health (1988). Before moving to Wisconsin in 1988, he served as the Director of Medical Services for the State of Vermont Health Department from 1983 to 1987, Director of the Vermont Health Department's Child Development Clinic from 1982 to 1983, and a practicing developmental pediatrician in the Vermont Child Development Clinic from 1977 to 1983.

Dick has been an AAP Fellow for more than 20 years and was active in the Vermont Chapter of the AAP before coming to Wisconsin, where he immediately became a member of the Wisconsin Chapter AAP Executive Committee. He serves as the Community Access to Child Health (CATCH) coordinator for the state and as Chair of the MCH Committee. His leadership has inspired and supported many students and residents (who spend time with him at the Wisconsin Division of Public Health and who listen to his Grand Rounds and many other talks) and pediatricians in Wisconsin to become more actively involved in their communities. He has helped Dr. Grace Heitsch, Dr. John Meurer, and other pediatricians to obtain funding for CATCH and Healthy Tomorrows Partnership grants. He initiated and collaborated with Dr. Earnestine Willis on developing a slide presentation, "Child Health in Wisconsin: Data and Dialogue", which has been recognized as an important contribution by Dr. Tom Tonniges of the national AAP CATCH program. Dick organized the 1993 Annual Meeting of the Wisconsin Chapter, entitled "Pediatric Challenges for the 1990s: Making Change Happen," one of the most exciting and innovative meetings that we have ever had. He also organized the Chapter's "Adopt a Classroom" campaign for the 1998 Child Health Month, and in 1999, he was voted Wisconsin Pediatrician of the Year by our Chapter.

Dr. Aronson's leadership and creativity have been instrumental in establishing and implementing the "Five Guiding Principles" for MCH services and systems in Wisconsin: family-centered care, community wide leadership, health promotion and resiliency, outreach and needs assessment, and cultural competence. These principles have influenced multiple MCH programs and systems of care in the state. He has inspired people and organizations throughout Wisconsin to conceive of MCH as standing for "Making Community Happen." His creative conception of these principles has led to their acceptance in many states around the country.

As a result of his leadership, the Title V MCH agency in the state of Wisconsin has been responsible for guiding several new and important initiatives in the state that strive to put the Five Guiding Principles into practice. For example, he was the driving force in creating and implementing Prenatal Care Coordination as a Medicaid benefit, and this effort has mobilized communities, organizations, and people throughout the state to improve birth outcomes. This program has led to the increased availability of early and comprehensive prenatal care to some of Wisconsin's lowest income mothers, and is certainly in part responsible for the (continued next page)

(Dr. Aronson- continued)

continuing reduction in the number of low birthweight babies in Wisconsin.

His strong and visionary leadership has also been evident in Milwaukee Common Ground, a unique community-based collaboration that started in 1993 and that uses a philosophy espoused in the book "Future Search" to bring together public and private agencies, professionals, community members, and families to address some of the fundamental causes of infant mortality in Milwaukee, such as racism, sexism, turfdom, and political maneuvering and cynicism. Dick has acted as a consultant to other programs and communities regarding similar programs. The success of his "Common Ground" program was a contributing factor to the Wisconsin Chapter's 1997 national Outstanding AAP Chapter Award.

Dick has also played key leadership roles in the following:

* Establishing the Fourth Street Center in Beloit in 1989, a one-stop shop facility that has won wide praise and recognition throughout the country.

* Helping to develop community-based, family-centered, and culturally competent infant mortality reduction projects for Milwaukee and in the Native American communities in Wisconsin. He has helped guide a unique research project that uses a resiliency-based and community-driven methodology for determining specific strategies for reducing African American infant mortality in Wisconsin.

* Developing a statewide perinatal substance abuse education program and organizing efforts to bring together health, social services, AODA, education, and family stakeholders to address systems issues related to addiction.

* Working with Medicaid managed care to make it more responsive to the MCH population. Dr. Aronson holds clinical faculty appointments in pediatrics at Wisconsin's two medical schools, and he is on the Editorial Board of Pediatrics.

Our Chapter is sorry to see Dick and his family leave Wisconsin, but we and the children of Wisconsin have benefited much from his dedicated work during the past 14 years. We thank him much and wish him good fortune in the state of Maine.

AAP Committee on Pediatric Workforce Report Aaron Friedman, MD, FAAP

A number of reports were heard by the committee including the recent Pediatric residency match which showed a decline in the number of Medical Students entering Pediatrics and for the first time in years not all the residency slots were filled. Discussion was held regarding a proposal to have a number of pathways in order to fulfill the Board requirements to sit for specialty certification and some of these pathways will reduce total time to certification from 6 to 5 years. The committee worked on drafts of Workforce Policy to be presented to the Board of the AAP and also on Policy statements regarding underrepresented minorities; culturally effective pediatric care; and scope of practice, which has to do with our relationship to non physician providers. Data was also reviewed to be considered for publication by members of the COPW and reports were heard from the Subcommittee on Women in Pediatrics.

PROS Co-Cordinator Opportunity Available

The position for Wisconsin PROS co-coordinator is open for applicants. This is an opportunity to network directly with PROS studies' primary investigators and have "hands on" experience in research development. The co-coordinator will be part of a diverse group of individuals who have the common interest of doing office-based research. Meetings are held twice a year, one in Chicago during spring and another in the fall, usually held at the AAP National Conference site. These meetings always promise intellectual stimulation and camaraderie.

If interested, please contact Dr. Abraham R. Rodriguez at 608 364 2200 or email anpr1@aol.com

PROS Report Abraham Rodriguez, MD, FAAP

PROS -Pediatric Research in the Office Setting

What we are doing:

- Producing large-sample studies of interest to pediatrics
- Creating easy to do studies that blend in with our busy practices
- Increasing practitioner involvement through participation in PROS-Net and PROS website (www.aap.org/pros). We welcome feedback on studies as well as suggestions on possible research topics.
- Disseminating new knowledge of clinical relevance to the practitioner

PROS Pearls: *Increasing Identification of Psychosocial Problems 1979-1976*

Today's pediatricians, families and children appear to be facing an increasing number of psychosocial problems, when compared with families almost 20 years prior.

The comparison suggests an almost threefold increase in such problems as identified by clinicians. From 1979 to 1996, clinicians identified psychosocial problems increased from 6.8% to 18.7% of all pediatric visits among 4-15 year olds.

The increases were associated with increases in the proportions of single-parent families and Medicaid enrollment. The authors discounted a number of different other possible explanations for the increases, including: 1) differences in clinician-patient familiarity between the two study samples, 2) differences in clinician characteristics 3) increased recognition due to better training in behavioral problems, and 4) patient demographics.

The authors found increases in all categories of psychosocial problems except for mental retardation. Showing the greatest absolute increase was the proportion of visits by children noted to have ADHD, which jumped from 1.4% to 9.2%. However, even without ADHD, the 1996 sample had nearly twice as many psychosocial problems as the 1979 sample.

The authors conclude that any true increases in psychosocial problems are likely due to adverse changes that have occurred in the social conditions of families and children. Study by Kelleher KJ, et al *Pediatrics* 2000;105:1313-1321

District VI Chair Report

Kathryn Nichol, MD, FAAP

I just experienced another very busy and productive Board of Director and Advisory Committee meeting. Much time was spent on discussing immunizations and administrative fees. As many of you know, CMS did not, initially, want to admit that there was time and work required by physicians in administering vaccines. The agency was concerned that the cost would be prohibitive, particularly considering the cost when administering vaccines to adults were included. They have recognized, however, that there is work involved on the part of MDs, and there will be a meeting this week with Tom Scully (from CMS), and Drs. Lou Cooper and Steve Edwards, along with AAP staff. They will be attempting to incorporate language in the Final Rule with regard to the immunization administration issue. It would be an evaluation and management (E/M) code, and if approved, there will be an educational and informational campaign to ensure that AAP members are aware of the opportunity to correctly be reimbursed for time consuming efforts. I can't stress enough how much effort the leadership of the AAP is expending trying to obtain a fair resolution of this issue.

There was also time spent on discussing, what, if anything, the AAP could have done to prevent or lessen the reaction to the CoParenting Statement. The BOD recognizes that there are some issues or topics, particularly those involving social issues, which may be divisive to some of the membership. The BOD does not feel those topics should be avoided, but, if anticipated, the hope is that a better process of alerting and educating members as to what and why this policy is being developed can be utilized. Clearly, the media may sensationalize, or put a spin on a statement that was not intended by the authoring committee. This happened with the CoParenting statement. The existing policy development process already has an incredible number of steps and checks and balances, but in the future, the BOD will have an even greater role in being sensitive to statements that have the potential for being divisive.

The May meeting is when the strategic plan for future years is discussed and approved. The strategic plan is continuing to evolve, with more attention being given to developing more specific goals and objectives, with measurable outcomes. We are also prioritizing the objectives that are the most important to accomplish. Hopefully, this will help the managerial staff at the AAP, and also the chapters, committees and sections who look at the AAP strategic plan for some direction. The items that have been stressed for years remain very important—namely, access, quality health care for our children, closer linkage between chapters, committees and sections, appropriate reimbursement for pediatricians and the services they provide, continuing to improve and provide educational opportunities for our members, and recruiting and retaining our members. A challenging agenda.

The AAP is in the process of developing an office for International Pediatrics. It is a continuation of efforts to provide educational materials and assistance to pediatricians and children beyond our borders. It is an exciting initiative.

The AAP has been closely watching the Westside Mother v. Haaveman lawsuit which was initially filed on July 12, 1999 by several Medicaid recipients, child advocacy groups, and the Michigan Chapter of the AAP and the Michigan Chapter of the AAP Dentists. The suit sought to enforce the rights of children under the Michigan Medicaid program to receive care as required under federal Medicaid law. The suit charged that the state has failed to provide appropriate care required under the EPSDT program, failed to inform eligible children and their families of EPSDT benefits. The District Court ruled in favor of a motion to dismiss the Michigan AAP Chapter and the Michigan AAPD Chapter for lack of standing. In addition they ruled March 26, 2001 against the plaintiffs and dismissed the suit, the ruling indicating that Medicaid beneficiaries may not sue state officials for failure to provide benefits required by federal Medicaid law. The decision was appealed and the AAP filed an amicus curiae brief on the appeal. The US Court of Appeals for the Sixth Circuit reversed the District Court opinion on May 15 and remands the case back to District Court for reconsideration. The court ruled that: *Federal conditions in Medicaid and similar programs are not merely contract provisions, but are federal laws, *Laws validly passed by Congress under its spending powers are the supreme law of the land, * Michigan Medicaid officials acting unlawfully in refusing to implement mandatory elements of the Medicaid program can be sued in court, * State officials are not protected from a cause of action against them for alleged noncompliance with the EPSDT requirements of Medicaid law.

I remain so impressed by the AAP staff and their passion for children and the AAP. We all are very blessed to have such wonderful people working so hard for all of us.

Hoping you all have a wonderful, safe and relaxing summer.

WIAAP Annual Meeting

“Adolescent Medicine Update”

Held at Kalahari Resort and Conference Center

Well Attended

Dr. Steve Matson, Annual Meeting Co-Chair along with Drs. James Meyer and Patricia Kokotailo, reviewed the program with Carolyn Evenstad, Chapter Executive Director at the registration table. Nearly 100 Chapter members, Wisconsin Association of Pediatric Nurse Practitioner members and state pediatricians attended the all day conference which focused on adolescent issues.

Chapter Membership Update

Carl Eisenberg, MD, FAAP

If any of you have colleagues who belong to the AAP but who do not belong to the Wisconsin Chapter, please encourage them to join in our activities. With another state budget deficit predicted for the next biennium we will all need to work together to assure children's issues don't get short-changed. Remember, there is no longer a huge tobacco money pot for the legislators to tap! By working together we have a better chance of impacting this kind of problem.

Membership in the WIAAP does continue to grow. Since the beginning of the year the number of paid FAAP's who belong to the WIAAP increased from 377 to 387 with total paid membership increasing from 553 to 569. Our total membership increased from 700 to 752 (this includes 14 medical students and 125 WI pediatric residents.) There is data for all membership categories available for review. If you are interested please contact the Membership Committee which is chaired by the Chapter's Vice President.

It will be interesting to see what happens with all of these membership numbers over the next few fiscal years. Fiscal year 2001-2002 was the first full year of operation for the AAP's Chapter Membership System (CMS.) This web based CMS permits state chapter membership committees to more easily track different categories of membership.

Since the March issue of The Wisper, Membership Committee member Dr. Abraham Rodriguez and Chapter Executive Director Carolyn Evenstad have communicated with 66 new members informing them about the structure of our Chapter, its activities and membership benefits.

The Chapter's e-mail distribution list, WIAAP-NET, currently has 179 subscribers with 147 of those having confirmed e-mail addresses. If you did NOT receive a message from WIAAP-NET dated 5/25/02 with the "TEST" in the subject line and believe you are a subscriber or would like to be a subscriber please contact me at CEisenbrg@AAPSCOT.ORG with your most current e-mail address. Please remember this service is a free membership benefit and serves to keep you up to date on many WIAAP activities. The officers as well as board and executive committee members frequently use this e-mail distribution list to post announcements or to solicit input.

We welcome and encourage all WIAAP members to subscribe.

**THIS NEWSLETTER
IS BEING SUPPORTED BY
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First Annual Donald B. Burandt Memorial Lecture August 28, 2002

Supported by a Wisconsin Academy of Pediatrics Foundation memorial fund, the first Donald B. Burandt memorial lecture will be held at Beloit Memorial Hospital on Wednesday, August 28, 2002 at 8:00 AM. Dr. Thomas Saari, University of Wisconsin, Madison, will give a presentation on "Immunization Controversies in Wisconsin."

Dr. Burandt, who died in August 2001, was a practicing pediatrician in Beloit for over 36 years. His community participation included being Vice President of Medical Affairs at Beloit Memorial Hospital, City of Beloit Health Officer and 14 years as a school physician. He was a long time, active member of the WIAAP serving most recently as Secretary/Treasurer.

Wisconsin Academy of Pediatrics Foundation (WAPF) Halim Hennes, MD

The WAPF is a 501 C (3) organization established in 1999 to serve Wisconsin children and pediatricians independent of the Wisconsin Chapter of the American Academy of Pediatrics.

The purposes of the WAPF are:

1. To develop and conduct educational seminars and programs promoting the health and safety of children in the State of Wisconsin
2. Provide Scholarship support for medical students and pediatric residents
3. Solicit gifts and grants from individuals, estates, trusts, associations, corporations, or other entities, all to or for the benefit of, or to carry out the charitable, educational, and scientific purposes of the foundation and chapter.

Current ongoing projects:

1. A legislative conference for pediatric residents in the State of Wisconsin was held in Madison under the leadership of Dr. Tim Cordon from the Department of Pediatrics at the University of Wisconsin. This program will be held annually.
2. Annual support for pediatric summer externships for medical students from the Medical College of Wisconsin and the University of Wisconsin School of Medicine.

Planned Projects

1. Annual memorial lecture at Beloit Memorial Hospital in memory of Dr. Donald Burandt, the founder of the Foundation and late secretary/treasurer of the Wisconsin Chapter of the American Academy of Pediatrics.
2. A grant application was submitted to Glaxo SmithKline to plan, train, implement, and evaluate an asthma diagnosis and management CME program in the State of Wisconsin under the leadership of Dr. John Meurer from the Medical College of Wisconsin.

For more information about the foundation please contact Carolyn Evenstad

Wisconsin's Progress Toward Universal Newborn Hearing Screening - A Progress Report
 Sharon Fleischfresser, MD, FAAP

Each year an estimated 200 babies are born in Wisconsin with hearing loss. In 2000 the Joint Committee on Infant Hearing recommended that all infants be screened prior to hospital discharge, diagnosed by at least three months of age and enrolled in intervention by no later than six months.

In spring 2002, Wisconsin Sound Beginnings Program in the Division of Public Health (DPH) sent a survey to all Wisconsin hospital-based birthing facilities to query them about their hearing screening programs. The goal of the survey was to assess the number of hospitals that had operational Universal Newborn Hearing Screening (UNHS) programs in the past year, the number of babies that had a hearing screen before discharge, the number referring from hearing screens, and what kind of follow-up actions were taken. All 102 hospitals that had birthing facilities in 2001 responded to the survey.

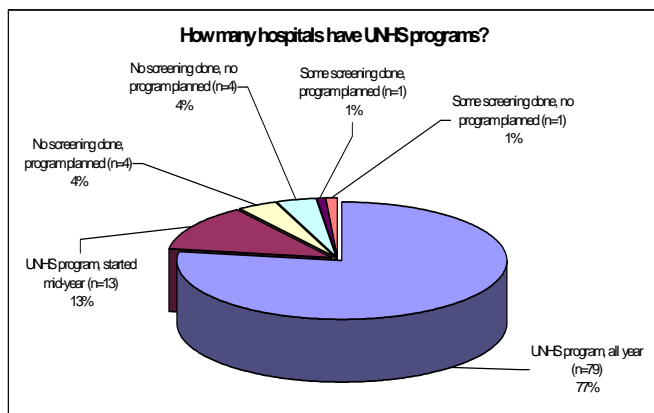
How many hospitals had UNHS programs in 2001?

All hospitals were asked if their facility had a Universal Newborn Hearing Screening (UNHS) program and if not, if they were screening any babies. Of the 102 birthing facilities, 92 said that they had a UNHS program in 2001, a dramatic increase from two UNHS hospitals in 1997 and 33 UNHS hospitals in 1999. Of the 92 UNHS hospitals, 13 indicated starting their program mid-year. Five facilities that do not currently have a UNHS program plan to start a program by 2003. One of those had been screening some of the babies born in the facility. Five facilities do not have any plans to begin a UNHS program. One of these hospitals currently does hearing screening on an outpatient basis. All of the hospitals with no plans to start a UNHS program deliver fewer than 100 babies a year and are located in predominantly rural areas.

In summary, Wisconsin had 92 UNHS hospitals in 2001 (90%), had 94 hospitals that had screened any babies (92%), and expects 97 hospitals to have UNHS programs by 2003 (95%).

What percentage of babies were born in a screening hospital?

In 1999, the Wisconsin legislature established by statute that if, by August 5, 2003, the Department of Health and Family



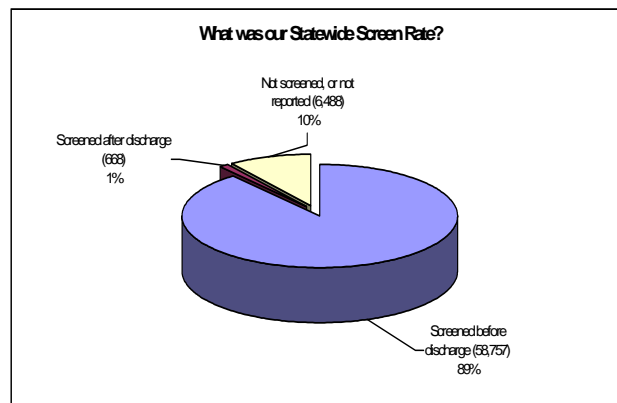
Services determines that fewer than 88% of all deliveries in the state are performed in hospitals that have a newborn hearing

screening program, every hospital shall, by January 1, 2004, have a newborn hearing screening program (WI Stat. 253.115). Of the 102 birthing facilities in Wisconsin, 100 reported delivering a total of 65,913 babies in 2001. UNHS hospitals reported delivering 63,205 babies (96%) and hospitals screening any babies reported delivering 64,346 babies (98%). Because an additional five facilities will be adding UNHS programs before 2003, we can conclude that Wisconsin hospitals have met and exceeded legislative requirements. (In the table below, "n" refers to the number of hospitals that reported the number of babies screened.)

What Percentage of babies were born in a screening hospital

	# babies	% of all babies born in reporting hospitals
Hsp with UNHS program (n=91)	63205	95.9%
Hsp with screening any babies (n=93)	64346	97.6%
Hsp that did not screen at all (n=7)	1567	2.4%
All reporting hospitals (n=100)	65913	100.0%

What was our statewide screen rate?



Of the 94 screening hospitals, 86 hospitals reported the number of babies they screened in 2001. A total of 58,757 babies had a newborn hearing screen before they were discharged from their delivery hospital stay (89% of reported 65,913 babies born). Thirty-seven hospitals reported screening 668 babies after discharge, on an outpatient basis (1%). A total of 59,425 (90%) of babies reported by our birthing facilities received at least one hearing screen within their first month of life. Again, this is a dramatic improvement over the 33% of newborns screened for hearing loss in 1999, and exceeds the 73% screened that DPH predicted for 2001.

Of the 6,488 (10%) babies who were not screened, a percentage were not screened by their birthing facility because they were transferred to a different hospital. A further percentage may have been screened, but were not reported in the survey.

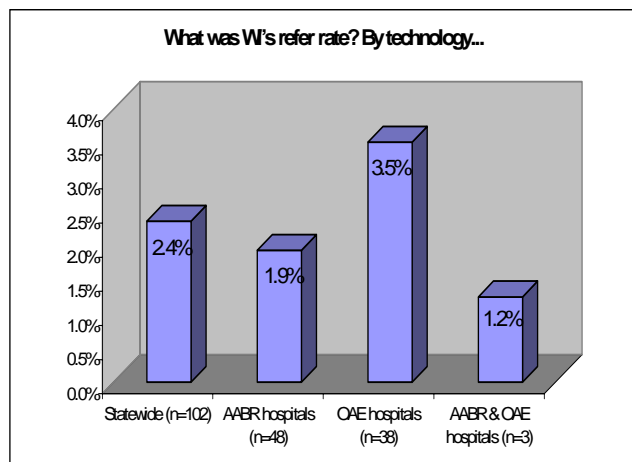
What was the statewide rate of referral from the newborn hearing screen?

Of the 58,757 babies who were screened before discharge from their delivery hospital stay, 1,385 did not pass their hearing screen in one or both ears. This results in a 2.4% refer

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rate, which is on par with previously estimated refer rates for Wisconsin (2.6%) and falls within national expectations of refer rates (2.0 – 4.0%).



The refer rate differed by the type of technology hospitals were using. Hospitals using AABR had a lower refer rate than hospitals using OAE (1.9% and 3.5%, respectively). Hospitals that used a combination of AABR and OAE had the lowest refer rate (1.2%).

While Wisconsin has made good progress in implementing newborn hearing screening, the goal of the Wisconsin Sound Beginnings Program is to meet the recommendations of the Joint Committee for **all** babies. As a pediatrician you play a critical role in ensuring that:

- **All newborns in your practice have been screened, and parents are aware of the screening results**
- **Newborns and infants who refer on screening receive prompt comprehensive audiologic assessment;**
- **Infants diagnosed with hearing loss receive timely medical specialty evaluation and referral to Birth –3, Wisconsin's early intervention program.**

Recently copies of *Babies and Hearing Loss: A Guide for Providers about Follow-up Medical Care* was sent to over 3000 Wisconsin health care and early intervention providers. This booklet provides you:

- A simple guide to best practices in follow-up medical services for the diagnosis and management of infants with hearing loss and their families
- A list of publications for professionals to find additional information that pertains to their field of interest
- A guide to the other professionals who may be involved in their patient's comprehensive care
- A list of community, statewide, and national resources that you may make available to families with infants who are deaf or hard of hearing

Additional copies are available for providers from the Wisconsin Association for Perinatal Care, (608) 267-6060, or may be downloaded at www.perinatalweb.org. in the

WORLD BREASTFEEDING WEEK 2002: “BREASTFEEDING- HEALTHY MOTHERS AND HEALTHY BABIES”

Karen Pletta, MD, FAAP, IBCLC

World Breastfeeding Week is celebrated all over the world on August 1-7 and marks the anniversary of the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding, which was adopted in 1990 by 32 governments and 10 United Nations Agencies. Each year a different theme is selected to generate public awareness and support for breastfeeding.

This year, the World Breastfeeding Week theme is “Breastfeeding: Healthy Mothers and Healthy Babies”. This theme focuses on the need to protect, promote and support the health and well being of mothers as well as the need to protect, promote and support breastfeeding, for healthier babies and children. The goals for WBW 2002 are 1) to reinstate breastfeeding as an integral part of women's reproductive cycle and health, 2) to create awareness of women's right to humane and non-invasive birthing practices and 3) to promote the Global Initiative for Mother Support (GIMS) for Breastfeeding. The GIMS is a new global initiative that aims to improve the environment of support for a mother to initiate and sustain breastfeeding. Such support may include encouragement, accurate and timely information, humane care during childbirth, hands-on assistance and practical tips. Women need support of professional health care providers, employers, family, friends and the community. It is the goal of GIMS to work to create conditions so that women can have a healthy pregnancy, birth and lactation. This also includes conditions that support employed women practicing exclusive breastfeeding for the first six months and continued breastfeeding after the introduction of complementary foods.

Ideas for action to promote women's health and support, foster humane birth practices and to promote breastfeeding can be found in a free World Breastfeeding Week action packet through the World Alliance for Breastfeeding Action at <http://www.waba.org.br/wbw2002.htm>. The packet also includes resources such as reference books, videos and websites. La Leche League coordinates a World Walk for Breastfeeding that is held every year during World Breastfeeding Week in local communities to promote breastfeeding. LLL can be contacted at www.lalecheleague.org to find out how to get involved in your local community walk. Other ideas for pediatricians include:

- 1) Provide breastfeeding information for parents seen at prenatal visits.
- 2) Encourage parents seen prenatally to attend breastfeeding classes.
- 3) Support and encourage breastfeeding for patients e.g. positive reinforcement comments, referral for outside help as needed, “certificate” for child's baby book that recognizes mom for length of time mom breastfed child/provided breastmilk.
- 4) Participate in breastfeeding committees or coordinating groups at local, regional and national levels.
- 5) Encourage local hospitals to become Baby-Friendly and/or help those hospitals, which are Baby-Friendly to maintain their quality, evidence-based practices.

For a copy of the breastfeeding certificate and/or if you wish to become more involved in breastfeeding issues via WI AAP, please feel free to email me at karen.pletta@uwmf.wisc.edu.

IMMUNIZATION and INFECTIOUS DISEASE NEWS

June, 2002

Tom Saari, MD, FAAP

Vaccine Shortage Report:

WCIP (Wisconsin Council for Immunization Practices) met on June 7th and received reports from all the immunization manufacturers involved with the vaccine shortages we have experienced the past 18 months

PCV7 Vaccine: The bad news first. The manufacturer of PCV7 (Wyeth) had not shipped any vaccine for 6 weeks late this spring. Their original projected production goal of 2 million doses a month by this June has not materialized and their shipments remain below the 1.3 million doses needed every month to satisfy adequate dosing of the national birth cohort. We are now told that production of PCV7 will not normalize until the end of 2002 when a second manufacturing facility supposedly comes on line. Those of us who thought we could liberalize our use of PCV7 in hopes of catching up with infants who had fallen behind with partial priming and incomplete boosting will have to scale back once again to avoid the " rags to riches " fluctuation in vaccine supplies. At last count, the Wisconsin Immunization Program VFC inventory was only 1900 doses for the entire state. The public health priority level remains " extreme " and is likely to remain that way for the foreseeable future. The best advice I can give is that is you happen to be sitting on a moderate inventory of PCV7, conserve some in anticipation that your next order won't appear for a while. My plans to begin " catching up " have been aborted and I am now resigned to a lost cohort of infants who will be reaching the age of 2 years without all of their PCV7 doses on board.

Varicella Vaccine: Merck reported shipping varicella vaccine 4 days a week, up from the normal 3 day per week shipping schedule. They claim this will completely correct the backlog of varicella vaccine that had grown to a 10 week delay and do not anticipate any problems for the rest of the year. The list of states implementing a varicella immunity requirement for day care and school aged children has now grown to 38. WCIP has concluded there should be sufficient varicella vaccine supplies this summer to accommodate the children in day care and the 2002 kindergarten and 1st grade cohorts of children affected by the progressive Wisconsin Administrative Rule. The resumption of initial immunization of infants starting at 12 months of age may also be resumed if your shipments are in excess of that needed to bring your school and daycare bound children into compliance over the next 2 months. (Note: A 1 ½ year old child was recently admitted to our hospital with cerebellar ataxia that developed on the 9th day post onset of his chicken pox rash. The mother had refused the varicella vaccine when it was offered.)

MMR Vaccine: The MMR drought appears to be subsiding with Merck reporting elimination of their backlog in June. There should be adequate MMR this summer to bring all kindergarten children into compliance with the school requirement for 2 doses. Keep in mind that the State Immunization Program and the WIR will now accept MMR given within the 4 day grace period before the child's first birthday (but not 5 days!!!) as being legal for school entry. However, you should do your best to continue to schedule children on or shortly after their first birthday for

MMR # 1 because of better cellular immunity responses that are key to lifelong anamnestic responses to wild measles virus exposures.

DTaP Vaccine: GSK has shifted part of their DTaP (Infanrix ^R) to " Tip-Lock " single-dose syringes to meet impending OSHA requirements. The sum of their multi-dose vial production plus that of the single-dose form will meet projections this summer to meet the national monthly need. (It is expected that Infanrix ^R will finally be FDA approved for the 5th dose of a 5 dose Infanrix ^R series this fall.) Aventis production of 2 component Tripedia ^R has reached 500,000 doses per month and all of their production will be delivered to the CDC for the VFC program for the foreseeable future. Aventis' newly approved 5 component DAPTACEL ^R is targeted for the private sector market and will add to the overall national DTaP supply. DAPTACEL will be sold at a \$4 to \$5 premium.

Td Vaccine: The Td supply from Aventis is accelerating as vaccine is now being supplied to physician's offices for the first time in 18 months. Expectations are that normal use of Td for routine boosting of middle school children will be possible this fall. It is still wise to restrict current Td supplies for trauma prophylaxis (wounds, burns, international travel to diphtheria endemic areas).

Hepatitis B Vaccine: Supplies of Merck's hepatitis B vaccine (Recombivax ^R) have steadily improved and are more readily available, particularly for hospital birthdosing. Engerix-B ^R, the GSK hep B vaccine, will have its trace thimerosal content from manufacturing processing completely removed over the next 6 to 12 months. Although the current amount is miniscule and without any remote health consequence, a few pediatricians continue to express reservations about giving it to it newborns for birth dosing.

Comvax ^R: Significant shortages of Merck's Hib / HBV combination vaccine have developed since production ceased for a period this past winter. This situation is expected to continue until the end of 2002 and has seriously affected the availability of the PedVaxHib PRP-OMP component that is used for the combo product. Pediatricians who used PedVaxHib for infants at 4 months of age to avoid giving a 4th dose of HBV when using a birth dose will find PedVaxHib impossible to get.

Influenza: The manufacturers of inactivated trivalent vaccine have had good growth of the three components chosen for the 2002-2003 vaccine and so any delays in flu vaccine will not be because of balky viruses. Aventis is projecting up to 43 million doses of their vaccine will be available in time for the Fall flu season. Wyeth is anticipating making 22 million doses and expect a similar experience in delivery to what they had last year. Their shipments will be released later than their competitors because of the more stringent conditions they have been subjected to under their FDA consent decree. Evans (Medeva) is expected to be on schedule. Aventis will make a tiny amount (11,000 doses) of thimerosal-free vaccine for pediatric use this year in anticipation of the gradual shift in focus to immunizing healthy children 6 to 23 months of age. To date, all inactivated flu vaccines in multi-dose vials contain 25 ugm of mercury per adult dose from the thimerosal preservative used. (Remember that children under 3 years of age receiving inactivated flu vaccine for the first time need 2

half adult doses one month apart.) The alert regarding thimerosal historically applied only to exposures in children under 6 months of age. But there are concerns by those formulating the policy to make routine yearly immunization of healthy children for morbidity reduction and pandemic control that the thimerosal controversy will adversely impact on this effort. A widely available pediatric thimerosal-free influenza vaccine will hopefully ease this dilemma.

The intranasal live attenuated cold adapted trivalent influenza vaccine may gain approval for this Fall. However, rumors about price estimates for this vaccine now hover around \$60 per dose. As with the inactivated vaccine, 2 doses separated by a month will be needed for children receiving Flumist^R for the first season.

Meningococcal Vaccine for College Freshmen: The manufacturer of meningococcal polysaccharide vaccine (Aventis) has initiated a controversial campaign promoting their vaccine directly to the families of college freshmen. Although the American College Health Association (ACHA) has been proactive in this vein, neither the AAP nor ACIP has shared their enthusiasm because of low disease incidence and poor cost / benefit. The Aventis meningococcal vaccine has been in chronic short supply and has been primarily used for outbreak control. So there are concerns by some that by the company creating increased demand through advertising, that clinics may be caught without vaccine when parents / patients come knocking at the door. Meningococcal quadravalent polysaccharide vaccine comes in multi-dose vials and single – dose syringes and a clinic’s monthly order is divided between the 2 by the distributor. Once prepared, the multi-dose vials must be used within a 10 day period. Aventis has established a new return policy in which you will be reimbursed for up to 5 unused doses in a 10 dose vial. Aventis has increased the potential monthly allotment of this vaccine to 250 doses per clinic per month with the potential to get more during peak periods of demand by college students (late summer and Xmas break). East Coast schools continue to be more aggressive in mandating this vaccine for entering freshmen compared to the rest of the country. The AAP and ACIP recommend that practitioners not deny meningococcal vaccine to any college student who wants it.

Vaccine Safety:

Thimerosal: Thimerosal in vaccines has been receiving a lot of negative press because of a number of law suits filed by enterprising attorneys. Despite evidence to the contrary, they would like to capitalize on anti-vaccine speculation that has tried to connect the mercury content in thimerosal with a host of neurodevelopment disorders including autism spectrum disorders (ASD), ADHD, speech delays and tics. No such connection has been established and a recent Institute of Medicine (IOM) report could identify no support for these claims. The AAP has produced a number of pieces of information for physicians and parents in response to these claims and they should be appearing shortly on the AAP web site. Additional information on thimerosal is also found on the National Network for Immunization Information (NNii) and the National Immunization Program (NIP) websites. I listed those sites in previous WIsper articles.

The only vaccine on the market that remains with trace thimerosal from manufacturing processes is the GSK hepatitis B

product with less than 0.5 ugm ethyl mercury / dose. All other vaccines used for the routine childhood immunization schedule in patients under 6 months of age have 0 thimerosal in them. One of the criticisms heard has been that some physicians still have thimerosal containing vaccines in their refrigerators that they are still giving to kids. I would like to believe most of go through vaccine so fast that there is no chance of that happening. It is probably a good idea to check your supplies just in case because parents are being instructed in parenting magazines to demand your office is thimerosal free.

Immunization of Premature and Low-Birthweight Infants:

I have completed a review of the literature concerning the immunization of preterm (PT) and low-birthweight (LBW) infants for the AAP-COVID and my recommendations will be incorporated into the 2003 Red Book for next year. Premature infants are at higher risk for the morbidity and mortality associated with vaccine preventable disease. Yet they are underimmunized for the first 2 years of their lives compared to term infants because of a series of misconceptions we all tend to have regarding their immune systems and how vaccine behave. There are three main changes that will be incorporated pertaining to premies:

1. PT and LBW infants should receive PCV7 vaccine starting at 2 months chronological age and can be expected to respond as well as term infants to the vaccine with a similar safety profile.
2. PT and LBW infants < 2000 grams birthweight born to HBsAg (-) mothers can receive their first dose of HBV vaccine at 30 days of age regardless of the extremes of gestational age or birthweight. They no longer need to wait until reaching 2 months chronological age or 2000 grams weight before receiving dose #1. Clinically stable PT infants > 2000 grams birthweight can be given a birthdose just like term babies.
3. All PT infants are considered at increased risk of complications from influenza and should be considered for routine inactivated influenza vaccine starting at 6 months of age at the onset of the influenza season. As with term infants, 2 doses one month apart are needed if the PT infant has not previously received influenza vaccine.

As always, I welcome comments, questions and your perspective on immunization matters:

Tom Saari, MD, FAAP tsaari@facstaff.wisc.edu
(608) 263-9733

(President's Report—continued)

Carl Eisenberg developed the Chapter's web page.

2000-01 saw the further development of many activities begun previously along with a growth of pediatricians involved in public health departments (6/00=15 - 6/01=44). John Meurer took a lead position in Wisconsin on the asthma issue. There was an increase in attendance at the spring educational meeting, thanks to the work of Lorelle Manion and her "interest" survey and program planning.

In 2001-02 the Chapter was saddened by the death of Don Burandt. The Chapter updated its strategic plan. Highlights during this year include the planning of the asthma educational program directed at primary care providers which will be implemented in 2002-03. John Meurer is working with Todd Mahr, who this year is President of the WI Allergy Society. Jeff Lamont piloted the first meeting with school nurses and medical providers in CESA 9 held May 15th in Wausau. More will follow. Tim Corden and Jill Funk organized the first "Resident Legislative Day." It was rated a success and more are in the future. Tim Corden and Carl Eisenberg have allowed pediatricians to continue to be recognized as capable of doing kindergarten eye exams! Bill Perloff continues to advocate for children's issues in the EMS arena. Tom Saari continues to keep all pediatricians informed of the latest in the complex world of immunizations with his up to the minute "Wisper" articles. Kathy Barkow, year after year, keeps plugging along on the bike helmet issue. Sue Bernstein and Sharon Fleischfresser are the WI "Medical Home" docs and are out there doing a great job of advocating. Murray Katcher just keeps educating on all forms of safety issues and will serve as the Chapter CATCH coordinator. See the legislative report in the Wisper for more information on what the Legislative Committee is involved in. The annual spring meeting on adolescent issues was a success under the leadership of Steve Matson, Jim Meyer, and Pat Kokotailo.

Congratulations to Murray Katcher on his appointment to the AAP Committee on Community Health Services; and to the reappointed Tom Saari – Committee on Infectious Diseases; David Bernhardt – Committee on Sports Medicine & Fitness; and John Meurer – Committee on Child Health Financing.

The Chapter needs to say a special "Good-bye" to Dick Aronson. "The children of Wisconsin and their pediatricians thank you for all you have done for us. Have fun in Maine!"

As I close out this last "president's article," I want to say thank you to all the special people noted above who have made my presidency doable. I have faith that Carl, Halim, and Jeff will lead the Chapter well. I encourage each member to get involved not only in the Chapter, but also in Chapter activities in your local community for that's where the kids are. Finally a huge THANK YOU to Carolyn Evenstad, Chapter Administrator, for all she has done to keep WI AAP moving forward; one has to be in this position to truly appreciate her.

Kindergarten Eye Examination AAP Guidelines Jane Kivlin, MD, FAAP

The examination form approved by the State of Wisconsin for Kindergartners has several check off items. All but the gross estimation of peripheral vision (fields) are standard elements of a pediatrician's eye examination as covered in the AAP's policy statement, Eye Examination and Vision Screening in Infants, Children, and Young Adults (RE9625). (<http://www.aap.org/policy/1461.html>, Pediatrics 98:153-157, 1996) The state form indicates that at a minimum, these items should be completed. The items are listed below, with annotations.

In an asymptomatic child without a concerning family history, normal findings on these exam elements indicate a very low likelihood of serious eye problems. Abnormalities indicate a need for a comprehensive eye evaluation, as per AAP guidelines.

1. Brief History (General health and eye-health) of the child, including family history.
 - General health is already covered by well child checks.
 - Eye health: trouble with vision, mis-aligned eyes.
 - FH--strabismus, poor vision
2. General external observation of the child's eyes and surrounding structures
 - Eyelids and orbits-ptosis, lid lesions, proptosis, injection, discharge, crusting
3. Ophthalmoscopic examination through an undilated pupil
 - Optic nerve, vessels and if lucky, macula
4. Gross measurement of peripheral vision
 - Is the child distractible in the 4 quadrants of the visual field of each eye? The outer, or temporal, field is most important in childhood. Pituitary tumors are still very rare.
5. Evaluation of eye coordination and function (alignment and motility)
 - Do the eyes move fully and are they straight to a cover test looking across the room and at reading distance?
6. Visual Acuity for each eye separately. The most important screening.

See Appendix 2 of AAP Eye Examination policy statement :

<http://www.aap.org/policy/01461.html>

Kindergarten Eye Examination

The Wisconsin Medical Society continues to support our efforts with respect to the Kindergarten Eye Examination. The WMS information is included below for your review. Also, please note the AAP Guideline article by Dr. Jane Kivlin on the previous page, you may find that useful as well. In addition, the State of Wisconsin, Department of Regulation and Licensing “KINDERGARTEN EYE HEALTH EXAMINATION REPORT” is included as an insert. — Carl Eisenberg, MD

Dear Colleague:

Last year, the Wisconsin legislature passed a new statute which encourages children entering Kindergarten to get an eye evaluation or exam by December 31 of their first year of school. The Wisconsin Medical Society, along with the Wisconsin Academy of Ophthalmology, the Wisconsin Chapter of the American Academy of Pediatrics, and the Wisconsin Academy of Family Physicians worked together in support of the *Children’s Vision Initiative*.

This new law *does not mandate* that parents obtain a comprehensive eye examination before entering school. However, it does properly encourage a *voluntary* evaluation of the child’s eye and vision function. This can be provided by a physician – such as the child’s primary care doctor or an ophthalmologist – or by an optometrist. Under the statute, the Medical Examining Board and the Optometric Examining Board approved a form that must be used for parents to report the eye exam to their local school district.

A copy of the form is enclosed. It’s also available on the WMS website at: <http://www.wismed.org>.

There has been some confusion this year as a result of somewhat misleading information put out by the Wisconsin Optometric Association and the State Department of Public Instruction. For example, some parents incorrectly believe they must obtain a comprehensive eye examination to comply with the

goals of the *Children’s Vision Initiative*. However, all of the elements included on the reporting form certainly can be accomplished in the course of the primary care physician’s normal exam. Please refer to the back of this letter for additional information. The American Academy of Pediatric’s policy statement, *Eye Examination and Vision Screening in Infants, Children and Young Adults* may be viewed on the Internet at: www.aap.org/policy/01461.html.

Secondly, we have become aware of “unapproved” forms being given out by some school districts. Please note that there is one form to be used, that being the one approved and distributed through the Wisconsin Department of Regulation and Licensing. If you receive any other form from a parent, we recommend that you substitute the “official” form. (Please forward a copy of any improper forms you receive to Liz Schumacher at the WMS office so we can inform the school district as to use of the correct report form.)

Thank you for your efforts to help in making the *Children’s Vision Initiative* a successful program. If you have any questions, please contact Liz Schumacher (608-442-3769) or Alice O’Connor (608-442-3762) at the Wisconsin Medical Society.

Sincerely,

Mark Andrew, M.D. - Wisconsin Medical Society

Michael L. Murphy, M.D.- Wisconsin Academy of Ophthalmology

William Raduege, M.D. - Wisconsin Academy of Family Physicians

Joanne Selkurt, M.D. - Wisconsin Chapter - American Academy of Pediatrics

Facts About the Children’s Vision Initiative Eye Evaluation

The Wisconsin Department of Regulation and Licensing is responsible for distributing a reporting form approved by the Medical Examining Board and the Optometry Examining Board. The form *does not* require disclosure of the exam results, only that six specific factors were checked. Below are the exam elements and a short commentary about each. We believe all of these can be accomplished easily in a primary care physician’s office during the normal exam. In an asymptomatic child without a negative family history, normal findings on these exam elements generally indicate a very low likelihood of serious eye problems. Abnormalities indicate a need for a comprehensive eye examination, as noted in the American Academy of Pediatrics policy statement. In that instance, the primary care physician may want to consider making a referral to an ophthalmologist for a complete

Report Form Exam Element

Comment

Brief history (general health and eye health) of the child, including family history	General overall health (already covered by well-child check). Any signs of eye strain, trouble seeing, headaches with eye use, or observations of a wandering eye. Any family history of amblyopia or strabismus.
General external observation of the child’s eyes and surrounding structures	Any gross anomalies of the iris, pupil or surrounding structures. Eyelids and orbits, ptosis, lid lesions, proptosis, injection, discharge, crusting.
Ophthalmoscopy examination through an undilated pupil	Optic nerve, vessels and if lucky, macula. Is red reflex normal?
Gross measurement of peripheral vision	May be accomplished with brief finger counting confrontation fields. Is the child distractible in the four quadrants of the visual field of each eye? (Outer, or temporal, field most important in childhood.)
Evaluation of eye coordination and function (alignment and motility)	Do the eyes move fully and ar they straight to a cover test looking across the room and at reading distance? (See Appendix 2 of AAP eye examination policy statement.)
Visual acuity for each eye (separately)	An important part of the evaluation. Your medical records should include notation of what type of test used, e.g.,

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Mark Your Calendars

August 2002

**Donald B. Burandt Memorial Lecture
Wednesday, August 28, 2002
8:00 AM - Beloit Memorial Hospital**

September 2002

**Friday, September 13, 2002
Holiday Inn East, Madison**

**10:00 AM
WI Chapter Board of Directors
Executive Committee**

**8:00 AM
WI Academy of Pediatrics
Foundation (WAPF)**

October 2002

**AAP National Conference & Exhibition
October 19-23, 2002
Boston, MA**

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