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Connecticut Chapter of
American Academy of
Pediatrics

When Should Infant Begin Seeing A Dentist?

CTAAP Annual Meeting

Thursday, June 16, 2011
Four Points Sheraton
Meriden, CT

3:00PM - 6:00PM - CME Programs
6:00PM - 9:00PM - Reception and Dinner

The Pediatrician as a Specialist: Rounding Out Your Practice

Topics include:

- Physical exam techniques and tips on ordering x-rays
- Overuse sports injuries
- Atopic dermatitis

CME Programs Only: \$25
CME Programs & Dinner: \$75

For more information [open this link](#).

Registrations by e-mail Yvette.ctaap@gmail.com, by fax 860-727-9863 or by mail. Deadline for registration June 10th.

New District I Newsletter

AAP's District I which includes Maine, Vermont, Rhode Island, Massachusetts, Connecticut, New Hampshire, Atlantic Provinces of Canada and Quebec has launched a new regular newsletter entitled "The District Digest." News items include outstanding chapter awards, district-wide meetings, AAP's Top 10 2011 Resolutions and more. Please [open this link](#) to see the full version of this informative newsletter.

[The District Digest.pdf](#)

Request for Proposals from CATCH

AAP announces that it is seeking requests for funding to it's CATCH (Community Access to Child Health) program. This is the 18th year that AAP has offered this grant program to pediatricians. This year's grant cycle includes a special call for projects that focus on American Indian/Alaska Native children. Completed applications are due July 29th, 2011. Please [open this link](#) to for more information.

[Catch RFP.pdf](#)

CTAAP Endorses CT Asthma Advisory Council Recommendations

CTAAP has endorsed recent recommendations developed by the Connecticut Asthma Council. The recommendations include payment for asthma care that is coordinated by a primary care medical home, improved reimbursement for comprehensive primary care asthma management visits, in-home interventions targeting patient-specific asthma triggers and making out-of-pocket costs for pharmacotherapy supplies more affordable.

The goal of these recommendations is to significantly reduce acute care costs and to improve national measures of effective asthma

management. You may open this link to read the complete report entitled "Connecticut Asthma Reimbursement Consensus Statement and The Primary Care Medical Home Model."

CTAAP encourages individual practitioners as well as practices to endorse these recommendations.

[CT Asthma Council Reimbursement.pdf](#)

FDA Warning on SimplyThick, Infants and Necrotizing Enterocolitis

The FDA is advising parents, caregivers and healthcare providers not to feed SimplyThick, a thickening product, to premature infants. The product may cause necrotizing enterocolitis (NEC), a life-threatening condition. To date, the agency is aware of 15 cases of NEC, including 2 deaths. The product was mixed with mothers' breast milk or infant formula products.

In the cases that that FDA is aware of, the infants were fed SimplyThick to help with swallowing difficulties resulting from premature birth.

If you are aware of any cases, please respond directly to emergency.operations@fda.hhs.gov

For more information contact Matthew Cartter, MD, PHD, State Epidemiologist, Connecticut Department of Public Health, Hartford, CT matt.cartter@ct.gov

When Should Infant Begin Seeing A Dentist?

Parents often are unsure of when infants should begin seeing a dentist. CNN Health recently posted a clear and concise answer to this question that can be found by opening this link. AAP recommends that the first visit occur when the 1st tooth appears generally between 6 months and 1 year.

[Read Full Article](#)

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CTAAP | 104 Hungerford Street | Hartford | CT | 06106



Connecticut Chapter American Academy of Pediatrics Annual Meeting

Thursday June 16, 2011 • FOUR POINTS by Sheraton • 275 Research Parkway, Meriden, CT

Please join us for CME, Networking, Chapter Update, Cocktails and Dinner

THE PEDIATRICIAN AS A SPECIALIST:

ROUNDING OUT YOUR PRACTICE

MELINDA SHARKEY, M.D.

Assistant Professor of Orthopedic Surgery,
Yale University School of Medicine

*"Knock Knees, Bowed Legs and Pigeon Toes:
Differentiating Normal from Abnormal."* Physical
exam techniques and tips on ordering
appropriate x-rays.

~ 3:00 - 4:00 pm

CARL NISSEN, M.D.

Director, Elite Sports Medicine

"Overuse Injuries: Recognizing and Preventing Them"
Overuse is a relatively misunderstood topic for
us all and yet it affects 50% of young athletes.

~ 4:00 - 5:00 pm

JAMES ROSEN, M.D.

"New Concepts in Management of Atopic Dermatitis."
Hot topics in atopic disease.

~ 5:00 - 6:00 pm

COCKTAILS, DINNER & AWARDS

6:00 - 9:00 pm

Lt. Governor Nancy Wyman invited guest.

~ Simultaneously, there will be Practice Managers
lunch & Programs. 1:00 - 6:00 pm. Including
speaker Jennifer L. Cox, Esq. Cox & Osowiecki.
For details go to www.ct-aap.org

Registration

Name: _____

Address: _____

email: _____

I will attend...

- CME meetings only
(\$25 on/before June 1st - \$35 after June 1st)
- CME meetings/Dinner & Awards
(\$75 on/before June 1st - \$100 after June 1st)

Registrations may be emailed (yvette.ctaap@gmail.com)
or faxed (860-727-9863) or mailed.

Please make check payable to CTAAP, and mail to:
104 Hungerford Street, Hartford, CT 06106


Residents are invited to attend with no charge, but
MUST be registered

Deadline for Registration is JUNE 10, 2011

This activity has been planned and implemented in accordance with the essentials and standards of the Connecticut State Medical Society through the joint sponsorship of Norwalk Hospital and CTAAP.

The Norwalk Hospital is accredited by the Connecticut State Medical Society to sponsor continuing medical education for physicians. The Norwalk Hospital designates this continuing medical activity for a maximum of 3 AMA PRA category 1 credit(s)[™]. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The speaker of this activity has no relationship with any commercial organizations providing direct or indirect financial support including but not limited to gifts, special incentives, medications, devices or other products. If a relationship exists, it will be announced to the audience verbally and a separate disclosure will be signed by the speaker.

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CALL FOR PROPOSALS—2012 Planning Funds and Cycle 1 Resident Funds Programs

Applications available May 2, 2011—submissions due July 29, 2011

Applicants notified December 2011—projects begin January 2012

The Academy is accepting submissions for its 18th annual Community Access to Child Health (CATCH) Planning Funds and Resident Funds grants. This grant cycle includes a special call for projects that focus on American Indian/Alaska Native children and projects to improve access to immunizations for children who are most likely to experience barriers.

Grants of up to \$12,000 will be awarded on a competitive basis to pediatricians to plan innovative community-based child health initiatives that will ensure all children, especially underserved children, have medical homes and access to health care services. Priority is given to projects that will be serving communities with the greatest health disparities. A pediatrician must lead the project and be significantly involved in proposal development and project activities.

Grants of up to \$3,000 also will be awarded on a competitive basis for residents to plan or implement community-based child health initiatives. Resident projects must include planning activities or demonstrate completed planning activities, and may include implementation activities. To ensure project completion, residents who are in their 1st or 2nd year of residency on the application submission due date are eligible to apply; 3rd-year residents may apply if they will be chief resident in their 4th year. PGY-3 residents are eligible to apply as coapplicants.

For more information or to apply for a grant, visit www.aap.org/catch/planninggrants.htm or www.aap.org/catch/residentgrants.htm, e-mail catch@aap.org, or call 800/433-9016, ext 4916. Applications will be available online only.

Join more than 1,000 pediatricians who, through their CATCH grant projects, have learned that local child health problems can be solved locally, often using local resources.

One pediatrician *can* make a difference!

Connecticut Asthma Reimbursement Consensus Statement and The Primary Care Medical Home Model

WHY THE HEALTH SECTOR NEEDS TO IMPLEMENT BEST PRACTICES FOR ASTHMA: A PERSPECTIVE FROM PROVIDERS

For the last two years the CT Department of Public Health Asthma Program's statewide Asthma Advisory Council, and partners from across the state and New England have met and discussed the urgent need for action to decrease the burden of acute asthma care, improve asthma symptom control and decrease costs of asthma in Connecticut.

This consensus statement grew out of discussions among clinicians, Medicaid Managed Care Organizations, and members of professional provider associations to create a document that summarizes the financial support and reimbursement that providers need in order to make sustainable improvements in asthma management in CT.

Background

In 2009, the median prevalence of adult asthma (10.2%) in New England states was higher than the US (8.8%). Furthermore, the prevalence of CT adults reporting current asthma increased from 7.8% in 2000 to 9.4% in 2009. In 2009, the estimated prevalence of diagnosed asthma in CT children was 11.9%.

Many CT residents with asthma are not receiving the comprehensive asthma care and self-management education necessary to understand and effectively manage their disease; a fundamental reason is that our health care system does not directly pay for these services. CT clearly has specific population subgroups that are disproportionately affected, and as such utilize a high percentage of health care dollars.

- ◆ Asthma is the single most avoidable cause of hospitalization, yet it is consistently one of the most common admitting diagnoses in pediatrics.
- ◆ In 2009, Connecticut spent over **\$112 Million** for acute care due to asthma as a primary diagnosis: \$80.3 Million on hospitalization charges and \$32.6 Million on emergency department (ED) visit charges.
- ◆ Residents of our five largest cities: Bridgeport, Hartford, New Haven, Stamford, and Waterbury account for 41 percent (\$46 Million) of the \$112 Million cost of asthma acute care costs in 2009.
- ◆ Of the \$112 Million, \$78 Million (69%) were paid for by public funds (Medicaid or Medicare). In Connecticut's five largest cities, 79% (\$36 Million) of asthma hospitalizations and ED visits were paid by public funds. In contrast, public funds paid for 63% (\$42 Million) of asthma hospitalizations and ED visits of residents from the rest of the state.

Asthma Costs could be reduced with a shift from an acute sick care model to a preventative/chronic disease management model that can also improve health and quality-of- life.

These consensus recommendations are grounded in the following principles which are well established in the literature and supported by public health surveillance:

- Asthma is a chronic disease with disparate burdens that needs to be addressed in the context of an appropriate health care delivery model that values preventative care , as opposed to the current acute care model with its high cost and poor outcomes. Populations that suffer disproportionately from asthma include children, low-income people, some minorities, and the elderly.
- Best practices that implement the National Asthma Education and Prevention Program (NAEPP) Expert Panel Report (2007) provides the clinical framework for shifting the focus of asthma management to the lower cost diagnosis, prevention/ patient self-self-management and monitoring venues and reduce the occurrence of acute care at the highest cost level.

- Reimbursement targeted for patient self-management education, addressing home environmental triggers and smoking cessation are key factors in prevention that are not supported in the current healthcare delivery model.
- Best practices can occur in a variety of settings, but would be most effective with the establishment of a Medical Home for patients with asthma.
- The Chronic Care Model, which identifies “change concepts” for elements of the health care system essential to high-quality chronic disease care and encourages patients to take an active role in their care, is a useful framework for effective management of asthma that works well within a Medical Home.

The Primary Care Medical Home Model (PCMH) A Primary care medical home is a health delivery model that coordinates care for preventive, chronic, and acute healthcare needs. The goal is to provide continuity of accessible and effective care for patients and their families.

This primary care model facilitates partnerships between primary care providers, families and the community for care delivery within and outside of the medical practice. These key components and characteristics of a PCMH use a patient and family-centered approach to provide effective chronic care management for asthma or any chronic disease:

- ◆ Financial Support to Attain Clinical Outcomes
- ◆ Accessibility to Care
- ◆ Family/Professional Collaborations
- ◆ Patient and Provider Education
- ◆ Care Coordination
- ◆ Clinical Information Systems
- ◆ Support for Evidenced-based Practice Standards
- ◆ Program Evaluation

Therefore this consensus statement is based on a commitment to the following health care delivery system principle:

Every patient deserves and needs an accessible primary care provider who functions within the context of PCMH principles.

Not being able to identify an accessible primary care asthma provider is a major contributing factor to fragmented care that results in avoidable and costly acute care utilization. This resultant cycle perpetuates the current asthma culture that is a prime example of our current health care system dysfunction and economic pitfall.

RECOMMENDATIONS FOR PAYERS

Payers have a central role in promoting and supporting best practices for asthma. Policies and programs that acknowledge the validity of existing data supporting this shift in health care utilization can improve overall quality of care in a cost effective manner.

This chronic disease management approach requires increased reimbursement for comprehensive primary care visits as outlined below.

As a result of this comprehensive and preventative care investment, providers should expect reimbursement based on outcome measure performance. In addition, payers are encouraged to strengthen their partnerships within a PCMH model by providing services and incentives that support a unified approach to comprehensive asthma management.

According to Insurance

Coverage for Asthma:

A New England Gap Analysis (ARC, 2010) four priority areas were identified for payers to address in order to overcome barriers to consistently support comprehensive asthma care:

- * Reimburse for programs that provide asthma self-management education in the clinic/office, community, and home settings
- * Financial support for home assessments and remediation for environmental asthma triggers
- * Utilization of a broader team of well-trained care providers, including nurses, certified asthma educators, respiratory therapists, environmental counselors and community health workers
- * Reclassify medication tiers to make out-of-pocket costs for pharmacotherapy and supplies more affordable

1. Financial support for asthma care consistent with the National Asthma Education and Prevention Program (NAEPP) Asthma Expert Panel (2007) within a PCMH includes:

A. Assessing and Monitoring Asthma Severity and Asthma Control

- ◆ Establish an asthma diagnosis
 - * History and physical exam
 - * Spirometry or pulmonary function testing
 - * Consider co-morbidities or alternate diagnosis
 - * Identify patient specific allergens and triggers
 - ◇ Consider home, school, and workplace
- ◆ Use asthma severity classification chart to initiate therapy
- ◆ Use asthma control chart to adjust therapy
 - * Step-up and step-down
- ◆ Use fractional concentration of nitric oxide in exhaled air (FENO) if available
- ◆ Schedule follow up care based on level of control, impairment, and risk
 - * Follow up focus may be medical management, education, or both
 - ◇ Every 2-6 weeks while gaining control
 - ◇ Every 1-6 months to maintain control



B. Education For a Partnership in Asthma Care

- ◆ Tailor education to literacy level of patient and family
- ◆ Appreciate the role of cultural beliefs, practices, and health care values in achieving effective asthma management and control
- ◆ Promote use of Certified Asthma Educators (AE-C)
- ◆ Provide self-management education
 - * Understanding asthma
 - ◇ As a chronic disease
 - ◇ As a disease that can be improved and controlled
 - * Asthma control
 - ◇ Self-assessment and symptom report
 - ◇ Peak flow monitoring for appropriate patients
 - * Use of the Written Asthma Action Plan
 - ◇ Mutually acceptable asthma management goals
 - Daily control
 - Managing worsening symptoms
 - * Medications
 - ◇ How medications work
 - ◇ Proper inhalation techniques
 - Rationale for daily control medication
 - Indications for quick-relief medications
 - Concerns about side effects
 - * How to avoid environmental factors that worsen asthma
 - ◇ Patient specific allergens
 - ◇ Identification of trigger exposures
 - ◇ Address home, school, and workplace
- ◆ Provide care coordination to facilitate education into all points of care where health professionals interact with patients
 - ◇ Within PCMH
 - ◇ Variety of community settings
- ◆ Facilitate Smoking cessation
 - ◇ Patient
 - ◇ Family
 - ◇ Child care providers
- ◆ Educate office staff on clinical protocol, including phone triage for acute symptoms and medication refills
- ◆ Develop mechanisms for proactive follow up such as internal and external communication linkages
- ◆ Provide case management for high-risk patients



C. Control of Environmental Factors and Co-morbid Conditions That Affect Asthma

- ◆ Ensure identification of patient specific allergens
 - * Differentiate annual from perennial allergens to tailor interventions
- ◆ Supplement patient education with resources and interventions to minimize allergy exposure
 - * Consider home assessments and interventions, especially when adequate control is difficult to achieve
 - * Utilize local public health resources
 - ◇ Housing authorities
 - ◇ Cleaning and allergy supplies
- ◆ Provide care coordination with schools and workplaces to determine if the indoor environment is a contributing factor to inadequate asthma control
- ◆ Promote easy access to annual flu vaccination
- ◆ Provide care coordination with specialty providers and programs to address co-morbid conditions, including:
 - * Obesity
 - * Smoking cessation
 - * Immunotherapy
 - * Gastro-esophageal Reflux Disease (GERD)

D. Pharmacologic Therapy

- ◆ Provide quick-relief medication for any asthma diagnosis severity level
- ◆ Provide long-term control medication for any level of persistent asthma
- ◆ Provide ongoing assessment of severity and control
 - * Consider care coordination for patient education when step-up therapy is indicated to address contributing factors when medication increases are made
 - ◇ Ensure inhaled medication is achieving adequate lung deposition
 - ◇ Obtain an accurate usage frequency over a specified timeframe
 - ◇ Assess for inadequate environmental interventions
 - ◇ Assess for financial or cultural barriers to maintaining asthma plan
- ◆ Reduce or eliminate co-pays that are a barrier for medication adherence
- ◆ Redesign drug formularies
 - * Ensure that brand name drugs that are clinically indicated and/or for which there are no generic alternatives are placed in a lower-cost category
 - * Standardize formulary tiers for asthma medication to improve time management issues for providers and care coordinators
 - * Provide multiple prescriptions for inhalers when needed for multiple households, school, or work
 - * Provide anti-static spacing chambers for MDIs under the drug formulary without co-pay
- ◆ Reimburse for smoking cessation medications and nicotine replacement therapy as indicated

2. Support for Chronic Disease Management Programs in Partnership With the PCMH:

- ◆ Develop and maintain asthma registries consisting of relevant information on individual patients and groups of patients that can be accessed and used by the range of caregivers involved in providing asthma care
- ◆ Provide clinical decision-support mechanisms that assist providers to make treatment decisions against benchmarks for best practices
- ◆ Provide primary care case managers who coordinate asthma care in a variety of clinical practice settings
- ◆ Pilot projects that deliver comprehensive asthma management. Track cost and health benefits to contribute to supporting data
- ◆ Recognize the value that certified asthma educators (AE-C) add to obtaining and sustaining clinical and financial outcome measures

RECOMMENDATIONS FOR PUBLIC AGENCIES

Public agencies at the local, state and federal levels can play important roles in mitigating the social and environmental conditions that contribute to asthma, and in promoting best practices. While public agencies can carry out some of the same functions as medical practitioners, they are uniquely capable of establishing population-level approaches and capacity for implementing particular kinds of interventions. They can also take leadership in reducing the fragmentation of health care delivery and financing, which often undermines quality of care.

The recommendations that follow envision partnerships between public agencies, payers, providers/health systems, schools and community organizations.

1. Governmental and non-governmental agencies in conjunction with the legislature can and should work together to strengthen capacity for preventive services in a PCMH model that focus particular attention to highest need populations.
2. Public agencies should identify, strengthen and enforce laws and regulations aimed at preventing exposures to environmental asthma triggers and improve social and environmental conditions with health implications.

CONCLUSION

Connecticut has an opportunity to take the initiative necessary to address the health and financial burden of asthma. We have the science and data; we need the enterprise and leadership to forge a new approach to an unrelenting problem. By supporting a health care system focused on chronic disease management within a PCMH model, payers can create the opportunity for providers to overcome barriers, improve asthma care, and be held accountable for attaining clinical outcome measures. This consensus statement provides a foundation for us to work together for a healthier Connecticut.

ENGAGE COLLEAGUES



To provide your support of the Connecticut Provider Consensus Statement, please complete the form on the following page.

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SIGN ON

Thank you for your support

Please share with your colleagues

SUPPORT



**“What the Health Sector Needs to Implement Best Practices for Asthma:
A Perspective from Providers”**

Connecticut Provider Consensus Statement

The following individuals and organizations, with deep experience in asthma management, contributed to and/or support the recommendations in this statement entitled, “What the Health Sector Needs to Implement Best Practices for Asthma: A Perspective from Providers”.

This statement captures a broad consensus among health care providers for asthma care and who participated in discussions and/or contributed content. These contributors to and supporters of the document have a range of opinions about which recommendations are the most important and implementation steps to meet those recommendations.

Many health care providers will engage in the coming year(s) to identify and promote the recommendations and implementation steps they believe have the most potential to begin reversing the burden of asthma in Connecticut.

My signature indicates I am authorized to sign for the organization/practice indicated below:

Professional Organizations/Associations:

Provider Name, Credentials and Signature:

Organization Name:

Town/State:

Individual Practitioners:

Provider Name, Credentials and Signature:

Affiliation:

Town/State:

E-mail this sheet with your information and scanned electronic signature to:
mcorjulo@aces.org

Fax this sheet with your information and signature to: **203-498-6891**

Mail this sheet with your information and signature to:

**Michael Corjulo
350 State Street
North Haven, CT 06473**

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