



THE WORKING PEDIATRICIAN

THE NEW JERSEY PEDIATRIC SOCIETY

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Winter 2008

Preventing Influenza--The Case for Immunizing Children at School

Faced with the fact that current recommendations for vaccinating high-risk people such as the elderly against the flu don't seem to be reducing the incidence of seasonal influenza in the United States, U.S. policymakers are considering recommending flu shots for school-age children 5 to 18 years old.

There is logic in such an idea, since school-age children are more likely than adults to contract influenza and spread it to high-risk populations, including the adults in their own households. In the most recent flu season for which data are available (2004-05), only 10 percent of healthy children were immunized against flu.

That brings up the possibility that school-based immunizations might offer "an efficient and feasible approach to increase the coverage of school-age children, which would be expected to reduce the spread of influenza and decrease the burden of seasonal flu on households and communities." Whether school-based immunizations would be economically warranted is not clear, with some analyses indicating that immunizing healthy school-age children isn't cost-effective.

To find out more about this relatively untested idea, researchers, who acknowledge, they were funded by the vaccine maker MedImmune, looked at the cost effectiveness of a program in which more than 15,000 children were offered nasal live attenuated influenza immunizations at school.

They found, that there was a statistically significant reduction of flu-like symptoms in the vaccine-offering schools, less health care resource use, and fewer absences from school and work. Those advantages are important, but that still leaves the question of whether the immunizations were economically warranted, the researchers said.

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WEDNESDAY, March 12, 2008

THE NEW JERSEY PEDIATRIC SOCIETY/QPNA WINTER CME MEETING UPDATES IN VACCINE DELIVERY & PUBLIC COMPLIANCE

GUEST SPEAKERS

Andrew Bernstein, MD, MPH



**Lisa McHugh, MPH, New Jersey
Influenza
Surveillance Coordinator**



**Dorothy Williams, Statewide
Immunization
Registry Coordinator**



This meeting has been made possible by an unrestricted education grant from



Peds In A Pod.....

*The Editorial Corner
Barry Prystowsky, M.D.*

A strong economy of health depends on a strong healthy economy. In-other-words, health care providers, be it clinicians, hospitals, dialysis centers, surgical centers or pharmacies can lower their cost if producers, suppliers and transporters of health care goods are in a healthy competitive market. This market needs to operate free from restraints of a central regulatory government authority such as the one that currently runs Medicare or Medicaid and of central regulatory corporate bureaucracies such as managed health care companies. Only then can the health care consumer, the patient, level the cost in the health care industry.

Now that we know how to fix the health care crisis, let's look back at everything we've done wrong. To start with, the central regulatory authority of Medicare drove up prices in the industry and then cut reimbursement to providers but not to producers or suppliers of health care goods. They should have learned from the mistake of wage and price fixing during the Nixon administration. Ford and Carter started deregulation of industry but not of health care.

Private managed health care industry caused further destabilization by not returning profits from lowered hospital bed days to the consumer. Corporate management interfered in the natural market forces between the consumer and the producer of health care goods. Forcing hospitals and physicians to take less pay on the premium dollar was not passed on to consumer savings and served only to disrupt the practice of medicine.

Finally, the government, impotent to

arbitrate any appeals on the part of consumers these last two decades, now encourages corporate health care management to force all providers, be it hospitals or physicians, to sign unfair contracts and run their business at a loss.

Alan Greenspan, former chair of the Federal Reserve Board, saw a healthy market economy as one without unnecessary government regulations, allowing sound investment by producers listening to the free will of consumers. John Kenneth Galbraith, said a healthy economy must do away with large corporate management in order to restore the shareholder's voice and the consumer's free will.

Finally, let's look at the consumers, our patients, and their struggle to get the health care they deserve. Today I phoned the New Jersey Child Advocate, an office recently created, and asked her to help four tax paying hard working poor families, released from New Jersey Family Care last year by mistake, who cannot get reinstated. They are without insurance, unable to afford it, and overqualified for Medicaid.

Let's look at the disabled children who don't qualify for the State Catastrophic Fund, who are overqualified for Medicaid, and whose parents have to miss work due to poorly covered home health care services. Let's not forget the poorly immunized inner city population who along with illegal immigrants close hospitals not subsidized by charity care.

I conclude by reminding our governor and the presidential candidates to consider the growing pains that the socialized centralized eastern block governments overcame to be a free market enterprise. Put health care back into the hands of the people and you will find homes for the middle class, immunize the poor, and lend home health care support to the disabled

Legal Eagles & Legislative Liaisons.....

New Jersey becomes first to require influenza vaccination for child care & school entry

New Jersey became the first state to require influenza vaccination for children of preschool age following approval by a public health advisory board this past December.

The New Jersey Department of Health & Senior Services now requires that all children who attend preschool or a licensed day care center receive an annual influenza shot. Three additional mandates require that children attending preschool receive the pneumococcal vaccine and that children in sixth grade receive the meningitis vaccine and a diphtheria and tetanus toxoids and acellular pertussis booster.

The new statute will go into effect Sept. 1, 2008. The new requirements “will have a direct impact on reducing illnesses, hospitalizations and deaths in one of New Jersey’s most vulnerable populations — our children,” stated former Commissioner of Health. Fred Jacobs, MD.



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Food For Thought



Study Finds Vaccine Preservative Is Not Linked to Risks of Autism

A California study has noted that Autism cases in that state have continued to climb even after a mercury-based vaccine preservative that some people blame for the neurological disorder was removed from routine childhood shots, a study has found.

Researchers from the State Public Health Department found that the autism rate in children rose continuously in the study period from 1995 to 2007. The preservative, thimerosal, has not been used in childhood vaccines since 2001, except for some flu shots.

Doctors stated that the latest study added to the evidence against a link between thimerosal exposure and the risk of autism and that it should reassure parents that vaccinations do not cause autism. If there was a risk, the doctors said, autism rates should have dropped from 2004 to 2007.

THE ASSOCIATED PRESS

Published: January 8, 2008



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RSV SUMMARY OF CHARGES BY COUNTY
2004-2006

COUNTY	COUNT	SUM LOS	SUM CHARGES
Atlantic	296	726	\$4,180,662
Bergen	299	938	\$6,711,337
Burlington	145	354	\$2,183,110
Camden	328	1,006	\$7,031,155
Cape May	70	223	\$708,992
Cumberland	126	423	\$2,475,909
Essex	688	2,636	\$15,326,099
Gloucester	124	303	\$1,747,779
Hudson	464	1,927	\$15,182,554
Hunterdon	50	178	\$1,192,561
Mercer	300	873	\$7,665,242
Morris	224	728	\$4,628,134
Middlesex	420	1,501	\$9,658,814
Monmouth	386	1,178	\$7,091,243
Ocean	255	822	\$5,060,408
Passaic	455	1,774	\$16,475,777
Salem	22	69	\$251,284
Somerset	168	560	\$3,835,702
Sussex	118	313	\$1,594,798
Union	322	1,206	\$6,755,428
Warren	56	160	\$1,395,849
Non NJ	111	307	\$2,261,914
TOTAL	5,427	18,205	\$123,414,751

**Prevention is the only way to reduce
staggering costs**

*NJPS/QPNA & The Children's Emergency
Medical Fund of New Jersey are grateful for
Medimmune's
support of our continuing
education programs.*

**Pediatric RSV Admissions by County
& Month 2006**
Month of Admission

County	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Atlantic	37	17	4	6	1	1	0	0	0	1	9	1	77
Bergen	17	8	4	0	0	2	0	0	1	6	15	2	55
Burlington	8	6	6	2	0	0	0	1	1	4	9	1	38
Camden	26	16	4	4	0	0	0	0	3	4	25	2	84
Cape May	7	12	3	1	0	0	0	0	1	0	1	2	27
Cumberland	9	5	2	0	0	0	0	0	1	1	2	2	22
Essex	43	23	9	6	2	0	0	1	1	2	54	12	153
Gloucester	11	7	3	1	1	0	0	0	0	2	9	2	36
Hudson	32	10	7	0	4	1	2	0	3	30	45	3	137
Hunterdon	3	2	5	0	0	0	0	0	0	0	6	1	17
Mercer	23	16	9	3	4	0	0	0	1	17	22	3	98
Middlesex	44	14	10	8	1	0	1	0	4	5	18	6	111
Monmouth	43	19	11	2	0	0	0	0	1	12	28	6	122
Morris	28	12	2	2	2	0	1	0	0	3	9	3	62
Ocean	29	15	8	6	1	1	0	0	2	1	11	1	75
Passaic	29	6	8	6	1	0	0	0	3	9	26	9	97
Salem	2	0	0	0	0	0	0	0	0	0	3	0	5
Somerset	18	3	4	0	0	0	0	0	0	3	6	2	36
Sussex	14	11	3	2	0	0	0	0	0	3	4	3	40
Union	25	11	1	2	1	0	0	2	3	7	33	5	90
Warren	2	0	0	0	0	0	0	0	0	0	0	1	3
Non NJ	6	9	2	1	0	0	1	0	1	1	7	0	28
Total	456	222	105	52	18	5	5	4	26	111	342	67	1413

**Pediatric RSV Discharges by County
& Month 2006**
Month of Discharge

County	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Atlantic	35	18	6	5	2	1	0	0	0	1	9	0	77
Bergen	19	8	4	0	0	2	0	0	1	5	15	1	55
Burlington	9	6	6	2	0	0	0	0	2	4	8	1	38
Camden	24	18	6	4	0	0	0	0	3	3	23	3	84
Cape May	9	11	4	1	0	0	0	0	1	0	1	0	27
Cumberland	11	5	1	1	0	0	0	0	1	0	2	1	22
Essex	52	21	9	8	2	1	0	1	1	1	50	7	153
Gloucester	11	7	4	1	1	0	0	0	0	2	9	1	36
Hudson	32	13	8	0	2	3	2	0	3	26	43	5	137
Hunterdon	4	2	5	0	0	0	0	0	0	0	6	0	17
Mercer	23	14	11	4	4	0	0	0	0	18	19	5	98
Middlesex	49	13	12	7	2	0	1	0	4	3	18	2	111
Monmouth	44	18	17	2	0	0	0	0	1	9	31	0	122
Morris	29	14	2	1	3	0	1	0	0	3	9	0	62
Ocean	25	20	8	6	1	1	0	0	2	1	10	1	75
Passaic	37	7	8	6	1	0	0	0	3	8	24	3	97
Salem	2	0	0	0	0	0	0	0	0	0	3	0	5
Somerset	18	5	3	1	0	0	0	0	0	3	6	0	36
Sussex	16	10	4	2	0	0	0	0	0	1	6	1	40
Union	24	14	1	4	1	0	0	2	3	6	32	3	90
Warren	3	0	0	0	0	0	0	0	0	0	0	0	3
Non NJ	6	9	2	1	0	0	1	0	0	1	8	0	28
Total	482	233	121	56	19	8	5	3	25	95	332	34	1413

Some of the factors in the trial:

- In the intervention schools, 47 percent of children received the intranasal influenza vaccine and 56 percent of those got a second dose;
- The average vaccination cost per household in the intervention schools was \$41.66, much more than the average \$5.56 families spent for flu shots in non-participating schools. But when expenditures by families for over-the-counter medications, herbal supplements, and emergency care and hospitalizations were included, costs somewhat evened out between intervention and control schools and were higher for families in the non-immunizing schools.

While admitting that there were flaws in the research model, including that all the medical data was self-reported, the researchers concluded that school-based influenza immunization with the nasal vaccine used in the trial "is cost-effective over the season," meaning the several weeks of the year in which influenza incidence is at its peak.

And as to effects other than money, the researchers admitted they did not attempt to value the long-term educational and achievement consequences when student are absent from school with influenza. They did note, however, that in school districts where funding is based on average daily attendance, there are real financial benefits for schools from higher attendance. They estimate that during the peak week of influenza incidence, schools that offer vaccine may lose an average of \$784 as the result of student absences, while schools without vaccine are likely to lose an average of \$1,395.

The study also looked at the time it takes to immunize a student at school as compared with providers' offices. What the researchers refer to as "mass vaccination" can run to as high as 30 per hour, they note, once staff are trained, while the average time for office-based vaccine administration is about 10 to 15 minutes of professional time per dose.

"Our findings suggest that school-based immunization programs are cost-neutral after the peak week alone and cost-saving over an influenza season." And if economic benefits of immunization to the household are included, the researchers concluded, "The clinical and economic benefits of expanding immunization to school-age children deserve further consideration."

The article "Benefits and Costs of Immunization Children Against Influenza at School" appears in the January 23, 2008, issue of Health Affairs, a publication of project HOPE.

**THE NEW JERSEY PEDIATRIC SOCIETY ADOPTED
STANDARD & FORWARDED TO INSURERS
NOVEMBER, 2006**

**COMMUNITY STANDARD OF CARE FOR THE
PREVENTION OF SEVERE RSV DISEASE**

Michael Lamacchia, M.D.

The CDC defines the beginning of the RSV season as when greater than 10% of the isolates tested for RSV are positive. This isolate monitoring is done by various academic institutions in our region. Over the last five years, the RSV season has been from the beginning of October to the end of April. Recently, RSV isolates have reached 10% as early as late September. This letter is to remind our members that based upon historical data, dosing for Palivizumab (Synagis®) should begin October 1st and extend through April 30. Below are our criteria for Palivizumab (Synagis®) candidates.

Infants with CLD or CHD < 2 years old

- Chronic Lung disease (CLD/BPD), hemodynamically significant Congenital Heart Disease (CHD), or other serious condition that compromises pulmonary or immune function (other than prematurity)

Premature infants with CLD or CHD:

- ≤ 28 weeks if born ≤ 12 months before start of RSV season
- 29-32 weeks if born ≤ 6 months before start of RSV season
- 32-35 weeks if born ≤ 6 months before start of RSV season with additional risk factors

Documented RSV Risk Factors:

- School-age siblings
- Daycare attendance (CDC defn: ≤ 2 unrelated children for ≥ 4 hours per week)
- Exposure to environmental air pollutants
 - Tobacco smoke exposure
 - Wood-burning stoves
 - Outdoor Air pollutants
 - * Carbon monoxide (common cause of winter pollution)
 - * Ozone (a year-round problem in some areas)
 - * Industrial air pollution (particulate matter, nitric oxides, lead, sulfur dioxides, etc.)
- Severe neuromuscular disease
- Congenital abnormalities of the airways
- Low birth weight (< 2500 g)
- Crowded living conditions

Palivizumab prophylaxis, respiratory syncytial virus, and subsequent recurrent wheezing.

EA. Simoes, J. Groothuis, X. Carbonell-Estrany, C. Rieger, I. Mitchell, L. Fredrick, J. Kimpen Long-Term Respiratory Outcomes study Group

Department of Pediatric Infectious Diseases, University of Colorado School of Medicine and The Children's Hospital, Denver, CO 80218, USA.

OBJECTIVE: Children who experience respiratory syncytial virus (RSV) lower respiratory tract infections (LRTIs) early in life have high rates of subsequent recurrent wheezing. Palivizumab, an anti-RSV monoclonal antibody, has 78% to 80% efficacy in preventing RSV hospitalization in premature infants without chronic lung disease. We hypothesized that palivizumab, by ameliorating or preventing early RSV LRTI in preterm infants, might decrease later recurrent wheezing. **STUDY DESIGN:** A cohort of preterm infants who had received palivizumab and were not hospitalized for RSV (n = 191) or who never received palivizumab (n = 230; 76 who were hospitalized for RSV and 154 who were not), were prospectively followed for 24 months beginning at a mean age of 19 months. The subjects were assessed for recurrent wheezing by caretaker or physician report. **RESULTS:** The incidences of recurrent wheezing and physician-diagnosed recurrent wheezing were significantly lower in the 191 palivizumab-treated subjects (13% and 8%, respectively) compared with all 230 untreated subjects (26%, P = .001 and 16%, P = .011, respectively) and with the 154 patients in the subgroup not hospitalized for RSV LRTI (23%, P = .022 and 16%, P = .027, respectively). The effect of palivizumab treatment remained significant after adjustment for potential confounding variables.

CONCLUSIONS: Our study suggests that preventing RSV LRTI with palivizumab may reduce subsequent recurrent wheezing in premature infants.

PMID: 17586188 [PubMed - indexed for MEDLINE]

The Journal of Pediatrics, Volume 151, Issue 1,

(July 2007) Pages 34-42.e1

MARK YOU CALENDER
WEDNESDAY, APRIL 30, 2008

SPRING CME MEETING

Early Detection of Bleeding Disorders in Children
With Special Focus On
Platelet Disorders, Mild Hemophilia,
Von Willebrand's Disease, & Pediatric Thrombosis



Alice Cohen, M.D.

Dir. Division of Hematology &
Oncology, Newark Beth Israel Medical
Center - Flo Okin Oncology &
Blood Disorders Center
The Comprehensive Hemophilia Treatment Center



Peri Kamalakar, M.D., Medical Director

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through the use of electronic medical records