Pediatric Nurse Practitioners National Association of — Utah Chapter

December 2011 Edition

Editor: Lisa Sharp

President's Message

By Lisa Runyon

First and foremost – thanks to each of you as NAPNAP members for your commitment to our profession and to improving children's health. We are one chapter in a nationwide network that provides the framework and leadership for pediatric nurse practitioners across the United States.

There have been many accomplishments for our Utah NAPNAP chapter this year.

We had 48 attendees for our Fall Conference at Shriners Hospital for Children, September 22nd and 23rd. This conference has continued to provide a tremendous networking opportunity for NAPNAP members and many other nurse practitioners.

Plans are underway for **next year's conference**, hosted again at Shriners Hospital for Children in Salt Lake City, UT on **September 20-21, 2012** – so mark your calendars! **Registration will be online this summer**.

Thanks to Barb Faust and Teresa McNaught for planning our successful November Continuing Education dinner meeting and the great presentation on Adolescent Medicine at Trio Café in Cottonwood Heights. Twenty-three nurse practitioners attended.

We look forward to our Spring dinner in late March/early April 2012 and another great topic and networking opportunity.

Groundwork continues on potential legislation regarding the Nurse Practice Act changes that would delete the requirement for a consultation and referral plan for those prescribing schedule II-V medications.

A meeting with the Utah Nurse Practitioner organization is planned for December as we explore the options that are available. Anyone with specific questions is welcome to contact me for upcoming meetings and the specific proposed legislation.

Best wishes to each of you and your families for a wonderful holiday season from your Utah NAPNAP Board!

Lisa Runyon, President
Utah NAPNAP Chapter

Lisa.runyon@imail.org

President- Elect Introduced

Hi, my name is Teresa McNaught, I was born and raised in Calgary, Alberta, Canada where I attained my nursing degree. My family and I moved to Sandy, Utah in 1992.

I started as an RN in the Newborn ICU at the University of Utah, later worked with Gary Chan, MD conducting research in pediatrics. I received my Pediatric Nurse Practitioner (CPNP) Master's degree at the University of Utah in 2003.

As a CPNP, I have practiced in pediatric neurology and pediatric cardiology at Primary Children's Medical Center. For the last five years I have been working in private practice at Southpoint Pediatrics in South Jordan.

I have been married over 20 years, have three children, and love calling Utah home.

I am honored to be president elect for the NAPNAP Utah chapter. It is my hope that in the short future we can help increase the awareness of why NAPNAP Utah chapter is beneficial to all nurse practitioners. By increasing our membership we can better influence the legislature and medical field in general of the benefits we have to offer the health care industry.

I look forward to working with the committee and help advance these goals throughout the coming years.

There is a link to Bright Future resources for adolescents sent by Nicole L. Mihalopoulos, MD, MPH.

15th Annual Pediatric Conference 2011

Thank you to the conference committee for another successful pediatric conference. We appreciated all who were able to attend and all of the presenters. Once again there were many opportunities for learning on a variety of topics including philanthropic opportunities both in Salt Lake City and Africa. We want to express our appreciation to all those involved in it's success from the committee, to Shriners Childrens Hospital and the vendors for their financial support. If you would like to help with the 2012 conference or have a topic you would like to learn more about, please contact next years co-chairs, Lisa Runyon or Kathy Lindsay.

Nominations Opening for 2011-12

The Utah Chapter of NAPNAP will be holding elections in the spring for the following positions; ***President-elect*** who will orient with our current President-Elect, Teresa McNaught and

become President the following year. ***Secretary*** is a two year position and ***Treasurer*** is a two year position.

Our current Treasurer, Rob Nichols, has agreed to continue for another two years and will be on the ballot in the spring. If any of you are interested in following Rob and orienting for the Treasurer and running for that position in two years let me know.

Please consider participating in your board and running for one of the positions. Elected board members are eligible for financial support to the annual national NAPNAP meeting. Being part of the national meetings is an exciting opportunity. If you have any questions please contact me at n.c.brown@comcast.net.

Many thanks,

Nancy C Brown

Nomination Chair

Editorial Comment

By Lisa Sharp

There was a fascinating editorial from Clinician Reviews, October 2011, volume 21, Number 10 entitled "Where Have All the PNP's Gone? I would encourage you to read it. Go to www.clinicianreviews.com.

The article speaks on why the PNP role was created originally to serve the underserved. Unfortunately, there is still so much more to do in behalf of our pediatric population. We who practice in this realm see the significant need, but must constantly deal with all kinds of limited resources to meet these needs.

The article addresses how few institutions teach the PNP role now in light of the cost of education, the new DNP programs, lack of funding for pediatrics, lack of interest by those entering programs etc. I would add to that a constant need for the importance of the future of the world, our children, to be elevated to the role they deserve and need. This need is at all levels from parents who need to have the desire to parent successfully to our educational systems to our need for funding from all societal levels.

Not long ago I was seen by an FNP for some varicose veins, one health risk of nurses. She asked me why I didn't set up a practice based on a "cash for service basis". She said, "You could make a lot more money you know."

I thought about that statement for the next several days. I would like to make more money, but that isn't how the world of pediatric health care works. I cringe when I tell a mother with several children that we will have to see all of the children and test them for "strep"
knowing her co-pay's are $30-$50 as per insurance contract, not to mention the cost of medication.

. I certainly do not claim to have all of the answers to our healthcare systems many faults and expenses. But somehow we have to be willing to continue looking for the answers remembering our children are certainly our future.

Please include any comments in response to this editorial and we will include them in our next newsletter

Nurse Practitioner Dinner

Our CE dinner meeting was held November 15th at the Trio restaurant. The guest speaker was Nikki Mihalopoulos MD, an adolescent specialist with the University of Utah. It was a great interactive evening. She had two very helpful handouts available. The first (pdf) is a representation on the stages od adolescents, the second is a listing of reading materials and sites to help parents and adolescents understand the changes in their lives and suggested tools to help with an easier transition through these stages.

Stages of Adolescents

Reading List for Parents of Adolescents.doc

(See attachments)

The BMI and the Waist Circumference

The **Body Mass Index**, BMI, is widely accepted as a way to diagnose and monitor metabolic problems, particularly obesity. Insurance companies and Health Regulatory agencies are strongly recommending that a patient's BMI be included in a patient's medical chart, hopefully to trigger some action or treatment if it is above 25. As productive as the BMI is, it is not always the best measurement of obesity and predictor of coronary vascular disease.[1] The new concept of "*Normal-Weight Obesity*" illustrates this point, since it is possible to have a high percentage of body fat with a normal BMI and a significant increase in the risk of heart disease.[2] BMI measurements also failed to accurately track obesity trends in children and adolescents from 1999-2006.[3]

A number like the BMI, or for that matter blood pressure or cholesterol reading, while certainly good measurement to keep in mind, can be easily "put away" and even forgotten, until the next check up at the doctor's office. In contrast, the **Waist Circumference**, WC, is a measurement of the infamous beer-belly, may be a better indicator, if not the most practical. Many clinicians feel the WC should be measured at each visit.[4] Any man with a WC over 40 inches and any woman over 35 inches may be suffering from a metabolic dysfunction, insulin resistance, or even a degree of inflammation,[5] and

[1] American Journal of Clinical Nutrition 2007;85:35

[2] J. Family Practice News, April 15th 2008, page 9

[3] JAMA 2008;299:2401

[4] AJCN 2006;84:449

[5] J. Metabolism Clinical and Experimental 2008;57:1315

has a higher risk of cardiovascular disease.[6] However, problems may be seen as early as 31.5 inches for a woman and 37 inches for a man. A rough estimate is that the WC should be half of one's height.[7] Comparing the BMI to the WC we now see that **"Mortality [is] Linked to Waistline, Regardless of BMI."**[8] The WC is such a compelling way to predict a shorter lifespan[9] and so easy to carry out that Japan has instituted laws to get people between 40 and 74 years of age to shrink their waist below 33.5 inches for men and 35.4 inches for women. Those who fail the test are given dietary instructions. If they do not shrink enough, people are asked to attend special classes to meet their goal of reducing the overweight population by 10% in 2012 and by 25% in 2015.[10]

Other authors have shown that the WC is even useful in teenagers;[11] it should be standardized for their age to increase its use in screening.[12] WC also applies to children, albeit, in smaller, but proportional waist sizes. Any child with a WC above the 90th percentile may have insulin resistance,[13] which increases their risk of cardiovascular diseases as they grow older.[14]

The Waist to Hip ratio may also be calculated. This ratio should be under 0.8, and a ratio above 0.8 signals that the waist is larger than it should be. (This is why "*apple-shaped*" people have the most problems.[15]) However, since the Waist to Hip ratio requires a little math, it is not as practical as the WC. No doubt the BMI is here to stay. But clinicians should consider using the WC measurement as an additional tool to determine a patient's risk for metabolic syndrome, insulin resistance, and cardiovascular disease. In addition, clinicians should educate patients about their WC and what they can do to return it to a healthy range if it is at a level that suggests medical risk factors, since they will be seeing their WC for the rest of their lives.

---

[6] British Medical Journal 2005;330:1363
[7] J. Clinical Epidemiology, March 2008
[8] J. Archives Internal Medicine 2010;170:1293
[9] New England J. of Medicine 2008;359:2105 & "Waist Circumference and All-Cause Mortality in a Large US Cohort," J. Arch Intern Med 2010;170(15):1293
[10] Salt Lake Tribune, June 15th 2008
[11] J. Pediatrics 2008;153:845
[12] AJCN 2006;83:3, 36
[13] J. Lancet 2007;369:2059
[14] AJCN 2007;86:549
[15] J. Lancet 2005;366:1640