CME ARTICLES

Improving the Quality of Life in Children through Pediatric Palliative Care, Murphy, Forbes, Plaxe, Stone, Cambria, Heneman, 6

The Integral Role for Pediatric Palliative Care in Our Current Healthcare Environment, O'Reilly, Vassalo, 10

CASE REPORT

A Rare Case of Extensive DVT in an Adolescent Boy, Agasthya, Ahmed, Presenza, Scattergood, 14

RESIDENT VOICE

Review of Sleep Disorders in Pediatric Primary Care, Vagrecha, Mak, Venkat, 26

LEGAL

How to Identify and Respond to Payor Audits, Beades, 19

BRIEF

Dyslexia: A Primer for Pediatricians, Selznick, 22

LEGISLATIVE

Trenton Update, PSI, 18

PEDIATRIC INITIATIVES

Pediatric Oral Health Medical-Dental Collaboration, Ballance, Sulla, 34

PROGRAM UPDATES

Pediatric Psychiatry Collaborative, 20
Critical Congenital Heart Defects, 36
New Jersey Immunization Network, Medical Home, 37

RESOURCES

Catastrophic Illness in Children Relief Fund Commission (CICRF), Prontnicki, 25
6 CME Activity
Improving the Quality of Life in Children Through Pediatric Palliative Care
By Susan Murphy, MD
Paulette E. Forbes, MPH, MS, APN
Donna Plaxe, MSN, RN, CPNP, CPON
Pamela Stone, RN, BSN, CPON, CHPPN, CHPN
Karen Cambria, MEd
Robin Heneman, RN, CHPPN

10 CME Activity
The Integral Role for Pediatric Palliative Care in Our Current Healthcare Environment
By Colin O’Reilly, DO, FAAP, FACOP, FCCM
Sheryl Vassallo, MD, FAAP, FAAHPM

14 Case Study: A Rare Case of Extensive DVT in an Adolescent Boy
By Nisha Agasthya, MD
Rafat Ahmed, MD
Thomas J. Presenza, DO
Emily Scattergood, MD

31 A Rare Case of Lymphadenopathy with Prolonged Fever in a Toddler
By Prashant Jha, MD
Sabah Kalyoussef, DO

34 Pediatric Oral Health Medical-Dental Collaboration: Perspectives from a Pediatrician and a Dentist
By Cathleen M. Ballance, MD
Maxim Sulla, DDS

22 Dyslexia: A Primer for Pediatricians
By Richard Selznick, PhD

26 Resident Voice: Review of Sleep Disorders in Pediatric Primary Care
By Anshul Vagrecha, MD
Daniel Mak, MD
Anu Venkat, ND

New Jersey Pediatrics is published quarterly by NJAAP. For information about the publication including article submissions and advertising opportunities, please contact Michael Weinstein at mweinstein@njaap.org or by phone at (609) 631-5687

Advertisements in New Jersey Pediatrics do not imply NJAAP endorsement of the product, services, or claims made for any product by a manufacturer.

Advertisers in New Jersey Pediatrics do not influence articles, their content or the opinions expressed in this publication.
For those of you who attended our Annual Conference and Exhibition, we hope you left energized and engaged. The Conference reached record attendance, with nearly 200 doctors and an additional 60 attendees comprised of guests, speakers and sponsors. The Conference offered nationally recognized speakers including: Drs. Arturo Brito, Paul Offit, Warren Seigel, Lawrence Eichenfield, Meg Fisher, Benard Dryer, Diane Calello, Binita Shah, Samantha Leib, Susan Brill, Jason Nudelman and David Krol.

For those of you who were unable to join us, consider attending the 26th Annual School Health Conference on October 18, 2017 at The Palace at Somerset Park, Somerset, NJ. This event will also feature an impressive array of recognized and respected speakers.

On May 4, 2017, the United States House of Representatives voted to pass the American Health Care Act (AHCA) (and thereby repeal most of the Affordable Care Act-ACA) by a narrow margin of 217 to 213. The bill is currently under deliberation by the Senate, where early indication suggest changes will be made and sent back to the House.

What does this all mean?
Under the AHCA:

- Insurance subsidies in the form of tax credits will be tied to a person’s age rather than income, but will phase out for individuals making over $75,000 a year.
- People under 30 will be eligible for a credit of $2000, while people over 60 would be eligible for $4000. These subsidies will not be tied to the cost of insurance, but instead, will be paid directly to the insurer by the federal government.
- A new fund is established to provide around $85 billion in tax assistance due to high premiums for individuals age 50 to 64.
- The tax penalty will be dropped. Individuals without coverage for more than two months will face a “continuous coverage” surcharge of 30% when purchasing a new insurance plan.
- The employer mandate, requiring large companies to provide health insurance to employees or face financial penalties, will be repealed.
- Young people will still be permitted to remain on their parent’s health insurance plans until the age of 26.
- Insurers will be barred from setting a limit on amounts they have to pay to cover someone.
- Insurers will be permitted to charge elderly customers up to 5 times what they charge young adults. Under the ACA, insurers were able to charge only up to three times the charge to young adults.
- Insurers are unable to deny coverage to people who have preexisting medical condition.

The AHCA establishes $100B in state innovation funds to enable states to create programs, such as reinsurance or high risk pools. An additional $15 billion is appropriated to states for risk mitigation programs focused on mental health and substance abuse. In addition, $8 billion is available for states that obtain Limited Waivers to permit health status underwriting.

The National AAP publically opposed repeal of the ACA. Teams from around the country met with Congress leaders, requesting they keep children’s needs at the forefront and urged them to resist all efforts that erode the advances achieved in health coverage for children. Lastly, the American Academy of Pediatrics conveyed the message that they are ready to work with Congress to ensure that health care for children is protected and strengthened.

I want to make sure that each and every one of you remember that our Washington, DC office is there fighting for us and our patients:

The American Academy of Pediatrics
Department of Federal Affairs
601 13th Street, NW
Suite 400 North
Washington, DC 20005 USA


In closing, I urge each of you to get involved and stay involved. Visit our new office, view our website and join a committee, write or call a representative. I also want to wish each of you, your families and the patients and families for whom we care, a healthy and safe summer, 2017!!
CEO's Column

Fran Gallagher, MEd
Executive Director, CEO

All children need access to quality pediatric healthcare—period. Yet the proposed AHCA clearly moves away from this basic need. NJAAP is calling all pediatricians to speak up…and we're here to help.

One of the reasons you are regarded among the most trusted advocates is that pediatricians put children’s welfare in the forefront of their advocacy efforts. As a Chapter, we take advocacy and educational outreach efforts seriously. We work to ensure the pediatrician’s voice, as the experts in children’s health, is represented at the table to advocate for children and their families.

Recently, the U.S. House of Representatives passed the American Health Care Act by a vote of 217-213. The bill is now being considered by the U.S. Senate, where a group of 13 Republican Senators are working on amending the bill to garner the 50 votes needed for passage. So, now is the time to speak up.

NJAAP is actively engaged in scheduling “Drive Bys”, the NJ version of the National “AAP Fly In” where AAP Chapter Presidents convened to discuss critical children’s health issues in DC followed by visits with representatives on the Hill. Our “Drive Bys” include NJAAP leadership, staff and constituents meeting with Federal representatives to convey, in a bipartisan tone, that our Chapter can and protecting the essential health care needs of all children; and the inherent public health risks created by the proposed Medicaid cuts. A few stats related to NJ Family Care:

- NJ is projected to lose $665 million in Medicaid funding from 2020-2026. Medicaid will have funding caps for children with special health care needs and Medicaid expansion would be eliminated in 2020—where does the shortfall come from?

- In 2015, 74,594 (3.7%) of NJ Children under 18 years were without health insurance—this is down from 123,456 children (6%) in 2010. The proposed cuts will lead to an increase in uninsured, an increase in ER usage and an increase in children with unmet preventative and mental and behavioral health needs. Where will the uninsured go for care? Likely ERs, yet Charity Care has been decreased by over 90 million dollars in the Governor's budget.

- In 2015, 696,602 (10.2%) of adults were uninsured, a significant decrease from 2010 when 1,027,702 (15.5%) were without health insurance.

AAP and ACNJ Child Heath, 2017

For additional facts, visit www.NJAAP.org, membership site for the updated AAP Toolkit. The overarching message for you as a member of an NJAAP “Drive By” team or as an individual is: Please keep the needs of America’s children at the forefront as you consider amending the healthcare system. I urge you to reconsider moving forward with any proposal that moves health coverage for children backward.

What a Spring season! A Children’s Ball honoring pediatric champions and youth, a timely ALD to Zika Conference, a terrific Annual meeting with nationally recognized speakers, which drew over 260 participants including approximately 200 pediatricians, and numerous Pediatric Council on Research and Education Q1 educational opportunities. Thanks to our event team leaders Bert Mulder and Cortney Mott, and the support of exceptional leadership and staff, all were successful. Thanks to our PCORE teams of MD Champions and staff who run our exceptional programs, all of which are supervised by Harriet Lazarus, MBA, COO overseas.

continued on page 36
Thanks in no small part to Benard Dreyer, MD, Immediate Past President of AAP, increased attention is now being focused on the mounting impact social determinants of health have in the lives of countless children and families. The impact is often overwhelming and the results can be devastating and life-long.

Consider the escalating distress that comes from living in an unsafe environment or being homeless and battling poverty, confrontning unemployment, not having transportation or enough nutritious food to get through the day. Children are living in homes with parents battling substance use and many are living in fear of the next outburst by an angry parent, or being exposed to domestic violence between a parent and his or her partner. And each day more stories emerge on immigrant families’ fear of being torn apart and deported if they attempt to get needed help for their children. These daily experiences are real and they are creating toxic stress in the lives of far too many children, which in turn leads to fear, depression, anxiety and an eroding sense of safety.

Many evidence-based screening tools are becoming available to pediatricians that are designed to increase the practice’s sensitivity to these issues. However, many pediatricians are reluctant to dig too deep around these issues because they do not know what to do with the answers they may receive. For screening to be effective and useful, there must be clear and available next steps that can be accessed by the practice and the family.

New Jersey makes available some of the most sophisticated and accessible array of supports and services for families in need. Sadly, for most pediatricians, knowledge of these resources remains in a black box. I would like to share with you a few of the most impressive:

1. Children’s System of Care (CSOC): A 24/7 service that provides community and home-based support for families in crisis. If a child has behavioral concerns that could cause major family crisis, a Mobile Response team will make a rapid visit to stabilize the home situation and begin the process for ongoing support. The program is insurance blind and free. This service is unique to NJ and still unknown and underutilized by pediatricians. The number for families to call is 877. 652.7624.

2. Families can contact NJ Connect at 855-652-3737 for substance abuse concerns, support and guidance.

3. Central Intake: Every county has a Central Intake agency that provides easy accesses to information and referrals about local services that exist to support all families including: immigrant health issues, housing, financial need, child care, domestic violence etc. The phones are answered by a person not a machine. The focus are prenatal to age 5. To find the number of the office in your county visit: http://bit.ly/2qTmogA

4. Statewide Parent Advocacy Network (SPAN): Parents helping other parents advocate for families in need, education for parents about their rights, working with the schools and accessing resources. Have families call 800-654- SPAN or visit the SPAN website: http://www.spanadvocacy.org/

5. Family Success Centers (FSC): Another innovative program unique to NJ. Sponsored by the NJ Department of Children and Families, there are now 56 centers across the State that work with area families to provide support, training and services. The centers are small and homely and very welcoming to any parent who seeks help or a social network. Each county has at least one Center. Consider visiting your local FSC to learn more about the staff and services offered. Find your nearest FSC here: www.nj.gov/dcf/families/support/success/

6. Mom-2-Mom: Another state wide service that provides peer-to-peer support to families with children with special needs. Helpline 24/7 Call 877-914-Mom2

7. Financial Aid: The State supports a Catastrophic Illness in Childhood Relief Fund; 800-335-FUND for information (Note: See pg. 25 for more information)

An office manager or nurse in the practice can call and obtain more details. Personnel from these programs are very willing to come to the office and present information about the programs face-to-face. This helps you to get to know the people in charge and to develop a relationship with them. This networking pays off in dividends because you or your staff can call with concerns or questions and talk to a person that you now know.

NJAAP will continue educating our members about these and other resources that can help you help the families for whom you care.
Improving the Quality of Life in Children through Palliative Care

The importance of palliative care has been endorsed by multiple medical groups (AAP, 2000; Field & Burman, 2003). The American Academy of Pediatrics (AAP) supports an integrated model “in which the components of palliative care are offered at diagnosis and are continued throughout the course of illness whether the outcome ends in cure or death.” (AAP, 2000) This model ensures that children and their families benefit from pediatric palliative care services throughout the trajectory of their illness, instead of just at end of life, as is in the case of hospice care. The Center to Advance Palliative Care (CAPC) has established referral guidelines for pediatric palliative care. This guide suggests which diagnoses should be referred automatically for palliative care consults and provides suggestions for additional medical conditions that could benefit from a palliative care consult. Some conditions include, but should not be limited to, children with high-risk malignancies, pulmonary disease, cardiac conditions, genetic anomalies, neurological/neuromuscular conditions and metabolic diseases (CAPC, 2014).

Hospice is a philosophy of care that focuses on providing a natural and comforting environment at the end of life for individuals with a terminal illness. The goal is to manage symptoms and provide comfort when there is no longer the possibility for a cure. There is a distinct difference between palliative care and hospice in terms of timing: hospice is purely at end of life and it incorporates palliative care, whereas, palliative care is appropriate care aimed at relieving symptoms and enhancing quality of life throughout the continuum of the diagnosis.

One of the most challenging aspects of pediatric palliative care and hospice care is helping patients and their families transition their goals of care as they move from a course of curative therapy to end of life. Particularly challenging is when to initiate discussions that center around this transition. In a model where patients are cared for in a continuum from the point of diagnosis through the trajectory of the treatment these discussions can occur more frequently and comfortably. Relationships between the interdisciplinary medical team and family are created naturally and forged throughout the continuum of treatment (Hospice and Palliative Medicine, 2013). The term DNR, do not resuscitate, is very hard for patients, parents and families to hear. No parent or caregiver wants to discuss withholding treatment from their child. Most families perceive withholding care as giving up. On the other side, medical providers may have the sense of loss and/or failure that the therapy agreed upon did not provide the child a positive outcome. The agonizing nature of these discussions from both the medical team and family can often create a barrier that may prevent necessary discussions that would provide the child with a more comfortable manner of death while meeting the unique needs of that child and family’s goals at end of life.

There are over 50,000 deaths among children less than 19 years old in the U.S. each year. More than one million infants and children are living with chronic, complex and/or life-limiting conditions (Wang, Burns-McGrath and Watts, 2010). Patients with conditions that were once considered fatal are surviving longer, but oftentimes with much discomfort and suffering. These patients often have complex illnesses that require care from multiple specialties, each with a limited focus. As a result, the uncoordinated, fragmented care that they receive negatively impact their quality of life (Edlynn, Derrington, Morgan, et al, 2013).

Research conducted among children with cancer has shown that those children who die undergo significant suffering before death (Wolfe, Grier, et al 2000). Furthermore, of the over 50,000 children who die each year, only about 5,000 receive hospice services, which mean that the vast majority of children who might benefit from palliative care and hospice services are not being reached (National Hospice and Palliative Care Organization, 2001). As a result of increased survivability and life-threatening diagnoses, there is a greater need for services ranging from symptom control to psychosocial management. Accessing such services can be challenging, however, because of the reluctance or fear to confront death/dying openly with children and their families, and because of the misunderstanding about the philosophy of palliative care and hospice being synonymous with each other.

Palliative care as defined by the World Health Organization (WHO), is “an approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, impeccable assessment and treatment of pain and other problems, physical, psychological, social, and spiritual” (WHO, 2008). The goal of palliative care is to prevent and relieve suffering so that patients and their families can have the best possible quality of life, irrespective of the stage of their disease or the need for therapy. Palliative care is provided throughout the continuum of care for patients who have a chronic, complex, or life-limiting condition and their families.
Medical ethicists discovered that in many cases patients’ preferences for end-of-life care were not being met (Meier and Beresford, 2009). Additionally, advance directives were often inadequate for patients with serious illness or frailty and are not designed for use in pediatric populations. In 1991 the POLST (practitioner orders for life-sustaining treatment) Paradigm began (National POLST, 2012). Although the POLST Paradigm began in Oregon, many states began to follow and adopt their own programs to fit their unique legal, medical and cultural contexts within their states. New York, Pennsylvania, Washington, West Virginia and Wisconsin were among the first group of states to develop these types of programs. In September 2004, the National POLST Paradigm Task Force (NPPTF) convened to set quality standards for POLST Paradigm forms and programs. Presently, the National POLST Office resides in the Oregon Health & Science University Center for Ethics in Health Care (OSHU CFE) and is completely supported through private philanthropy (National POLST, 2012).

On December 21, 2011, New Jersey signed legislation that enabled patients to indicate their preferences regarding life-sustaining treatment. (The National Law Review, 2011) That law called for the creation of a standardized POLST form that would be signed by a patient’s attending physician or advanced practice nurse and would provide instruction for health care personnel to follow for a range of life-sustaining interventions. The form was made available in February 2013.

POLST is an actionable set of medical orders, recommended for persons with advanced, chronic, or progressive illnesses that have a life expectancy of less than one year. The POLST helps to define the patients’ end of life goals of care and can limit medical interventions, clarify medical treatment, provide explicit direction about resuscitation, and/or include direction on such decisions as intubation, dialysis, antibiotics, tube feeding. POLST is a medical order that travels through any setting, which may include hospital, home, outpatient clinics, or school settings (National POLST, 2012).

POLST focuses on a continuation of care and not the absence of care. It is appropriate for pediatric and adult patient populations and allows for the pursuit of different medical interventions for the patient and/or parents to choose. The POLST form is a tool that provides structure to the most difficult conversation most medical professionals will have and provides guidance to the medical professional for assisting the patient and family in their transition to end of life. The POLST is not a static document; as a patient’s illness progresses, their goals of care and decisions about life sustaining interventions may change and the POLST may be modified at any time to meet these changes.

Case Study

A healthy 30 year-old pregnant woman with 4 children, ages 1 to 7, presents with a normal pregnancy until her 20 week ultrasound where it was noted that the infant had severe anomalies consistent with Trisomy 13. The Maternal Fetal Medicine group (MFM) performed a diagnostic amniocentesis and the diagnosis of Trisomy 13 was confirmed. Parents were offered to terminate the pregnancy, but declined. The parents were referred to the high-risk obstetric clinic (HROB). The HROB clinical team reviewed with the parents that a diagnosis of Trisomy 13 is considered to be a lethal anomaly with no known interventions to significantly alter the natural course of the pregnancy.

Discussions with the HROB and MFM helped to bring about a shift in perspective of the parents understanding that certain medical interventions could prolong, cause pain and/or suffering, and would not affect the ultimate outcome for this infant.

A collaborative plan of care was created with interdisciplinary team involvement that included the parents, HROB, MFM, Pediatric Palliative Care and the Neonatal and Pediatric divisions. The plan of care was flexible with clear documentation of the goals and wishes of the parents’ pregnancy, labor and delivery, and infant care. The plan focused on the parents wish that the birth as well as the death be as natural as possible. The parents wanted to hold and feed their infant, and give only those measures that would provide comfort and relieve pain and suffering. The family was adamant that they did not want intubation, oxygen, cardio or respiratory monitoring, or intravenous attempts for the infant after the birth. Following multiple discussions, a POLST form was completed for the care of the infant.

In addition, both parents wanted to stay with their infant after birth and during the mother’s stay in the hospital. For many reasons, the parents were unsure whether they wanted to take their baby home. It was at this point that the team needed to think out of the box and create an additional plan if the infant were to live past the mother’s discharge from the hospital. Hospital protocol would have been to transfer the newborn to the neonatal intensive care unit. This transfer would not have allowed the family to remain with the infant in the way that they wished: holding, feeding, bonding, and caring for the infant in a relaxed, quiet and loving environment. The team’s collaborative efforts allowed for the coordination of the infant’s care and the ultimate transfer to an inpatient pediatric room with the parents.

The infant lived beyond the mother’s stay in the hospital; the infant and parents were transferred to the pediatric inpatient unit supported by the interdisciplinary team. The
pediatric palliative care team provided assistance and support to the pediatric team for symptom management, comfort care and psychosocial support for the infant and parents. On the fourth day of life, the infant died peacefully in the arms of the parents with other family members present. In the end, they swaddled and held their infant as they wanted.

The journey for this family and infant was one of love and comfort. The availability of palliative care services allowed the care team to fulfill the wishes and goals of parents whose infant’s health was complicated by lethal anomalies. While the life for this infant was only days, the parents were able to have their goals and wishes for their baby and family respected. In the end, a multidisciplinary approach was achieved and created profound lasting memories for a family that had to deal with the devastation of losing their baby.

**Discussion**

The goal of pediatric palliative care is to provide comprehensive, multidisciplinary care to the patient and family from the point of diagnosis to the resolution of the condition, whether through cure or death. The palliative care team’s responsibilities include managing pain and other uncomfortable symptoms, facilitating communication, supporting decision-making, and helping to coordinate care. This case pulls together all aspects of pediatric palliative care and hospice to provide the best possible care for an unborn infant and family. Palliative care began at the point of diagnosis, in this case, the parents learning their unborn infant had a devastating diagnosis of Trisomy 13, and continued through the rest of the pregnancy, birth, life and death of the infant. The interdisciplinary approach of the team provided the family with the support they needed throughout the trajectory of this infant’s short life and death. Contributing to this plan of care was the administration of the POLST, which brought together all of the medical goals of care as well as the parent’s goals and wishes for the infant. The POLST brings together an actionable set of orders and becomes a part of a patient’s medical record. It ensures that the wishes of that patient are fully accessible to the entire medical care team in one concise location. The POLST is available at www.nj.gov/health/advancedirective/polst.shtml.

Care coordination is an important and necessary part of medical care for patients and their families who are faced with complex, chronic and life-threatening conditions. It is critical that timely medical decision planning among members of the interdisciplinary team and the family be executed jointly to prevent suffering and to improve the quality of life for children and their families. Pediatric palliative care services should be an integral part of any medical decision planning for children facing life-threatening conditions.

**References**


continued on next page
1. Palliative care is an approach that improves quality of life in patients with life-limiting illness in the last 6 months of life.
   a. True ______
   b. False ______

2. Palliative care goals of treatment include physical, psychological & spiritual treatment.
   a. True ______
   b. False ______

3. The goal of hospice is to manage symptoms & provide comfort when there is no possibility of cure.
   a. True ______
   b. False ______

4. The AAP supports an integrated model in which palliative care is offered to children with chronic conditions:
   a. Last 6 months of life
   b. When they develop more symptoms
   c. At diagnosis of a life-threatening illness
   d. None of the Above

5. Palliative care is only to be offered to children with the following conditions:
   a. Severe neurological conditions
   b. Genetic abnormalities
   c. High-risk malignancies
   d. All of the above

6. In which state was the POLST first initiated:
   a. New Jersey
   b. Oregon
   c. New York
   d. Rhode Island

7. POLST stands for:
   a. Pediatric orders for life sustaining treatment
   b. Physician orders for life sustaining treatment
   c. Position on life sustaining therapy
   d. Practitioner orders for life sustaining treatment

8. In which year was legislation signed into law regarding POLST in New Jersey?
   A. 2011
   B. 2004
   C. 2013

9. POLST can only be signed by the patient’s attending.
   a. True ______
   b. False ______

10. POLST is valid only in the hospital setting.
    a. True ______
    b. False ______

CME Instructions

Read the CME-designated article and answer the Summer issue, quiz questions above. Print your name and phone number and mail or fax this form within six months from the date of issue to: NJAAP CME Quiz, 50 Millstone Road, Building 200, Suite 130, East Windsor, NJ 08520 • Fax: 609.842.0015

NAME __________________________ PHONE __________________________

EMAIL________________________________________

Submitter must answer 8 of the 10 questions correctly to qualify for CME credit

Accreditation Statement:

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Medical Society of New Jersey through the joint providership of Atlantic Health System and the American Academy of Pediatrics, New Jersey Chapter. Atlantic Health System designates this live activity for a maximum of 1.0 MA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Atlantic Health System is accredited by the Medical Society of New Jersey to provide continuing medical education for physicians.
The Integral Role for Pediatric Palliative Care in Our Current Healthcare Environment

Pediatric palliative care has evolved over the past several years into a care delivery model which has proven to be an integral component in the current health care environment. As defined by the World Health Organization, “Palliative palliative care is the active total care of the child’s body, mind, and spirit, and also involves giving support to the family. It begins when the illness is diagnosed and continues regardless of whether or not a child receives treatment directed at the disease.” When further exploring its role and defining the care delivery model, Pediatric palliative care is a multifaceted approach of healthcare delivery which emphasizes quality of life of all children with life-limiting or life-altering conditions, as well as their families. Care focuses on the prevention and relief of suffering and addresses the physical, psychosocial, emotional, and spiritual needs of the patient and the family.

Historically, the term “Palliative Care” was thought to be synonymous with “end of life care.” In prior traditional care models, after diagnosis was made, efforts were directed at curative care. When and if curative care was exhausted and did not achieve a “cure”, care would be transitioned to what medical providers termed “palliative care,” “hospice care,” or “end of life care.” The current care model and practice of Pediatric palliative care varies greatly from this historical delivery model, with the focus on palliative efforts starting at disease diagnosis and occurring in varying amounts in conjunction with disease-directed therapy. As the disease evolves, the role of Palliative Care often increases. In this care delivery model, there is an individualized coordination of care directed at the underlying illness with emphasis on physical, emotional, social, and spiritual needs of the child and the family. Throughout the care continuum, there is continuous reevaluation and adjustment of care based on goals set in a team approach by the multi-disciplinary, multi-specialty medical team and family unit. This helps to delineate the individualized, multi-faceted needs of the patient and his or her family and places emphasis on those needs throughout care planning. While pediatric palliative care includes end-of-life and bereavement care, it is much more broad in its delivery spectrum as care is provided and adjusted throughout a child’s life. This care model also emphasizes continuous communication regarding goals of care with the entire multidisciplinary care team spanning all specialties involved.

The patient population who should be considered for this model of care is vast and continually increasing. Any child diagnosed with life-limiting or life-altering disease should be considered a candidate for pediatric palliative care. Patients who have multiple components to their medical care (i.e. multiple subspecialists) or require multiple hospitalizations due to their underlying diagnosis would benefit from Pediatric palliative care. As medicine continues to advance and the role of technology increases in the day-to-day care of our patients, the volume of patients continues to rise as patient complexity increases.

Pediatric palliative care is coordinated and delivered by specialists in the field. Both allopathic and osteopathic licensing boards have designated certifications for Hospice and Palliative Care Medicine and there are several fellowship programs in palliative care across the country. In addition, physicians who had additional clinical training and clinical experience in the field were eligible through 2013 for board certification via a clinical pathway. Once initiated, the components of an inpatient Palliative Care consult are multi-faceted and include chart reviews, interviews with primary and subspecialist physicians, nurses and all other members involved in care, including social workers, child life specialists, and chaplaincy as appropriate. In addition, extensive patient and family interviews are conducted. The patient and family interviews include symptom assessment, psycho-spiritual assessment physical exam, discussion of prognostication, goal setting, and disposition planning. Communication with the primary medical team addresses symptom and pain management, direction of care to meet patient and family-defined goals, and further triage of additional services including pain management, psychological needs, rehabilitation, as well as other outpatient therapies. At the later stages of disease, when encompassing more end-of-life care, the palliative care team facilitates discussion regarding home care, hospice care, DNR orders and planning for possible death, and helps to facilitate the appropriate disposition with the primary team.

The care model of Pediatric palliative care has similar principles to Adult Palliative Care, but care delivery and implementation are altered due to many factors. The cognitive ability and emotional maturity of the patient population may lead to limited communication when assessing patient needs and desires regarding goals of care. Along the same lines, while patient autonomy is a focus of adult medicine, family autonomy is weighed more heavily in the pediatric population, with parents and legal guardians having more inherent “ownership” over care delivery and planning. Furthermore, the diseases in the pediatric population differ from the adult population. When life-limiting or life-altering disease is diagnosed in the pediatric population, there are varied emotional and psychological impacts on the family unit, which ultimately affects the complexity of the parent, child, and sibling relationship. All of these factors must be taken into account for effective delivery of care, both palliative as well as disease-directed.
While this all-encompassing model of care delivery may seem ideal, barriers exist in today's healthcare environment that must be overcome to insure successful implementation. Some of the chief barriers include: lack of exposure and family perception of palliative care, lack of professional training, communication difficulties when discussing difficult topics, population awareness, and limitation of resources. In a study of hospitals enrolled in the Childrens' Oncology Group, a set of childrens' hospitals that expectedly would have a high prevalence of pediatric patients with life-altering diagnoses, Pediatric palliative care was only available at 58% of institutions. 1 The availability of such services may be workforce related. In an assessment of the current palliative care workforce, a recent study showed that an acute shortage of Hospice and Palliative Care Medicine physicians exists, with an estimated gap of up to 18,000 individual physicians needed to achieve mature staffing of the existing number of hospice- and hospital-based palliative care programs. 2

While access to care may be limited, another barrier lies within the burden of diagnosis and prognosis in the pediatric population. In a study of barriers to palliative care for children published in Pediatrics, nurses and physicians surveyed cited that the most frequent barriers were the patient's uncertain prognosis as well as the family's unwillingness to accept the diagnosis of an incurable condition. 3 In addition to family resistance to accepting such diagnoses, the pediatric community has demonstrated difficulty in discussing such diagnoses with families in an appropriate manner, which may limit palliative discussions regarding goals of care.

A study published in Pediatrics examining the delivery of care and effective communication reported that medical staff felt inexperienced in communication with patients and families. In this study, families reported distress about the way bad news was delivered to them by healthcare professions. Ultimately, 54% of medical staff surveyed reported that adequate care was not delivered secondary to these communication issues. 4 Deficiencies in the ability to deliver bad news and conduct difficult discussions spanned all levels of training. In a study of pediatric residents, attendings, and fellows, when asked to provide self-assessment of ability to effectively deliver bad news, one half of all attending physicians and two thirds of fellows did not feel sufficiently knowledgeable or comfortable in their ability to deliver bad news. More strikingly, all pediatric residents felt insufficiently knowledgeable for independent practice of this skill. 5 Given that effective communication, often occurring in times of family duress, is critical to effective delivery of pediatric palliative care, our skill set as pediatricians may create an additional barrier.

Even though many barriers exist, there is still a great need to forge ahead and promote the effective delivery of pediatric palliative care. In a randomized control trial studying the impact of an inpatient palliative care team, patients who had palliative care involvement reported greater satisfaction with their care experience and with their providers' communication. These patients had fewer ICU admissions on readmission, as well as lower total healthcare costs 6 . Regarding quality of care, a prior study found that palliative care patients had improvement in care quality and also reported that a higher percentage of their emotional and spiritual needs had been met. 7

Cost should not be a leading factor in determining a patient's care delivery, however, the principle of social justice and the current medical and economic climate in the United States do promote a need for cost effective medical care. In a comprehensive study, US hospital palliative care consultation programs have been shown to significantly decrease cost in both subsets of patients alive at time of hospital discharge as well as decreasing costs in those patients who had died during hospitalization. A decrease was noted in both direct costs per admission as well as in indirect costs per day, with significant reductions in pharmacy, laboratory, and intensive care unit costs. In further assessment, decrease in cost of care was directly related to timing of consultation; early consultations were associated with earlier reduction in costs. 8

With its positive effect on patient satisfaction, quality of care, and decreased total cost of medical care, Palliative Care should be seen as one of many key components in the restructuring of our current medical system. While barriers do exist, the promotion of this care delivery model will aid in overcoming barriers and will facilitate improved care delivery as a whole to our pediatric patients.

References

7. Does palliative care improve quality? A survey of bereaved family members. Gelfma et al. Hertzberg Palliative Care Institute of the Brookdale Department of Geriatrics, Mount Sinai School of Medicine, NY, NY

**Biography:**

Colin O’Reilly, DO, FAAP, FACOP, FCCM is the Medical Director of the Pediatric palliative care service at the Goryeb Children’s Hospital of Atlantic Health in Morristown N.J. He also is a Pediatric Critical Care attending at the same institution. He is board certified in General Pediatrics by both the American Board of Pediatrics and the American Osteopathic Board of Pediatrics, board certified in Pediatric Critical Care Medicine by the American Board of Pediatrics, and is board eligible in Hospice and Palliative Care Medicine. He was trained in Palliative Care at the Harvard Medical School Center for Palliative Care and completed the Program in Palliative Care Education and Practice Program. He is also active in Bioethics, with additional training at the Kennedy Institute of Bioethics at Georgetown University.

Sheryl Vassallo, MD, FAAP, FAAHPM is a Palliative Care Physician at the Goryeb Children’s Hospital of Atlantic Health in Morristown, NJ. She is also a Pediatric Hospitalist at the same institution. She is board certified in General Pediatrics and Hospice and Palliative Care Medicine by the American Board of Pediatrics. She was trained alongside Dr. O’Reilly in Palliative Care at Harvard Medical School Center for Palliative Care and completed the Program in Palliative Care Education and Practice Program.

**CME Quiz—Integral**

1. According to a study of hospitals enrolled in the Children’s Oncology Group, pediatric palliative care was available in what percent of the participating hospitals?
   a. 17%
   b. 25%
   c. 58%
   d. 75%
   e. 85%

2. Pediatric palliative care is a multifaceted approach of health-care delivery that emphasizes:
   a. The quality of life of all children with life-limiting or life-altering conditions
   b. Addressing the physical, psychosocial, emotional and spiritual needs of the patient and family
   c. Focus on the prevention and relief of suffering
   d. All the above

3. The World Health Organization defines pediatric palliative care as the active total care of the child’s body, mind and spirit and also involves giving support to the family.
   a. True ______
   b. False ______

4. Components of a multi-faceted Palliative Care consult include:
   a. Chart reviews
   b. Extensive patient and family interviews that include symptom assessment, psycho-spiritual assessment, physical exam, discussion of prognostication, goal setting and disposition planning
   c. Interviews with primary physicians, subspecialists, nurses, and all other members involved in care
   d. All of the above

5. Any child diagnosed with life-limiting or life-altering disease should be considered a candidate for pediatric palliative care.
   a. True ______
   b. False ______

6. At the later stages of disease, the Palliative Care team should facilitate discussion regarding home care, hospice care, DNR orders and planning for possible death.
   a. True ______
   b. False ______

continued on next page
CME Quiz from page 12

7. Barriers to overcoming for ensuring the successful implementation of Pediatric palliative care include all of the following, except:
   a. Family perceptions of Palliative care
   b. Lack of training and communication difficulties when discussing difficult topics
   c. Abundance of resources
   d. Population awareness

8. A 2010 article that appeared in the Journal of Pain and Symptom Management reported an estimated gap of up to 18,000 physicians needed to achieve mature staffing of existing number of hospice and hospital-based palliative care programs.
   a. True ______
   b. False ______

9. Nurses and physicians cited that the most frequent barriers were a patient’s uncertain prognosis and the family’s unwillingness to accept the diagnosis of an incurable condition.
   a. True ______
   b. False ______

10. In a randomized control trial studying the impact of an inpatient palliative care team, patients reported all the following except:
    a. Greater satisfaction with their care experience
    b. Increased healthcare costs
    c. Fewer ICU admissions and readmissions
    d. Greater success in meeting emotional and spiritual needs

CME Instructions

Read the CME-designated article and answer the Summer issue, quiz questions above. Print your name and phone number and mail or fax this form within six months from the date of issue to: NJAAP CME Quiz, 50 Millstone Road, Building 200, Suite 130, East Windsor, Nj 08520• Fax: 609.842.0015

NAME ______________________________ PHONE ______________________________

EMAIL ______________________________

Submitter must answer 8 of the 10 questions correctly to qualify for CME credit

Accreditation Statement:

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Medical Society of New Jersey through the joint providership of Atlantic Health System and the American Academy of Pediatrics, New Jersey Chapter. Atlantic Health System designates this live activity for a maximum of 1.0 MA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Atlantic Health System is accredited by the Medical Society of New Jersey to provide continuing medical education for physicians.
**Case Study: A Rare Case of Extensive DVT in an Adolescent Boy**

Nisha Agasthya, MD  
Department of Pediatrics, Division of Hematology/Oncology, Children's Regional Hospital, Cooper University Hospital

Rafat Ahmed, MD  
Department of Pediatrics, Division of Hematology/Oncology, Children's Regional Hospital, Cooper University Hospital

Thomas, J. Presenza, DO  
Department of Pediatric Radiology, Children's Regional Hospital, Cooper University Hospital

Emily Scattergood, MD  
Department of Pediatric Radiology, Children's Regional Hospital, Cooper University Hospital

**ABSTRACT:** Pediatric venous thrombosis is uncommon and has lower incidence than adults. However it is associated with significant morbidity. Here we present a case report of a 13-year old African American boy who was found to have deep vein thrombosis (DVT). He initially presented to the office for routine evaluation of anemia, and was found to have extensive bilateral venous thrombosis of his lower extremities. Extensive work up for Thrombophilia showed that he had elevated D-Dimer, Lipoprotein A and Homocysteine levels with the discovery of being heterozygous for Methylene—tetrahydrofolate reductase enzyme mutation. His anemia work up revealed not only abnormal iron studies, but also low Vit B12 levels. Given his history of bowel resection as a preterm infant with necrotizing enterocolitis (NEC). Further imaging studies revealed he has congenital anatomic variant of IVC. With limited information regarding birth and family history, it is unclear if his high homocysteine level is inherited or nutritional. This case illustrates the need to have high clinical suspicion for early diagnosis and thorough evaluation since a patient may have multiple causes for thrombosis.

**PRESENTATION:** The patient is a 13 year old male with past medical history of ADHD, preterm birth and bowel resection as a neonate for necrotizing enterocolitis (NEC), who came to Hematology clinic for evaluation of anemia found on routine labs. During review of systems he admitted to have left lower extremity pain (mostly over the ankle) for 2 months, intermittent, dull achy type. During the summer he admitted to spending most of his time playing video games on the couch. He was seen by his Pediatrician for left ankle pain who suspected he had ankle sprain and recommended RICE (rest, ice, compress and elevate) treatment. Subsequently his pain resolved and now he had right lower extremity pain from 2 weeks, initially burning type which progressed to squeezing in quality, worse in the thigh, aggravated by walking and partially relieved by rest. There was no history of trauma or any other associated symptoms at this time. It was unsure to what extent his bowel was resected as a consequence of his NEC. No family history was available as he was adopted. Parents were concerned with restricted physical activities after the onset of these complaints.

**RESULTS:**

**White cell count:** 6.2 x 10³/µL (64 % segmented neutrophils, 29% lymphocytes, 6% monocytes, 1% eosinophils)

**Hemoglobin/ Hematocrit:** 8 g/dl and 27.2 (MCV 59.6 FL, MCH 17.5g/dl, MCHC 29.4 g/L)

**Iron Saturation:** 5% (15-50%)

**Serum Iron:** 18 mcg/dl (42-135 mcg/dl)

**Lipoprotein A:** 155 (<75ng/dl)

**Factor VIII:** 290

**Fibrinogen:** 409,

**D-Dimer:** 4.11 (0.50 mcg FEU/mL)

**Protein C, S, ATIII:** WNL.

**INR:** 1.5, **PT:** 16.1 s (9.5s-12.2s), **aPTT:** 23.8 s

**Homocysteine:** 114.5 (<15)

**Vit B12:** 69 (211 - 911 pg/ml), **Vit B6:** 8

**MTHFR DNA mutation:** Positive for one copy of A1298C mutation.

**Factor V Leiden mutation and Prothrombin gene mutation:** Negative

Physical exam findings include, grade 2/6 early systolic murmur loudest in the left parasternal area, swelling but no obvious edema of bilateral lower extremities at the thigh and calf with normal gait. The remainder of the physical exam yields unremarkable results.

**continued on next page**
**MRV abdomen without contrast:** Nonvisualization of the IVC caudal to the level of L2. Sub optimally demonstrated numerous prominent collateral venous vessels. The findings may indicate extensive central venous thrombosis versus variant congenital venous anatomy versus a combination of congenital variant and thrombosis.

**DISCUSSION:** Our patient had extensive evaluation of his extensive lower limb DVT. Labs and Duplex scan concluded that he had extensive DVT with elevated D-Dimer, Homocysteine and Lipoprotein A levels, anisopoikilocytosis hypochromic anemia, silent carrier alpha thalassemia and low serum iron. He was started on low molecular weight heparin (LMWH) 60 mcg every 12 hours and his Anti Xa levels were therapeutic. He was also started on Ferrous Sulfate for his iron deficiency anemia.

Current MRV scan of the abdomen is indicative of a possible congenital anatomical variant of IVC that could be causing his prothrombotic state. Multiple studies have shown that anatomical variation of the IVC can lead to venous thrombosis. Our patient has multiple inherited and acquired risk factors that have increased his chances of developing thrombosis causing his extensive DVT.

Currently he continues to follow with Pediatric Hematology and is on coumadin therapy along with monthly Vit B12 injection.

**PATHOGENESIS:**

Traditional understanding of DVT pathophysiology focuses on the formation of thrombi in the setting of three factors proposed by Virchow (Virchow's triad):6

- Damage of the vascular endothelium
- Venous stasis
- Hypercoagulable state

In theory, familial thrombophilia could be caused by any genetically determined defect of the coagulation or fibrinolytic systems that causes accelerated thrombin formation or impaired fibrin dissolution.

Most common inherited causes of thrombophilia include:1, 2, 3

<table>
<thead>
<tr>
<th>Prevalence in general population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor V Leiden mutation (F5 R506Q - activated protein C [APC] resistance)</strong></td>
</tr>
<tr>
<td>3%-7%</td>
</tr>
<tr>
<td><strong>Prothrombin G20210A mutation (factor II G20210A prothrombin mutation)</strong></td>
</tr>
<tr>
<td>0.7%-4%</td>
</tr>
<tr>
<td><strong>Protein C deficiency</strong></td>
</tr>
<tr>
<td>0.2%-0.5%</td>
</tr>
<tr>
<td><strong>Protein S deficiency</strong></td>
</tr>
<tr>
<td>0.03%-1%</td>
</tr>
<tr>
<td><strong>Antithrombin deficiency</strong></td>
</tr>
<tr>
<td>0.02%-0.3%</td>
</tr>
</tbody>
</table>

Other causes also include hyperhomocysteinemia,4 Antiphospholipid syndrome, elevated coagulation factors VIII, IX, or X2, dysfibrinogenemia.3

**DIFFERENTIALS:** Musculoskeletal disorders (muscle or tendon strains or tears), lymphatic obstruction, venous insufficiency, a ruptured popliteal (Baker) cyst, cellulitis, sciatica, muscle hematoma, and postthrombotic syndrome.

**DIAGNOSIS:** Duplex sonography is the primary noninvasive diagnostic method for DVT. There are several types of venous ultrasonography (US). They include compression ultrasound (B-mode imaging only), duplex ultrasound (B-mode imaging and Doppler waveform analysis), and color Doppler imaging alone. Although these types of venous ultrasonography are sometimes used interchangeably,5 Compression B-mode ultrasonography with or without color Duplex imaging has a sensitivity of 95% and a specificity of 96% for diagnosing symptomatic, proximal DVT. For DVT in the calf vein, the sensitivity of venous ultrasound is only 73%.9

Venography remains as the reference standard of testing but is being performed less often due to complications associated with it, which include superficial phlebitis and DVT itself. It is useful only when non-invasive tests have been inconclusive for diagnosis.4

Magnetic Resonance Venography (MRV) provides non-invasive diagnostic technique to venography with sensitivity of 93% (95% [CI]: 89% to 95%) and specificity of 96% (95% CI: 94% to 97%).10 MRV does have inherent advantages over US, especially in its ability to delineate extravascular anatomy.14

Computed Tomography Venography (CTV) can also be used, however it is important to remember about exposure to ionizing radiation. There is little evidence to support the use of CTV to diagnose DVT other than as a workup for pulmonary embolism. However, CTV may be considered a reasonable alternative to MRV for pelvic DVT or when US is nondiagnostic.13

**SCORING:** The MPTS score based on a positive or negative family history, idiopathic versus triggered venous thromboembolism (VTE), results of thrombophilia testing, thrombotic locations and extension, and short-term patency rates will help physicians to classify children at risk and to estimate the duration of anticoagulant following a first event and secondary prophylactic anticoagulation in any clinical risk situations prone to thrombosis in later life.7

continued on page 16
CONCLUSIONS: Our patient’s is a rare case since he has both inherited and acquired risk factors for thrombosis. His thrombosis is extensive given the multiple prothrombotic risk factors.

- Inherited causes of pediatric venous thromboembolism are rare but a diagnosis that has been kept in the clinician’s mind.
- Duplex US is the most common non-invasive imaging technique of diagnosis with high sensitivity and specificity.
- Lab tests need to be done to diagnose inherited thrombophilia with detailed family history.
- Treatment consists of LMWH or UFH and length of treatment can be established with MPTS scoring system. Oral anticoagulants are often used for prolonged lengths of treatment.

REFERENCES

4. Venous Thromboembolism, Wendy, Hematology, Chapter 144, 2039-2047.e4

Munster Pediatric Treatment Severity (MPTS) Scoring for acute pediatric VTE

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive family history</td>
<td>1</td>
</tr>
<tr>
<td>Idiopathic DVT</td>
<td>2</td>
</tr>
<tr>
<td>Single inherited thrombophilia</td>
<td>1</td>
</tr>
<tr>
<td>Combined inherited thrombophilia/APLS</td>
<td>2</td>
</tr>
<tr>
<td><strong>Location of DVT</strong></td>
<td></td>
</tr>
<tr>
<td>Calf</td>
<td>0</td>
</tr>
<tr>
<td>Leg</td>
<td>1</td>
</tr>
<tr>
<td>Pelvis</td>
<td>2</td>
</tr>
<tr>
<td>Pulmonary/Cerebral DVT</td>
<td>3</td>
</tr>
<tr>
<td><strong>Patency</strong></td>
<td></td>
</tr>
<tr>
<td>Complete</td>
<td>0</td>
</tr>
<tr>
<td>Partial</td>
<td>1</td>
</tr>
<tr>
<td>No patency</td>
<td>2</td>
</tr>
</tbody>
</table>

TREATMENT: Unfractionated Heparin (UFH) or Low molecular weight Heparin (LMWH) is the initial treatment of choice. None of the other oral or parenteral alternatives have been studied in children. Both UFH and LMWH act by catalyzing the action of antithrombin (AT)-III. There are several LMWHs available, and they have variable inhibitory effects on thrombin. For this reason, the PTT is not a reliable measure of the anticoagulant effect of LMWH, and the anti–factor Xa activity is used instead. The optimal duration of anticoagulation for children with thrombosis is not well established. Current guidelines recommend that neonates receive 6 weeks-3 months of therapy for venous thrombosis, and older children receive 3-6 months of therapy. Patients with strong inherited thrombophilia, recurrent thrombosis, and APLS (Anti Phospholipid Antibody Syndrome) may require indefinite anticoagulation.

Thrombosis and Sickle cell disease and trait: It is well known that patients with sickle cell disease (SCD) are at risk for thrombotic complications like arterial and microvascular thrombosis from chronic activation of platelets and coagulation factors. However, there is only some evidence in the adult population about increased risk for spontaneous DVT. Studies have shown that there have been some cases of thromboembolic phenomenon with sickle cell trait that is contributed by significantly higher levels of d-dimer, thrombin-antithrombin complexes, prothrombin fragment 1.2 and absolute monocyte levels. Some authors recommend anticoagulation in all hospitalized patients with sickle cell trait after gynecological, urologic and orthopedic surgical procedures. However, these studies are limited to the adult population.

Scoring:

≤2 points = low risk, treat for 3 months
3-5 points = medium risk, treat for 6-12 months
≥6 points = high risk, treat for >12 months or lifelong with risk adapted changed

12. Complications Associated with Sickle Cell Trait: A Brief Narrative Review, Geoffrey Tsaras, MD, MPH, Amma Owusu-Ansah, MD, Freda Owusu Boateng, MD, Yaw Amoateng-Adjepong, MD, MPH, PhD, American Journal of Medicine, Vol 122, No.6[13] Suspected Lower Extremity DVT Expert Panel on Vascular Imaging: Michael Hanley, MD1; Joseph Donahue, MD2; Frank J. Rybicki, MD, PhD3; Karin E. Dill, MD4; Dennis F. Bandyk, MD5; Christopher J. Francois, MD6; Marie D. Gerhard-Herman, MD7; Sanjeeva P. Kalva, MD8; Emile R. Mohler III, MD9; John M. Moriarty, MB, BCh10; Isabel B. Oliva, MD11; Matthew P. Schenker, MD12; Richard Strax, MD13; Clifford Weiss, MD.14


7. Thrombophilia in the young, U. Nowak-Göttl1, K. Kurnik2, A. Krümpel1, M. Stoll3,1Pediatric Hematology/Oncology University Children's Hospital Münster, 2University Children's Hospital Munich, 3Leibniz Institute for Arteriosclerosis Research, University of Münster, Germany


9. Deep vein thrombosis: a clinical review, Emeka Kesieme,1 Chinanye Kesieme,2 Nze Jejbina,3 Eshiobo Irekpita, and Andrew Dongo1


MEMBER BENEFIT

Medical Malpractice Insurance

HOW MUCH CAN YOU SAVE

Exclusive Member Benefit

The New Jersey Chapter, AAP, and NJAAP Purchasing Alliance have partnered with Positive Physicians Insurance Exchange (PPIX) to provide you exclusive proprietary member rates on Medical Malpractice Insurance. These excellent rates are 28% below PPIX’s standard rates. In addition, when switching to Positive Physicians Insurance Exchange (PPIX) under a claims-made policy, PPIX will offer prior acts coverage. The simply means that PPIX will honor the retroactive date shown on your current policy. PPIX, one of the only professionally managed, physician driven medical malpractice companies in the country, has a Financial Stability Rating® of A, Prime, from Demotech, Inc.

Interested? Contact Debbie Gass, Senior Underwriter at 484-323-1192 to obtain a quote.

MEMBER BENEFIT
Legislative Update

Joe Simonetta
Public Strategies Impact

Tracie DeSarno
Public Strategies Impact

The Governor’s proposed budget for Fiscal Year 2018 includes $5 million for the statewide expansion of the Pediatric Psychiatry Collaborative. As a collaboration of pediatric primary care physicians and mental health specialists, this program aims to improve the ability of providers to screen, treat, refer, and care manage, as well as increase access to mental health services for children with mental, behavioral health and/or substance use issues. The Governor’s budget also includes an additional $10 million appropriation to the Department of Health for lead testing. We expect both of these items to remain in the budget. The Legislature must adopt and the Governor sign the state budget by July 1, 2017.

On the Legislative front, the Legislature passed and sent to the Governor S2348/A3799, which amends current law requiring only students participating in intramural sports programs organized by a public or nonpublic school in the head injury safety program to now include students who participate in interscholastic sports programs. Under current law, the Department of Education was required to develop and implement, by the 2011-2012 school year, a head injury safety training program on recognition of symptoms of head injuries and the appropriate amount of time to delay return to play for a student who suffers a head injury. The program must be completed by school physicians, coaches, and athletic trainers involved in public or nonpublic school interscholastic sports programs. The law also required school districts to develop a written policy concerning the prevention and treatment of sports-related concussions among student-athletes. Finally, the law provides that students who participate in interscholastic sports programs who sustain or are suspected of having sustained a concussion or other head injury while engaged in a sports competition or practice must be immediately removed from competition or practice and may not return until evaluated and cleared by a physician.

Two pieces of legislation have been introduced concerning the administration of vaccines by pharmacists: S3008/A4762 provides that a pharmacy intern or extern may administer injectable medications, biologicals, and immunizations to patients by injectable or needle free delivery methods, but only under the direct supervision of a licensed pharmacist. S3086/A4761 expands the authority of pharmacists and pharmacy interns and externs to administer vaccines. This legislation allows pharmacists to independently initiate and administer to patients who are three years of age or older any vaccine that is recommended by the Advisory Committee on Immunization Practices (ACIP) in the current Centers for Disease Control and Prevention “Recommended Immunization Schedule for Persons Aged 0 through 18 Years”. A vaccine initiated and administered by a pharmacist pursuant to the bill is to be initiated and administered pursuant to a standing order issued by an authorized prescriber and consistent with current ACIP recommendations. The bill permits pharmacy interns and externs to administer vaccines to patients who are 18 years of age or older, subject to the same requirements that currently apply to pharmacists who administer such vaccines. Additionally, the vaccine is to be administered pursuant to one of the following: (1) a prescription issued by an authorized prescriber; (2) an immunization program implemented pursuant to a standing order; or (3) an immunization program, including programs sponsored by government agencies, which are not patient specific. The bill also permits pharmacy interns and externs to administer an influenza vaccine to a patient who is seven years of age or older. For a patient who is under 18 years of age, the pharmacy intern or extern may not administer the vaccine except with the permission of the patient’s parent or legal guardian. For a patient who is under 10 years of age, a pharmacy intern or exter may not administer an influenza vaccine unless the vaccine has been prescribed for the patient by an authorized prescriber.

Finally, in light of federal efforts to repeal and replace the Affordable Care Act (ACA), including repeal of the essential health benefits (EHB) requirements, Senator Gill introduced S3180, which requires health insurers to continue providing coverage that at least meets the EHB requirements contained in the Patient Protection and ACA, as those benefits were defined for New Jersey on January 1, 2017.

Essential health benefits (EHBs) include items and services in the following 10 benefit categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The federal government defines EHB based on state-specific EHB benchmark plans, which in 2017 in New Jersey is a plan offered by Horizon Healthcare Services in the small group market, called the Advantage EPO Silver 100/50.
A recent report from the Office of Inspector General ("OIG") revealed the success and increased efforts of the federal government in seeking to recoup monies paid to providers. According to the report, FY 2016 saw 1,564 convictions, 998 civil settlements and judgments and almost $1.9 billion in criminal and civil recoveries. For the fifth year in a row, civil settlements and judgments increased from the year before.

Private Payors have similarly increased their efforts to recoup monies paid to providers through post-payment audits. While insurers are less transparent about their recoupment efforts, private payors have been just as aggressive and successful as their government counterparts.

Pediatricians across the state are seeing an increase in audits. Therefore, it is imperative that every practice have an audit response plan in place to identify problematic audits and respond accordingly.

Audit Response Plan

When a practice receives a letter from the CMS, the New Jersey Medicaid Fraud Division or a private payor, someone at the practice must be responsible for:

1. Reviewing the audit letter to determine whether it is routine, seeking recoupment or investigating fraud, waste and abuse;
2. Ensuring compliance with the audit so that all documents responsive to the audit are produced in a timely manner;
3. Ensuring a copy of all documents sent are kept for the practice’s records; and
4. Reaching out to healthcare counsel in the event the audit concerns allegations of fraud, waste, abuse or other potential civil or criminal exposure.

Red Flags

Provider agreements require physicians to routinely provide patient charts. These requests are generally routine in nature and concern a small number of charts. When a request is for a large amount of patient charts or dates of services (30 or more), usually that is a red flag and precursor to an overpayment demand.

Also, audit and document request letters contain language that can also alert a provider as to the payors’ intentions. Both public and private payors investigating potential fraud, waste and abuse will state they are investigating “billing aberrancies” or advise that the practice or provider has been identified as an “outlier.”

These terms, and similar phrases, are red flags that should not be ignored as it is an indication that the practice may be the subject of a criminal and/or civil investigation.

Responding

When responding to an audit, the physician whose records are being audited must review the records prior to their production for accuracy and responsiveness. Too many times physicians delegate the work of preparing the response to a staff member who fails to provide all relevant documents, does not keep a copy of the records produced and/or fails to comprehend the severity of the situation.

If the demand letter has red flags that indicate the physician or practice is being investigated for potential fraud, waste and abuse or as an outlier, immediately contact a healthcare attorney to assist in the production and assess the physician or practice’s exposure.

Post-payment audits continue to increase as both public and private payers are more and more successful in their recoupment efforts. In response, all practices should have an audit response plan in place to differentiate routine audits from problematic audits and respond accordingly.

Reference

1 https://oig.hhs.gov/oei/reports/oei-09-17-00210.pdf
Pediatric Psychiatry Collaborative

Pediatric providers in eleven New Jersey counties now have quick access to mental/behavioral health consultative and referral services for the children and families in their care. With funding from the New Jersey Department of Children and Families, the Pediatric Psychiatry Collaborative (PPC) has been operational since July 2015 through a collaborative partnership between Hackensack Meridian Health, Cooper University Health, Saint Peter’s University Hospital and the New Jersey Chapter, American Academy of Pediatrics. This collaborative mental health model provides consultative support between pediatricians and psychiatrists to ensure appropriate screening, assessment, diagnosis, and treatment of children, adolescents, and young adults presenting in pediatric primary care settings with mental and behavioral health concerns and/or disorders. More than 300 pediatric providers are currently participating in the program.

To date, participating pediatricians report having screened 45,105 patients for mental/behavioral health disorders, and mental health consultation services have been provided through the regional Hubs for 2,218 patients.

The ABP-Approved Maintenance of Certification (MOC) Part 4 quality improvement initiative, the Mental Health Collaborative (MHC) program aims to help pediatricians increase their use of standardized mental and behavioral health screening tools, anticipatory guidance, referrals and care coordination to support the early detection of mental health issues, and improve the provision of mental health care in the primary care setting.

Participating providers receive:

- Training on standardized mental/behavioral health screening tools and integration of best practices
- Opportunities to network with colleagues, experts, and community support organizations, through collaborative learning sessions
- An AAP Mental Health Toolkit, along with many other tools and resources
- Hands-on technical assistance for implementing screening through office-based visits
- 25 ABP Part 4 MOC points upon program completion

Overall for the first two years of the Mental Health Collaborative MOC program, mental/behavioral health screening for children under age 6 increased from 29.6% at baseline to 71.8% at the end of the program, while screening for children ages 6-18 increased from 36.7% at baseline to 77.4% the end of the program (see Figure 1).

To support their efforts at mental/behavioral health integration, PPC providers have the option to participate in educational programs developed and led by the NJ Chapter.

"The program increased our referrals, improved patient awareness, and increased screening for all ages."

Dr. Dina Hanna,
Plaza Pediatrics

"Using the screening tools captured more patient information and streamlined the referral process when assistance was needed for the family. Because of this project, we are now very effective in caring for the whole child. And we have reached 100% screening!"

Dr. Charles Flores,
Pediatrics Day & Night

We are now identifying kids that might have slipped through the cracks, and giving parents resources when they had nowhere else to turn."

CHOP Gibbsboro

Continued on next page
In addition to the optional MOC Part 4 program, PPC Hub participants have access to informative monthly webinars with content experts. Recent topics include: Treatment of Anxiety and Depression in Primary Care, Evaluation and Management of Common Sleep Problems, and Suicide Prevention. Monthly e-newsletters sent to all hub participants also highlight mental health issues covered in the news, provide links to community resources, and resources for providers to help educate parents.

An MOC Part 2 program, “Managing Common Mental Health Issues in Pediatric Primary Care” was piloted at the May 24th NJAAP Annual Conference. Over 40 providers attended the session, which provided a comprehensive overview for integrating mental/behavioral health into primary care practice. The two-hour presentation offered best practice strategies, as well as tools and resources for pediatric providers on identification, treatment, referral and care coordination of mental and behavioral health issues.

Continuation funding from DCF will enable NJAAP to again offer both MOC programs to interested providers in the currently served counties in the coming year. Curricula to address substance use disorder screening, anticipatory guidance, referral and care coordination will be added to the MOC programs in the coming third year.

NJAAP encourages all providers interested in joining the PPC to register online at: www.njaap.org/ppc-mental-health-moc-program-registration/.

For more information about the PPC, including the requirements, and how to register, please visit: www.njaap.org/programs/mental-health/.

“We are much more comfortable addressing mental/behavioral health. Now, 100% of our kids are getting screened.”

Dr. Vanda Bruner, Bayshore Pediatric Associates

My pediatrician told me about the Hub and explained that he could request assistance regarding my son’s anxiety disorder. Within two weeks of putting in the referral, I had a call from a wonderful post-doctoral fellow telling me they were working on finding a mental health provider in my network. I soon received an email from the Hub with information for a psychologist who was in my network and could see my son for therapy. I am glad my pediatrician has access to the Hub because my son finally has the mental health support that he needs. The help my son received by the Hub should be accessible to all children in our state.”

Amy Kratchman, parent
Dyslexia: A Primer for Pediatricians

Richard Selznick, PhD
Director: Cooper Learning Center
Dept. Pediatrics, Cooper University Healthcare
Psychologist/Nationally Certified School Psychologist

Largely as a result of grass-roots advocacy groups (see www.decodingdyslexianj.org) lobbying for changes in state legislation and departments of education, we are now in the decade of dyslexia. Even mild reading problems shown by a child often lead parents to ask pediatricians whether a child is dyslexic and pediatricians are on the front line in responding to parent requests.

Mythologies

There are pervasive inaccuracies and mythologies about dyslexia that interfere with parents seeking appropriate assessment and treatment. Among the more common and untrue myths include:

- Dyslexics read upside-down or backwards.
- No one really knows what dyslexia is.
- Only neurologists can test for dyslexia.
- A determination about dyslexia can’t be made until a child is in third grade.

There are many more mythologies.

Dispelling such myths is the first step toward understanding dyslexia.

Dyslexia/Reading Disability

The definition of dyslexia refers to difficulty developing accurate and or fluent word recognition, along with poor spelling and decoding abilities. These problems are believed to arise from a neurological predisposition rather than instructional shortcomings (see appendix for definition used by the International Dyslexia Association and adopted by the NJ Department of Education).

Decoding Deficiency

Central to understanding dyslexia is the term “decoding”. To understand decoding, let’s look at a made up word, “fabulationingly”. Such a complex word can be readily “decoded” by those without dyslexia. In fact, most upper elementary school children can look at this word and rapidly read it without much effort. For dyslexics, with their limited “decoding” skills, they look at such a word and have no idea how to segment it into its component parts. Effectively, they guess based on limited clues inherent in the word. For example, they may guess at the word using a nonsense word to substitute for a real word (e.g., “machanake” for “mechanic”).

Large, multisyllabic words are particularly challenging for dyslexics. It is in the fourth grade range that many of these “low frequency” words become predominant in the text. An example of such “low frequency” words typical of the fourth to fifth grade range are words such as, institute, fabulous, pedestrian, and porcupine. Since these words do not appear too often in typical reading material, dyslexics feel at a loss as to how to respond to them. When they encounter such words they may eventually read the word correctly, but they typically arrive at a correct response at a considerable cost in terms of mental effort. This effort lowers mental energy reducing the child’s capacity to understand what is being read.

When explaining dyslexia to parents, I usually use a word like “porcupine” to help demystify and reduce the mythologies, such as reversal and backward reading. A child can go through all of elementary school and never encounter the word “porcupine.” There would be little to no opportunity to practice with such a word. Without an internalized and adequate sense of decoding, the dyslexic child may read the word in the text as something like, “The pricopinneys (porcupines) were in the forest.”

(Bear in mind, that for most children, approximately 80% of the population have adequate decoding skills by the time they complete third grade.)

A child I evaluated recently, Samantha, age 9, is a good example of a decoding deficiency impacting her reading. Samantha was given the following sentence taken from a third grade selection—“She hid her boat in seaweed.” Samantha read the sentence as “She hid her boat in ‘Sweden.’” (Note that there are no signs of reversals in this misreading.)

When asked a comprehension question about where the boat was hidden, Samantha confidently answered, “Sweden”. So often what are called “comprehension problems”, really represent a misreading of text such as shown by Samantha’s reading of “Sweden” for “seaweed”.

Phonological Component of the Language

Within the definition of dyslexia there is reference to the “phonological component of the language”. This refers to traits or abilities that correlate with dyslexia and are strong predictors of difficulty with reading, spelling and writing. A classic example of such a phonological component is a task called “phonemic awareness”. Within a typical phonemic awareness task a child is asked something like, “Say the word ‘flip.’” (The child says the word.) Then the child is told, “Now say it again, but don’t say /fl/” (presented as the sound /fl/ not as the letter /fl/). For most children they can do the task pretty easily by the age of five. For dyslexics it’s a different story and they have great difficulty with such a process, as well as other phonological tasks such as rhyming.

continued on next page
Neurobiological

As a physician, it is important to clarify the term “neurobiological in origin” that is present within the definition. Typically, the phonological system is the neurobiological component that is the prime culprit. Some people confuse “neurobiological in origin” to mean some type of neurological dysfunction or brain deficit. While fMRI studies conducted in research highlight areas of the brain that are active or underactive while reading activities take place, largely these studies shed light on brain variation. For practical purposes, it is important for practitioners to try and normalize things for parents and children so they do not take away the notion that there is some type of neurological damage that is involved.

Beside the variation of neurodevelopmental functioning seen in dyslexia, “neurobiological in origin” also refers to the fact that in the vast majority of instances one or the other parent shares similar traits. That is, the dyslexia has been inherited and passed down. Even if the parent was not formally assessed as a child, most will comment something like, “Yep, I was just like that as a kid….I always hated reading and my spelling is atrocious. It still is.”

Not Just a Reading Problem

While most people focus on the reading aspects of the difficulty for dyslexic children it is important to emphasize that when a child is dyslexic, 99.9% of the time, they have accompanying issues with spelling and writing. In fact, it is really in the qualitative assessment of spelling and writing that the flavor of dyslexia comes through (see sample in appendix). As a physician, do not be lulled if the parent reports that the child does well in spelling. Almost always this success in spelling represents memorizing words for a spelling test that are quickly forgotten. Also, open-ended writing (e.g., write about your weekend) is particularly problematic for the dyslexic child

Common Strengths

While in managing dyslexia the deficits are certainly the central concern, it is helpful to bear in mind that for most dyslexics they typically have strengths that serve them well in a variety of activities and endeavors. For example, most dyslexics show strong abilities with tasks that are strongly rooted in visual thinking. In my book, The Shut-Down Learner, which is largely about dyslexia, I describe many of the children as, “Lego Kids”. Fields such as architecture, engineering, and the arts and others are strongly represented by those who are strong in visual spatial thinking, yet they do not read, spell or write very well.

Assessment

There are different levels of assessment ranging from a brief screening to a more comprehensive assessment that may be appropriate. The assessments are typically conducted by psychologists who specialize in dyslexia, but other learning specialists can perform an adequate assessment. Some of the components of an evaluation involve single word decoding, reading fluency, reading rate, word reading efficiency, spelling and written expression. In more comprehensive assessments, cognitive functioning and phonological processes are also evaluated.

Treatment

When it comes to treatment, the “Orton-Gillingham” methodologies, or multisensory language-based approaches, represent the gold standard. There are a number of Orton-based methods on the market, (e.g., Wilson, Project read), but they are very similar in their emphasis and delivery. The Orton approaches are not new and have remained fundamentally unchanged since the 1940s. While schools increasingly are offering these methods, parents are wise to seek outside treatment with practitioners who can offer highly individualized remediation.

In summary, more and more pediatricians will be asked to comment on dyslexia. Understanding dyslexia in basic terms to help reduce parent mythologies can be enormously helpful to parents.

Appendix:

Figure 1. Components of Successful Reading Process
The visual from the previous page shows the major components of the reading process. In other words, to be an adequate reader one would have all five of these components functioning adequately. Dyslexia primarily involves the first three components of reading: phonemic awareness, decoding/phonics, and fluency.

**International Dyslexia Association Definition of Dyslexia**

“Dyslexia is a specific learning disability that is neurobiological in origin. It is characterized by difficulties with accurate and/or fluent word recognition and by poor spelling and decoding abilities. These difficulties typically result from a deficit in the phonological component of language that is often unexpected in relation to other cognitive abilities and the provision of effective classroom instruction. Secondary consequences may include problems in reading comprehension and reduced reading experience that can impede growth of vocabulary and background knowledge.”

**Writing/Spelling Sample**

The following is a recently obtained sample from a third grade dyslexic with average cognitive abilities.

Richard Selznick, Ph.D. is a psychologist and director of The Cooper Learning Center, Department of Pediatrics, Cooper University Healthcare (www.cooperlearningcenter.org). He is the author of the “Shut-Down Learner,” and “Dyslexia Screening” (www.shutdownlearner.com).
Dear NJAAP Member,

In response to concerns about the influence of climate change on children's health in NJ, nationally, and worldwide, AAPNJ is forming a Committee on Climate Change Response. We are inviting you to join this important committee. We plan to meet in person twice a year, and then by phone once a month. The committee will be chaired by Dr. Polly Thomas with support from Dr. Jeanne Craft, who helped draft the Rutgers report on Climate Change in New Jersey.

To learn about AAP’s activities nationally, please read about climate solutions at: http://bit.ly/1PPNsP9

We hope to have about 10 committee members, from across NJ. If you are interested in joining the committee please contact, Fran Gallagher by email, fgallagher@njaap or by phone, 609.842.0014. If you have questions, please email Polly Thomas (pthomas@smgnj.com) or Jean Craft (jacraft@aol.com).

We look forward to hearing from you.

Sincerely,

Jeffrey Bienstock, MD, President, NJAAP
Fran Gallagher, CEO, NJAAP
1. INTRODUCTION:

Sleep is essential in the growth and normal development of children. There are studies to support that deeper stages of sleep and restful sleep is necessary for effective day time functioning and also for long term learning and memory consolidation. Various sleep problems including bedtime resistance, sleep onset delay, poor sleep duration, sleep anxiety, night awakenings, parasomnias, sleep disordered breathing and daytime sleepiness are seen in children. They are present in 25-50% of preschool age children and up to 40% of adolescents. Sleep disorders are also seen in common neurological conditions such as primary headaches, epilepsy and neurodevelopmental conditions such as ADHD and Autism spectrum disorders. In this review article we would like to discuss approaches to common sleep problems.

Case report

A 6 year old boy presented to our outpatient child neurology clinic with a 2 week history of spells occurring out of sleep. He had experienced abnormal episodes that were somewhat stereotypic in nature occurring shortly after he fell asleep. He would wake up screaming. He would push his hands on the bed and his eyes would open wide. He would start to bounce up and down; episodes were brief lasting for few seconds before returning to sleep. There was no diaphoresis. Is this sleep arousal, a parasomnia such as a confusional arousal or a night terror?

Further detailed clinical history revealed that our patient has always been early to wake up between 4-5 AM. He has had several events in the last few months within 10-15 minutes of awakening. His mother attributed these to possible tantrums. He would start yelling loudly as if he is scared and would grab his mother’s arms. He would then start moving his fingers and his R hand. Subsequently he would shake, his body would vibrate. He would yell out and repeat sentences. His eyes would be wide open and he would look straight ahead with poor responsiveness. Occasionally he would spin or walk in a circle. He would come out of it within 1-2 minutes. No incontinence. Based on this history patient was admitted to our epilepsy monitoring unit (EMU). A typical arousal was captured with ictal electroencephalographic changes (EEG) and a diagnosis of frontal lobe epilepsy was made. Patient was initiated with anti-epileptic drug treatment with oxcarbazepine and he has remained seizure free to date with no further confusional arousals.

2. TYPES OF SLEEP DISORDERS:

Sleep disorders in children are widely prevalent and preventable. Childhood sleep disorders can largely be categorized by either an inappropriate sleep quantity or poor sleep quality. Inadequate duration of sleep for age can be the result of timing of sleep, difficulty initiating sleep or in adolescents a conscious decision to sleep less. Poor sleep quality can be the result of fragmented sleep due to frequent disruptions leading to arousals such as parasomnias or sleep apnea.

2.1 Insomnia

Insomnia in childhood is largely a behavioral problem and more common in toddlers and preschoolers.

Table 1. Insomnia types

<table>
<thead>
<tr>
<th>Sleep Onset</th>
<th>Limit setting</th>
</tr>
</thead>
</table>
| Characteristics | • Child learns to fall asleep only under certain conditions (e.g. being rocked, fed)  
• During the night, child is not able to self-soothe after brief arousals and cannot sleep without same conditions | • Difficulty initiating or maintaining sleep  
• Children either stall or refuse to go to sleep  
• Inadequate limits set by caregivers |
| Management | • Focuses on establishment of regular sleep schedule and bedtime routine  
• Goal is to allow child to “self-soothe”  
• Extinction (let child cry) vs graduated extinction (periodic checks on child with successively longer intervals) |
2.2 Circadian rhythm disorders

The type of disorder that applies most to pediatrics is delayed sleep phase syndrome. This sleep disorder is commonly seen in adolescents as well as in adults. The essential problem is timing of sleep rather than quality of sleep.

Table 2. Circadian rhythm disorders

<table>
<thead>
<tr>
<th>Diagnostic criteria</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sleep is often delayed by conventional times by 2 hours or more with typical culprits being excessive stimulation before bedtime such as television or other electronics</td>
<td></td>
</tr>
<tr>
<td>• Take afternoon naps or sleep in later on weekends which further exacerbates the circadian rhythm disruption</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Involves improving sleep hygiene by avoiding naps and caffeinated beverages and decreasing bright light exposure in the evening</td>
<td></td>
</tr>
<tr>
<td>• Restricting the use of electronics around bedtime</td>
<td></td>
</tr>
<tr>
<td>• Maintenance of sleep schedule is important</td>
<td></td>
</tr>
</tbody>
</table>

2.3 Parasomnias

Parasomnias are undesirable physical events that can occur during any phase of sleep.

Table 3. Parasomnia types

<table>
<thead>
<tr>
<th>Night terror</th>
<th>Nightmare</th>
<th>Sleepwalking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase of sleep</td>
<td>non-REM</td>
<td>REM</td>
</tr>
<tr>
<td>Characteristics</td>
<td>Tachycardia, tachypnea, flushing, diaphoresis, increased muscle tone</td>
<td>Post-awakening anxiety and difficulty returning to sleep</td>
</tr>
<tr>
<td>Management</td>
<td>• Scheduled awakening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Short-acting benzodiazepines</td>
<td>• Focus on maintaining good sleep hygiene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Avoid exposure to frightening stimulus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Night light</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Focus on protecting child from harm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Alarms placed on doorknob to alert parents of child’s waking</td>
</tr>
</tbody>
</table>

2.4 Sleep-related breathing disorders - Obstructive sleep apnea

Table 4

<table>
<thead>
<tr>
<th>Risk factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adenotonsillar hypertrophy</td>
<td></td>
</tr>
<tr>
<td>• Obesity</td>
<td></td>
</tr>
<tr>
<td>• Craniofacial abnormalities (e.g. midface hypoplasia, micrognathia)</td>
<td></td>
</tr>
<tr>
<td>• Down syndrome</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Associations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cor pulmonale</td>
<td></td>
</tr>
<tr>
<td>• Pulmonary hypertension</td>
<td></td>
</tr>
<tr>
<td>• Systemic hypertension</td>
<td></td>
</tr>
<tr>
<td>• Poor learning</td>
<td></td>
</tr>
<tr>
<td>• ADHD</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adenotonsillectomy is first line therapy</td>
<td></td>
</tr>
<tr>
<td>• Continuous positive airway pressure is an option for non-surgical candidates or those who respond poorly to surgery</td>
<td></td>
</tr>
</tbody>
</table>

continued on page 28
3. DISORDERS COMPLICATING OTHER ILLNESSES

Sleep disorders are associated with other neurological and developmental disorders often complicating their management. Appropriate treatment of the underlying sleep disorder may have therapeutic implications, in terms of improving the underlying neurological condition.

Sleep problems are commonly seen in children with Autism spectrum disorders. These children will experience almost the entire spectrum of sleep disorders from decreased sleep latency and reduced sleep duration to circadian rhythm disruptions and parasomnias. The prevalence was as high as 87% in one study. Authors of various studies recommend a combination of non-pharmacological measures like sleep hygiene and pharmacological options like melatonin.

Sleep disorders have been well described in children with ADHD. Studies have estimated sleep problems to be 5 times higher in ADHD patients than in healthy control. Patients often report subjective complaints like nocturnal awakenings, restlessness and parasomnias; objectively, clinicians could find delayed onset of sleep, higher shifts in sleep patterns and total decreased sleep time.

Restless leg syndrome and periodic sleep movement disorders (RLS/PSMD) are associated with ADHD. Iron therapy in those with low ferritin levels reduces RLS symptoms.

As high as 49% children with migraine headaches experience sleep problems. Management of sleep often leads to a reduction in headaches. Sleep deprivation, poor quality of sleep and alteration in circadian rhythm are known triggers for migraines. Sleep problems are also common in various genetic syndromes like Duchenne muscular dystrophy, Rett syndrome, Prader Willi syndrome and Down syndrome. Children with obesity suffer from shorter sleep duration with the risk being twice as high.

Children with epilepsy represent a rather special subset of patients. Epilepsy itself causes sleep disruption and anti-epileptics often affect sleep independent of their anticonvulsant actions. Sleep modulates the expression of interictal epileptiform discharges. In some epileptic syndromes, activation of epileptiform discharges in sleep causes cognitive, language, memory and neuro-psychiatric problems, which seriously impacts quality of life. Seizures can be precipitated by sleep deprivation and sleep hygiene is essential in preventing recurrent seizures.

Sleep has also been found to be abnormal in up to 75 to 88% children with chronic kidney disorder.

4. APPROACH TO SLEEP DISORDERS DIAGNOSIS AND SCREENING:

Pediatricians and families alike are often stumped and lost when it comes to screening, diagnosing and treating sleep disorders. While guidelines exist for some of the most prevalent pediatric disorders, sleep problems lack such defined guidelines. The question then arises - how do you screen for them and when do you jump the gun and order a sleep study? What can be considered a comprehensive approach to diagnose and screen these disorders?

4.1 HISTORY AND PHYSICAL:

The diagnostic process includes a comprehensive history and a complete physical exam. Important clues can be obtained from both.

4.1.1 HISTORY:

Delineate the entire sleep sequence of a child including the events leading up to bedtime, the time of sleep onset, whether the sleep is punctuated by any snoring, restlessness or other disturbances, and their transition on waking up including the events of the remainder of the child’s day including any periods of daytime sleepiness, anxiety, restlessness and environmental factors.

4.1.2 PHYSICAL EXAM:

Look for hypertrophied tonsils, chronic cough, deviation of and/or hypertrophy of the nasal septum and neurological deficits.

4.2 BEARS Criteria

A comprehensive history plays a central role in the evaluation of sleep disorders and the following BEARS criteria provide a good screening tool for the same.
Resident Voice continued

Table 5. BEARS criteria

<table>
<thead>
<tr>
<th>BEARS criteria</th>
<th>Preschool child</th>
<th>Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedtime problems</td>
<td>Does your child have a problem going to bed?</td>
<td>Problems falling asleep?</td>
</tr>
<tr>
<td>Excessive daytime sleepiness</td>
<td>Is the child taking multiple naps during the day?</td>
<td>Sleeping during school, driving or other activities?</td>
</tr>
<tr>
<td>Awakenings during the night</td>
<td>Frequent awakenings during the night?</td>
<td>Do you often wake up and have difficulty falling back to sleep?</td>
</tr>
<tr>
<td>Regularity and duration of sleep</td>
<td>Does he/she have a regular bed and awake time?</td>
<td>What time do you go to bed? Time you wake up? What is the total sleep duration?</td>
</tr>
<tr>
<td>Snoring</td>
<td>Does the child have trouble breathing or periods of apnea at night?</td>
<td>Do you snore a lot every night?</td>
</tr>
</tbody>
</table>

4.3 ROLE of SLEEP STUDY:

A polysomnogram/overnight sleep study can prove to be a powerful aid for the clinician trying to manage pediatric sleep problems.

Consider an early sleep study or sleep center referral in these situations -

- Positive BEARS screen
- Child is restless or if he/she snores, sweats or wakes up frequently during the sleep.
- Clear discordance between reported severity and clues on physical exam.
- Presence of risk factors including some of the neurological and/or developmental disorders detailed above.

4.4 Role of Video EEG and admission to epilepsy monitoring unit (EMU)

Admission to a video EEG /epilepsy monitoring unit to capture a typical event needs to be considered if a child is experiencing

- Stereotypic spells with nocturnal arousals with diagnostic uncertainty on a polysomnogram
- Clinical history favoring seizures- bicycling, thrashing, grunting, hyper motor non agitated behaviors, versive head turning or distressed emotional behaviors
- Family history of epilepsy

TABLE 6: DIFFERENT TESTING MODALITIES

<table>
<thead>
<tr>
<th>TEST</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polysomnogram (PSG)</td>
<td>Measuring sleep and breathing activity across various channels including recording the EEG, EMG, EOG and airflow monitoring to provide a wealth of information about sleep patterns.</td>
</tr>
<tr>
<td>Multiple Sleep Latency test (MSLT)</td>
<td>Performed following an overnight PSG monitoring daytime sleep pattern/naps in short intervals. Indicated in children with narcolepsy, cataplexy, hypersomnia or increased daytime sleepiness.</td>
</tr>
<tr>
<td>Maintenance of wakefulness test</td>
<td>Performed during the day to measure a patient’s ability to remain awake. Does not need to be preceded by a PSG and helpful in patient where excessive sleepiness can be dangerous (ex. Operating vehicles, etc.)</td>
</tr>
<tr>
<td>Actigraphy</td>
<td>A watch like device that the child wears to monitor movement in order to relay information about wakefulness and sleep.</td>
</tr>
<tr>
<td>Smartphone Apps</td>
<td>Several apps to help monitor sleep stages or promote sleep hygiene available. However, these are not FDA approved.</td>
</tr>
</tbody>
</table>

5. AAP RECOMMENDATIONS ON SLEEP HYGIENE:

The American Academy of Pediatrics (AAP) recently endorsed new recommendations on sleep times for children as outlined in the June 2016 statement by the Academy of Sleep Medicine.

Recommendations were made for the minimum and maximum number of hours of sleep certain age groups should receive during a 24 hour period for optimal health,

- Ages 4-12 months: 12-16 hours (including naps)
- Ages 1-2 years: 11-14 hours (including naps)
- Ages 3-5 years: 10-13 hours (including naps)
- Age 6-12 years: 9-12 hours
- Age 13-18 years: 8-10 hour

The mainstay of management includes maintaining robust sleep hygiene.
6. CONCLUSION:
Pediatric sleep disorders and problems represent a large and heterogeneous group. While it is difficult to view these problems through a common periscope, it is important to realize that these disorders share common etiologies, diagnostic approaches and treatment modalities. Primary care providers are often on the front lines and it is imperative that they understand the implications of these problems for the affected families.

REFERENCES:
Introduction:

Kikuchi-Fujimoto disease is histiocytic necrotizing lymphadenitis, a rare, usually self-limiting disease that was first reported in patients of Asian heritage. Though, cases are now described among all ethnic groups. In children, it presents as a fever of unknown origin and a high index of clinical suspicion is required to reach a diagnosis.

Case Description:

We present an atypical case of Kikuchi-Fujimoto disease in terms of young age at presentation and significant leukocytosis in a 2-year-old previously healthy female child. The child had almost 4 weeks of continuous high grade fevers with significant bilateral cervical lymphadenopathy. She received multiple antibiotic courses without any improvements and had extensive work up for fever including fine needle aspiration cytology with no definitive diagnosis. She had prolonged hospitalization and required excision biopsy for the diagnosis which showed infiltration of cortex and paracortex with proliferating histiocytes and scattered histiocytes among the lymphoid cells of cervical lymph nodes.

Discussion:

Kikuchi-Fujimoto disease (abbreviated KFD) is a rare, benign and self-limiting condition of unknown cause and a pathogenesis usually characterized by cervical lymphadenopathy with or without fever for duration varying from 1 to 4 months. On reviewing the literature, it appears that compared to adult cases in children, males are more commonly affected and febrile presentation is more common. The recurrence rate for KFD is 3%. Affected patients have a high probability of developing autoimmune diseases, notably SLE (Systemic Lupus erythematosus). For cases with persistent lymphadenopathy, treatment with systemic steroids or intravenous immunoglobulin is advised.

1) Introduction:

Kikuchi-Fujimoto disease is histiocytic necrotizing lymphadenitis, a rare, usually self-limiting disease originally reported in patients of Asian heritage. Cases are now described in all ethnic groups and familial cases have also been reported.\(^1\) The average age of presentation is 10.1 ± 2.8 years\(^2\) with lowest reported case being 18 months old.\(^1\) Male predominance has been reported with male to female ratio 2.8:1.\(^4\) In children, the presentation is varied and may include fever of unknown origin, with bilateral posterior cervical adenitis being more common than unilateral lymphadenitis, fever, malaise and elevated erythrocyte sedimentation rate. Average size of enlarged lymph nodes is about 2-4 cm in size, and painful or tender in 50% of cases. These lymph nodes may be multiple, and must be differentiated from lymphoma.

2) Case Presentation

A 2-year-old, previously healthy female, presented to the pediatric floor with 3 weeks of fever between 101.5°F to 103°F and bilateral painful neck swelling restricting neck movement (left greater than right side). She was seen by her pediatrician multiple times and had an earlier inpatient hospitalization prior to being admitted to our facility. She had received two courses of antibiotics (Augmentin and Clindamycin) without significant improvement in her illness. There was no sign of weight loss or any palpable lymph nodes elsewhere. No significant family history or history of sick contacts or animal exposure. She was current on her vaccinations and was developmentally appropriate for her age. On examination, the patient was febrile with stable vitals and all growth parameters were in expected range. She had left sided ovoid soft to firm mass 8cm × 6cm behind the angle of jaw, extending from just below pinna of left ear to posterior 1/3 of mandible, non-tender, non-fluctuant or mobile, no erythema or exudate. Neck movement was restricted due to size of swelling, but not painful and there was no change in size of enlarged lymph nodes while crying. She has three lymph nodes on the right-side. Each 1 cmx1 cm in size and non-tender to exam. The remainder of her physical examination was unremarkable.

Her blood work showed a WBC count 24,400/ mm\(^3\), ESR – 85 mm/hour and CRP—128 mg/dl. Serology was negative for Epstein Barr Virus and Bartonella with negative PPD and normal chest x-ray.
She underwent a Fine Needle Aspiration Cytology (FNAC) which was reported as negative for any malignant cells. The sample was also negative for Acid fast bacilli, silver methenamine stain for fungal etiology and immunohistochemistry showed no evidence of lymphoproliferative disorder. Flow cytometry showed no detectable B or T cell lymphocytes.

Scattered histiocytes with oval to crescentic nuclei among lymphoid cells and abundant apoptotic debris and proliferation of blastoid cells especially around capillaries suggestive of Histiocytic Necrotizing Lymphadenitis/Kikuchi-Fujimoto’s Disease.

3) Discussion

Kikuchi disease is a rare, benign condition of unknown cause and pathogenesis is usually characterized by cervical lymphadenopathy with or without fever for duration varying from 1 to 4 months. With lymph node involvement, patients may have rash and hepatosplenomegaly. It is associated with leukopenia, elevated CRP, ESR, LDH which mimics malignancy. Histopathology of the involved lymph nodes differentiates Kikuchi disease from several more serious conditions. It has been described in all age groups, but pediatric cases differ from adults as shown in Table 1.

Table 1: Comparison of pediatric to adult cases of Kikuchi Disease

<table>
<thead>
<tr>
<th></th>
<th>Children</th>
<th>Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male: Female</td>
<td>2.8:1</td>
<td>1:3-4</td>
</tr>
<tr>
<td>Presentation</td>
<td>Febrile&gt; Afebrile</td>
<td>Afebrile&gt; Febrile</td>
</tr>
</tbody>
</table>

Excision Biopsy and Histopathology

(Histology Pictures: Courtesy Dr. Gamboa, MD, Attending at the Department of Pathology, Saint Peter’s University Hospital)
This case was atypical and unusual in terms of the patient’s very young age of presentation and leukocytosis rather than leukopenia commonly associated with Kikuchi Disease. A high index of suspicion is required when children present with enlarged lymph nodes with prolonged course and unresponsive to antibiotics; and lymph node biopsy with pathological examination should be considered. Recurrence rate for Kikuchi Disease is 3%.3

Affected patients should be followed for some time afterwards, as children can develop autoimmune diseases notably, Systemic Lupus Erythematosus (SLE).6 Important differential diagnoses to be considered for similar presentation would be cat-scratch disease, infectious mononucleosis, Kawasaki disease, leprosy, sarcoidosis, syphilis, systemic lupus erythematosus, toxoplasmosis, tuberculosis and tularemia.2

Considering the self-limiting nature of Kikuchi-Fujimoto’s Disease, antibiotics were discontinued for this case. The patient was discharged with follow up should swelling persists or recurs beyond 6 months; at which point treatment with IVIG or steroids would be considered. At the time of discharge, she had been afebrile for more than 72 hours.

No effective treatment has been established for Kikuchi disease. Signs and symptoms usually resolve within one to six months. Patients with severe or persisting symptoms should be treated with glucocorticoids or intravenous immunoglobulin with apparent clinical benefit.5,6

3) References:


Acknowledgment

The authors thank Dr. Gamboa, MD, Attending at the Department of Pathology, Saint Peter’s University Hospital for providing histology pictures of lymph node biopsy for this patient.
Pediatric Oral Health Medical-Dental Collaboration: Perspectives from a Pediatrician and a Dentist

Cathleen M. Ballance, MD
Department of Pediatrics
Jersey Shore University Medical Center

Maxim Sulla, DDS
Center for Advanced Pediatric Surgery
Bristol Myers Squibb Children’s Hospital
Robert Wood Johnson University Hospital

“As a pediatrician and fervent advocate for children’s oral health in New Jersey, my involvement in advancing children’s oral health and prevention interventions has focused on building strong medical-dental partnerships and educating practicing physicians, physicians in training and community organizations about the critical role oral health plays in shaping a child’s present and future health and well-being.”

Cathleen Ballance, MD

Together with Yasmi Crystal, DDS, Cathleen Ballance, MD developed an “EPIC (Educating Practices in the Community)” curriculum on Integrating Oral Health into Routine Well Care Visits, geared towards pediatricians. Dr. Ballance then teamed up with Dr. Crystal, Dr. Sherman, DDS, Dr. Sulla, DDS and other dental providers to deliver this curriculum along with a hands on fluoride varnish training to pediatric offices throughout New Jersey. They also conducted grand rounds at several academic medical centers across the state and educated many pediatricians in training at academic institutions. In addition, Dr. Ballance participated in educating workers from the NJ Division of Child Protection and Permanency (DCP&P), dental hygienists and community workers using this curriculum.

Dr. Ballance had the honor of speaking at the NJDA’s Oral Health Summit in 2011 about the Pediatrician’s role in children’s oral health; and again for the 2017 Oral Health Summit, where she participated in a panel discussion on medical dental collaboration best practices with Yasmi Crystal, DDS and David Krol, MD. In addition, Drs. Ballance and Crystal participated in a televised educational excerpt on Health Beat with Sara Lee Kessler several years ago. More recently, Dr. Ballance helped in celebrating the 15th anniversary of Give Kids a Smile with many dental colleagues including the ADA, NJDA, Rutgers Dental School and Henry Schein Cares in N.Y.C. and the Rutgers Dental School in Newark.

Dr. Sulla, DDS, NJAAP’s Oral Health Champion and current president of the NJ American Academy of Pediatric Dentistry also believes in the benefits to children of developing close collaborative relationships between dentists and pediatricians. Similarly to Dr. Ballance, he walks the walk. “I have been fortunate, for many years, to have had exceptional interdisciplinary professional relationships with many local pediatric offices. The New Brunswick Pediatric Group and Debbie Kessous, MD, have always been proactive with me in joining forces. We have collaborated on important dental issues such as the importance of good oral hygiene, promoting healthy diets, and adequate fluoride exposure and child safety.”

Dr. Sulla reports that significantly more babies are being referred to dental providers by the age of one. He feels this is a direct result of the collaborative relationships built between pediatricians and dentists. As with anything, there is always room for improvement. It is important for pediatricians to understand normal oral growth and development, home care techniques, dietary considerations and most importantly, the establishment of a “dental home” by the age of one or the eruption of the first tooth—whichever comes first. Pediatricians undoubtedly need support from local dentists to help answer oral health questions for the parents of their patients. This will only serve to enhance the referral link.

Drs. Sulla and Ballance extol the fact that the NJ Oral Health Coalition has enabled the channels of communication between doctors and team members to always be open, thereby allowing them to prevent some serious oral health issues in the young pediatric population. This open communication has also allowed them to identify, treat, monitor and avoid repeat problems.

Dr. Sulla highlighted a few examples of some cases where medical-dental collaboration led to the successful outcome of a child’s treatment. Dr. Kessous contacted Dr. Sulla’s Freehold office to advise him of a critical situation: there was a toddler in her office that had put a pet hamster in her mouth. The toddler’s tongue had a deep wound with a tear. Her parents came to Dr. Sulla’s office and he and his staff were able to clean up the wound and achieve hemostasis. On subsequent follow up visits, the soft tissue appeared to be healing well sans any functional or cosmetic complications. Another time, Dr. Kessous referred a child to Dr. Sulla’s office with extensive early childhood caries because of prolonged bottle-feeding. This child had inadequate home care. Dr. Sulla was able to treat this young apprehensive patient utilizing oral conscious sedation in his office. He spoke with the parents about the importance of good home care along with positive changes in dietary habits to help reduce and eliminate chronic caries.

continued on next page
Citing these examples, Dr. Sulla portrays the effect of his goal, which is to reach out or respond to local medical professionals in an effort to establish an atmosphere of trust. In striving for common ground and honest dialogue, this allows all professionals involved to move forward enhancing medical and dental collaboration, which can only help to serve oral health literacy.

The NJ Oral Health Coalition’s work has grown and strengthened since 2008 towards improving the quality and access of children’s preventive oral health services. At a local level, the group has successfully trained many primary care providers who are now integrating preventive oral health strategies into routine well child visits. They have also successfully integrated oral health into pediatric residency education at a few NJ academic medical centers. Scores of medical, dental and community professionals have had exposure to the EPIC program and awareness of children’s oral health has increased. The NJAAP in collaboration with the NJDA-Oral Health Coalition created an outstanding website healthyteethnj.com, which contains abundant information and resources for parents and professionals.

Although the NJ Oral Health Coalition has made much progress in increasing awareness and education of health professionals and community organizations, additional efforts to further improve access to appropriate oral health services and recruit additional medical and dental champions must be sustained. If you would like to get involved, become an Oral Health Champion or obtain office based training for your practice, reach out to Juliana David, Oral Health Program Director at 609.631.5738 or jdavid@njaap.org.

Feel like it’s getting too difficult to retain your independence?

Advocare gives independent physicians the best of both worlds — the opportunity to retain their autonomy while enjoying the benefits of being part of a highly respected medical group. As a physician owned and governed organization with nearly 600 providers and 200 practice locations in NJ and PA, Advocare is independent from any insurer, hospital system or financial investor. We fiercely value our independence, as we know that no one will look out for our interests better than we can. To learn more, give us a call (856) 872-7055. There’s no obligation, just some very helpful insights.
Critical Congenital Heart Defects (CCHD) Screening & Zika Screening and Surveillance Programs

The Pulse Ox Screening program benefits infants and families by aiding early detection of Critical Congenital Heart Defects (CCHD) and other previously unrecognized conditions. As reported to the NJ Birth Defects Registry through March 31, 2017, 26 infants with CCHD were detected and received prompt and potentially life-saving intervention due to the screening with pulse oximetry. Screening with pulse oximetry also aided in the early detection of previously unrecognized non-critical congenital heart defects in 24 infants and serious non-cardiac medical conditions in 13 infants. The CCHD Screening: New Jersey Reference Guide has been updated. Download a free copy at www.njaap.org/wp-content/uploads/2016/02/CCHD-Guidebook-rev-April-2017-1.pdf

Zika

The “ALD to Zika: Newborn Screening and Surveillance in NJ” conference held on April 25 covered a wide range of informative topics. Nicole Spillane, MD from Hackensack UMC spoke on Critical Congenital Heart Defects (CCHD) screening with a success story of an infant with CCHD who was detected due to screening. Zika presentations featured special guest speaker Dr. Fernando Ysern, Puerto Rico Chapter President who shared his experiences with Zika and an expert Zika panel including Drs. Meg Fisher, Thomas Westover and Edward Lifshitz. Speaker slides for the entire conference are currently available at http://njaap.org/zika/education/ The conference was recorded and will soon be available at www.njaap.org/zika/education/ for viewing.

Ask the Zika Experts Webinar: Recording Now Available!

Did you miss our “Ask the Zika Experts” Webinar on April 26? You can now watch the archived webinar to hear our expert panelists

CEO’s Column continued from page 4

Missed the Annual Meeting? Mark your calendars for October 18, 2017 and join colleagues at the School Health Conference, at The Palace in Somerset NJ—another exceptional meeting filled with nationally recognized experts and opportunities to network with colleagues and learn about new resources in your community. November 30th is this year’s NJ Immunization Conference … learn, have fun, network, and recharge yourself with the hottest topics in immunization designed to help raise immunization rates.

Our summer issue highlights offers value to our members. See 10 for two CME articles on Palliative Care. This will help you meet the 2-hours required every two years. Take note of our newest malpractice discounts from our NJAAP Purchase Alliance highlighted in the Member’s Only area at www.njaap.org. Our Quality Improvement projects and opportunities, including exciting Resident offerings, are threaded throughout this issue and are in alignment with the NJAAP Agenda for Children. Our dedicated staff stands ready to explore your passions and interests, describe benefits you may find useful, and learn of your new ideas. Please visit our website at www.NJAAP.org to learn more or call us at 609.842.0014.

Thank you for your dedicated efforts on behalf of children and their families. Your membership makes a difference. If you’re reading this, but not yet a member, I hope you’ll join today and lend your voice to our collective advocacy and educational outreach efforts.

Best Regards,

CEO’s Column
The New Jersey Immunization Network (NJIN) and the New Jersey Chapter, American Academy of Pediatrics (NJAAP) has partnered with Dr. Su Wang, Director of the Center for Asian Health at St. Barnabas Medical Center and the Hepatitis B Coalition in New Jersey; the Rutgers University, Office of Continuing Professional Education; and the NJ Department of Health to develop an interesting and effective on-line perinatal Hepatitis B education module for pediatric, obstetrics, delivery room staff, and primary care providers. After rigorous testing and evaluation, the project is complete and awaiting approval for CME and CNE credits before launching. For more information on this or other initiatives, please contact NJIN by visiting www.immunizenj.org or call 609-842-0014.

Medical Home

Springfield Pediatrics, located in Union County, with 3 locations in New Jersey, is currently working with the team at NJAAP, to achieve National Center for Quality Assurance Recognition (NCQA). Rolando Lozano, Office Manager, has taken the lead for the Project, along with Sunny Gazahi, Consultant for the practice. The group has chosen to utilize the National AAP Digital Navigator as a tool to help them compile and centralize all of the documentation and necessary reports required by NCQA to receive Recognition. The National AAP Digital Navigator is a web-based software application that can help guide patient care decisions, promote family and patient education, and support administrative functions, and is based on the 2014 NCQA Standards. They’ve work to date has been focusing on completing a Practice Brochure and a Patient/Family Satisfaction Survey, which helps them satisfy PCMH Standard 2 A, Factor 3—Team Based Care; Continuity - having a process to orient new patients to the practice - and PCMH Standard 6 C, Factor 1 – Measure Patient/Family Experience – for conducting a practice survey using any instrument to evaluate patient/family experiences on at least three of the following categories: Access; Communication; Coordination or Whole person care/self-management support. NJAAP Team Members, Judie Grandjean and Ruth Gubernick, PhD, PCMHCC have assisted with review of the documents and reports and have offered suggestions for some fine tuning of the materials. Springfield Pediatrics has also provided the team with access to their Digital Navigator for ease of review accessibility. Springfield Pediatrics intends to submit for Recognition in the very near future and is in the process of uploading their “completed” documents into the NCQA Survey Tool. The graphic below shows a screenshot of their National AAP Digital Navigator Screen showing the status of their current progress. Contact the MEdical Home Team for more information.
Two Hundred and sixty pediatricians and affiliated healthcare professionals congregated in the Palace at Somerset Park for the New Jersey Chapter, American Academy of Pediatrics Annual Meeting. This year’s meeting was designed for healthcare professionals focused on staying abreast of the latest advances in the care of children from infancy through adolescence. Attendees reported the Conference successful in delivering critical knowledge and guidance on pediatric care and its application within the healthcare setting. The Conference once again featured participation from a record number of respected exhibitors.
Two hundred and sixty pediatricians and affiliated healthcare professionals congregated in the Palace at Somerset Park for the New Jersey Chapter, American Academy of Pediatrics Annual Meeting. This year’s meeting was designed for healthcare professionals focused on staying abreast of the latest advances in the care of children from infancy through adolescence. Attendees reported the Conference successful in delivering critical knowledge and guidance on pediatric care and its application within the healthcare setting. The Conference once again featured participation from a record number of respected exhibitors.

ANNUAL MEETING
Wednesday, May 24, 2017
The Palace at Somerset Park

7th Annual Children’s Ball
Wednesday, April 19, 2017
The Palace at Somerset Park

(NJAAP Vice President, Alan Weller, (left) MD, MPH, FAAP & Chapter President, Jeffrey Bienstock (right), MD, FAAP present trophy and check to Outstanding Achievement Award winner, Anirudh Muralidharan)

(Pediatrician of the Year, Elliot Rubin, MD, FAAP Accepts Award from NJAAP President, Jeffrey Bienstock, MD FAAP)

(Pediatric Champion
Arturo Brito, MD, MPH, FAAP)

(r to l) NJAAP CEO, Fran Gallagher, MEd joins Jeffrey Bienstock, MD, FAAP and Alan Weller, MD, MPH, FAAP to present, Bob Foster, the Outstanding Community Service Award to the Boy’s & Girls Club of Clifton)
Protect your child from lead exposure. Know the sources of lead contamination:

**Lead based paint**
If your house was built before 1978

**Imported goods**
Some imported goods such as toys, cosmetics, candy, and spices

**Herbal remedies**
Some herbal remedies and folk medicines

**Leaded pipes**
Old water pipes with lead

**Ceramic pottery**
Lead has long been used in ceramic ware in glazes

Get your child tested at ages 1 & 2, and get the facts at nj.gov/health/childhoodlead or follow #kNOWLEAD