Pediatrician of the Year

Nwando Anyaoku, MD

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Science vs Fear: Who Do You Trust?

It has been several weeks since the physician from Medecins Sans Frontieres tested positive for Ebola and he has been released from the hospital free of the virus. None of his contacts have contracted Ebola. The nurse who was kept in a quarantine tent outside of a New Jersey hospital is back in Maine and out of the quarantine period without having contracting Ebola. The two nurses from Dallas who did contract Ebola while caring for the West African, Mr. Duncan, have no detectable viral loads and are doing well.

So, why does Ebola-phobia persist, and what’s driving it to the point of mass hysteria? Is it the result of an over sensationalizing media and/or misguided political leaders? Our leaders in government had the advantage of knowledgeable medical advisors within their departments of health and at the Centers for Disease Control itself. The elected officials had ready access to the facts needed to reassure and calm the public of unrealistic fears. These resources should be utilized to the fullest to avoid the spread of misinformation and fear.

It is crucial that the disease is halted at its west African source and that volunteers continue to provide relief work without fear of becoming pariahs upon their return to the US. Ebola, while having a high mortality rate, has a low risk of transmission and requires direct contact with bodily fluids from an infected individual (or animal source). It is not spread through the air or water. In western Africa there have been to date 15,145 cases and 5,420 deaths. In the United States there have been five cases, and several others who came to the US for treatment for their disease contracted in western Africa. Except for Mr. Duncan, and more recently, Dr. Martin Salia, they have all recovered. To date, none of the contacts that have been under surveillance for exposure or possible exposure to patients in the US have contracted Ebola.

Flu

In contrast, influenza disease is transmitted primarily via large respiratory particle droplets and is relatively easily to spread via casual contact with an infected individual. Over the last 30 years, on average over 200,000 people were hospitalized with influenza related diagnoses, mostly in those over 65 but also for <5yrs (ranging from 3,000-20,000/year). It is estimated that there are 24,000 flu related deaths/year (range 3,000-49,000) with on average 124 (range 57-197) in children <19 years. Flu vaccines are available each year with variable efficacy but studies have shown efficacy rates in the 70's in preventing hospitalization in adults and children.

Nonetheless something in the order of only 45% of the eligible population gets the flu vaccine for a variety of reasons - yet, anecdotes commonly abound: “We never get the flu vaccine, and we’ve been fine” and “I got the flu vaccine once and I got the flu from it.”

Measles

Likewise, measles is highly contagious and cases have been on an upswing in 2014 with 603 cases and 20 outbreaks covering 22 states. This dramatic increase is attributed to a combination of vaccine refusal/hesitancy and international travel.

Whooping Cough

Pertussis cases numbered 48,277 in 2012 with 20 deaths, the highest since 1955. 27 states report increasing cases of pertussis from 2013 to 2014 and California is currently undergoing its second epidemic in 4 years.

HPV

While not easily transmissible, HPV is responsible for approximately 14 million new cases/year and an estimated 26,000 new cancers attributed to HPV. In 2013 the teen coverage rates for all 3 HPV vaccines was 33% for girls and 14% for boys.

Unfortunately, the fear of the vaccine outweighed the fear of the disease. Ironically, in some cases, previous years of successful eradication programs are partly to blame. The public has no memory or context for these vaccine preventable diseases. The iconic photos of families lined up for blocks to receive polio vaccines are in black and white, and therefore seem to hearken back to the distant past and a time long-forgotten.

And so, science is obscured or forgotten and the flames of irrational social fear continues. It is left up to us, as physicians, to educate our patients, their families, the public and our political leaders as to the reality of the real risks associated with emerging as well as re-emerging and ongoing vaccine preventable infectious diseases.

Together, we can play a powerful role in helping counter the disconnect that exists between the evidence-based risks of infectious dangers to the public and the media-focused sensationalist approach that continues to distort the facts. As pediatricians, we possess the knowledge – and public trust necessary to begin re-connecting the dots appropriately: low risk situations-> appropriate measures, real dangers-> evidence-based solutions. Working In tandem with AAP national and NJAAP, we can smartly share these important messages using all the communication tools at our disposal; including mainstream and social media, advocacy efforts with our political leaders, the New Jersey Immunization Network (NJIN), and by the word of mouth guidance we provide every day.

Sincerely,

Elliot Rubin, MD, FAAP
Executive Director’s Column

Fran Gallagher, MEd
Executive Director, NJAAP

It’s the time of the year that inspires gratitude, reflections, and looking to the future – a future certain to offer unprecedented challenges. It’s my hope that the challenges ahead motivate you to play an active role in helping us shape the future of pediatric health care in New Jersey. You may be familiar with the phrase “be at the table, or risk being on the menu…”

Thanks to many of you, NJAAP is at the table. For those of you considering joining us at the table, know that when you join us at ‘the table’ our voice and influence become increasingly important.

Reflecting on just a few highlights our Chapter has accomplished with the help and support of many of our members, I am proud to report:

- 14 infants with CCHD were detected through newborn screening with pulse oximetry. For more details on the life saving results of this NJ AAP and NJ DOH partnership, see pages 20 & 21.

- Pediatricians are required to complete 2 CMEs of training related to end-of-life care every 2 years. If you missed it, check the NJ AAP Members Only website (www.aapnj.org-Members Tab) for the NJ Pediatrics 2013 Fall Issue and page 6 of this issue. Each issue highlights a 1 Category 1 CME activity to help you meet this 2 CME requirement.

- Leadership has initiated strategic planning to support and assist NJ pediatric practices meet the challenges of practice transformation. NJAAP is taking important steps to build capacity for providing members greater support in this area, including plans to apply for a CMS Innovations Grant, which will submitted this January—stay tuned. A special thanks to our Officers, Executive Council Members, Editorial Board members, and PCORE Executive Advisory Council members who were at the table.

- NJAAP continues meeting with Medicaid and Department of Banking and Insurance working to resolve critical issues including, but not limited to access to care, payments and more. Our Practice Management and Government Affairs Co-Chairs: Drs. Richard Lander, Andrea Katz, Alan Weller, Jeanne Craft and myriad other pediatricians and office managers are playing a leading role at this table and we are making progress. Join us!

- We reach out to legislators and other decision makers to provide pediatric expertise and education related to key issues: medical homes, payment, scope of practice, vaccination issues and bills on the legislative table such as training requirements for pediatricians, sale of raw milk, and more – all issues that impact the health of your patients and your profession as pediatricians.

- NJAAP is a key stakeholder in planning the Horizon Medical Home Pilot. Pediatricians taking part in the pilot are receiving payments for written care coordination plans. Children’s health care is improved & unnecessary ER visits decreased. Chronic care management is being supported! The program is scheduled to expand in 2015.

- NJAAP is a leader for promoting preventative oral health care in our state. We advocated for laws that support oral health risk assessment, varnishing, counseling/educating parents, and referring to dental homes. Pediatricians are now receiving payment for in-office varnish treatments!(See New Payment info at aapnj.org)

- Over 2000 pediatric direct health care providers (pediatricians and nurses) participated in NJAAP educational opportunities throughout 2014 including; Conferences, Quality Improvement Programs, MOC Part IV QI and other grant-funded prevention and wellness programs focusing on:

  - raw milk, and more – all issues that impact the health of your patients and your profession as pediatricians

continued on next page
Recent media attention to professional football player, Adrian Peterson’s corporal punishment of his son brought spotlight to the ‘spare the rod, spoil the child’ attitude of many parents and leaders in this country. Certainly the severity of the injuries to Peterson’s son is far from the normal consequence of corporal punishment, but the episode demands a fuller discussion about the value or detriment of such beatings. Is parenting about how to respond to misbehavior or about teaching children how to live a responsible life? As pediatricians, we can play a pivotal role in advising parents about how and why to discipline.

Many parents say they parent the way they were parented. As a society we demand more education about how to drive a car than about how to parent a child. Polls continue to show that almost 90% of parents believe it is acceptable to use corporal punishment, usually spanking, to modify misbehavior. The parent’s usual response is “I turned out OK, so it must work.” AAP polls show that over 70% of pediatricians believe that corporal punishment is also an acceptable means of discipline.

If the goal of discipline is to stamp out annoying behaviors and put an end to an uncomfortable situation, then hitting, screaming, and guilt all do work in the short term. But, they also lead to shame, pain and then too often to avoiding future punishments by sneaking, hiding, lying, and decreased communication and sharing.

The basic aim of good parenting is to teach and mentor the child to make good decisions, to be honest and trustworthy, to be empathic, to communicate effectively, to understand how to self correct when things go badly, to be a good citizen, a responsible and caring adult.

One major component of more focus on the mental health issues of children is the prevention of such issues. A comfort with positive parenting, attention that starts with anticipatory guidance as early as six to nine months of life is so very important. National AAP has some easy to read hand outs and New Jersey AAP has been actively involved with trainings. The MOC offered by NJAAP—Strengthening Pediatric Partners- also has dedicated attention to parenting. Learn more about these and other programs at www.aapnj.org. We hope that you can take advantage of many of these offerings.

Sincerely,

Steven Kairys, MD, MPH, FAAP

Executive Directors’ column continued

Medical Home, Oral Health, Obesity Prevention, improving immunization rates, identifying and treating the triggers of toxic stress, CCHD, child abuse and neglect prevention and more.

- Grant program evaluations enable us to highlight the differences made by each these programs make – see NJAAP @Work throughout this issue to learn more.

In my work advocating for children and supporting pediatricians, and as a parent of four grown children and grandparent of 3, my respect and appreciation for pediatricians as those who provide the very best care for children and support for their families runs deep.

I also wish to thank each of you for your role in helping to build the viability and strength of our Chapter, whether as a participant in one of our numerous committees, as an attendee at one or more of our conferences, as a participant in our MOC or other QI program, or simply as an avid supporter of our work on your behalf. For those of you who have considered but not yet moved on playing an active role, I leave you with this questions to ponder.

Are you at ‘the table’?

Best wishes to you and your family for a happy and healthy holiday season!

Warm Regards,

Fran Gallagher, MEd
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.

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.

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 (OSHUCFE) 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/advance-directive/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

Quiz follows on next page
### CME Quiz

1. Palliative care is an approach that improves quality of life in patients with life limiting illness in the last 6 months of life. True or False
   - 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

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 the above

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

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, 3836 Quakerbridge Road, Suite 106, Hamilton, NJ 08619 • Fax: 609.842.0015

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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 is accredited by the Medical Society of New Jersey to provide continuing medical education for physicians. 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.
Updated Recommendations and Guidance Regarding the Prevention of RSV Lower Respiratory Tract Infections in Infants

The American Academy of Pediatrics (AAP) recently updated its policy statement on the prevention of respiratory syncytial virus (RSV) infections in infants. (Pediatrics 2014. 134 (2):415-420). This was a joint statement by the Committee on Infectious Diseases (COID) and the Bronchiolitis Guidelines Committee. This update replaces the most recent recommendations published in the 2012 Report of the Committee on Infectious Diseases (29th edition of the Red Book). Palivizumab is a humanized mouse monoclonal antibody and the only biologic approved by the Food and Drug Administration to reduce the risk of severe RSV lower respiratory tract disease in infants with chronic lung disease, congenital heart disease and prematurity.

Why the update?

The AAP Policy Statements are reviewed at least every three years to see if anything has changed in terms of burden of disease, newer approaches to treatment or prevention, and any new data regarding the pharmacokinetics, safety and efficacy of the biologic - all based on a critical review of the recent/interim literature since the last set of recommendations.

Based on the systematic review, the benefit from the administration of palivizumab to infants is limited. Healthy infants born at 29 weeks or greater have a similar RSV hospitalization rate as full term infants unless they have hemodynamically unstable congenital heart disease (CHD) or chronic lung disease (CLD). Based on the review, the children with CHD most likely to benefit from palivizumab prophylaxis include infants with acyanotic CHD who take medication for congestive heart failure, will require surgical correction and those with severe pulmonary hypertension. The AAP recommends consultation with the pediatric cardiologists regarding infants with cyanotic CHD regarding the use of prophylaxis. Infants with CHD who are at risk include: 1) infants with ASD, small VSD, PS, uncomplicated AS, mild coarctation of the aorta and PDA. 2) infants who have already undergone corrective surgery and no longer require medication for heart failure, 3) children in their second year of life, 4) children with mild cardiomyopathy who no longer require any medication.

So let’s break it down!

Who should get palivizumab prophylaxis?

• Infants in the first year of life who are born before 29 weeks, 0 days’ gestation.

• Preterm infants in the first year of life with chronic lung disease (CLD) of prematurity, defined as birth at <32 weeks, 0 days’ gestation and a requirement for >21% oxygen for at least 28 days after birth.

• Preterm infants in the second year of life born at less than 32 weeks, 0 days’ gestation who required at least 28 days of oxygen after birth and who continue to require supplemental oxygen, chronic systemic corticosteroid or bronchodilator therapy within 6 months of the start of the RSV season.

For which infants should palivizumab prophylaxis be considered?

• Infants in the first year of life with hemodynamically significant heart disease.

• Children younger than 24 months who will be profoundly immunocompromised during RSV season.

• Infants in the first year of life with pulmonary abnormalities or neuromuscular disease that impairs the ability to clear secretions from the upper airways.

• Native Alaskan and Navajo and White Mountain Apache infants in the first year of life, using RSV surveillance.

Who should NOT get palivizumab prophylaxis?

• Otherwise healthy infants born at or after 29 weeks, 0 days’ gestation.

• Infants in the second year of life except for those who required at least 28 days of supplemental oxygen after birth and who continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy).

• Insufficient data are available to recommend palivizumab prophylaxis for children with cystic fibrosis or Down syndrome.

Other recommendations:

• A maximum of 5 monthly doses of palivizumab (15 mg/kg per dose) may be administered intramuscularly every 30 days during the RSV season to infants who qualify for prophylaxis in the first year of life. Some of the infants who qualify for prophylaxis and are born during the RSV season may require fewer doses. For example, an infant born in January would receive his/her last dose in March.

• Monthly prophylaxis should be discontinued in any infant who is hospitalized for a breakthrough RSV infection. The chance of another RSV hospitalization in the same season is less than 0.5%.

In summary, the above recommendations represent a thorough review of the literature and evidence based guidance for the use of palivizumab in the prevention of serious lower respiratory tract disease due to RSV in infants at risk for severe RSV disease.
Success in school starts with reading. When children become good readers in the early grades, they are more likely to become better learners throughout their school years and beyond. Learning to read is hard work for children. Fortunately, research is now available that suggest how to give each child a good start in reading. Becoming a reader involves the development of important skills, including learning to: USE language in conversation, LISTEN and respond to stories read aloud, RECOGNIZE and name the letters of the alphabet, LISTEN to sounds of spoken language, CONNECT sounds to letters to figure out the “code” of reading, READ often so that recognizing words become easy and automatic, LEARN and USE new words, UNDERSTAND what is read.

In June 2014, the AAP announced a collaborative partnership with “Too Small to Fail”, a joint initiative of the Bill, Hillary and Chelsea Clinton Foundation and Next Generation. The organizations have dedicated to promote early literacy and ensure that health care providers have the necessary tools they need to promote talking, reading out loud and singing to children every day starting in infancy.

The “Books Build Connections” toolkit, available online at www.aap.org/literacy, incorporates new recommendations on early literacy issued by the AAP, which emphasizes discussing literacy into each primary care visit. The toolkit will help pediatricians more easily explain to parents the importance of talking, reading and singing in order to support development of infants’ brains and vocabulary. It provides updated, practical resources for pediatric professionals, as well as anticipatory guidance to promote early learning.

The toolkit includes tip sheets, parent handouts and other publications for pediatricians to use. Resources include:

- Ways to promote early literacy in the medical home
- Background on the science of early literacy
- Parent-friendly tips on sharing books with children at specific ages, from birth through age 10

Pediatricians Should Promote Early Literacy in Their Practice continued on page 30

Shilpa Pai, MD, FAAP
Rutgers-Robert Wood Johnson Medical School

Sleep Medicine at CNNH

Introducing Sleep Specialist Ralph Gallo, MD!

Dr. Gallo will join our multi-disciplinary team of experts, helping to evaluate and treat:

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Healthy Homes: Lead Today is not the Lead of Yesterday

Elyse Pivnick, MCP
Director of Environmental Health
Isles, Inc.

Lead poisoning is still with us, and so are outdated research and policies that don’t help today’s children.

Pediatricians are undoubtedly aware in a general sense of lead’s adverse role on a child’s developing brain, but are often uninformed about current research that shows how even very low blood lead levels (BLL) can trigger learning and behavior problems in young children.

New and credible studies document that children are failing to learn and are demonstrating behavioral problems due to lead exposures well below the Centers for Disease Control’s recently reduced blood lead “reference standard.” Seven separate studies show the effects of low lead exposure on students in North Carolina, Chicago, Connecticut, Detroit, Ohio, Milwaukee and Rhode Island including low performance on reading and math tests starting from lead exposures as low as <3ug/dl and were more likely to fail 3rd grade reading and math tests and to be classified as learning disabled.

Did you know that the worst impact on a child’s development occurs when a child’s BLL increases from 1 to 10 μg/dL? Experts estimate a child may lose anywhere from 3.9 to 7.4 IQ points, compared to levels between 10 to 30 μg/dL when the incremental loss is 2.5 to 3.0 IQ points. Low-level chronic exposure may have an even greater effect on IQ than a single instance of very high BLL.

New Jersey lead poisoning regulations are less protective than today’s CDC policies. The Garden State still only categorizes a child as lead poisoned and eligible for state services if he/she had one test of at least >15 ug/dl or two consecutive tests of >10 ug/dl. New Jersey pediatricians can do better by being aware, per CDC, that there are no safe lead levels for children and being watchful for symptoms that may indicate a child has lead poisoning i.e., inability to remember facts; reduced auditory processing impeding the ability to read; poor executive function; inability to control behavior; and inability to learn no matter how hard a child tries.

Parents, pediatricians, educators and government need to work together to prevent lead poisoning in the first place, and their actions must also be synchronized to help a child once identified with an elevated blood level.

Some things to do:

• In New Jersey, case management services are not available for children with lead levels below 10ug/dL, so if your patient has a level below 10, write a prescription for a home visit by a public health nurse or a home inspector to assess home for lead paint risks. (Yes, you can do this!)
• At the time an elevated blood level is identified, ensure that your families understand the impacts and signs of lead poisoning at low levels.
• Recommend that the child be placed in a high quality childcare setting because there is evidence that a structured environment is particularly helpful to a lead poisoned child.
• Refer children to the federally funded Child Find program in your area for monitoring and intervention if needed.
• Share lead levels with a child’s school so that staff can watch for symptoms and provide testing and programs tailored to the child’s needs.

Pediatricians can help prevent lead poisoning by advocating better housing code enforcement in their communities and by becoming champions for their lead poisoned children.

Other resources:

Health Effects of Low Levels of Lead (2013)

http://www.nj.gov/education/specialed/childfind/

References
2. www.nchh.org/Portals/0/Contents/Glance_Childhood_Exposure.pdf

Superstorm Sandy Recovery: Healthy Homes & Lead Poisoning Prevention

In an effort to ensure elevated blood levels and other post-Sandy health issues are recognized and addressed by NJ’s health care professionals, NJAAP is administering the Superstorm Sandy Recovery Healthy Homes and Lead Poisoning Prevention Initiative, a program funded through NJDOH.

NJAAP will implement this outreach strategy in collaboration with the three Regional Childhood Lead Poisoning Prevention Coalitions in the state’s nine most impacted counties: Bergen, Hudson, Essex, Union, Middlesex, Monmouth, Ocean, Atlantic and Cape May. NJAAP will also distribute educational materials identified, secured and printed by Isles, Inc., a Trenton-based non-profit community development agency, on behalf of the Initiative.

For more information, please contact: Harriet Lazarus at hlazarus@aapnj.org
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The effective delivery of services across the lifespan of chronically ill children poses perhaps one of the most difficult challenges in the modern age of health care. The role of primary medical caregivers is undisputed, but institutions are increasingly bringing pediatric and adult specialists together in this pursuit. In practicality, this often means continuing to treat their own pediatric patients into adulthood, but it can also expand the pediatric subspecialists’ referral base to include adult patients with typical pediatric diseases.

The practice of pediatric sleep medicine is a good example, as many of the pediatric sleep patients will typically remain at risk of recurrence of sleep disruption during their lifespan. This is especially true for the neurodevelopmentally disabled children with sleep problems but also applies to the non-impaired. These disorders include primary sleep disorders such as sleep apnea, insomnia, narcolespy, sleep movement disorders and also certain sleep-seizure syndromes or systemic disorders such as atopy, reflux, chronic pain and more specific syndrome related symptoms that cause sleep disruption. Risk factors often act synergistically but many are preventable or at least manageable.

One of the more complex examples is insomnia in developmentally delayed patients. As adults, their relative developmental delays may put them in the pediatric range for their abilities to self regulate, therefore behavioral insomnias of childhood may apply to developmentally delayed adult patients and they may respond to therapies specifically targeting those. Furthermore, developmentally delayed patients’ neurological and psychiatric comorbidities, such as hypotonia, spasticity, epilepsy, learning disability, psychiatric problems or systemic comorbidities such as reflux, chronic pain, effects of bone and joint deformities, abdominal discomfort or obesity may all pose risk for recurrence at any point in their lifetime. Their pediatricians, pediatric neurologists and developmental specialists may know which risk factor applies to the specific patient. Importantly, recurrent insomnia, especially with concomitant daytime sleepiness may render intractable the primary developmental or neurological problems, such as epilepsy at any age which may be the only indication of disrupted sleep’s daytime effect.

In the new international classification of sleep disorders-3, the diagnostic categories of insomnia are greatly reduced to Chronic Insomnia Disorder (Primary Insomnia in ICD-10) and Short-Term Insomnia (Adjustment insomnia in ICD-10).

In the pediatric population, the prevalence of chronic insomnia is about 4%, at least 15% of which become chronic. Newly diagnosed insomnia is associated with frequent upper airway inflammation (atopy in general), temperamental disposition, lower parental educational level in childhood and with mental health issues and substance abuse, during adolescence (Zhang, 2011; Hasler, 2014). Systemic conditions, temperamental disposition and mental health problems were associated with persistence into adulthood (Zhang, 2011).

It is no surprise, that children with autism, developmental delay or ADHD frequently have sleep onset and or maintenance insomnia, as well as those with anxiety disorders, mood disorders and even epilepsy or even chronic headaches.

A full review of the diagnostic approach to insomnia is beyond the scope of this article but systemic disorders must be ruled out first (Malow, 2012). The diagnostic workup always starts with a sleep history as well as a medical and neuropsychiatric review of symptoms and includes a detailed sleep log (including naps) for at least two weeks to reasonably rule out certain sleep-wake cycle disorders or some insomnias. Actigraphy is a adjunct diagnostic tool and objectively accesses the sleep-wake cycle in insomniacs. Polysomnography (PSG) is usually not indicated for sleep onset insomnia unless restless legs syndrome is suspect in a less verbal child or if exaggeration of insomnia symptoms is suspected at any age, like in paradoxical insomnia. PSG is a good screen for sleep disordered breathing disorders but less so for periodic limb movement disorder as causes of sleep maintenance insomnia.

The National Sleep Foundation is in unanimous agreement that there is no evidence for the benefit of pharmacologic management of pediatric insomnias at present but emphasized the need for focused research in high priority populations such as children with autism, ADHD, mood and anxiety disorders, including PTSD. (Mindell, 2006).

In the pediatric population, there is only moderate level evidence for behavioral interventions in young children and low evidence for children and adolescents. Studies are lacking in special needs populations (Meltzer, 2013). In the adult population, however, cognitive behavioural therapy (CBT) can produce significant clinical improvements in sleep, daytime function and several quality of life measurements, regardless of age, gender, type or duration of the complaint. In fact, severe pretreatment insomnia, daytime impairment and low psychological well-being were associated with better response to CBT. (van Houdenhove, 2011)

The classic medications for insomnia are benzodiazepines, SSRIs and more recently medications with different mechanisms of action have entered the market. Most recently suvorexant, an orexin antagonist (the neurotransmitter involved in narcolepsy) became FDA approved. Amongst adults, off-label use of antipsychotics, antidepressants or anticonvulsants are common and in fact surpassed the use of FDA approved treatments (Walsh, 1999 & 2004).
The West African Ebola outbreak began in Guinea in early 2014; the initial announcement was reported by the World Health Organization on March 25, 2014. There was not much excitement here or elsewhere and the outbreak blossomed. In July, a traveler to Nigeria was the source of a relatively small outbreak there, which has been contained. In the United States, the interest in Ebola virus disease escalated when 2 infected healthcare workers were transferred to Atlanta for treatment. Then on September 30, the first case of Ebola virus disease diagnosed in the United States was reported in Texas. Subsequently 2 nurses were infected and Ebola became the center of news reports for weeks. To understand the disease, I have summarized what we know about this virus.

Ebola virus outbreaks were first recognized in 1976 in what was then called Zaire, now the Democratic Republic of the Congo; the virus was named after the Ebola River which flowed through the area of this early outbreak. Outbreaks of Ebola hemorrhagic fever have continued to occur, primarily in central Africa; most outbreaks involved fewer than 100 to a few hundred patients. In nature, the virus is found among bats; the bats do not become ill but transmit the virus through saliva when they partially eat fruit or through their feces, guano, which contaminates foods eaten by bush animals including monkeys and apes. People are infected by exposure to the bats or to bushmeat, both of which are handled, butchered and often eaten. Person to person transmission occurs by way of body fluids, especially blood. The virus is present within the blood, urine, saliva, sweat, feces, vomit, breast milk, and semen. Within healthcare settings the virus is transmitted by needle sticks or exposure of mucus membranes or non intact skin to infected body fluids. The current outbreak of Ebola hemorrhagic fever in West Africa is the largest ever reported; it infects people of all ages. Thousands have been infected and death rates exceed 50%. Because not all infected people have had hemorrhage, the disease is now referred to as Ebola virus disease. The incubation period for Ebola is about 3 weeks. Thus, it is important to consider this infection in travelers returning from West Africa. Suspected cases should be reported to the local health department immediately so care can be initiated and spread prevented.

Since the September and October cases in Texas, an additional case was diagnosed in the United States in a physician who had cared for Ebola patients in West Africa. He was diagnosed and treated in New York City at Bellevue Hospital. All three healthcare workers diagnosed in the United States have survived and been released from medical care. None of their contacts have developed disease. Unfortunately, the patient in Texas died of the infection; none of his family contacts or contacts outside the hospital became ill.

From our limited experience with Ebola virus disease, it seems clear that patients do not transmit the infection during incubation or during the time they are mildly affected. The only transmissions that occurred were to nurses caring for the Texas patient who was dying of his disease. Increased infection control measures have been put into place in all US hospitals to protect healthcare workers. Isolation and tracking has been implemented to ensure that the members of the public are not exposed to the virus.

While I think it is unlikely we will be caring for patients with Ebola virus fever, it is highly likely that you have been taking care of children with enterovirus D68. This enterovirus has circulated in the past in the United States and during the late summer and fall, it made a comeback. Like all enteroviruses, the viruses live in the gut but cause disease outside the gut. This strain has caused respiratory infection and respiratory failure. Although most infected patients will be either asymptomatic or have mild illness, a few will get into trouble with respiratory distress. Severe respiratory illness is most common in children with underlying asthma but it is not limited to these children. Recently the virus was recovered from a cluster of patients in Colorado with muscle weakness and abnormalities on magnetic resonance imaging of the spinal cord. Several patients from Philadelphia are being tested and it is likely that more will be reported. This virus was likely the cause of an outbreak of infantile paralysis in California in 2012. Since polioviruses are enteroviruses, it is not surprising that another enterovirus might cause acute paralysis. In fact this has happened with several strains of enterovirus. Enteroviruses are shed in stool for weeks after an illness and are present in respiratory secretions for days to weeks. Thus it is likely that many children in New Jersey shed the virus during this past summer and fall. There is no specific antiviral therapy. Testing for the virus is expensive and the specific test for D68 was being done only at the Centers for Disease Control and Prevention. It was recommended that testing be limited to seriously ill children such as those being admitted to the Pediatric Intensive Care Unit. Fortunately, the cold weather seems to have stopped this enteroviral strain; in general, enteroviruses circulate from spring through summer to early fall. The state and the Centers for Disease Control and Prevention are no longer accepting specimens. The good news is that this outbreak is over but, it is December and respiratory syncytial viruses are here and influenza is beginning to appear as well. It is not too late to protect yourself, your patients, your staff and your family members by getting immunized and washing your hands. As I have heard from many of you in the past, it’s always something!
Legal: Transitioning a Practice to Electronic Medical Records

By: Michael J. Schoppmann, Esq.
Guillermo J. Beades, Esq.

Many medical practices these days are contemplating joining the ranks of those providers who have transitioned to a paperless practice or have begun the process of moving to an electronic medical record (“EMR”). Regardless of the reason for such a change, when preparing to make the transfer from paper to electronic medical records, a practice should carefully review the requirements outlined by N.J.A.C. 13:35-6.5.

Under this statute, New Jersey law specifically outlines the eight (8) criteria a practice must follow if it chooses to prepare and maintain records electronically. These criteria govern, among other things, the number of forms of identification that must be present on each patient chart, when the patient record needs to be created (timeliness), how the record should be signed, how dictations should be handled, how to address multiple practitioners accessing patient files and the safeguards necessary for ensuring all patient files are automatically copied and subject to back-up.

The transition from paper to electronic is, unfortunately not a simple task and requires the purchase of a reputable, established and high compatibility electronic medical record system to ensure compliance with both state and federal regulations, particularly in the interests of meeting Meaningful Use. Meaningful Use is the shorthand title commonly used to refer to the federal government’s EHR Incentive Program which pays financial incentives to providers who can demonstrate that they are significantly, or “meaningfully”, using their EMR. The determination as to whether or not one is meeting Meaningful Use is established through a complex list of various key patient care measures that each provider must attest to meeting on an annual basis. Providers should confirm that their EMR system is Certified Electronic Health Record Technology (“CEHRT”) under the Meaningful Use program; without a certified system, regardless of whether the provider meets the meaningful use measures, the provider cannot qualify for any incentive payments. Most importantly, physicians must never forget that the form in which the medical record is recorded, be it on paper or electronically, does not change the obligation of every practice to comply with the growing and increasingly complex state and federal regulations that govern medical records.

Mr. Schoppmann may be contacted at 1-800-445-0954 or via email - MSchoppmann@DrLaw.com

For additional content, download the NJAAP app at iTunes, Google Play or Amazon. Search “New Jersey Pediatrics” & download. It’s another FREE MEMBER BENEFIT

THE NEW JERSEY CHAPTER, AMERICAN ACADEMY OF PEDIATRICS PRESENTS FIFTH ANNUAL New Jersey Children’s Ball SPOTLIGHT on CHILDREN Wednesday, April 22, 2015 @ 6:15 PM The Palace at Somerset Park ~ Somerset, NJ

A similar trend is observed in pediatrics; antihistamines and alpha2 agonists comprise the majority (Stojanovsky, 2007). However, specific off label medications may be more effective in specific subpopulations of insomniacs.

In conclusion, treatment of the pediatric onset chronic sleep problems of the developmentally delayed may be better cared for by the primary doctor, pediatric neurologist, developmental specialist and sleep physicians. This implies that the primary care doctor work closely together with the pediatric sleep physician, pediatric neurologist and developmental specialist and beyond knowing the risk factors for the particular disorder they are also cognizant of which risk factors pertain to that particular patient. With the right bioinformatic tools, this approach will reduce duplication of diagnostic tests, unnecessary testing and improve all clinical outcome
The Legislature spent a significant amount of time over recent months developing a comprehensive bill package to tackle the heroin and prescription drug epidemic in New Jersey. The package, consisting of 21 bills, focus on the need to improve paths to evidence-based prevention, treatment and recovery efforts for those addicted to opiates.

The following lists the legislation in the package.

- **S2366/A3612** would require that, prior to issuing a prescription for a schedule II controlled dangerous substance or any other opioid drug which is a prescription drug, a practitioner must discuss with the patient, or the patient’s parent or guardian (for patients under 18 years old and not an emancipated minor) the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The practitioner must also obtain a written acknowledgement from the patient or the patient’s parent or guardian that this discussion has taken place.

- **S2371** would expand the responsibilities of the State’s poison control and drug information program. The bill would require a health care provider to notify the program after treating a patient for a drug overdose, regardless of whether the overdose resulted in death. The notification would be required to include the following information, to the extent that such information is made available: (1) a description of the circumstances surrounding the overdose, including, but not limited to, an indication of the cause and location of the exposure; (2) demographic information, including, but not limited to, the age, sex, and county of residence of the person who suffered the overdose; and (3) an indication of the type of drug that caused the overdose.

- **S1998/A3129** would require all physicians to register for the state Prescription Monitoring Program to identify instances of doctor shopping and/or rogue prescribers operating “pill mills”.

- **S2370/A709** would increase public awareness of safe disposal of prescription drugs by requiring pharmacists and prescribers to notify patients of proper and safe disposal options.

- **S2374/A3717** would increase the rate that Medicaid providers are reimbursed for evidence-based behavioral health care to the going market-rate.

- **S2180/A3450** would ensure those with behavioral health care conditions are eligible through their insurance to receive services prescribed by licensed physicians, physician assistants, psychologists, clinical social workers and certified advance practice nurses by prohibiting insurance companies to deny coverage through their own utilization management review.

- **S2376/A3718** would help doctors coordinate with specialists through telecommunications rather than expensive face-to-face patient visits by creating a grant in the Department of Health to expand remote medical consultation.

- **S2367/A3713** would update New Jersey’s core curriculum on substance abuse to make sure students are receiving effective prevention education.

- **S2029/A1015** would enhance data collection and resource targeting by government agencies by allowing students with guardian permission to participate in voluntary surveys.

- **S2369/A2859** would increase the number of places individuals can drop off unused prescription drugs by expanding “Project Medicine Drop” locations across the state.

- **S2371/A3715** would expand the responsibilities of the State’s poison control and drug information program.

- **S2372/A1436** creates a Statewide Opioid Law Enforcement Task Force to identify, investigate and prosecute illegal sources and distribution of opiate drugs and to provide training for law enforcement and health care professionals.

- **S2373/A3716** would provide consumers with a better understanding of treatment options by requiring the Department of Mental Health and Addiction Services to annually compare and rank substance abuse providers.

- **S2375/A3700** would remove red tape that keeps ambulatory care facilities from providing behavioral health care services without multiple licenses.

- **S324/A2266** would create a Behavioral Health Insurance Claim Advocacy Program to provide assistance and advocacy in navigating insurance bureaucracy to those with behavioral health care conditions.

- **S2377/A3719** would require New Jersey’s colleges and universities to provide substance abuse recovery housing options.

- **S2047** would ensure that the Department of Human Services have regulatory oversight of substance abuse treatment facilities.

- **S2378/A3720** would extend the Overdose Prevention Act to provide immunity to law enforcement professionals for delivery of an overdose antidote and would require all syringe access programs to carry and dispense the antidote to needle exchange participants.

- **S2379/A3721** would create a three-year pilot program to enroll pre-trial incarcerated individuals in Medicaid, providing more individuals with coverage and eligibility to enroll in court supervised substance abuse treatment programs.

- **S2380/A3722** would ensure that inmates are receiving treatment approved by the agency with the most appropriate expertise and experience by requiring joint regulatory authority over prison-based mental health and substance abuse programs between the Department of Corrections and the Division of Mental Health and Addiction Services.

- **S2381/A3723** would permit successful completion of certain drug treatment programs operating in state prisons and prohibition drug court programs for those who are using certain medication assisted treatment such as methadone.

**RAW MILK ALERT**

The Assembly Agriculture Committee voted unanimously to release **A543**, permitting the sale of raw milk by a person holding a valid raw milk permit. Support efforts to ensure this legislation is not brought before the full Assembly by downloading a letter of opposition template from the NJAAP website and emailing it to your legislator. We encourage any and all efforts to ensure this legislation does not advance any further.
Case Study - A Constellation Of Recurring Symptoms: Is The Answer In The Rash?

Srividya Naganathan, MD
Marcos Alfie, MD
Teenu Cherian, DO
Jersey Shore University Medical Center

A 10 year old male with recent past history of viral illness, presented with recurring symptoms of abdominal pain, bloody stools, rash, joint pain, and hematuria over a period of 6 weeks.

Initially, he presented with 1 day history of left sided abdominal pain, vomiting, and hematuria. On abdominal exam, bowel sounds were present with left lower quadrant (LLQ) voluntary guarding and tenderness. The remainder of the exam was normal. Lab work was positive only for trace blood (3-5 RBC/HPF) on urinalysis. Hematuria may be a symptom of nephrolithiasis, urinary tract infection, glomerulonephritis, or IGA nephropathy. With no history of fevers and a urinalysis negative for leukocytes or nitrates a urinary tract infection was unlikely. An abdominal CT was done to further evaluate the patient’s symptoms and it displayed an abnormal loop of proximal small bowel with wall thickening and edema distal to the duodenal junction and proximal jejunum (Figure 1). It was negative for signs of intussusception, obstruction, or nephrolithiasis. On subsequent exams, the patient developed a palpable peticchial rash on his forearms and lower extremities bilaterally. While petechiae and purpuric rashes may indicate a variety of diagnosis including Rickettsial infections, meningococemia, and idiopathic thrombocytopenic purpura, the patient’s clinical picture was consistent with Henoch-Schönlein Purpura (HSP). Following clinical improvement, he was discharged home.

Subsequently, the patient returned 1 day after discharge with worsening abdominal pain and rash, vomiting, and bloody stools. A maculopapular, petechial rash was noted bilaterally on upper/lower extremities (Figure 2, 3). On exam, his abdomen had signs of peritoneal irritation with LLQ tenderness. The rest of his exam was normal. Lab work demonstrated an elevated ESR of 36 mm/hr, occult blood positive stool, and a negative urinalysis. Repeat CT scan showed interval worsening with increased segmental mural thickening of the mid jejunum and ascites (Figure 4). No evidence of intussusception was found. As his symptoms were consistent with HSP, he was monitored for clinical improvement and soon discharged home.

Twenty one days later the patient returned with joint pain and swelling, a persistent rash, abdominal pain with bloody stools, vomiting, resolving testicular swelling and pain, and hematuria. The testicular exam on admission was normal with no apparent edema or tenderness to palpation. However, the patient had right wrist swelling and tenderness as well as a purpuric rash over the extremities, buttock, and chest. The abdomen was soft with bowel sounds and right-sided tenderness. An abdominal ultrasound re-demonstrated small thickened bowel loops with no evidence of intussusception. The patient was evaluated by both rheumatology and nephrology and they concurred that his symptoms were consistent with HSP. However, due to the severity of his clinical presentation and the recurring nature of his condition, he was started on methylprednisolone with improvement in his abdominal pain. Once he was tolerating oral intake well, he was discharged home.

Subsequently, the patient returned 1 day after discharge with worsening abdominal pain and rash, vomiting, and bloody stools. A maculopapular, petechial rash was noted bilaterally on upper/lower extremities (Figure 2, 3).

Discussion

HSP is an immune mediated disorder with IgA deposition and leukocytoclastic vasculitis involving the skin, joints, GI, and renal systems. It is the most common vasculitis in childhood occurring between the ages of 3 and 10 in 14-20/100,000 children per year. Although the etiology is unknown, it is suspected to be triggered by viral infections. The classic tetrad of HSP includes purpuric rash, joint pain, GI, and renal symptoms. Less frequently, patients may have neurological, cardiac, pulmonary, or testicular involvement. Most commonly, patients develop a palpable purpuric rash and arthritis/arthralgia. The purpuric rash may precede or follow other systemic manifestations. In 30-40% of cases, abdominal pain may precede the rash, while in 15%-25% of cases joint pain may be the first presenting sign. Diagnosis is clinical and difficult to make without the presence of the rash. However, it is important to keep a high index of suspicion for HSP in patients with abdominal and joint pain until the characteristic rash appears and the diagnosis is made evident. In addition to intussusception as a potential acute complication, renal disease is the major long-term complication. Therefore, patients require close follow up with serial evaluation of blood pressure and urinalysis for 6 months.

Most cases of HSP are self-limiting with recurrence in 1/3 of patients. Treatment is largely supportive but more severe manifestations may require additional therapies including corticosteroids, intravenous immunoglobulin (IVIG), and plasmapheresis. There are no standardized guidelines or consensus in the role of corticosteroids in the treatment of HSP. Studies in hospitalized patients show the early use of corticosteroids provides significant relief of joint pain, resolution of abdominal pain in 24 hours, reduction in the need for surgical intervention, as well as decreased need for analgesic medications. Furthermore, a 2007 systematic review suggested a potential reduction in the persistence of renal disease as well as recurrence of HSP with use of corticosteroids.

While corticosteroids may relieve abdominal pain symptoms, complications such as perforation or intussusception may be masked. When corticosteroids are initiated, therapy should be tapered over a course of 4-6 weeks. Abruptly stopping corticosteroids or tapering too quickly may cause a flare in symptoms. Furthermore, as treatment extends over a prolonged period of time, the adverse effects continued on next page
With funding from the Horizon Foundation for New Jersey, the New Jersey Immunization Network (NJIN) completed a yearlong project with five pediatric practices to gain practice-level insights and data on patients’ current immunization status, increase awareness among primary health-care providers about the importance of age-appropriate childhood immunizations, and identify barriers and challenges to providing immunization.

Participating practices ranged in size from a single-provider to a large pediatric practice and were located in Ocean, Burlington and Morris Counties. To begin, each practice pulled a random selection of 30 charts of their 24-35 month old population. From this information, NJAAP assessed baseline immunization rates utilizing the Comprehensive Clinical Assessment Software Application (CoCASA) from the CDC. This information was used to identify practice strengths and weaknesses and areas where the Model for Quality Improvement would be effective.

On-site visits were conducted with each practice to provide a Practice Innovator Session that included discussing data results, sharing information on best practices including use of NJIIS, and identifying opportunities for improvement. In addition, practices were invited to attend a monthly Technical Assistance call with QI Specialists to discuss their on-going quality improvement efforts. Each practice was also provided with a free EQIPP (Education in Quality Improvement in Pediatric Practice) module from the National AAP, for which physicians are eligible to receive Part 4 MOC credit.

A follow-up patient chart analysis was conducted to assess changes in practice performance. The table below summarizes the findings.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Initial data pull</th>
<th>Post-program data pull</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice A</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>Practice B</td>
<td>77%</td>
<td>90%</td>
</tr>
<tr>
<td>Practice C</td>
<td>87%</td>
<td>80%</td>
</tr>
<tr>
<td>Practice D</td>
<td>67%</td>
<td>73%</td>
</tr>
<tr>
<td>Practice E</td>
<td>62%</td>
<td>94%</td>
</tr>
</tbody>
</table>

*Rate is based on the 4:3:1:3:1:4 (4Tdap; 3Polio; 1MMR; 3HIB; 3HepB; 1Var; 4PCV) schedule of childhood immunizations by age 24 months

Interestingly, the practices that experienced significant increases in immunization rates attribute that result to their beginning to assess immunization status at sick-child visits in addition to well visits and initiating immunization of mildly sick children. A strong physician recommendation was identified as an important factor. The practice showing a slight decline in immunization rates was upgrading its EMR system at the time and indicated that may have affected the reported values.

In working with pediatric providers, all of whom operate on a tight margin of time and staff, NJIN found that flexible scheduling and the ability to collaborate remotely via webinar were helpful in building practice engagement and commitment.

Constellation continued

associated with corticosteroids must be considered. Patient may experience hypertension, hyperglycemia, neuropsychological changes, growth suppression, and adrenal insufficiency among the many known adverse effects of corticosteroids.

Although the current literature supports that early use of corticosteroids is associated with improved outcomes for abdominal pain and renal involvement in HSP, there is insufficient evidence to recommend its routine use.

More prospective randomized controlled trials are required to establish evidence based guidelines for physicians.

References

Baby Are You Blue?

Terry M. Anderson, MD
Cardiac Center - Voorhees
The Children’s Hospital of Philadelphia
Clinical Professor of Pediatrics
University of Pennsylvania Perelman School of Medicine

Baby Baby are you blue?
Baby, let me take a look at you.

Even though you look so pink,
Let’s see what the pulse ox thinks.
Screening is easy to do,
All you need is the pulse ox rule.
Screen at 24 hours or more,
But definitely before Baby is out the door.
Sample the right hand, sample either foot,
Record the numbers and take a look.

If both are 95% or more,
Then there’s just one thing more.
If the difference is less than or equal to three,
Baby passes and is home free.
If Baby’s numbers do not agree,
He or she should probably see Cardiology.

Baby are you blue?
Baby, we MUST let the pulse ox take a look at you.

Al though the lyrics are simple and somewhat corny, there is truth in what is written. Newborns do not need to be blue to fail their pulse oximetry screen for critical congenital heart disease (CCHD).

Although the lyrics are simple and somewhat corny, there is truth in what is written. Newborns do not need to be blue to fail their pulse oximetry screen for critical congenital heart disease (CCHD).

Cyanotic heart defects in newborns can easily go undetected on physical examination alone. You may ask, how can I miss a “blue baby”? Am I color blind? Am I looking in the wrong places? Rest assured, there is a scientific explanation for our failure to recognize these newborns. As I will explain below, hypoxemia, which is a hallmark of most CCHD, does not always result in cyanosis.

Almost half of all CCHD are the so called cyanotic heart defects. These defects (such as the classic five T’s - Tetralogy of Fallot, Transposition of the great arteries, Tricuspid or pulmonary atresia, Truncus arteriosus and Total anomalous pulmonary venous return) have low arterial blood oxygen saturations. These are anatomic anomalies of the heart with hypoxemia as a result of either right to left shunting, diminished pulmonary blood flow or a combination of both. All have hypoxemia, but, all may not have associated cyanosis.

As I promised, here is the scientific explanation for our failure to detect CCHD.

Hypoxemia is a biochemical phenomenon that occurs when oxygen saturations are lower than normal. We can define hypoxemia as oxygen saturations that are less than 95%. Hypoxemia is a characteristic finding in CCHD. Cyanosis on the other hand, is a physical finding. It is the bluish discoloration of the tissues and skin visible to the human eye. It is important to note that hypoxemia will present as cyanosis only when levels of reduced hemoglobin in the capillary bed exceed 3-5 gm/dL.

For example, in the average normal newborn with hemoglobin of 20 gm/dL, the oxygen saturation must be less than 85% to produce cyanosis. Don’t stumble over the math, it’s simple. In this case, there is 15% desaturated blood and 15% of the hemoglobin of 20 gm/dl results in 3 gm/dl of reduced hemoglobin. Based on the definition, that is enough to produce cyanosis. However, a saturation of 88% in the same patient may not result in cyanosis and assuming there are no murmurs or other signs of heart disease, the cyanotic heart defect may go undetected. It is also important to note that anemic newborns may not appear cyanotic until oxygen saturations are much lower. For example, a newborn with a hemoglobin of 10 gm/dL will not have 3 grams of reduced hemoglobin until the oxygen saturation is 70% or less. The key point is that the perception of cyanosis may be unreliable until arterial desaturation is profound. This is why CCHD in newborns many times goes undetected.

But on the other hand, when you detect cyanosis it does not always mean CCHD or other disease processes with associated hypoxemia. Visible cyanosis can occur with normal arterial oxygen saturations. With decreased cardiac output, the arteriovenous (AV) difference widens from a normal of approximately 40% to more than 60% due to increased extraction of oxygen at the tissue level. This results in elevated levels of reduced hemoglobin in the capillary bed and thus the visual appearance of cyanosis even though arterial saturations are normal. Polycythemia can also produce visible cyanosis. In some newborns, the hemoglobin levels may be so high that even with a normal oxygen saturation and a normal AV difference there will be more than 3 gm/dL of reduced hemoglobin in the capillary bed and thus, the appearance of cyanosis. Many refer to this as the plethoric cyanosis of the newborn. It may be difficult to differentiate from true hypoxemia; however, oxygen saturations will be normal.

continued on next page
In all newborns, the determinants for cyanosis are arterial oxygen saturations (hypoxemia), hemoglobin levels (oxygen capacity) and arteriovenous differences. To produce reduced hemoglobin in the capillary bed of more than 3 gm/dL and thus cyanosis, the arterial oxygen saturations are low, hemoglobin levels are very high or the AV difference is increased.

If nothing else, remember the following points:

- The human eye detects cyanosis.
- The pulse oximeter detects hypoxemia.

Hypoxemia, a characteristic finding in CCHD, may be present when cyanosis is not. Therefore, CCHD screening with pulse oximetry works. And most importantly, early detection of CCHD reduces morbidity and mortality.

### Results of CCHD Screening with Pulse Oximetry

*August 31, 2011 – September 30, 2014*

**Screening Coverage**

- Number of live-births: 313,005
- Number eligible to be screened: 304,211
- Number screened: 303,211
- Proportion of eligible births screened: 99.6%

Of the 208 infants who were reported to the NJ Birth Defects Registry as having failed the screen, 97 received diagnostic evaluations solely due to screening.

**Detected through newborn screening with pulse oximetry:**

**14 infants with CCHD**

- Coarctation of the aorta (5)
- Ebstein anomaly (1)
- D-Transposition of the great arteries (2)
- Tricuspid atresia (1)
- Total anomalous pulmonary venous return (5)

**12 infants with CHD**

- Atrial septal aneurysm
- Atrial septal defect
- Pulmonary artery/pulmonary artery branch stenosis
- Ventricular septal defect

**9 infants with serious non-cardiac conditions**

- Sepsis
- Pneumonia
- Persistent pulmonary hypertension
- Pulmonary bulla
It’s 3 AM and you are attempting to gather the proper words to explain to a couple that their beloved child will never be the same. I have to convert newly acquired medical knowledge into laymen’s terms for the family to understand. How would I begin to explain the extent of what happened or how I attempted to save their child’s life but was unsuccessful? As residents, one of our worst nightmares is telling parents that their child has a serious medical illness, injury, or is no longer with us. Some may believe that medical school or the USMLE exams are the toughest hurdles we face, but if you ask me, by far the most daunting task is breaking bad news to a family.

Goryeb Children’s Hospital-Atlantic Health System has implemented an invaluable project to enhance residents’ skills in communicating bad news to parents in challenging situations. Originally conceived by Dr. Anthony Orsini, a neonatologist, the Breaking Bad News Program™ uses improvisational actors and actresses utilizing unscripted case scenarios in stark contrast to standardized OSCE patients who utilize scripted responses. As a result, the actors and actresses can adjust their emotional responses to include crying and grief to outward anger and hostility based on the how the resident presented the information. The residents are videotaped delivering the bad news and are evaluated using a standardized tool created for the Breaking Bad News Program™ by several members of the Atlantic Health System's faculty in Pediatrics, Neonatology, and Palliative Care and validated internally during the first Breaking Bad News pilot program in 2012. The tool evaluates our preparation and ability to review what transpired, our accountability and reactivity, as well as breaking the bad news gradually while still strengthening the relationship with the family.

**It was the first training situation where I was looked at as the leader of the care team**

The professional improvisational actors and actresses provided their feedback to the course faculty. That feedback along with the faculty’s feedback was given to the residents after the encounter, while we were able to review and reflect upon the video. Several parents of children with chronic medical conditions or special needs also sat on the review panel in order to offer their perspective.

I have vivid memories of the scenario presented to me. I had the parents of a 6 year old boy who was neurologically devastated secondary to a drowning. As soon as I broke the news that their child will never be the same, the rush of emotions came pouring out. First was sadness and grief followed by disbelief and skepticism, which quickly became self-reproach. It was an emotional train ride and it required that each emotion be addressed which allowed me to truly hone my skills.

I quickly learned that this conversation would no longer go the way I intended, but rather, at the parents’ pace. I learned not only how to empathize with the family, but also that silence can be golden and that sometimes less is more.

Thus far, I can say without a doubt that this was one of the most nerve wracking situations in my medical training; not solely because I was evaluated by attendings that I strive to impress on a daily basis, but because it was the first training situation where I was looked at as the leader of the care team rather than “just the resident”. I was suddenly expected to take sole responsibility for the care the patient in the scenario received and explain the outcome to the family. As a medical student, you dream of the day where you become the “boss”, but here I was, trembling while a father shed his tears onto my scrubs because I was the “boss”.

Nonetheless, having these conversations is something I plan to become all too familiar with in my future career in Pediatric Emergency Medicine. During these intense moments there are so many things you have to take into account, the verbiage used, your body language, whether to sit or stand, physical contact, or how quickly you take the family to see their child. These are just a small set of valuable skills I learned from the Breaking Bad News Program. If you have never had the opportunity to be part of such an experience, I feel it behooves you to pursue this invaluable training.

**Advocacy Day Conference in Washington DC**

Antoinette Williams M.D.
Pediatric Resident PGY I
Robert Wood Johnson University Hospital- New Brunswick

The American Academy of Pediatrics hosted Advocacy Day Training in Washington DC on October 27th at the Hilton Garden Inn. The goal of the Conference was to provide background information on advocacy pertaining to pediatricians, furnish participants with tools and information on how to best hold meetings with Representatives, Senators, and their staff on Capitol Hill. Senior members of AAP also shared personal stories, detailing their lives as child advocates and the impact it had on them personally and as practicing pediatricians. Lastly, members of the conference had the opportunity to meet with representatives in their Capitol Hill offices.

Having the opportunity to attend this year’s conference and interact with recognized political figure’s staff, really made for a wonderful experience. This experience also provided the opportunity to connect with a fellow resident from a different program, who was a native to New Jersey. As a team we reviewed information regarding CHIP funding expansion and Medicaid payment increase to equal that of Medicare. With guidance from the Advocacy Day training, we were able to develop and present to the staff members talking points, which detailed both informed political knowledge and our personal perspectives.

continued on next page
Resident Voice: Transitioning to a Niche in the Pediatric Workforce After Residency

Deep Grewal, MD, PGY 3
St. Peters University Hospital Pediatric Residency
Chethan Sarabu, MD, PGY-2
Rutgers Robert Wood Johnson Medical School Pediatric Residency

To be entrusted with the care of children is an awesome responsibility and privilege. As resident physicians in training we often feel hurled between rotations without the time to stop and reflect on the broader picture of why we were drawn into pediatrics in the first place. This is a critical question that will help guide our future careers. Pediatrics is a wonderfully broad field with many potential directions and niches to explore making it challenging to decide what to do next.

For residents, entering the “real world,” the job search seems like a daunting task when considering balancing specialty, location, practice structure, long-term goals, finances, benefits, malpractice, and personal life. Without these considerations, ideally each of us could choose our own preferred career route and structure to treat pediatric patients. Practically we have to find a way to intertwine all the factors harmoniously and discover the pediatric practice that fits best.

In addition to the core medical education, all residents would benefit from mentoring as a comprehensive approach to career building and job placement. The second year pediatric residents recently attended and experienced the annual Resident Career Day organized by the NJAAP. This event and others can help ease the transition from training resident to practicing physician. Similar to residency education, residents can continue to learn from the wisdom, knowledge and experience of our predecessors, from those who have just started practicing to those that have practiced for decades.

While guidance should be made available to residents and efforts should work to increase resident awareness of available career building resources, residents must play a proactive role as well to seek available opportunities to help guide them.

Partnerships between multiple agencies can strengthen and unify available resources; for instance, between the New Jersey Council of Teaching Hospitals, the NJAAP, and the individual residency programs. Residents should educate themselves and inquire about appropriate career planning and important time lines. Ultimately it is about developing a balance between the program providing enough guidance and direction, matching up with the resident developing a plan and seeking out opportunities.

As for determining where we are going next, that is still a work in progress.

This being my first time on Capitol Hill as an advocate, I was extremely nervous; however, I was also encouraged by the AAP leadership team. We were able to role play and received advice from the leaders on how best to approach meetings with political staff. As advocates, we were reminded to use our voices to speak on behalf of those who couldn’t. Once on Capitol Hill and after interacting with numerous interns and office staff, the day became less uneasy and more enjoyable. Also, as our confidence in our abilities to advocate increased, we were able to provide insight about the needs of our patients and for such programs from our experiences thus far.

We were able to meet with representatives from the offices of Sen. Cory Booker, Rep. Frank Pallone Jr. and Rep. Frank LoBiondo. All were receptive and listened closely to us. In one of our meetings, members in the office were unaware that the Medicaid payment increase bill existed. This provided us with an excellent opportunity to educate them on benefits of having physicians who accept Medicaid receive equal compensation as those who accept Medicare. Afterwards they were fully supportive and appreciative that we brought it to their attention.

All in all it was a great learning experience that will positively impact all future efforts to successfully advocate for political and community action issues that affect my patients.

Advocacy Day Conference continued

NJAAP@Work

2nd Year Residents focus in on NJAAP leadership during Resident Career Day 2014. Mark your calendars for Resident Career Day 2015, which will be held in September. Stay tuned for further details.
Influenza (the flu) is a contagious respiratory illness caused by influenza viruses A or B. It can cause mild to severe illness, and at times can lead to death. Every year in the United States more than 200,000 people are hospitalized from flu complications, and about 36,000 people die from flu. Hospitalization rates are highest among children (<5 years old) and are comparable to hospitalization rates among the elderly. Influenza disease puts young children at risk for hospitalization due to pneumonia, respiratory conditions, heart failure, and myocarditis. It is estimated that between 8,400 and 11,700 children <2 years of age are hospitalized each year as a result of influenza infection, whereas cases of other vaccine-preventable diseases are rarely seen. The 2013-2014 influenza season noted a high number of healthy people, including infants and older adults, needing ICU care, of whom 91% were not previously vaccinated.

Symptoms of flu include:

- fever or feeling feverish/chills*
- headache
- extreme tiredness/ fatigue
- cough
- sore throat
- runny or stuffy nose
- muscle aches
- Stomach symptoms, such as nausea, vomiting, and diarrhea, also can occur but are more common in children than adults

(*It’s important to note that not everyone with flu will have a fever)

Most healthy adults may be able to infect others beginning 1 day before symptoms develop and up to 5 to 7 days after becoming sick. Some people, especially young children and people with weakened immune systems, might be able to infect others for an even longer time.

Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

Influenza vaccine composition, formulation and indications

Annual influenza vaccination is the best method for preventing influenza disease, its transmission and potentially severe complications. ACIP (Advisory Committee on Immunization Practices) and the AAP (American Academy of Pediatrics) recommend annual influenza vaccination for all persons ≥ 6 months of age without contraindications. An annual vaccination is recommended for optimal protection because immunity wanes over time. For 2014–15, both trivalent and quadrivalent vaccine formulations are available and neither vaccine preparation is preferred over the other. Trivalent influenza vaccines contain 2 influenza A strains (A/California/7/2009 (H1N1)-like virus, an A/Texas/50/2012 (H3N2)-like virus) and an Influenza B strain (B/Massachusetts/2/2012-like virus [B/Yamagata lineage]).

The quadrivalent influenza vaccines contain the same antigens as the trivalent vaccine plus an additional influenza B strain (B/Brasilia/60/2008-like virus [B/Victoria lineage]).

The strains included in the 2014-2015 vaccine are unchanged from those in the 2013-2014 seasonal influenza vaccine.

1. In addition to universal immunization for all persons ≥ 6 months, special effort should be made to vaccinate certain groups, including: All children > 6 months of age with medical conditions that increase the risk of influenza-related complications (i.e., asthma, diabetes mellitus, hemodynamically significant cardiac disease, immunosuppression, neurologic and neurodevelopmental disorders)
   1. Children of American Indian or Alaskan Native heritage
   2. All household contacts and out-of-home care providers of
      a. Children with high-risk conditions
      b. Children less than 5 years of age and especially infants under 6 months of age
   3. All healthcare providers
   4. All childcare providers and staff
   5. All pregnant women, those considering pregnancy, those in the postpartum period and those that are breastfeeding during the influenza season

For the 2014–15 influenza season, multiple influenza vaccine formulations are approved by the Food and Drug Association (FDA) for use, including:

1. Quadrivalent live attenuated influenza vaccine (LAIV4)
2. Trivalent and quadrivalent inactivated influenza vaccines (IIV3 and IIV4)
3. Trivalent cell culture–based inactivated influenza vaccine (ccIIV3)
4. High-dose trivalent inactivated influenza vaccine (hd IIV3)
5. Intradermally administered IIV3
6. Recombinant trivalent influenza vaccine (RIV3)

Some of these vaccines are approved only for specific age groups and/or are more appropriate for persons with certain medical conditions. The vaccines approved for use in children under 18 years of age include LAIV4, IIV3 and IIV4.

Vaccine doses for children

Children aged 6 months through 8 years who are being vaccinated for the first time require 2 doses of influenza vaccine, administered ≥ 24 weeks apart. Children 9 years and older need only 1 dose. For children aged 6 months through 8 years who have received influenza vaccination during a previous season, please see Fig 1. Using this approach, children aged 6 months through 8 years...
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Children in this age group for whom one of these conditions is not met require 2 doses for 2014–15.

Approved Vaccines for children and vaccine preferences

Studies have demonstrated superior efficacy of LAIV, compared to IIV, in children aged 6 through 71 months, in preventing cultured-confirmed influenza. LAIV efficacy was higher than that of IIV against both antigenically drifted and well-matched influenza virus strains (19). For children and adults with chronic medical conditions placing them at a higher risk for influenza complications, data on the relative safety and efficacy of LAIV and IIV are limited.

In 2014, the Advisory Committee on Immunization Practices recommends the preferential use of LAIV for healthy children aged 2 through 8 years, when it is immediately available, and when the child has no contraindications or precautions. However, if LAIV is not immediately available, inactivated influenza vaccine should be used and vaccination should not be delayed.

LAIV is not indicated in the following populations:

- Persons aged <2 years or >49 years
- Those with contraindications listed in the package insert:
  - Children aged 2 through 17 years who are receiving aspirin or aspirin-containing products
  - Children who have experienced severe allergic reactions to the vaccine or any of its components, or to a previous dose of any influenza vaccine
- Pregnant women or those considering pregnancy
- Children who have a moderate to severe febrile illness
- Children with an amount of nasal congestion that would impede vaccine delivery
- Immunosuppressed children
- Persons with a history of egg allergy
- Children aged 2 through 4 years who have asthma or who have had a wheezing episode noted in the medical record within the past 12 months, or for whom parents report that a health care provider stated that they had wheezing or asthma within the last 12 months
- Children with a diagnosis of asthma
- Children who have received other live viral vaccines within the last 4 weeks (other live vaccines can be given on the same day as LAIV)
- Children with any condition that can compromise respiratory function or handling of secretions or can increase the risk for aspiration (i.e., neurodevelopmental disorders, spinal cord injuries, seizure disorders or neuromuscular abnormalities)
- Children who have taken influenza antiviral medications within the previous 48 hours
- Persons aged <2 years or >49 years
- Those with contraindications listed in the package insert:
  - Children aged 2 through 17 years who are receiving aspirin or aspirin-containing products
  - Children who have experienced severe allergic reactions to the vaccine or any of its components, or to a previous dose of any influenza vaccine
- Pregnant women or those considering pregnancy
- Children who have a moderate to severe febrile illness
- Children with an amount of nasal congestion that would impede vaccine delivery
- Immunosuppressed children
- Persons with a history of egg allergy
- Children aged 2 through 4 years who have asthma or who have had a wheezing episode noted in the medical record within the past 12 months, or for whom parents report that a health care provider stated that they had wheezing or asthma within the last 12 months
- Children with a diagnosis of asthma
- Children who have received other live viral vaccines within the last 4 weeks (other live vaccines can be given on the same day as LAIV)
- Children with any condition that can compromise respiratory function or handling of secretions or can increase the risk for aspiration (i.e., neurodevelopmental disorders, spinal cord injuries, seizure disorders or neuromuscular abnormalities)
- Children who have taken influenza antiviral medications within the previous 48 hours

Also, the safety of LAIV in persons with other underlying medical conditions that may predispose them to complications after wild-type influenza infection (e.g., chronic pulmonary, cardiovascular [except isolated hypertension], renal, hepatic, neurologic, hematologic, or metabolic disorders [including diabetes mellitus]) has not been established. These conditions should be considered precautions for the use of LAIV. In addition, persons who care for severely immunosuppressed persons who require a protective environment should not receive LAIV, or should avoid contact with such persons for up to 28 days after receipt, given the theoretical risk for transmission of the live attenuated vaccine virus.

Inactivated Influenza vaccine (IIV3 and IIV4) is also recommended for persons ≥ 6 months and the precautions and contraindications involving its use have not changed from 2013-2014.

IIV is preferred for:

- Children with chronic underlying medical conditions with an elevated risk for complications from influenza, including
  - Asthma or other chronic pulmonary diseases, including cystic fibrosis
  - Hemodynamically significant cardiac disease
  - Immunosuppressive disorders or therapy
  - HIV infection
  - Sickle cell anemia and other hemoglobinopathies
  - Children on long-term aspirin therapy, including juvenile idiopathic arthritis or Kawasaki disease
  - Chronic renal dysfunction
  - Chronic metabolic disease, including diabetes mellitus
  - Any condition that compromises respiratory function or handling of secretions or can increase the risk of aspiration, such as neurodevelopmental disorders, spinal cord injuries, seizure disorders or neuromuscular abnormalities
- Children with a diagnosis of asthma
- Children who have received other live viral vaccines within the last 4 weeks (other live vaccines can be given on the same day as LAIV)
- Children with any condition that can compromise respiratory function or handling of secretions or can increase the risk for aspiration (i.e., neurodevelopmental disorders, spinal cord injuries, seizure disorders or neuromuscular abnormalities)
- Children who have taken influenza antiviral medications within the previous 48 hours

Guidelines continued

continued on page 26
Contraindications for IIV:

- Infants younger than 6 months
- Children who have a moderate to severe febrile illness
- Severe allergic reaction to the vaccine or any component of the vaccine, or to a previous dose of any influenza vaccine

Precautions for IIV:

- Moderate to severe illness with or without fever
- History of Guillain-Barré syndrome within 6 weeks of receipt of influenza vaccine

Egg allergy and Influenza vaccination

With the exceptions of trivalent recombinant influenza vaccine (RIV3) and cell culture-based inactivated influenza vaccine (cIIV3), neither of which are licensed for use in children under 18 years of age, currently available influenza vaccines are prepared using chicken eggs. Published reviews have shown that severe allergic reactions to egg-based influenza vaccines are unlikely; however, there are reports of anaphylactic reactions in egg-allergic persons after influenza vaccination. In published studies, vaccines containing as much as 0.7 μg/0.5 mL of ovalbumin have been tolerated; however, a threshold below which no reactions would be expected is not known. Among IIVs for which ovalbumin content was disclosed during the 2011–12 through 2013–14 seasons, the reported maximum amounts were ≤1 μg/0.5 mL dose. ACIP and AAP recommend that persons with a history of egg allergy who have experienced only hives after exposure to egg should receive influenza vaccine. Because relatively few data are available for use of live attenuated influenza vaccine in this setting, inactivated influenza vaccines (IIV) should be used. RIV3 may be used for persons aged 18 through 49 years who have no other contraindications. Persons with a history of egg allergy who have experienced only hives after exposure to egg should receive influenza vaccine. Because relatively few data are available for use of LAIV in this setting, IIV or trivalent recombinant influenza vaccine (RIV3) should be used. RIV3 may be used for persons aged 18 through 49 years who have no other contraindications. However, IIV may also be used, with the following additional safety measures:

- Vaccine should be administered by a health care provider who is familiar with the potential manifestations of egg allergy; and
- Vaccine recipients should be observed for ≥30 minutes for signs of a reaction after administration of each vaccine dose.
- If the reaction is severe (ie, anaphylaxis involving cardiovascular changes, respiratory or gastrointestinal tract symptoms or reactions requiring the use of epinephrine), consultation with an allergist is recommended. Alternatively, RIV3 may be given if the patient is 18–49 years old. A previous severe allergic reaction to influenza vaccine, regardless of the component suspected of being responsible for the reaction, is a contraindication to future receipt of the vaccine. (Fig 2 on next page)

Chemoprophylaxis and treatment of Influenza

Although vaccination is the best method for preventing and reducing the impact of influenza, antiviral medications are a valuable adjunct. Treatment with influenza antiviral medications is recommended as early as possible for patients with confirmed or suspected influenza who have severe, complicated, or progressive illness; who require hospitalization; or who are at high risk for influenza-related complication. The greatest impact on outcome occurs if treatment is initiated within 48 hours of illness onset, but should still be considered if later in the course. Oral oseltamivir remains the antiviral drug of choice for the management of influenza infections for both treatment and prophylaxis. Inhaled zanamivir is an acceptable alternative. The FDA has licensed oseltamivir for children as young as 2 weeks of age; however, it can be used to treat both term and preterm infants from birth if needed. Full prescribing information can be found on http://www.cdc.gov/flu.

Both agents can also be used for chemoprophylaxis for certain high-risk populations, but it should not be considered a substitute for immunization. Oseltamivir prophylaxis can be used for children ≥3 months of age, however zanamivir is only recommended for prophylaxis for children ≥5 years of age. Recommendations for the use of chemoprophylaxis during an influenza outbreak is for:

1. Children at high risk of complications from influenza for whom vaccine is contraindicated
2. High risk children during the 2 weeks after immunization
3. Unimmunized family members or health care workers with ongoing exposure to high risk children
4. Control of influenza outbreaks for unimmunized staff and children in an institutional setting with high-risk children
5. Supplement to immunization for high-risk children
6. Postexposure prophylaxis for family members and close contacts of an infected person if they are at high risk for disease complications
7. High-risk children, their family members and close contacts and health care workers when circulating strains of influenza virus are not well matched with seasonal vaccine strains

Influenza surveillance reports for the United States are posted online weekly and are available at http://www.cdc.gov/flu/weekly. Additional information regarding influenza viruses, influenza surveillance, influenza vaccines and influenza antiviral medications is available at http://www.cdc.gov/flu.
Breastfeeding Support

- Breastfeeding education and instructional videos at gerber.com
- Coaching appointments with a Certified Lactation Consultant at gerber.com/CLC
- GERBER® Soothe Colic Drops for breastfed colicky babies

To learn more visit us online at medical.gerber.com or call 1-800-628-BABY (2229)

Reference


Figure 2. Approach to Children with Egg Allergy

**Necessary steps for administration of influenza vaccine to any child with egg allergy:
- In office observation for 30 minutes
- Appropriate resuscitative equipment available

Guidelines continued
Expiration for ACA Parity Payments Draws Near: Have you received All Your Reimbursements?

**ACa parity payments are set to expire on January 1, 2015:**

Designed to incentivize providers to contract with Medicaid and NJ FamilyCare HMOs, the parity payments required these plans to reimburse eligible codes at Medicare rates for services provided between January 1, 2013 and December 31, 2014. Eligible codes include Evaluation and Management codes 99201-99499 and Vaccine Administration codes 90460, 90471-90474. At least quarterly, plans must produce a statement showing how the parity payment from each claim was determined. The statement is required to include the eligible services, the amount the plan paid or attributed to capitation and the parity payment due to the physician. Several offices reported the statements did not break down the payments to show what specific services were paid. Instead, only one CPT was listed, making reconciliation difficult.

For various reasons, however, including staff availability, the shear enormity of the statement, the extent of time between deposits and receipt of the statement, etc., most offices accepted their parity payments without question. But, as many practices have already learned, each office may want to review the statements to determine if any of the following errors or omissions have affected them.

Eligibility for ACA parity payments

Not all Medicaid/NJ FamilyCare plans were eligible for ACA parity payments. For Plan B members, there were periods of exclusion for specific Plan Status Codes (PSCs). Additionally, only E&M codes 99201 through 99499 and Vaccine Administration codes 90460, 90472 – 90474 were reimbursed. SCHIP members (state sponsored) were ineligible for parity payment.

From January 1, 2013 through September 30, 2013, the following PSCs were excluded:

- PSC 380 (Parents >AFDC < 133% FPL) **Plan A**. Services effective for dates of service after 10/1/2013.
- PSC 461 (Child 6 – 19, 107 – 142% FPL) – This plan code did not exist until 10/1/13. **Plan A** effective on 10/1/2013.
- PSC 462 (Medicaid Special 19 – 21) This plan code did not exist until 10/1/13. **Plan A** effective on 10/1/2013.
- PCS 497 (Plan D Parent 134% - 150% FPL) Was plan “D”, then moved to PSC 380 or Marketplace effective on 10/1/2013.
- PSC 498 (Plan D Parent 150% - 200% FPL) Was plan “D”, then moved to Marketplace effective on 10/1/2013.

January 1, 2013 – December 30, 2013, the following PSC was excluded:

- PSC 762 (Single Adult/Childless Couple 19 – 64 0 – 133% FPL – FM - ABP) **Plan A** in plan services effective on 1/1/2014.

Non payment of 90460.

For some insurance companies the parity payments dispersed Oct 2013 through Dec 2013 did not include payment for the vaccine administration code 90460. Check each parity statement to see if this code was omitted. If it was, carefully review the subsequent statements to see if payment was later captured and paid.

Attestation

For practices with more than one physician, verify you are receiving parity payments for each physician. If not, confirm (A) that the ACA Self Attestation Form was completed by the physician and (B) return to DMAHS, noting the date of receipt. The MCOs are required to confirm the effective date with DMAHS. It may be worthwhile pursuing any discrepancy to recoup any unpaid amounts.

Capitated claims denied as “no pre-cert, maximum allowable, etc.”

With capitated plans, offices expect zero payments for Evaluation and Management codes, and Physical Exams. Overlooking the insurance company’s adjustment rationale is too easy. In order to be eligible for the parity payment, the line must be processed for payment, and not denied. As an example, a well visit is denied as not the member’s PCP of record, because another provider in your practice was the PCP of record. Most practices would not correct such a claim because it’s a capitated service and therefore would not result in any additional payment money. Since this was not corrected within 30 days of processing, it would remain ineligible for parity payment.

Imputed fee schedule

The capitated plans utilize a formula to convert the capitated payments into an amount paid. This is referred to as an “imputed fee schedule”. Review your imputed fee schedule and understand how it was calculated. If you have a special contract, which allows for a higher capitation rate or “flat capitation” rate, verify it was taken into consideration when the calculations were determined.

Bundling the Well Visit

The capitated plan requires a -25 modifier on the Physical Exams and Vaccine Administration to be submitted in total units. Without the -25 on the well visit, it would be denied as bundled to the Vaccine Administration code. Administrations not billed in units may result in some being denied as a duplicate and until corrected these charges would remain ineligible for parity payment.

One fee-for-service plan did not require the -25 modifier or the administration units to be totaled until July 2013.

continued on next page
To help our nation's children move from hungry to healthy, there are new rules concerning foods sold in school. This article was written to make sure that you understand the new rules, in case you are asked by parents during their child’s wellness exam.

On July 1, 2014, the Competitive Foods in Schools: Interim Final Rule went into effect for the 2014-2015 school year. Under the rule, now all foods and beverages sold in school, and at any time during the school day, must meet strict nutritious guidelines. This covers foods sold a la carte in the cafeteria and through vending machines. The new regulation was required of the USDA by the Healthy, Hunger Free Kids Act 2010, to promote healthier and more nutritious smart snacks in schools.

To be allowed, competitive foods in schools must meet all of the Interim Final Rule nutrient standards and:

1. Have as the first ingredient one of the major food groups, which includes dairy; or,
2. Be a grain product with 50% whole grain; or,
3. Be a combination food with a quarter-cup fruit or vegetable; or,
4. Contain 10% of the Daily Value of a nutrient of public health concern – calcium, potassium, vitamin D or dietary fiber.

These nutrient standards set by the USDA, based on the Dietary Guidelines for Americans (DGA), support the importance of dairy’s role in the diet of school-aged children. Milk has high amounts of calcium, potassium and vitamin D for a total of 9 essential nutrients in one 8-ounce glass drink. The DGA recommends 3 cups of low-fat or fat-free milk, or milk products, daily for children aged 9 and older; and, 2.5 servings for school-aged children 8 and younger. This means low-fat and fat-free milk, and fat-free flavored milk, can be offered at all grade levels, with 8-ounce portions for elementary school children and 12-ounce portions for middle and high school students.

Reduced-fat cheeses, including part-skim mozzarella, may be offered in schools as long as they do not have more than 230 milligrams of sodium; and, most yogurt varieties already meet the sugar limit and are also eligible.

For more information about Interim Final Rule, please refer to the following resources:

Litarcy continued

• Advice for parents on the “secret to a smarter baby”

• Recommendation on choosing books for children based on age and topic

• Tips from pediatricians on reading with very young children

As pediatric health care providers, we, in the medical home, can promote early literacy in our practices and communities:

1. Familiarize ourselves with the evidence on the importance of reading, singing, talking and playing with children.

2. Implement a literacy promotion program in our practices. Share anticipatory guidance regarding early literacy and early learning to foster a love of books at each visit. (E.g. Reach Out and Read)

3. Encourage parents and other caregiver to read, talk, sing and play with their young children starting at birth.

4. Promote 5 R’s of early education: Reading together, Rhyming, Routines, Rewards, Relationships

5. Welcome children by entering the exam room with a book in hand. Model sharing books during the visit and use that book as a component of developmental surveillance.

6. Encourage parents to find high-quality early education opportunities for their children such as preschool or Head Start.

Resources:
www.aap.org - Pediatric Professional Resource: What Every Pediatric Professional Can Do To Promote Early Literacy and Early Learning

HOW ONE COW CONTRIBUTES TO A SUSTAINABLE FOOD SYSTEM

NUTRITION & HEALTH BENEFITS
Few foods deliver dairy’s powerhouse of nutrients in such an affordable, delicious and readily available way.

1 cow produces on average 144 servings of milk per day.

That’s enough to provide 48 people with 3 daily servings of low-fat milk.

And this would deliver:
- 90% DV for calcium
- 90% DV for vitamin D
- 30% DV for potassium
- 48% DV for protein

+ additional nutrients essential for health

DV: Daily Value

Milk is ~17c per serving

NUTRIENT MANAGEMENT
Rich in nutrients, cow manure fertilizes the land for growing more crops for people and animals.

1 cow produces 17 gallons of manure per day.

That’s enough fertilizer to grow 56 pounds of corn or 84 pounds of tomatoes.

 Valerie from Reuse
Having four stomachs means cows can recycle food that people can’t eat.

75% of a cows’s diet is not consumable by humans.

By-products from the human food and fiber industries (e.g., citrus pulp and cottonseed) are converted to milk rather than sent to landfills.

Taking it Further
Manure is also becoming a source of additional value. Anaerobic digester systems convert manure and commercial food waste into:

- Electricity
- Fuel for cars and trucks
- Fertilizer and fiber

$200 per cow per year in combined revenues and cost savings

The issues facing children with brain injury are vast and complex; therefore the response and approach to support them needs to be equally comprehensive," stated a study done in 2013. Children in New Jersey are no exception. Data from the New Jersey Department of Health, Center for Health Statistics, for the year ending in 2011, indicated that 1,346 children and youth aged 0-21 were hospitalized with Traumatic Brain Injury (TBI) and an additional 34,880 were seen in emergency departments. Additionally, the Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports.

Children and adolescents with concussion are no doubt in your practice; however, you most likely also see children and adolescents with more severe injury that has resulted in life long disability. Parents and guardians may not be familiar with the programs and services of the Brain Injury Alliance of New Jersey. Pediatricians knowledgeable about how pediatric brain injury affects families are in a perfect position to direct them to the Alliance for information and support.

The Brain Injury Alliance of New Jersey (BIANJ) is a statewide nonprofit organization dedicated to improving quality of life people experience after brain injury. The following resources have been developed through BIANJ to assist pediatricians as well as parents of children who have sustained a brain injury:

- Support services to assist families affected by brain injury, including: a Family Support program that provides care coordination to families, support groups, and a Helpline to assist families and professionals at 1-800-669-4323.
- Return to school materials, including: Brain Injury: A Guide for School Nurses, Concussion in the Classroom, Brain Injury: A Guide for Educators, and additional resources available to download from our website at www.bianj.org or in hard copy by ordering online or calling 732-745-0200
- Free webinars and archived webcasts on topics related to pediatricians, such as: Concussion in Younger Children, Student Transition Re-Entry Program Webinar: Connecting Hospitals and Schools, Brain Injury in Students, and more.
- Free materials and trainings on preventing brain injury in children including those focused on transportation safety and teen driving, sports concussion, helmet safety awareness, and more.
- Coming Soon: A CME approved online course for pediatricians and physicians to learn more about concussion, including identification, treatment, management and the New Jersey Concussion Law & Model Policy.

For more information about any of the Brain Injury Alliance of New Jersey’s free programs and services, or about working with children with brain injury and concussion, contact the Brain Injury Alliance of New Jersey’s Helpline at 1-800-669-4323, 732-745-0200, or visit us online at www.bianj.org.

Reference
Family Voices: Explaining a New Diagnosis to Parents

Pediatricians may have to give families the news that their child has a diagnosis of a disability or special healthcare need. What is said and how it is presented can greatly impact the parents.

*Explaining the difference between screening and diagnosis*

Families may not understand that a screening only tests for the possibility of a condition. Then if warranted, more diagnostic testing is performed for a particular condition. Pediatricians can also share checklists which may help hesitant families decide on testing (see Resources.) Conversely, parents may have concerns that their child isn’t doing what they should be doing by a certain age, or something else is awry. Parents should be encouraged to bring their concerns to their pediatrician as families are often the first to notice developmental delays and/or characteristics of a disability.

*Giving the diagnosis to families*

When a pediatrician has to deliver the news, they should know that families may need both information on the condition and emotional support. Parents need more than just the name of the condition; they need accurate information from reputable sources. There are a variety of sources that have information on a diagnosis that pediatricians can share. These include: (also see Resources)

**American Academy of Pediatrics-information for families**

- [http://www.healthychildren.org/English/health-issues/Pages/default.aspx](http://www.healthychildren.org/English/health-issues/Pages/default.aspx)

**Exceptional Parent Annual Resource Guide**

- [http://digital.turn-page.com/t/99327](http://digital.turn-page.com/t/99327) (click on “free preview” then “archived”)

**Maternal & Child Health Bureau “Knowledge Paths”**

- [www.mchlibrary.info/families/index.html](http://www.mchlibrary.info/families/index.html)

**Parent Center Hub**

- [http://www.parentcenterhub.org/repository/specific-disabilities/](http://www.parentcenterhub.org/repository/specific-disabilities/)
- [http://www.parentcenterhub.org/repository/aprendizaje/Spanish](http://www.parentcenterhub.org/repository/aprendizaje/Spanish)

**Rare Disorder/Genetics**

Understanding how genetics affects their child’s condition may help parents feel as if the symptoms finally “have a name.” Other times, the child’s condition is so rare that information is not readily available from the usual sources. Good genetic information for families can be found at:

**Genes in Life** (basics of what genetics means for families)


“Children and Youth with Special Healthcare Needs in Healthy People 2020: A Consumer Perspective”

- [http://www.geneticalliance.org/publications/healthy-people](http://www.geneticalliance.org/publications/healthy-people)

Information on rare disorders is available at:

- **National Organization for Rare Disorders** - [http://www.rarediseases.org/rare-disease-information/rare-diseases](http://www.rarediseases.org/rare-disease-information/rare-diseases)
- **Genetic Alliance Disease Info Search** - [http://diseaseinfosearch.org/](http://diseaseinfosearch.org/)

Many times, not knowing is worse for families. If parents are informed by their child’s pediatrician about the condition, and connected to reputable information, resources, and emotional support, they won’t feel so helpless or hopeless.

**Support for Families**

Sometimes the best help for parents is talking with another family who has been in the same situation. There are one-to-one matching groups, online groups, and support groups. NJ Parent-to-Parent matches trained volunteer parents to families of children with the same condition at [http://www.spanadvocacy.org/content/nj-statewide-parent-parent](http://www.spanadvocacy.org/content/nj-statewide-parent-parent) (for Spanish click on “translate”) Friends Health Connection also matches individuals with the same condition, or their caregivers at [http://friendshealthconnection.org](http://friendshealthconnection.org) and they offer free webinars with national health care experts. The NJ Self Help Clearinghouse has information on all support groups statewide at [http://www.njgroups.org/](http://www.njgroups.org/) or Spanish [http://www.mededfund.org/NJgroups/Cultural-Language.pdf](http://www.mededfund.org/NJgroups/Cultural-Language.pdf).

**Helping Children with Special Needs Understand their Condition**

When children start asking questions, they may just want to know what their condition or disability is called before they start understanding what it means. Children need to understand that they are not “better or worse” but different. Pediatricians and families can explain that a diagnosis should not define the child or limit their hopes and dreams. Resources on explaining the diagnosis to the child are available from Kids Health at [http://kidshealth.org/parent/medical/](http://kidshealth.org/parent/medical/) or Spanish at [http://kidshealth.org/parent/en_espanol/index.html](http://kidshealth.org/parent/en_espanol/index.html). Physical or visible disabilities seem to be easier to explain and to understand for children and even adults. For older children, there is a publication called Accepting My Disability at [http://www.going-to-college.org/myplace/disability.html](http://www.going-to-college.org/myplace/disability.html). SPAN’s Youth Resources for Empowerment webpage, [http://www.spanadvocacy.org/content/youth-resources-empowerment](http://www.spanadvocacy.org/content/youth-resources-empowerment), has wonderful resources and tools for youth and young adults with disabilities.

continued on next page
Explaining a New Diagnosis continued

Where to Refer Families for Community Services

For children from age birth to 3, the Early Intervention system can do an evaluation to determine eligibility. The NJ Early Intervention System (NJEIS) information can be found at http://www.state.nj.us/health/fhs/eis/index.shtml. There are also “Regional Early Intervention Collaboratives” which are nonprofits that “plan and coordinate the state’s early intervention system at the regional/community level” and can be found at http://www.njeis.org/. The Parent Center Hub has a good overview of early intervention at http://www.parentcenterhub.org/?s=early+intervention or Spanish http://www.parentcenterhub.org/?s=intervencion+temprana.

NJ is fortunate to now have a Department of Children and Families. For information on developmental disabilities and/or mental health for children, see http://www.state.nj.us/def/families/csc/. The Division of Disability Services publishes “NJ Resources” at http://www.state.nj.us/humanservices/dss/documents/RD%2013_SpanishES.PDF. The Family Support Center (FSC) publishes a similar guide, the “Options Manual” at http://njcaregivers.org/wp-content/uploads/2013/08/Options2010.pdf or Spanish http://www.fscnj.org/wp-content/uploads/sites/4/2013/10/Options-Manual_Spanish.pdf. The FSC also has a searchable database of services like transportation, etc. at http://www4.irissoft.com/IFTWSQL4prod/show/home_show.aspx. Families of individuals with disabilities need to recognize that they have an extra role as caregiver. The Caregiver Action Network has a Family Caregiver Toolbox found at http://caregiveraction.org/resources/toolbox/. There is information on communicating with health professionals, how technology assists with caregiving, financial planning etc. (Also see Resources for helpful contacts for families.)

Pediatricians can help facilitate information dissemination and provide support for parents. If families know ahead of time what to expect, they can take better care of their child, resulting in better health outcomes and happier, more productive, and more independent lives.

Additional Resources for Parents and Professionals:

Screening
“What to Expect & When to Seek Help” - Bright Futures
http://www.brightfutures.org/tools/

Act Early - Centers for Disease Control

AAP recommendations on developmental screening

First Signs – family guidance on discussing concerns with doctors
http://www.firstsigns.org/concerns/if.htm

Diagnosis/Specific Conditions

Health Central www.healthcentral.com

WebMD http://www.webmd.com/

Health Finder: U.S. Department of Health & Human Services
http://www.healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases or http://www.healthfinder.gov/espanol/Spanish (click on “Recursos de salud”)


Medline Plus www.nlm.nih.gov/medlineplus/healthtopics.html or

Developmental Disabilities – Medline Plus

Disabilities - Medline Plus

Family Support Contacts
Caregiver Action Network (202)772-5050

Division of Disability Services (888)285-3036

Family Support Center (800) FSC-NJ10

Friends Health Connection (800)48-FRIEND

NJ Parent-to-Parent 800-654-SPAN X 121

NJ Self-Help Clearinghouse (800) FOR-MASH

Lauren Agoratus M.A. Counseling is the parent of a youth with multiple disabilities and is the NJ Coordinator of Family Voices, the national network that “works to keep families at the center of children’s health care.” She also serves as the Central/Southern Coordinator for the NJ Family-to-Family Health Information Center (F2FHIC). In NJ, Family Voices and F2FHIC are housed at the Statewide Parent Advocacy Network (SPAN), www.spanadvocacy.org.
The CATCH Program is a national program of the American Academy of Pediatrics that increases children’s access to medical homes or specific health services supporting pediatricians and communities who are involved in community-based efforts for children. The CATCH program offers a variety of funding opportunities for pediatricians. Applicants will receive notice of funding decisions November 15, 2014, or sooner.

The next Call for Proposals opens November 3, 2014; submissions will be due January 30, 2015.

ASSISTANCE IS AVAILABLE

A network of pediatricians and pediatric residents is available to help you with everything from proposal development to project implementation. Submit your ideas to your Chapter Facilitators and Resident Liaisons.

PLANNING AND IMPLEMENTATION GRANTS

Up to $10,000 will be awarded on a competitive basis to individual pediatricians and fellowship trainees to plan innovative community-based child health initiatives that will ensure all children have medical homes and access to health care services not otherwise available in their community. Priority is given to projects that will be serving communities with the greatest health disparities.

All pediatricians are eligible to apply regardless of employment setting or retirement status.

All initiatives should incorporate screening for or connecting children to medical homes and available insurance programs.

RESIDENT GRANTS

Up to $2,000 will be awarded on a competitive basis for pediatric residents to plan and/or implement community-based child health initiatives. Projects must include planning activities or demonstrate completed planning activities, and may include implementation activities.

Eligibility requirement - postgraduate status as of July 31, 2014:

- PL-1 or PL-2
- PL-3 or below in medicine-pediatrics residency
- PL-3 if planning a chief resident year in 4th year
- PL-4 or below in triple-board residency
- PL-3 residents may apply as co-applicants

International Grant Opportunities are available through the I-CATCH Program

If you have any questions, please contact your NJ Chapter CATCH facilitators:

Dr. Paul Schwartzberg pschwartzberg@meridianhealth.com
Dr. Naveen Mehrotra nmehrotra67@gmail.com

The Reach Out and Read family congratulates Dr. Nwando Anyaoku on being named the New Jersey Chapter, American Academy of Pediatrics’ Pediatrician of the Year. We have seen firsthand her exceptional care and availability to her patients, her strength in advocating for the most vulnerable children, and her passion for addressing community child health needs.

Pediatricians take care of the whole child – one’s physical, social, cognitive, and emotional health. Dr. Anyaoku plays a key role in the development of her young patients. To this end, she is an exemplary provider of Reach Out and Read, which has been a program at Children’s Hospital of New Jersey Pediatric Health Clinic since 1996.

The national Reach Out and Read program works through pediatricians like Dr. Anyaoku to promote sharing books with children from their earliest months to stimulate a love of reading, enhance parent-child relationships, and prepare children for success in school. The simple, yet powerful, model accomplishes this through early literacy assessment and promotion.

At every well visit, starting in infancy and continuing through age 5, pediatricians give a brand-new, developmentally, culturally, and language-appropriate book to the child. The pediatrician then discusses early literacy practices with the parents and encourages daily shared reading in the home.

When we delve into young children’s struggles with learning, we often discover that their achievement gap stems from environmental influences in their lives. The impact of these negative environmental influences is greatest in the first 1,000 days of life. Research has shown that children in poverty hear 30 million fewer words than their more financially advantaged peers by age 4. This staggering gap means children are less ready when they enter kindergarten, leading to poor learning in grade school.

Working with Reach Out and Read, the American Academy of Pediatrics earlier this year released a landmark policy statement calling on pediatricians to promote reading aloud to children every day, starting in infancy. The recommendation is a critical step in closing the word gap and making books available to all families, especially those living in poverty.

Promoting children’s literacy requires work and commitment by the health care community, education, government, and industry, but the solution is not all that complicated. It’s as simple as helping parents open a book and share it with their child – just ask New Jersey’s Pediatrician of the Year!
Each year, referrals to child protective services agencies increase, and most of these referrals are made after an act of abuse or neglect has taken place. Strengthening Pediatric Partners quality analysis and improvement project sponsored by the NJAAP, aims to prevent these acts of abuse and neglect before they occur. Pediatricians learn how to integrate targeted screening for at-risk families into their clinical practice and to make prompt referrals for preventive services. Residents and faculty in the Department of Pediatrics at Rutgers New Jersey Medical School participated in the project this past year. Not only was it a way for several providers to obtain Part IV MOC credit, but it also allowed us to examine and improve our clinical practice in real and meaningful ways. And we saw real results.

Several mothers at risk for post-partum depression were helped by new ties we established with Family Success Centers in our community. Another mother who was overwhelmed by her toddler found relief when we were able to help re-involve the father in the child’s care. And our residents saw first-hand how thoughtful and systematic participation in the QI process can improve clinical practice.

We were able to successfully implement the project in both the primary care practice and in the emergency department. Utilizing prompts in the electronic medical record we were able to streamline the screening process and assure that a large number of providers could participate effectively in the process. Because of the benefits we saw, we plan to extend the project to the entire primary care practice and to the in-patient service so that our patients will receive comprehensive screening for child abuse and neglect in a sustainable and systematic way. The techniques we learned from this QI project will continue beyond MOC and help us to refine and improve the care we provide in this and other clinical areas.

Katharine Hodock, MD
Pediatric Resident, PGY-3
Rutgers New Jersey Medical School
Newark, NJ

Joseph Schwab, MD, MPH, FAAP
Associate Professor of Pediatrics
Rutgers New Jersey Medical School
Newark, NJ

The Sentinel Project

The Affordable Care Act expanded access to individual and small group health insurance that includes the promise of access to a broad range of health care services. Health plans are required to provide meaningful access to primary and specialty care, behavioral health services, and other needed treatment.

Because New Jersey lacks both a state health insurance exchange and a federally-funded state consumer assistance program, consumers may not know where to turn if their plans deny them coverage of the essential health benefits to which they are entitled by law. The Sentinel Project, run by Seton Hall Law School and the New Jersey Public Interest Law Center, is dedicated to assuring that consumers gain access to the services required by the new law.

The Sentinel Project will collect information from individual consumers, advocates, community groups, health care providers, health insurance plans, and state and federal government regulators, to assess the plans’ compliance. As part of the Project, attorneys and law students will provide advice and assistance to consumers denied access to care that is covered but unavailable – due to outright denial of an insurance claim or because an inadequate network of providers results in them having to wait for long periods or travel long distances for health care.

The Project will use the information it gathers to create a feedback loop between consumers’ experiences on the ground and those interested in ensuring access, including health insurance plans, government regulators, and the public. Its goal is to assist in the implementation of the new law by providing information and analysis on the behavior of individual and small group health plans in connecting their members to essential health benefits in a timely, convenient, and culturally-appropriate way.

Individual consumers, advocates, and community groups can contact the Sentinel Project by leaving a message on its hot line, 973-991-1190, or sending an email to contact@njsentinelproject.org. The website can be accessed at www.njsentinelproject.org. The Sentinel Project is supported by the Robert Wood Johnson Foundation.