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New Jersey Pediatrics is the Official Journal of the New Jersey Chapter, American Academy of Pediatrics

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President's Column

Jeffrey Bienstock, MD, FAAP
President, NJAAP

Accomplishments Through Engagement

Welcome to the Winter edition of New Jersey Pediatrics, covering the 2017–2018 Holiday Season. It is during this time of year that I reflect on the things that I am thankful for having received as well as the goodwill support that I have shared with others.

The year began with our Chapter having received the Outstanding Very Large Chapter Award at the Annual Leadership Forum of the American Academy of Pediatrics. We have been able to increase awareness of human trafficking, and entered the “100 & Change” MacArthur Foundation competition for a $100 million grant to fund a single proposal that promises real and measurable progress in solving a critical problem of our time. While we did not win, the chapter was able to forge relationships with many other partners, including the Emmy-winning actress Julia Ormond, who addressed our chapter during the Annual Children’s Ball through this video: https://www.youtube.com/watch?v=yKlbTolvKVc&feature=youtube.

We were able to expand the Pediatric Psychiatry Collaborative (PPC) into 20 counties throughout the state. The program is available for providers caring for children up to age 18 and requires the child’s primary care provider (PCP) to universally provide standardized mental/behavioral health screenings, including that of substance use, at each child’s well visit. PCPs refer patients to their regional Hub for access to child mental/behavioral health services. To learn more about and join this innovative collaborative that can provide you with quick access to psychiatric consultation and referrals to mental/behavioral healthcare services for your patients, reach out through our registration page: http://njaap.org/ ppc-mental-health-moc-program-registration/

We had a very successful Annual Conference & Exhibition: Restock Your Pediatric Toolbox in May with some amazing speakers.

School nurses are part of a child’s primary care health team and engaging the New Jersey State School Nurses Association (NJSSNA) was a Chapter priority as we promote and support each other’s mission. Linking schools to medical homes can enhance comprehensive care, promote prevention, wellness and chronic care management. This linkage came together at our Annual School Health Conference in October. We will now look to partner with the NJSSNA leadership and to develop agreed upon terms for a Memorandum of Understanding between the two organizations.

We continue to provide opportunities for MOC Part 2 & 4 activities. These include Good 4 Growth (early childhood development), Food Insecurity (simple 2-question screen and resource provision), and Mental Health (early identification through mental/behavioral/developmental health screening, substance use screening, and linking families to resources). We also offer Child Abuse and Neglect (CAN) prevention (anticipatory guidance and looking at triggers: e.g. toileting, crying, post-partum depression), HPV (increasing rates of HPV immunizations), and Lupus (early identification in minority populations and linkage to services and resources).

The theme of my presidency has been engagement. An extensive program to recruit and retain members is in place: membership value, payment reminders (electronically and mail), engaging and keeping our board members informed about lapsing memberships, sending welcome packets to new members, and recruiting at our events. We recruited 30 new members at the NJAAP Annual Conference and Exhibition. We engaged a second malpractice insurance carrier to our Purchasing Alliance, APEX for legal assistance and discounts on chart review assistance.

In mid-November, we reached a record high membership of 1,761. A pilot initiative is in progress to provide post-residents with a free membership, mentoring, and encouragement to become members after a year; we will know results in 2018. We continue to reach out to our membership on all levels: medical students, residents, early career physicians, academicians, seniors, subspecialists, underrepresented and minority physicians, international medical graduates, pediatric nurse practitioners and pediatric physicians’ assistants.

So if I could ask all of you for one holiday gift, it would be: Please get involved and stay involved.

HAPPY HOLIDAYS TO ALL OF YOU AND TO THE FAMILIES AND PATIENTS WE CARE FOR.
CEO's Column

Fran Gallagher, MEd
Chief Executive Office
NJAAP

Our AAP Outstanding Chapter Award inspired the continuation of an exceptional 2017 with unprecedented growth, including earning the trust of 100+ new members, and several new organizational partnerships. Member value benefits were enhanced: Positive Physicians and Medical Mutual are two A+ malpractice insurance companies offering deep discounts to our membership. In addition, affordable legal support and discounts on patient chart reviews by coding experts became available this year. Thanks to Bert Mulder, Director, Marketing and Business Development, leadership and staff were fully engaged in growing membership. Pediatricians in other states who value what NJ Chapter has to offer have also joined our Chapter. Thank you to all members and welcome to our newest additions!

This year, NJAAP launched 3 new Chapter Committees: Adolescent Committee chaired by Susan Brill, MD, FAAP, staffed by Bert Mulder and Harriet Lazarus, MBA, Climate Change Committee chaired by Polly Thomas, MD, FAAP, staffed by Bethany Kondavaty, MPH; and Immigration Committee co-chaired by Steven Kairys, MD, MPH, FAAP and Shilpa Pai, MD, MPH, FAAP, staffed by Lauren Kullmann. This year NJAAP also launched our Practice Managers Alliance, a sub-group of the Practice Management Committee co-chaired by Andrea Katz, MD, FAAP and Naveen Mehota, MD, FAAP and staffed by Cortney Mott, MEd. Members interested in participating should contact the Chairperson and/or staff. For a complete listing of our Committees, please check out the Annual Report on the Members site at www.NJAAP.org.

With the addition of several new CME and MOC (Parts 2 and 4) offerings, membership engagement in advocacy efforts and in NJ Pediatric Council on Research & Education (PCORE) quality improvement programs also reached a record high. Programs reached over 4,000 pediatricians and other health care specialists and providers. Leadership, membership, partners, and a dynamic team of staff and consultants are dedicated to efforts to ensure our mission of optimal health for children and support and skill building for the adults in their lives.

Congratulations to Connie Lin, winning artist of the New Jersey Pediatrics cover for this winter issue—beautifully done! Our Editorial Board Chaired by Puthenmadam Radhakrishnan, MD, FAAP and coeditors Michael Weinstein and Marcela Betzer, MPH will soon be submitting an application for New Jersey Pediatrics to be considered a Peer Reviewed Journal. Several years of featuring quality clinical and resource articles and CME opportunities has made this possible.

In his President’s Column, Jeff Bienstock, MD, FAAP features some of the work we’ve accomplished together. To see more details visit www.NJAAP.org and click on Member Login in the top right corner. In our Medical Director’s column, Steven Kairys, MD, MPH, FAAP, highlights a call to action to protect children living close to the poverty level. Much work is ahead and together, we have to make a difference and be a unified, strong voice for the most vulnerable children in NJ, the pediatricians who are caring for them, and the many partners working collaboratively on behalf of children and their families.

A sincere thank you to our NJAAP Executive Councilors, all of the engaged pediatricians and to our dynamic NJAAP staff for making 2017 a year of advances and preparation to face the work that lies ahead. Wishing all of you and your families a very Happy and Healthy Holiday Season!

Warm Regards,

Fran Gallagher

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Once again, health care for children living close to the poverty level is in jeopardy.

It is not as if we are doing so well with child health and safety statistics that we can afford to let millions of children have their health coverage lapse. The Child Health and Safety Index is an international statistic that measures all of the wealthy, developed countries on three scores: health at age one (a measure of infant mortality and low birth weight), preventive services (immunizations), and safety (death, accident and injury). An average score is 100; the best country is Sweden at 120. The worst country is the United States at 58.

Twenty years ago, Congress, in bipartisan fashion, agreed that Medicaid coverage left too many of the near poor without health insurance and therefore authorized the Child Health Insurance Program (CHIP). This program was enacted in order to cover the additional millions of children living close to poverty.

The definition of poverty in America is a family of four making less than $24,600 a year. That equates to one or more adults together making about 11 dollars an hour. Medicaid coverage covers up to 120% of poverty, or a little more than 13 dollars an hour. The CHIP program allows each state to determine the level of income; the average is 138% of poverty or about 15 dollars an hour. A few states, such as New Jersey, cover three times the poverty level - an additional 230,000 children. Nationally, even at only 138% of poverty, the added coverage provides health care for over 4 million children.

My greatest fear is that our country is numbed by the daily ‘breaking news’ and the rancor and the daily cruelties. There is so much news and so much distortion of the news that you have to channel it out in order to get to the next day. When polls and expert opinions hold no traction, then there seems little hope for the little guy—poor children.

We need to learn new tools if pediatricians are to be effective again as advocates in this current environment. Facts and data will not work, but human stories will. Stories of real people going about their lives, living in quiet desperation. Change always begins with changes of attitude, not a change of knowledge. Change demands a readiness, an ability to change, and that involves a different dialogue, a dialogue that engages and is inclusive.

Steven Kairys, MD, MPH, FAAP
Medical Director, NJAAP

The Children’s Health Insurance Program (CHIP): Who is Eligible?

Children 18 and under are eligible with higher incomes up to 355% FPL ($7,278/month for a family of four). Parents still need to renew the coverage each year. Children age 18 and under who are lawfully admitted can be eligible even if they have lived in this country fewer than five years.

Parents/Caretaker Relatives with income up to 138% FPL ($2,829/month for a family of four) must have tax dependent children in their household in order to be eligible under this category. The dependent children in the household must be insured also. Immigrant adults must have Legal Permanent Resident status in the US for at least five years in order to be eligible for NJ FamilyCare.

Adults without dependent children with ages 19-64 and income up to 138% FPL ($1,387/month for a single person and $1,868/month for a couple). Immigrant adults must have Legal Permanent Resident status in the US for at least five years in order to be eligible for NJ FamilyCare.

Pregnant Women up to 205% FPL ($4,203/month for a family of four). Pregnant women who are lawfully admitted can be eligible even if they have lived in this country fewer than five years.
Oral Health Social Norms

CME Activity

David M. Krol, MD, MPH, FAAP
Medical Director, New Jersey Healthy Kids Initiative
New Jersey Institute for Food, Nutrition, and Health, Rutgers

Oral health is an integral part of overall health and as medical providers we recognize poor oral health can profoundly affect an infant or child’s health and well-being. Pediatricians have an important role to play in maintaining children's oral health and preventing dental caries. Pediatrician’s, however, cannot address a child’s every health need. Thus, interprofessional collaboration, and in the case of oral health medical-dental collaboration, is an important strategy to provide safe, timely, efficient, effective, and equitable oral health care for children. This article will describe the important components that make up a successful medical-dental collaboration.

The Challenge

Dental caries (tooth decay) is a multifactorial, diet-dependent, fluoride mediated, transmissible infectious disease. It is the most common chronic disease of childhood.1 Approximately 23% of U.S. children aged 2–5 years, 21% aged 6–11 years, and 58% aged 12–18 year experienced caries in 2011-2012.2 Dental caries occurs when cariogenic bacteria in the dental biofilm (plaque) metabolize fermentable carbohydrates and produce organic acids. These acids dissolve the mineral structure of the tooth enamel and can lead ultimately to cavitation in the tooth enamel. Children 5 to 19 years of age from poor and racial or ethnic minority families, have higher rates of untreated dental caries than do their peers from nonpoor and nonminority families.3 In primary teeth, dental caries was significantly higher for both non-Hispanic black (21%) and Hispanic (19%) children compared with non-Hispanic white children aged 2–8 (10%).4 In permanent teeth, caries prevalence was higher among Hispanic children aged 6–11 (27%) compared with non-Hispanic white children (19%) or non-Hispanic Asian children (18%).

The Opportunity

Dental caries is a preventable disease and, therein, lies an important opportunity for medical-dental collaboration. The American Academy of Pediatrics, the American Academy of Pediatric Dentistry, the American Dental Association, and the American Association of Public Health Dentistry all recommend a dental visit for children by 1 year of age. In addition to the opportunity for pediatricians to include oral health in the medical home, it is also important that children establish a dental home. A dental home is the ongoing relationship between the patient and the dentist, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.4 It is the connection, and ultimately the collaboration between the medical and dental home where optimal oral health is found.

Rather than trying to provide specific examples of practices implementing successful dental-medical collaboration, I will instead focus on the key characteristics of such collaborations. This is not to say that excellent examples of medical-dental collaboration don’t already exist all around the country, rather, some aspects of excellent collaborations are based on models that depend on state-specific practice acts or demonstrations that have yet to prove sustainability. What follows, then, is a summary of what experience and evidence have shown to be the essential fundamental elements for forging and sustaining a successful collaboration between medical and dental professionals.

Recognition and Relationship Building

Best practices for developing a comprehensive medical-dental collaboration begins with recognition and relationship building, each of which are sustained through effective repeated communications.

Recognition

In a strong medical-dental collaboration, recognition exists on multiple levels and consists of shared principles and beliefs. The first of which, is the recognition that oral health is an integral part of every patient’s overall health. As an example, there is increasing evidence of a close association between oral diseases—especially periodontal disease - and systemic diseases, such as heart disease, diabetes and stroke.5,6 Also, it is important to recognize that obesity and dental caries share a key common risk factor, the volume and frequency of intake of sugar-sweetened food and drink. These are but two such associations that underscores the close relationship between a patient’s oral health and their overall wellbeing.

Relationship Building

Ensuring a patient’s overall health is also a critically important shared principle of a successful medical-dental relationship. Pediatricians, alone, cannot address every health need of a child. Comprehensive care in the context of a medical home requires a team of professionals working together to coordinate a patient’s care.5,10 When medical and dental professionals recognize this shared responsibility, each professional benefits.

Dental providers recognize that medical providers can help them keep their patients healthy through anticipatory guidance, prevention education and timely referrals. They also recognize the value of having a medical partner available to them when systemic diseases, some of which have an oral manifestation, arise in patients. Medical providers, in turn, recognize the benefit of dentists asking about the most recent medical visit, immunization status—especially flu and HPV.

continued on next page
In addition, in the case of adolescents, who may be less likely to see their pediatrician regularly, dental providers can emphasize the importance of staying connected to their pediatrician. Finally, and most importantly, there is greater potential for pediatricians to better manage systemic disease and improve health outcomes when their patient’s oral health is well managed by a collaborating dental provider.

Failure by either provider to recognize the importance of this shared responsibility can manifest itself in myriad ways including when a pediatrician fails to address the correlation between early and frequent juice intake, sugar-sweetened beverages and poor nutrition and childhood obesity. Conversely, the shared responsibility can also fail when the dental professional doesn’t adequately address proper nutrition and limited intake of sugar-sweetened beverages, emphasizing the negative impact each has on maintaining a healthy weight. More immediate impacts of the failed recognition of a shared responsibility include not sharing or failure to review the medication list, which can lead to potential adverse events or impacts on salivary flow and also the failure to share or review a complete medical history prior to taking a child to the operating room for a dental procedure.

Family-Centered Care

Another important principle of a strong medical-dental collaboration is the shared recognition of the family as the center of focus. Both the medical home and the dental home hold as a core tenet the provision of family-centered care. Such care can improve health outcomes, enhance the patient’s and family’s experience, increase patient and provider satisfaction, build on child and family strengths, decrease health care costs, and lead to more effective use of health care resources.

An equally important shared principle contributing to a strong medical-dental collaboration is a commitment to education and lifelong learning. This commitment includes not only the education of patients and families, but also personal education and other health care professionals. The education of other health care professionals includes the teaching of important emerging patient and family care topics. For instance, dental providers can play an important role in educating pediatricians about the prevention of dental caries and dental trauma. In addition, a strong medical-dental collaboration requires educating each other about who we are, how we work, and the depth of our expertise, information that can better prepare each professional to glean the information necessary to clearly communicate with the other.

Communication is the core of relationship building. Interprofessional communication, for some, can be new, may require some testing, and may have stops and starts before it is as comfortable as communicating within one’s profession.

Regarding medical-dental collaboration, communication can begin with simply reaching out. That may take the form of a phone call or a visit to the office of a local dentist, a presentation by a dental professional at the local pediatrician’s office, an informal connection at a community event, or a more formal gathering of professionals hosted by the local or state chapters of respective professional organizations. However these relationships begin, there are several options available for developing the collaborative communication process between medical and dental offices. This may take the form of referral agreements that spell out who should be referred and when, how the referral should be made (phone, fax, email, by patient or professional), and what information should be communicated. This final piece might take the form an agreed upon referral form that includes only the pertinent information most useful to the referred to professional.

**BEHAVIORS and ACTIONS**

As noted above, there are a set of principles that set apart successful from unsuccessful medical-dental collaborations. These principles allow for the foundation of a relationship to be built and sustained. In addition to shared principles, there also exist important behaviors displayed and actions taken that, in the most successful medical-dental collaborations, are shown by each professional.

**Dental Providers**

*Participation*

For the dental professional, participation is an important action to be taken. Participation, in this case, means participation in referral networks and remaining open to accepting referrals for patients of mixed insurance status. This can sometimes be very challenging for both dental and pediatric medical professionals when payment for services by some payers is low. In such cases, finding ways to accommodate patients covered by such payers is important and something that can at times be facilitated through good interprofessional relationships.

*Communication*

An extension of the importance of communication between professions is the provision by the dental provider of timely and complete information back to referring primary care providers. Communication should always be a bidirectional exercise. Thus, a referral from the pediatrician to the dentist should not be considered “complete” until the referring pediatrician receives information from the dentist for inclusion in the patient’s medical record. This is something that should be expected by the pediatrician from every health care professional to whom a child is referred.

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Advocacy

Advocacy is another important component of a well-functioning medical-dental collaboration. Both the dentist and the pediatrician should become champions for pediatric/dental-referral networks. As relationships advance, there will be opportunities to convey the benefits, challenges and solutions to others who might not yet be convinced of the value of such relationships. This willingness to share and advocate for similar relationships between colleagues will have an important impact on access to care in communities.

Resetting Social Norms

Finally, an integral step to establishing a sustainable collaboration is best described as norm-setting. This is the opportunity for dentists and pediatricians to reset social norms regarding oral health. Examples of such resets include accentuating that dental caries is a preventable disease and that losing teeth is not a normal part of aging. This conveys to patients and families the critical role self-care prevention strategies play in helping them manage their own oral health. For dental providers, it is the opportunity to orient patients to the idea that oral health can and should be included in routine medical care. It is an opportunity for dentists to ask their patients, “What did your primary care provider say the last time she checked your mouth?” Questions such as these help reinforce the importance of oral health in overall health.

Medical Providers

For medical providers, the key behaviors and actions are best summarized by the Oral Health Delivery Framework as Ask, Look, Decide, Act, and Document/Follow Up.11

ASK about symptoms that suggest oral disease and factors that place patients at increased risk for oral disease

A few simple questions can be asked to elicit symptoms of oral dryness, pain or bleeding in the mouth, oral hygiene and dietary habits, and length of time since the patient last saw a dentist. These questions can be asked verbally or included in a written health risk assessment. For instance: How many times a day does your child brush with fluoridated toothpaste?” and “How often does your child snack/drink sugared beverages between meals?”

LOOK for signs that indicate oral health risk or active oral disease

- Assess the adequacy of salivary flow
- Look for signs of poor oral hygiene, white spots or cavities, gum recession or periodontal inflammation
- Conduct examination of the oral mucosa and tongue for signs of disease

DECIDE on the most appropriate course of action

- Review information gathered and share results with patients and families
- Determine a course of action using standardized criteria based on the answers to the screening and risk assessment questions
- Review findings of the oral exam; and the values, preferences, and goals of the patient and family

ACT by delivering preventive interventions and/or placing an order for a referral to a dentist or medical specialist

- Preventive interventions delivered in the primary care setting may include:
  ✓ changes in the medication list to protect the saliva, teeth, and gums
  ✓ fluoride therapy
  ✓ dietary counseling to protect the teeth and gums, and to promote glycemic control for patients with diabetes
  ✓ oral hygiene training
  ✓ therapy for tobacco, alcohol, or drug addiction

DOCUMENT the findings as structured data to organize information for decision support, measure care processes, and monitor clinical outcomes so that quality of care can be managed

- Follow Up.
  ✓ If a relationship has already been built, know who to contact, how to contact, what information to provide, etc.

Conclusion

Interprofessional practice is a collaborative practice, which occurs when healthcare providers work with people from within their own profession, with people outside their profession and with patients and their families. In a successful medical-dental collaboration for children's oral health, pediatricians and dentists work collaboratively towards common goals to help children meet their highest potential for oral health. Success requires a shared recognition of the role that oral health plays in overall health and the role that each professional plays in maintaining a child’s oral health. It also requires that a strong mutual relationship be initiated and sustained by behaviors and actions that maximize success.

When healthcare providers work collaboratively, they seek common goals and are able to analyze and address any problems that arise. They make better use of their skills and knowledge and they are able to more effectively coordinate care according to patients’ needs. As a result, patients should receive higher quality care.
References


CME Quiz on page 11

Get Involved and Make a Difference!

Exasperated by all the political bickering? Fed up with just being another “provider” to your patients? Do you feel lately that your world is spinning out of control and you don’t know where to turn? Try turning to the NJAAP and consider becoming a leader in the Chapter that was awarded the American Academy of Pediatrics’ “Outstanding Very Large Chapter of the Year” recognition in 2017.

As a NJAAP Chapter Leader, you can help shape the future of practicing Pediatrics in NJ and even nationally. You will have a chance advocate for the causes you believe in, especially those that affect the health and wellbeing of children, as well as the profession you hold so dearly. In addition, you will have a chance to be a part of ongoing chapter efforts in Pediatric Continuing Education, Patient/Parent education, Patient Centered Medical Home, Mental Health Collaboration, Child Abuse and Neglect and many others.

As a NJAAP Leader, you—or a colleague you would like to nominate for a leadership position—will get to work with a topnotch, dynamic staff and a diverse groups of colleagues that are dedicated and exemplary role models.

To view the leadership role positions open or to cast a nomination that span Officers of the Executive Committee to Councilors and the Nominating Committee, please visit https://www.surveymonkey.com/r/Nominate2018EC. Alternatively, you can submit nominations to Nominating Committee Chair, Elliot Rubin, MD, FAAP at ehrubin@aap.net, NJAAP CEO Fran Gallagher at fgallagher@njaap.org or Director of Membership, Bert Mulder at BMulder@njaap.org
As I reflect on my trajectory from a young child from a poor family to President of the American Academy of Pediatrics, I recognized that my preschool experience had been significant. In 1965 I was five years old and living outside of Akron, Ohio, the oldest of four children. My family was eligible for a new program called Head Start, and I was the first of my siblings to attend. Head Start was a summer preschool program designed to get disadvantaged kids ready for kindergarten. I was an early reader, and my teacher noticed this and told me, “You are so smart! You could be a doctor when you grow up!” From that day on, I decided that I was going to be a doctor. And when I went through medical school, it was just natural that I would return to care for children—perhaps as a nod to a program that changed my life trajectory.

I started in pediatric practice in Richmond, Virginia as a parent of young children. In 1989, my kids were 3, 1, and not yet born! My part-time work was somewhat disparagingly referred to as the “Mommy track”. However, my development as a community pediatrician advanced in a profound way during this time. I learned about the illnesses and conditions of the children I saw in the office and correlated the information to the environment in which they lived. I recognized that kids spend minimal time in the pediatric office, and that their health was directly related to the community in which they lived. Their child care, preschool, housing, food, recreation, and family were the bedrock of their health, and often, the root cause of illness.

During this time, I learned that my role as a pediatrician was powerful. I could be the lynchpin in tying together strategies that helped improve the community in which all our children grow and develop. My involvement with church nurseries, library programs, childcare facilities, preschools and school health programs could make the difference in the lives of the children living in those settings. Pediatricians need to be involved in the community to help ensure that the children they care for have the best opportunity to develop healthy habits and ultimately for succeeding in life.

As a pediatrician, I know that a high-quality early childhood preschool experience is essential for the optimal development of young children. The Abecedarian Study, where poor children were randomized to a preschool experience of high quality early childhood education and nutrition, is still demonstrating superior health outcomes for these children 40 years later. The children who benefitted from preschool in the 1970’s have lower cholesterol, better cardiovascular health, and lower blood pressure than the children who were not in preschool.

Preschool is a common sense, cost effective way to invest in a generation of children who could have educational success, financial success, and better health outcomes. It’s time to put years of research into action, and make the commitment to enrich the lives of our future citizens in New Jersey. One of these kids just might become a doctor, a teacher, or president!
CME Quiz

1. Which of the following is not identified with the dental medical home?
   a. Comprehensive  c. Family Centered
   b. Fractional d. Accessible

2. In a strong medical-dental collaboration, recognition consists of shared principles and beliefs.
   a. True  b. False

3. There is increasing evidence-of-association between oral diseases and which of the following systemic diseases?
   a. Heart disease  c. Diabetes
   b. Stroke   d. All the above

4. In a successful medical-dental collaboration, dentists should provide pediatricians with which of the following?
   a. General education on dental caries
   b. Tooth brush recommendations
   c. Prevention of dental caries and dental trauma
   d. None of the above

5. How would you describe the disease of dental caries?
   a. Multifactorial  d. Transmissible
   b. Diet-dependent e. Preventable
   c. Fluoride-mediated f. All of the above

6. Approximately how many U.S. children aged 2-5 years had dental caries in the year 2011-2012?
   a. 12%  d. 37%
   b. 16% e. 44%
   c. 23% f. None of the above

7. What are some of the behaviors and actions that form a set of principles for inter-professional relationship building among providers?
   a. Participating in referral networks
   b. Going out to social events together
   c. Accepting referrals for patients of mixed insurance status
   d. Timely, bidirectional communication
   e. Completion of referral by communicating back what transpired with patient
   f. All except option b.

8. Advocacy is another important component of a successful medical-dental collaboration.
   a. True  b. False

9. What is an example of educating patients to reset social norms?
   a. Accentuating that dental caries is a preventable disease and that losing teeth is not a normal part of aging
   b. Emphasizing the role that self-care prevention strategies play in helping to maintain optimal oral health.
   c. For dental providers, orienting patients to the idea that oral health can and should be included in routine medical care.
   d. All of the above.

10. For primary care providers, some of the key preventive behaviors and practices that can be integrated in practice include:
    a. Changes in medication to protect the saliva, teeth, and gums
    b. Fluoride therapy
    c. Dietary counseling to protect the teeth and gums
    d. Oral hygiene training
    e. Therapy for tobacco, alcohol, or drug addiction
    f. All of the above

CME Instructions

Read the CME-designated article and answer the Winter 2017 issue, quiz questions above. Print your name and phone number and mail or fax this form within six months from the date of issue to: NJAAP CME Quiz, 50 Millstone Road, Building 200, Suite 130, East Windsor, NJ 08520• Fax: 609.842.0015

NAME __________________________ PHONE __________________________

EMAIL ______________________________________

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

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Legislative Update: New Beginnings

Joe Simonetta
Public Strategies Impact

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Public Strategies Impact

New Jerseyans elected Democrat Phil Murphy to serve as the state’s 56th Governor in November. Along with Murphy, voters elected his running mate, former Assembly Speaker Sheila Oliver to serve as the state’s second Lieutenant Governor. Murphy and Oliver defeated Lieutenant Governor Kim Guadagno and her running mate, Woodcliff Lake Mayor Carlos Rendo. Murphy and Oliver will be sworn in on January 16, 2018.

Governor-elect Murphy has already named Peter Cammarano as Chief of Staff and Matt Platkin as Chief Counsel. Cammarano served as Chief of Staff to former Governor Richard Codey. Prior to serving as Chief of Staff, Pete spent ten years working in the New Jersey Senate as Senator Codey’s Chief of Staff. He previously served as the Director of Public Affairs for the Department of Insurance during the tenure of Governor Florio, and as Deputy Director for United States Senator Frank Lautenberg’s 1994 re-election campaign. He is a former member of the New Jersey Casino Reinvestment Development Authority, and he served seven years as a member of the Metuchen Borough Council prior to being elected mayor in 2015.

Matt Platkin most recently served as Policy Director for Murphy for Governor. In that capacity, Matt managed the campaign’s internal research and policy team. He served in a similar role for New Way for New Jersey since 2015. Prior to joining New Way for New Jersey, Matt was an attorney at Debevoise & Plimpton LLP in New York, where his practice focused on criminal and regulatory investigations. He also maintained an active pro bono practice, representing indigent clients facing criminal and removal proceedings in federal and immigration court. Matt began his career working on economic policy at The Brookings Institution in Washington, D.C., where he advised members of Congress on policies to promote economic recovery and job growth in the wake of the 2008 financial crisis.

Democrats will continue to control both houses of the Legislature, increasing their margin in both houses. Democrats will control the Senate by a margin of 25-15 and the Assembly by a margin of 54-26. They currently control the Senate by a 24-16 majority and the Assembly by a 52-28 majority. All 120 legislative seats were up this year and Democrats were expected to retain control of both houses.

Here’s a rundown of some of the most closely contested legislative races in yesterday’s election.

In District 3, in the most expensive legislative race in the State’s history, Senate President Steven Sweeney easily defeated Fran Grenier, Chairman of the Salem County Republican Party. Grenier’s campaign was largely funded by the New Jersey Education Association after the union vowed to defeat Sweeney. The bitter feud between the NJEA and Sweeney dates back to when Sweeney struck a deal with Governor Christie to overhaul the pension and health care system for state employees in 2011 and worsened last summer after Sweeney would not call for a vote in the Senate on a ballot question to guarantee quarterly pension payments by the state.

In District 2, Republican Assemblyman Chris Brown defeated Democratic Senator Colin Bell, who was selected by Democrats to complete the term of the late Senator Jim Whelan. On the Assembly side, incumbent Democratic Assemblyman Vince Mazzeo, and fellow Democrat John Armato, a Buena Vista Township committeeeman, defeated Republicans Vince Sera, a Brigantine Beach councilman, and Brenda Taube, a former Margate City commissioner.

In District 11, Monmouth County Democratic Chairman Vin Gopal defeated incumbent Republican Senator Jennifer Beck. On the Assembly side, Democratic incumbents Eric Houghtaling and Joann Downey defeated Republicans Ocean Township Deputy Mayor Robert Acerra and Red Bank Councilman Michael Whelan.

In District 16, Incumbent Republican Senator Kip Bateman defeated Laurie Poppe, an attorney and social worker. On the Assembly side incumbent Democrat Andrew Zwicker and his running mate Roy Freiman defeated former Republican Assemblywoman Donna Simon and Somerset County Freeholder Mark Caliguire.

Two incumbent Assemblymen and one former Assemblyman will be joining the Senate in January, replacing long-time Senators who did not seek re-election. In District 7, Democratic Assemblyman Troy Singleton will replace Republican Senator Diane Allen. In District 13, Republican Assemblyman Declan O’Scanlon will replace Republican Senator Joe Kyrillos. In District 20, Union County Sheriff and former Democratic Assemblyman Joseph Cryan will replace Senator Raymond Lesniak, who ran unsuccessfully for the Democratic nomination for Governor.

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Legislative Update continued

There will also be a number of new faces in the Assembly. In District 7, Assemblyman Singleton will be replaced by Democrat Carol Murphy. In District 8, Republican Ryan Peters will replace incumbent Republican Assemblywoman Maria Rodriguez-Gregg who did not seek re-election. In District 13, Assemblyman O’Scanlon will be replaced by Republican Serena Dimaso. In District 19, Democratic Assemblyman John Wisniewski who ran unsuccessfully for his party’s nomination for Governor will be replaced by Democrat Yvonne Lopez. In District 24, Republican Harold Wirths, a former Labor Commissioner will replace Republican Assemblywoman Gail Priebus who did not seek re-election. In District 29, Democrat Shanique Speight will replace Democratic Assemblywoman Bonnie Watson who did not seek re-election. In District 40, Republican Christopher DePhillips will replace Republican Assemblyman David Russo who did not seek re-election.

Legislative Leadership for the 218th Legislature Set

Senate President Steve Sweeney and Senate Majority Leader Loretta Weinberg were reelected by the 25 members of the Senate Democratic Majority and Senator M. Teresa Ruiz was voted by the caucus members to serve as Senate President Pro Temp. Senator Sweeney filled the leadership team by selecting Senator Paul Sarlo as Deputy Majority Leader and chairman of the Budget and Appropriations Committee; Senator Sandra Bolden Cunningham as Deputy Majority Leader and chair of the Higher Education Committee, and Senator Nicholas Scutari as chairman of the Judiciary Committee.

The Assembly Democratic Majority chose Assemblyman Craig Coughlin to serve as the next Assembly Speaker. Democrats are expected to hold a 54-28 majority in the 2018-19 legislative session, the largest Democratic majority since 1978. Coughlin will succeed current Assembly Speaker Vincent Prieto. Assemblyman Louis Greenwald was chosen to continue serving as Assembly Majority Leader. Greenwald became Majority Leader in 2012 after serving as Assembly Budget Committee chairman from 2002 to 2011. Assemblyman Jerry Green will continue in his role as Assembly Speaker Pro Tempore. Coughlin named Assemblywoman Eliana Pintor Marin to helm the Assembly Budget Committee, replacing current Budget Chairman Gary Schaer. Pintor Marin will become only the second woman to Chair one of the Assembly’s revenue committees. Assemblywoman Shavonda will continue to serve as conference leader. Coughlin also indicated that he will be creating a new committee, the Science, Technology and Innovation Committee that will create legislation designed to put New Jersey at the forefront of emerging industries.

The New Jersey Senate Republican caucus re-elected Senator Tom Kean as its leader for the 2018-2019 legislative session.

The New Jersey Assembly Republican caucus voted to retain their leadership team of Assemblyman Jon Bramnick as minority leader, Assemblyman Anthony M. Bucco as conference leader and Assemblywoman Nancy Munoz as minority whip.

Connecting With Your Legislator

Easily locate contact information for your state Senator or Assembly Person

By Name—www.njleg.state.nj.us/members/abcroster.asp
By District—www.njleg.state.nj.us/districts/districtnumbers.asp
By Municipality—www.njleg.state.nj.us/districts/municipalities.asp
Legal Update: Fraud & Abuse Cases Focusing on the Vaccines for Children Program ("VFC")

Guillermo J. Beades, Esq
Frier Levit Attorneys at Law

As children's vaccines become increasingly expensive—and immunization programs more complex—the Vaccines for Children ("VFC") Program is experiencing an increase in fraud and abuse. In New Jersey, the CDC’s VFC Program is administered by the New Jersey Department of Health ("NJ DOH"), which is responsible for, among other things, investigating cases of fraud and abuse.

The concept of fraud is more straightforward than abuse. Fraud is an intentional deception or misrepresentation made by a provider with the knowledge that the deception could result in some unauthorized benefit to the provider or practice. It includes any act that constitutes fraud under applicable federal or state law.

Abuse is a more general concept that is defined as:

provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, [and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient]; or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.1

In an effort to curb fraud and abuse in New Jersey, the NJ DOH has been conducting more frequent unannounced on-site inspections. NJ DOH inspections focus on strict compliance with CDC guidelines set forth in the VFC Operations Guide, including, but not limited to:

1. Proper Storage of Vaccines, including log of thermostat readings, location of vaccines within the refrigerator, etc.
2. Entry of Vaccines into NJIIS/NJMODS Databases
3. Documentation of Vaccine Lot Numbers on EMR
4. Proper Usage and Disposal of Multi-Dose Vaccines
5. Proper Training of Staff
6. Proper Documentation of Emergent Use of VFC Vaccines for non-VFC Patients

Many times the NJ DOH will find some issues that, if minor, merely result in the practice receiving a letter outlining a Restitution Plan, which translates to repayment of vaccines unaccounted for on a dose-for-dose basis.

It should be noted that the failure to comply with a Restitution Plan typically results in the provider being removed.1

With the NJ DOH’s increased focus on fraud and abuse in the VFC program, pediatricians must carefully review their office policies and protocols to ensure that all staff and physicians of the practice are properly trained and comply with all VFC program requirements or face potential monetary penalties, licensure actions or criminal prosecution.

Reference


REMINDER: JANUARY 1, 2018 DIGITAL DATA LOGGERS REQUIRED

As of January 1, 2018, digital data loggers with detachable probes in buffer material will be required for any vaccine storage units that store federally funded (VFC and/or 317) vaccines. Back-up thermometer must also be a digital data logger.

In an effort to offset the cost associated with purchasing data loggers, the New Jersey VFC Program is offering a data logger to all VFC and/or 317 providers. If accepted, providers will be responsible for maintenance and recalibration of VFC-issued data logger.

If you are interested in receiving a device for your office at no cost, please contact the Vaccine Preventable Disease Program at (609) 826-4861.

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12/11/17   9:00 AM
We are thrilled to announce the return of Dr. Benjamin Hoffman as the Leonard P. Rome CATCH Visiting Professor for the New Jersey Pediatric Residency Advocacy Collaborative on April 24–25, 2018. Dr. Hoffman, professor of pediatrics at Oregon Health & Science University and associate director of the AAP Community Pediatrics Training Initiative, is a nationally recognized leader in curricula development around advocacy and community pediatrics. In 2013, he brought together faculty representatives from 7 of the 9 New Jersey pediatric residency programs, helping us launch the New Jersey Pediatric Residency Advocacy Collaborative (NJPRAC) in partnership with the NJAAP. Through this unique collaboration, we have instituted an annual Pediatric Resident Advocacy Day and NJAAP White Coat Day. Building on these successes, NJPRAC aims to strengthen our collaborative framework with the goal to obtain funding to support collaborative efforts through long-term foundation support.

With the 2018 Visiting Professorship, NJPRAC will develop a more robust curriculum with a focus on community partners state-wide. Community collaborations are critical to create strong, mutually beneficial relationships to form the foundation for advocacy training. Currently, the nine residency programs approach community collaborations differently. A needs assessment of all NJ pediatric residency programs is currently being performed. With 270 pediatric residents across nine residency programs, the impact each of these residents will have on our local communities will multiply exponentially. Ensuring that all residents who train in NJ (many of whom will remain here to practice) have a rigorous community experience means that NJPRAC will continue to create community-minded leaders who serve the children of our state while recognizing the impact that social determinants of health will have on the trajectory of a child’s life.

We are truly grateful for the support that the NJAAP has provided throughout the evolution of NJPRAC. In addition, we appreciate the commitment from leadership of all 9 NJ pediatric residency programs in growing and strengthening the collaborative. Upon completion of our needs assessment, the agenda will be finalized and distributed to all chapter members. We look forward to working with faculty and residents across the state to build a robust, sustainable curriculum for all pediatric residents.

New Jersey Chapter
American Academy of Pediatrics presents

Resident Career Day
Wednesday, April 11, 2018
Hilton Garden Inn, Edison, NJ

Designated for 2nd Year Pediatric Residents to assist them on understanding how their education can be put into practice

For additional information, visit www.njaap.org/events or call 609-842-0014
Case Study: 14-Year-Old Boy with a Mass In the Diaphysis of His Right Tibia

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Introduction

A 14-year-old, otherwise healthy boy presented to his pediatrician with 2 weeks of painless swelling in the right leg. He was referred to an orthopedic oncologist and underwent an X-Ray and MRI. Physical examination revealed a slightly palpable, immobile, and convex curvature of his right tibia. There was no history of fevers, chills, trauma, numbness, or tingling. No significant medical history. Family history included colon cancer and prostate cancer.

Laboratory tests that included CBC, Chemistries, PT/PTT, were normal. Imaging studies, AP/Lateral X-Rays of the right tibia, MRI of the right tibia with and without contrast (Figure 1A-D) were performed. A biopsy was subsequently performed.

Imaging Interpretation

Figure 1A (AP) and Figure 1B (Lateral) show a pre-operative plain radiograph of the right tibia and fibula. An expansile lytic lesion with a soap bubble/moth eaten appearance can be seen within the diaphysis of the tibia. The lesion extends throughout the midshaft in all dimensions of the tibia. It involves the cortex as well as the medullary canal. Endosteal thinning is noticed along the lateral and medial cortex. Sclerotic margins are present surrounding other areas of the lesion. There is no evidence of a periosteal reaction, but the lesion is expansile, with thinning of the lateral cortex. The tibia appears slightly bowed.

On T-2 fat saturated MR images, the lesion is hyperintense to muscle and fat (Figure 1C). In the sagittal view, the proximal portion of the lesion extends from the anterior tibial cortex to the posterior tibial cortex. The lesion is approximately 19.2 cm in length. Axial contrast enhanced images demonstrate cortical thinning along the medial aspect of the midshaft of the right tibia (Figure 2D). A very slight periosteal reaction can be seen laterally and medially. The tumor transgresses the cortex laterally in a small area, however the periosteum appears intact around this area and the expansile areas. There is no evidence of soft tissue involvement or of a hemorrhagic component.

Histology Interpretation

An open biopsy of the patient’s right tibial shaft was analyzed (Figure 3A-D). Grossly, a longitudinal section revealed an intramedullary tumor that involved the cortex (Figure 3A). Microscopically, the lesion demonstrates a biphasic pattern characterized by epithelial islands surrounded by abundant fibrous spindle cells (Figure 3B & 3C). The cells demonstrated mild pleomorphism, but no mitoses or necrosis were evident. The epithelial component was confirmed with a pan keratin immunohistochemical stain that spares the fibrous stroma (Figure 3D). The epithelial cells were CD31 negative.

Figure 1A-D. Pre-operative Imaging Right Tibia. AP view (1A) of the right leg demonstrates an expansile, multilocular, lytic lesion with “soap bubble” appearance and narrow zone of transition within the diaphysis of the tibia affecting the cortex and medullary canal. There is associated cortical remodeling and endosteal thinning. No cortical breakthrough is present and only a slight benign appearing periosteal reaction is present (Arrow I). Lateral view (1B) of the right leg corroborates the findings on the frontal projection. Sagittal fat saturated T2 weighted image (1C) of the left tibia demonstrates marked hyperintensity of the lesion, which extends from the anterior to posterior cortex. Axial contrast enhanced, fat saturated T1 image (1D) through the mid diaphysis demonstrates marked enhancement of the soft tissue mass, which completely obliterates the marrow. The cortex is thinned, but there is no extension of mass beyond the periosteum. No edema is present within the musculature.

Figure 2A-D. Gross Image and Pathology of Tibial Lesion. A longitudinal section shows a 9.2 x 3.6 x 2.7 cm intramedullary tumor that involves the cortex (2A). Low power (2B) and high power (2C) views demonstrate a lesion with a biphasic pattern characterized by epithelial islands (Arrow I) surrounded by an abundant fibrous stroma (Arrow II). Figure 2D shows the epithelial component demonstrating positivity for pan keratin.

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The main differential diagnosis in this patient is between osteofibrous dysplasia and adamantinoma. Both of these tumors arise from the tibia. Osteofibrous Dysplasia is a benign fibro-osseous lesion of bone that may prelude or regress into adamantinoma. OFD most commonly affects patients in the first two decades of life, rarely affecting them after skeletal maturity. It usually arises in the cortical bone of the anterior mid-shaft of the tibia. Clinically, this slow growing lesion most frequently presents with symptoms of swelling and mild discomfort as well as bowing of the tibia. A subtype of OFD is osteofibrous dysplasia-like adamantinoma. This subtype suggests a correlation between adamantinoma and OFD. Hazelbag et. al noted that the transformation of fibrous tissue into epithelial cells was a progression of osteofibrous dysplasia into adamantinoma. In this case, it is certainly plausible that osteofibrous dysplasia may have progressed into an adamantinoma, especially considering the minor bowing deformity present that is typical of OFD. Radiographically, OFD is associated with thinning and expanding of the anterior cortex, sclerotic rimming, and a “soap bubble” appearance. These lesions do not typically have a periosteal reaction, extend into the soft tissues or fill the medullary canal. MRIs are rarely useful for differentiating OFD from adamantinoma as both can be heterogeneous on T-1 and hyperintense on T-2 weighted sequences. For this case, an MRI is most useful for evaluating the extent of the tumor such as its length and intramedullary or soft tissue involvement that may be more suggestive of an adamantinoma. On axial MRI, adamantinoma is often expansile with complete involvement of the medullary canal, whereas OFD usually only involves the cortex of the tibia.

Adamantinoma is a low-grade malignant tumor with epithelial differentiation and a marked predilection to be located in the tibia. This tumor resembles the more prevalent ameloblastoma of the jawbone. Adamantinoma usually affects adolescents and young adults, however a study done by Moon and Mori reports a mean age of 32.9 years. Symptoms include swelling and local pain; 33% of patients have symptoms for longer than five years. While 85% of cases involve the tibia, there are reports in the literature involving all long bones. When bones other than the tibia and fibula are involved, unusual histological features have been noted. Histologically, this tumor can be composed of four different cell type patterns, but always with epithelial differentiation. The four patterns are basaloid, spindle, tubular, and squamous. Our case most closely resembles the spindle pattern: small, uniform spindle cells with the presence of clefts surrounded by epithelial cells. As stated before, adamantinomas demonstrate cytokeratin positivity. Adamantinoma may be misdiagnosed as osteofibrous dysplasia (OFD) because of their similarities. Czerniak et. al separated adamantinoma into two classes: a classic and differentiated type. The classic type has most of the features of OFD with the presence of epithelial cells, as in our case. The differentiated type is characterized by an OFD pattern with scattered positivity of cytokeratin for epithelial cells.

Figure 3. Intra-operative Image of Free Microvascular Fibular Graft. Unconnected vascular structures can be seen in the free microvascular fibular graft (Arrow I). Beneath the transferred fibula, the hemi-tibia allograft plated with screws to the proximal portion of the tibia can be seen.

Figure 4A-B. Post-operative X-Ray of Free Microvascular Fibular Graft. At 29 months post-operatively, proper alignment of the hemi-tibia allograft and free microvascular fibular graft can be seen in the proximal (4A) and distal (4B) portions of the tibia. This AP image shows two plates with screws spanning the entire defect.

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On October 19th, the Centers for Disease Control and Prevention (CDC) released updated guidance for the diagnosis, evaluation, and management of infants with possible congenital Zika virus infection. The updated guidance emphasizes the importance of pediatric healthcare providers assessing risk for congenital Zika virus infection, communicating closely with obstetrical providers, and remaining alert for any problems that may develop in Zika exposed infants born without birth defects. The CDC has also updated a two-page Pocket Guide: Evaluation for Infants with Possible Congenital Zika Infection to help healthcare providers caring for infants with possible congenital Zika virus infection.

- The revised guidance updates recommendations for the diagnosis, evaluation, and follow-up of infants in three main groups:
  1. Infants with birth defects consistent with congenital Zika syndrome born to mothers with possible Zika virus exposure during pregnancy;
  2. Infants without birth defects consistent with congenital Zika syndrome born to mothers with laboratory evidence of possible Zika virus infection during pregnancy; and
  3. Infants without birth defects consistent with congenital Zika syndrome born to mothers without laboratory evidence of Zika virus infection during pregnancy.
- The new guidance provides updated information on interpreting laboratory test results for infants.
- The updated guidance provides a review of new data and clarification of the guidance for prenatal diagnosis (serial ultrasounds and amniocentesis).

The new guidance also provides updated information on infant follow-up care:

- Recommendations for vision and hearing screening have been updated.
- Some previously recommended screenings (e.g., thyroid screening, hearing screening at 4- to 6-months of age) are no longer recommended because of a lack of data on whether these screenings are needed.
- For infants with birth defects consistent with congenital Zika syndrome, healthcare providers should monitor for an expanded list of potential problems. These include difficulty breathing, difficulty swallowing, and hydrocephaly. In addition, care and follow-up of these infants no longer depends on the infants’ Zika virus testing results.
- Infants without birth defects consistent with congenital Zika syndrome born to mothers with laboratory evidence of possible Zika virus infection during pregnancy should receive an eye examination by an ophthalmologist.
- For infants without birth defects consistent with congenital Zika syndrome born to mothers with exposure to Zika virus but no laboratory evidence, Zika testing and clinical evaluation beyond the standard evaluation and routine preventive care are not routinely recommended.


Notice: On October 20, 2017, CDC released updated interim clinical guidance for healthcare providers caring for infants born to mothers with possible Zika virus infection during pregnancy.

Changes in guidance include:

To assist healthcare providers with evaluation, diagnosis, and clinical management decisions, infants have been categorized into three main groups: 1) infants with birth defects consistent with congenital Zika syndrome born to mothers with possible Zika virus exposure during pregnancy; 2) infants without birth defects consistent with congenital Zika syndrome, but who were born to mothers with laboratory evidence of possible Zika virus infection during pregnancy; and 3) infants without birth defects consistent with congenital Zika syndrome born to mothers with possible congenital Zika virus exposure during pregnancy but without laboratory evidence of Zika virus infection.

For additional information go to: https://www.cdc.gov/zika/hc-providers/infants-children.html
Histological findings of OFD reveal fibro-osseous proliferation with woven bone trabeculae demonstrating prominent osteoblastic rimming. Osteofibrous-like adamantinoma and adamantinoma demonstrate keratin positivity. The feature that distinguishes adamantinoma from a classic OFD is the presence of epithelial cells and absence of bony trabeculae with osteoblastic rimming. In OFD, epithelial cells are absent or scanty scattered and bony trabeculae with osteoblastic rimming are abundant. Distinguishing these two tumors is important because adamantinoma can metastasize in up to 30% of cases. OFD can usually be observed, and if symptomatic, curedt and bone grafted. OFD has a high recurrence rate in skeletally immature patients. Due to the high recurrence rate of adamantinoma when treated with curettage, wide resection with a prosthesis or some form of structural bone graft should be considered. Chemotherapy and radiation are not considered effective.

The patient was treated with radical resection of the right tibia and reconstruction with a hemi-tibia fresh frozen allograft and free microvascular fibula transplant. An intra-operative photograph demonstrates the unattached blood vessel from the newly transferred microvascular fibular graft (Figure 3). The choice of a hemi-tibia allograft and free microvascular fibula transfer was preferred over prosthesis or complete allograft reconstruction due to low rates of infection, fracture, non-union, and hardware failure. Hypertrophy of the microvascular fibular graft is anticipated and has been reported to be associated with positive outcome. The tibia allograft, which was cut longitudinally, offers additional structural support to the transferred fibula until the fibula can heal and hypertrophy. Radiographs 29 months postoperatively demonstrate good healing of the allograft and fibula. The fibula has hypertrophied (Figure 4A-B). There have been no complications. The patient is currently ambulating without pain and normal knee function. This patient will be monitored periodically with follow-up radiographs at each visit for the next five years.

References

Talking To Caregivers About the HPV Vaccine: Guidance for Physicians

Charles Scott, MD
Past President, NJAAP
Chair, Quality Committee
Advocate, LLC

Vaccine hesitancy and refusal has been—and remains—a major challenge to pediatric practice’s immunization efforts, especially during the pre-teen check ups when discussing the Human Papilloma Virus (HPV) vaccine.

Gardasil—Merck’s branded vaccine, and the only available HPV vaccine in the USA, protects against 7 oncogenic strains and 2 genital wart-causing strains with up to 90% preventive effectiveness for the many body areas that can be infected by the HPV virus and subsequent potential cancers. The vaccine is approved for use in both males and females above age 9 to 21 for boys, and 9 to 26 for girls and is currently recommended for both sexes at ages 11 to 12. If the first dose is administered before the teen turns 15, it is a 2 dose series (separated by at least 5 months); if started at age 15 or later, it is a 3-dose series provided at 0, 2, and 6 month intervals.

Despite the vaccine’s safety and efficacy, immunization rates remain lower than with any other vaccine.

There are parents who absolutely refuse the vaccine, some who waffle and are on the fence, and some who fully accept the immunization for their children. All of us can speculate as to reasons why some parents are adamantly refuseniks: they consider HPV a “sex” vaccine, they don’t want to recognize that their soon-to-be adolescent will have certain refusenik thoughts and urges, they are convinced their child will never be exposed to the virus, and the list goes on and on. These parents may have their feet firmly in the sand, but even some within this group can be reasoned with and ultimately, change their minds. Many “wafflers” can be persuaded with the right messaging. The “acceptors” are easy—they understand the value of the vaccine as a cancer prevention strategy. Regardless of which parental grouping is in the exam room, your messaging is critical for successfully immunizing the pre-adolescent.

It is well documented that a physician’s recommendation is the single most important factor considered by parents. Remember that the messaging starts when the parent makes the appointment; it carries through from all staff—front desk, nursing MA’s, etc. as well as from the clinician. The thrust of this article will focus on the pediatrician/NP doing the evaluation.

A Clear Recommendation!

This is critical. “Today your child is due for his/her HPV cancer preventing vaccine as well as his/her flu shot (or Hep A).” Period! Unfortunately some physicians feel the need to go into lengthy explanations and disclaimers. Why? Do we go long with any other vaccine? Do you precede an MMR vaccination with a lengthy discussion about the ravages of measles, its symptoms and morbidity/mortality rates? Of course not. Your presentation of the HPV vaccine should be the same way—be CONCISE and CLEAR! In fact, the physician recommendation should not be overly strong. Sometimes coming on too strong can be a “turn-off” (methinks the lady/gentleman doth protest too much, to quote Shakespeare). Clear is better than strong. Avoid relating the disease to “sex”; it is cancer preventing—period!

Avoid presenting as an Option!

“You are due for the HPV vaccine.” Period! That is the clearest way to present it. Absolutely do not present as “your child can get the HPV vaccine if you’d like.” This is a vaccine strongly recommended by every professional organization: AAP, AAFP, Adolescent Societies, CDC, insurance companies, etc. In fact, it is a HEDIS indicator and very likely in the future our rates of HPV vaccination may be tied to payment schemata. When you matter of factly present as “you are due”, you are merely supporting the strong recommendations of all these professional groups. Do not even think that you are hiding anything by stating it this way. Hiding what? Obviously, if there are further questions from the parent, answer them honestly—but succinctly! Treat this vaccine no differently from any other. Do we tell the parent of a 2 month old that “you can get the DPT or Polio vaccine if you’d like”?

Important wording for any messaging

Clear, Concise, “due for”, Cancer prevention. These are the most important. Other considerations: start the discussion at the child’s 9-year check-up about the HPV vaccine; give the VIS (Vaccine Information Sheet from the CDC) and let the parent know the child “will be due for this vaccine in the next year or two”. Why not give the vaccine at the 10-year check? In reality, the younger the child, the less likely there will be any potential focus on sex. Another potential discussion point should there be any questions by the parent: the younger the HPV vaccine is given, the higher the protective antibody response. That is a fact. However, as a full disclosure, the higher protective antibodies don’t translate in to greater clinical efficacy. But I always explain to any parent that higher can’t be worse. I also “sell” to the parents of younger children (if I have to do any “selling” at all), that if given younger, the series is one fewer dose.

continued on next page
**Addressing Caregiver Hesitations and Most Frequently Asked Questions**

**Q. Won’t this vaccine give my child a green light for sex?**

**A.** Studies have shown that the HPV vaccine does not encourage sexual activity rates in adolescents. Remind parents that this is cancer prevention, plain and simple. The HPV vaccination does not promote sex it prevents cancer!

**Q. I’m worried about side effects and this vaccine is relatively new.**

**A.** This vaccine has been studied and followed for over 15 years (11 years from launch and a few years earlier with clinical trials) and tens of millions of doses of Gardasil and Gardasil 9 have been administered. Yes, some children feel discomfort and rarely, some faint afterwards, which is why we recommend the child refusenik remains in the waiting room for 15 minutes after receiving the injection. I always share with reluctant parents that “This vaccine is safer than driving your car—you have a greater chance of being killed leaving my parking lot than having a major problem with the HPV vaccine. So I have to assume you will stop driving now, right?” This point does persuade a few, although it does fall on deaf ears with those whose feet are dug in.

**Q. I want to wait until it is needed—when my child is considering sexual activity.**

**A.** It needs to be in place before it needs to be in place. Parents who think they will know when their child begins his or her debut are unrealistic. Point out that they likely will be aware of the sexuality of their child’s friends before they hear about their own son's/daughter’s activities. And, like any vaccine, the protection needs to be present before exposure. That's why it is best to get the vaccine between ages 9 and 12, before any of those normal pre-teen thoughts become actions.

**Q. I haven’t done my homework or research yet on this vaccine.**

**A.** Nothing is more frustrating than to hear this excuse in 2 sequential years. One of my pediatric colleagues from Florida likes to answer this question by stating: “Well I have done my homework and research—what would you like to know?” That is a fine approach. Another is to start at an early check up—like at age 9 and mention next year your child will get the HPV vaccine and hand out the VIS. It prompts the parent to do any investigation felt necessary. Then at age 10, if the parent again states they haven’t done the research, then you can ask them what they are waiting for? Clear recommendations 3 years in a row will often yield success by age 12.

**Q. My child isn’t going to have sex until marriage.**

**A.** You could point out that those who take the vow of abstinence until marriage statistically fall off the wagon with the same frequency as those who haven't vowed. However, it is easier to simply point out that, while the statement may be true, can they guarantee the purity of the future spouse? Are we going to get 100% acceptance ever on this vaccine? Of course not—nor will we get 100% acceptance of any other vaccine. The hardliners will not be swayed and their children will not be protected from the HPV-related cancers. I always document and read to the adamant parents what I am recording: “Parent declines Gardasil but does understand it prevents cancer.” I explain that I need to document in case (heaven forbid) their child gets a cancer that could have been prevented, it would not be fair to hold me responsible. It is also reasonable to have a refusenik parent sign a vaccine refusal form (can be obtained from NJAAP Chapter and National).

But, for the “wafflers”, following the above suggestions may improve your odds of protecting the kids—and your rates! Remember: Clear, Concise, “due for”, Cancer preventive in a firm recommendation. Those are the most important items to consider when approaching an HPV vaccine eligible patient. Better rates, better protection, better quality of care. Life doesn't get better than that!

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To register for the upcoming NJAAP HPV ECHO project, or for additional information, please contact Michael Weinstein or Candace Kimmel at (609) 842-0014.

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**AAP HPV ECHO**

*Project ECHO® (Extension for Community Healthcare Outcomes) is an innovative hub and spoke telementoring program that connects a multidisciplinary team of experts (hub) with primary care providers in local communities (spokes). Together, the experts and the primary care providers build a virtual “knowledge network” whereby participants learn from each other gaining access to evidence-based and capacity-building resources. The AAP HPV ECHO monthly sessions include a brief presentation by an HPV expert, followed by participants presenting their quality improvement (QI) work for discussion and problem-solving guidance. Through regular attendance, participants receive mentorship and grow their QI skills and self-efficacy around HPV vaccination.*

To register for the upcoming NJAAP HPV ECHO project, or for additional information, please contact Michael Weinstein or Candace Kimmel at (609) 842-0014.
Resident Voice: Resident Voice: The Federal Student Loan Forgiveness Program

Niva Shah, DO
PGY-3 Pediatric Resident
Goryeb Children’s Hospital
Atlantic Health System

Attaining a future in medicine, though rewarding, comes with the burden of hundreds of thousands of student loans for many, if not most. There are multiple refinance programs, repayment options, and loan forgiveness options. One in particular is the Public Service Loan Forgiveness (PSLF) Program. If a resident or other medical professional is employed by the government or by a non-for-profit organization, they may be eligible to receive a certain amount of loan forgiveness under this program. Briefly, the PSLF program forgives the remaining balance on strictly Direct Loans after completion of 120 qualifying monthly payments under a qualifying repayment plan. The application process, though simple, may seem overwhelming at first.

The first step is filling out the Employment Certification Form, which needs to be resubmitted annually and with each change in employer. The completed form should be sent to FedLoan Servicing with your employer’s certification. It may be mailed to the U.S. Department of Education at FedLoan Servicing P.O. Box 69184 in Harrisburg, PA 17106-9184. It may also be faxed to (717) 720-1628, or it may be uploaded directly on their website if FedLoan Servicing is already the primary loan servicer. This form is critical in making sure you work for a qualifying employer and ensures that each payment you make is a qualifying payment. A qualifying employer includes: any employment with a federal, state, or local government agency; a not-for-profit organization that is tax-exempt by the IRS under Section 501(c)(3) of the IRC; other not-for-profit organizations that are not tax-exempt under Section 501(c)(3) but act solely in public service; or serving full-time with the AmeriCorps or Peace Corps. The organization may not be a labor union or a partisan political organization.

Qualifying loans include direct loans only received under the William D. Ford Federal Direct Loan Program. Loans received under other programs may be consolidated into a Direct Consolidation Loan in order to qualify for the PSLF program. Consolidation can be done yourself or with the help of Student Debt Relief for a fee. Private loans do not qualify for forgiveness. A qualifying payment must be made for 120 months (payments do not have to be consecutive) and must be made after October 1, 2007 in order to qualify. Payments must be of the full amount on your bill (paying additional amounts does not speed up the process), on time, and while employed by a full-time qualifying employer. Loans may not be in a grace period, in deferment, or in forbearance.

After determining which loans may qualify for the PSLF program, a qualifying repayment plan must be selected. Only income-driven or income contingent repayment plans or Pay As you Earn Plans are eligible for the PSLF program. These repayment plans lower your monthly payments to 10-15% of your discretionary income. This is a separate application and may be filled out online.

After completing 120 qualifying payments, your Employment Certification for the Public Service Loan Forgiveness form will be reviewed at the time you are applying for forgiveness. You will be notified if at this time you qualify, if more information is necessary, or if more payments are necessary in order to qualify. If you are determined to qualify, your remaining loans will all be transferred to be serviced by FedLoan Servicing. At this time, an application for PSLF itself needs to be filled out and submitted. As only payments after October 2007 are eligible, the earliest someone may be eligible for forgiveness is this fall 2017. If there are any questions about PSLF, FedLoan Servicing may be contacted directly at 1-855-265-4028. If you think you may qualify for the PSLF, now is the time to act. Currently, there are no limits on the amount of money that may be forgiven and the forgiveness is NOT taxable income. This is a great opportunity for so many medical professionals who are overwhelmed by student loans and it is imperative to apply early to begin making qualifying payments.

Interns Rise Up

Jonathan Shayo
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M.D. Candidate, Class of 2017
Rutgers University

Interns rise up, from all over the nation,
Interns rise up, we are the foundation.
Years of hard work has brought us to this place,
We walked in with our heads high, smile on our face.
Don’t try to mistake it, don’t try to deny,
Responsibilities are fierce, expectations sky high.
The first few months, we stumble and we fall,
I call upon us, it’s time to stand tall.

Interns rise up, it’s our time to shine,
Interns rise up, we are on the front line.
Admissions, nursery, the floor we float,
All of us navigating in the same boat.
Novel, in a very unique position,
Feeling like an inadequate physician.
Struggling, getting many questions wrong,
Now more than ever, we must stay strong.

Interns rise up, the end is in sight,
Interns rise up, there is a flame to ignite.
Seniors, that’s us, in less than a year,
Step it up, kick it into another gear.
Expanding our knowledge, running the floor,
Becoming more efficient and reading more.
A bold proclamation, advice to the wise,
Don’t step on the interns, for we are on the rise!
Spinal Muscular Atrophy (SMA)

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Goryeb Children's Medical Center

Spinal muscular atrophy (SMA) is a condition that leads to a loss of motor neurons and subsequent loss of motor function. Its incidence is approximately 1 in 10,000 live births. It is most frequently due to a homozygous deletion of the SMN1 gene. The severity of the phenotype often, but not always, relies on the copy number of SMN2 genes that are present. The SMN2 gene produces a smaller and less stable SMN protein, and as such, the more copies of SMN2 you have, the less severe your phenotype.

Types of SMA

<table>
<thead>
<tr>
<th>Type</th>
<th>Age of onset</th>
<th>Phenotype</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>In utero</td>
<td>arthrogryposis, areflexia, fasciculations, respiratory failure, hypotonia—death within 1 month</td>
</tr>
<tr>
<td>1</td>
<td>0-6 months</td>
<td>hypotonia, difficulty with breathing / recovering from upper respiratory tract infections, areflexia, fasciculations, PMM*—never get to sitting</td>
</tr>
<tr>
<td>2</td>
<td>6 months</td>
<td>hypotonia, difficulty with breathing / recovering from upper respiratory tract infections, areflexia, fasciculations, scoliosis, PMM*—never get to walking</td>
</tr>
<tr>
<td>3</td>
<td>6-18 months</td>
<td>hypotonia, areflexia, motor developmental delays, fasciculations, scoliosis, PMM*—lose the ability to walk (~early teens)</td>
</tr>
<tr>
<td>4</td>
<td>Child-adult onset</td>
<td>areflexia, motor function loss, fasciculations, PMM*—slow progression; may or may not lose ability to walk</td>
</tr>
</tbody>
</table>

*PMM: polymyoclonus—tremor seen in patients with SMA

Up until fairly recently, only supportive care was offered to patients. This included regular visits with pulmonologists, gastroenterologists, orthopedists, and physical/occupational therapists or physiatrists. Often, neurologists fell to the wayside after a diagnosis was made.

Now, patients, caregivers, and their physicians are imbued with hope.

In December of 2016, the FDA approved a new medication for SMA called Nusinersen/Spinraza which is distributed by Biogen. This is the first FDA approved treatment for SMA. This therapy uses an antisense oligonucleotide that alters the splicing of SMN2 with the aim to produce a full-length SMN protein as a result. Since its approval, there has been a flood of eager and excited families pouring into neuromuscular clinics. A lot of them are looking for a cure. Spinraza is not that to most, as it was found to be most effective in pre-symptomatic babies. But to the many other children and adults who comprise the older population of SMA patients, it, at its least, offers the hope for clinical stability and prevention of further decline. It also offers the hope of even minimal improvement.

Setting up the administration of this intrathecally delivered drug is a feat that pales in comparison to the efforts that must be made to gain authorization for its dispensation from insurance companies. Additionally, older children/adults may already have had spinal fusions which block passage to the administration of Spinraza via lumbar puncture. Some patients have undergone laminectomies just to have access to the drug.

There are some other options on the horizon, though. They are all still in the research phase, but I’m sure we will be hearing a lot more about them in the news.

AveXis, Inc is a gene therapy company that has ongoing trials with promising results using intravenous gene transfer of SMN1 via adeno-associated virus 9. This is a “one and done” dose of medication.

Roche pharmaceuticals and PTC therapeutics have developed an oral antisense oligonucleotide that will soon enter trials in the US.

Interestingly, most patients want Nusinersen as soon as possible because it is FDA approved, so many of these newer drug trials may have difficulty with recruiting patients and are needing to create an arm of the study that focuses on the safety of the use of their drug in combination with Nusinersen.

In all, these are very exciting times for SMA. The patient community is incredibly intelligent and educated on the subject of their condition. This makes for a very unique patient-doctor relationship that involves bidirectional knowledge sharing and a true partnership in embarking on these new therapeutic journeys together.
Social Determinants of Health Monitoring in Pediatric Primary Care: Importance, Screening, Intervention, and Follow-up

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Peijia Zha, PhD, Rutgers School of Nursing, Newark

Abstract

Per Healthy People 2020, “social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks”. Social determinants of health especially those related to economic stability including poverty have a profound effect on child health and development. Using an exploratory descriptive cross-sectional design, New Jersey pediatric primary care clinicians were asked about the importance, practices, screening, intervention, and follow-up pertaining to social determinants of health. The final analyzed sample was 49. The top five factors rated as most important were: exposure to violence, early childhood education participation, exposure to crime, parental mental health (including substance abuse), and housing quality. Clinicians most routinely monitored for participation in early childhood education, parent’s mental health and substance abuse, child’s family composition, and child’s environmental toxic exposures. Intervention and follow-up for children with identified social issues included: ‘follow-up sooner than typical’, ‘referrals’, ‘parent education’, and ‘more frequent developmental screening’. New Jersey pediatricians recognized the importance of social and environmental factors to children’s health and development. However, some pediatricians did not monitor for the presence of such social and environmental factors (i.e., social determinants of health).

Keywords: Developmental Monitoring, Developmental Delay, Pediatric Primary Care, Poverty, Social Determinants of Health, Socioeconomic Status

1.1 Introduction

The purpose of this study was to elucidate the practices of New Jersey pediatric primary care clinicians in developmental monitoring including social and environmental elements as a risk factor for developmental delay. This report focuses on the three survey questions that asked about social determinants of health importance, screening, and follow-up practices.

Child health and development are influenced by many drivers including social determinants of health. “Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks”. Per Healthy People 2020, the key social determinants of health are economic stability, education, health and health care, neighborhood and the built environment, and social and community context. The Centers for Disease Control and Prevention (2015) estimate that socioeconomic/economic stability factors that include poverty, unemployment, food insecurity, and housing insecurity/instability drive 40% of a population’s health.

<table>
<thead>
<tr>
<th>Social determinants</th>
<th>Underlying factors of influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic stability</td>
<td>Unemployment, housing insecurity, food insecurity, and poverty</td>
</tr>
<tr>
<td>Education</td>
<td>Early childhood education and development, high school graduation, language and literacy, and higher education enrollment</td>
</tr>
<tr>
<td>Health and Healthcare</td>
<td>Access to health care, access to primary care, and health literacy</td>
</tr>
<tr>
<td>Neighborhood and built environment</td>
<td>Access to healthy foods, quality of housing, crime and violence, and environmental conditions</td>
</tr>
<tr>
<td>Social and community context</td>
<td>Social cohesion, civic participation, discrimination, and incarceration</td>
</tr>
</tbody>
</table>

Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (4th edition) endorses priority attention to social determinants of health at most well child health supervision visits. Bright Futures identifies risk factors in family and social determinants including abuse and neglect, homelessness, parental dysfunction, poverty, and separation or divorce. Bright Futures also recognizes that social determinants found beyond the immediate household have an impact on children and families in both the proximate and longer timeframes. These determinants include neighborhood conditions, the built environment including safe and green play spaces, the availability of affordable, nutritious food, geographic access to quality health care services, and quality education starting with early childhood developmental programs.
The final questionnaire consisted of 20 items. The survey included three questions about screening practices for social determinants of health. Participants were asked: how important do you believe (each of these individual) social and family factors are to a child’s development. Second, participants were asked: how routinely do you monitor for certain social and family factors. Lastly, participants were asked: what steps do you take if you identify a social issue that may negatively affect a child’s development. Two of the three questions were Likert scale questions with rating values, which offered a range of answer options from least (1) to most (5). One question was in multiple answer option form.

Recruitment and Sampling

A healthcare marketing company was contracted to provide New Jersey pediatric primary care clinician contact information. To collect data from 50 pediatric primary care clinicians, with an anticipated response rate of 25%, a random sample of 200 clinicians was drawn from the existing primary pediatric clinicians identified by the healthcare marketing company, employing an online random number generator. The survey was mailed to the pediatric clinicians during 2016. An incentive of a $10 gift card was offered for participation. The study was approved by the Rutgers University Institutional Review Board. The sample size calculation was based on a 90% confidence level and an accepted margin of error of 10% with a response rate of 25% from a targeted pool of 2,013 pediatric primary care clinicians .

1.3 Results

Description of respondents and their practice sites

Fifty-five responses were returned. Six of the responses were not included in the final analyzed sample of 49 because they were incomplete. The respondents included forty-seven pediatricians, one physician assistant, and one nurse. Most of the practices were private offices (n = 13) and clinics (n = 32). Three were Federally Qualified Health Centers and one was a hospital affiliated clinic. In aggregate, these practices served a diverse population comprised of 51% White, 15% African American, 15% Asian, and 19% Hispanic children. Most patients and families (n = 46, 94%) spoke English well. Many language options were available. Languages spoken by practice providers included Spanish (49%, n=24), Russian (8.2%, n=4), Chinese (8.2%, n=4), Hebrew (10.2%, n=5) as well as Hindi, Korean, French, Arabic, German, Polish, Czech, Portuguese, Turkish, Armenian, and Slovak. The number of well child health supervision visits reported for children ages 5 and under ranged from 15 to 1800 per month with the largest proportion of practices serving 100-200 children monthly. A larger proportion (57%, n=28) of the children served had private health insurance while 43% (n=21) had public insurance.

Important Social and Family Factors for Child Development as Reported by Pediatric Primary Care Clinicians

Pediatric primary care clinicians rated several individual social and family factors as important to a child’s development. There was a full range (5) of ratings (1 least importance–5 highest importance) for most of the areas. Only early childhood education and level of maternal education were more narrowly rated with a range of 3, minimum of 2, and maximum of 5 ratings. The top five factors rated as most important were: exposure to violence (mean = 4.37), early childhood education participation (mean = 4.16), exposure to crime (mean = 4.07), parental mental health (including substance abuse) (mean = 4.04), and housing quality (mean = 4.00). As reported, the least important factors were: transportation availability (mean = 2.74), parental occupation (mean = 3.20), and parental employment status (mean = 3.49).

Routine Monitoring of Social and Family Factors by Pediatric Primary Care Providers

After transformation of data to a dichotomous yes/no variable, the results revealed that pediatric primary care clinicians routinely monitored most often for participation in early childhood education (n= 43, 91.5%). Clinicians routinely monitored for parent’s mental health and for child’s family composition (n=36, 76.6%). Clinicians routinely monitored for child’s environmental toxic exposures (n=34, 72.3%). [Table 3 on following page]. Monitoring of early childhood education participation was consistent with the level of importance (mean = 4.16) rated by clinicians.

Poverty-related factors were routinely monitored less often by clinicians. Parents employment status was routinely monitored by 57.4% (n=27) of clinicians. Food insecurity was routinely monitored by 44.7% (n=21) of clinicians. Housing quality was routinely monitored by 31.9% (n=15) of clinicians. Family income was routinely monitored by 17.0% (n=8) of clinicians.

Despite rating exposure to crime as the third most important social and family determinant of health, only 36.2% (n=17) of participants routinely monitored for it. Similar rates of routine monitoring were reported for housing quality (n=15, 31.9%) and level of maternal education (n=18, 38.3%). Clinicians’ were least likely to monitor for transportation availability (n=10, 21.3%) and child’s access to safe parks and playgrounds (n=7, 14.9%). The lesser monitoring for transportation availability is consistent with its relative lack of importance (mean = 2.74) as rated by clinicians.

continued on page 26
TABLE 2. Factors Important to Child Development as Rated by Pediatric Primary Care Clinicians in New Jersey

<table>
<thead>
<tr>
<th>Factor</th>
<th>N</th>
<th>Range</th>
<th>Minimum (least important)</th>
<th>Maximum (most important)</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to violence</td>
<td>41</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>4.37</td>
<td>.942</td>
</tr>
<tr>
<td>Participation in early childhood education</td>
<td>45</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>4.16</td>
<td>.796</td>
</tr>
<tr>
<td>Exposure to crime</td>
<td>42</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>4.07</td>
<td>1.177</td>
</tr>
<tr>
<td>Parental mental health (including substance abuse)</td>
<td>46</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>4.04</td>
<td>1.228</td>
</tr>
<tr>
<td>Housing quality</td>
<td>40</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>4.00</td>
<td>1.062</td>
</tr>
<tr>
<td>Level of maternal education</td>
<td>45</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>3.78</td>
<td>.902</td>
</tr>
<tr>
<td>Food insecurity</td>
<td>41</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.76</td>
<td>1.157</td>
</tr>
<tr>
<td>Family composition</td>
<td>44</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.59</td>
<td>1.187</td>
</tr>
<tr>
<td>Environmental toxic exposures</td>
<td>40</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.58</td>
<td>1.279</td>
</tr>
<tr>
<td>Family income</td>
<td>42</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.52</td>
<td>1.174</td>
</tr>
<tr>
<td>Parental employment status</td>
<td>43</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.49</td>
<td>1.183</td>
</tr>
<tr>
<td>Parental occupation</td>
<td>45</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.20</td>
<td>1.120</td>
</tr>
<tr>
<td>Transportation availability</td>
<td>42</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>2.74</td>
<td>1.149</td>
</tr>
</tbody>
</table>

Developmental Screening Tool Use

An open-ended question asked: which developmental screening tool do you use. The question did not specifically inquire about social determinants of health screening. Thirty-eight clinicians responded to this question. A variety of tools were used by clinicians.

One clinician reported using the Survey of Well-being in Young Children (SWYC). The SWYCP screening tool incorporates some social determinants of health-related questions connected to depression, abuse, violence and discord, and hunger. Two participants reported using the ‘Bright Futures’ Pediatric Intake Form. The Pediatric Intake Form assesses for multiple risk factors for child health and development including parental depression, substance use, intimate partner violence, parental history of abuse, social supports, single parent household, and frequent relocations. [Table 4 on following page].

TABLE 3. Monitoring for Social and Environmental Factors as Reported by Pediatric Primary Care Clinicians in New Jersey

<table>
<thead>
<tr>
<th>Do you monitor for?</th>
<th>Area</th>
<th>N</th>
<th>Percent of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s participation in early childhood education</td>
<td>43</td>
<td>91.5%</td>
<td></td>
</tr>
<tr>
<td>Family composition</td>
<td>36</td>
<td>76.6%</td>
<td></td>
</tr>
<tr>
<td>Parental mental health</td>
<td>36</td>
<td>76.6%</td>
<td></td>
</tr>
<tr>
<td>Child’s environmental toxic exposures</td>
<td>34</td>
<td>72.3%</td>
<td></td>
</tr>
<tr>
<td>Parent’s employment status</td>
<td>27</td>
<td>57.4%</td>
<td></td>
</tr>
<tr>
<td>Parental occupation</td>
<td>26</td>
<td>55.3%</td>
<td></td>
</tr>
<tr>
<td>Food insecurity</td>
<td>21</td>
<td>44.7%</td>
<td></td>
</tr>
<tr>
<td>Level of maternal education</td>
<td>18</td>
<td>38.3%</td>
<td></td>
</tr>
<tr>
<td>Child’s exposure to crime</td>
<td>17</td>
<td>36.2%</td>
<td></td>
</tr>
<tr>
<td>Housing quality</td>
<td>15</td>
<td>31.9%</td>
<td></td>
</tr>
<tr>
<td>Transportation availability</td>
<td>10</td>
<td>21.3%</td>
<td></td>
</tr>
<tr>
<td>Family income</td>
<td>8</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Child’s access to safe parks and playgrounds</td>
<td>7</td>
<td>14.9%</td>
<td></td>
</tr>
</tbody>
</table>

continued on next page
TABLE 4. Select Assessment/Screening Tools that Incorporate Certain Social Determinants of Health Factors

<table>
<thead>
<tr>
<th>Tool</th>
<th>More information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bright Futures Pediatric Intake Form</td>
<td><a href="https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_intake_form.pdf">https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_intake_form.pdf</a></td>
</tr>
<tr>
<td>KySS Assessment Questions</td>
<td><a href="https://www.napnap.org/ProgramsAndInitiatives/MentalHealth/MentalHealthGuide/MentalHealthGuideHandouts.aspx">https://www.napnap.org/ProgramsAndInitiatives/MentalHealth/MentalHealthGuide/MentalHealthGuideHandouts.aspx</a></td>
</tr>
<tr>
<td>Two question food insecurity screening tool</td>
<td><a href="http://www.aappublications.org/content/early/2015/10/23/aapnews.20151023-1">http://www.aappublications.org/content/early/2015/10/23/aapnews.20151023-1</a></td>
</tr>
</tbody>
</table>

Twenty-six participants reported using MCHAT/MCHAT revised and 10 participants used Ages and Stages (ASQ/ASQ-3). Of note, 12 clinicians reported using the ‘Denver/ Denver Developmental’ tool for developmental screening with an additional two clinicians reporting using the ‘Denver Prescreening Developmental Questionnaire’ (PDQ). One participant reported using the Edinburgh Postpartum Depression tool with mothers. Other tools reported used by one clinician each were: ‘milestones developmental’, PEDS Child Screening Test, ‘EHR Developmental Screening’, PEDS Response form, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Exam forms.

When a Social Issue that Impacts Development is Identified: Interventions and Follow-up

The final survey question asked: what steps do you take if you identify a social issue that potentially may affect a child’s development. Forty-eight clinicians responded. Thirty-four (70.83%) clinicians reported they would ‘follow-up sooner than typical’. Twenty-two (45.83%) clinicians responded they performed ‘more frequent developmental screening’. Thirty-one (64.58%) clinicians provided ‘parent education’. Thirty-three (68.75%) clinicians provided ‘referrals’. Four (8.33%) clinicians reported they ‘do not screen for socio-economic status or other social determinants of health’ factors.

Limitations

The cross-sectional survey design offered a snapshot of prevalent development surveillance and screening practices and social determinants of health-related beliefs and practices, however, some limitations should be considered. Some limitations pertain to the survey method itself. The total survey error perspective refers to an aggregate of seven potential errors with survey research which can introduce bias: coverage error, sampling error, nonresponse error, specification error, measurement error, adjustment error, and processing error. Coverage error may have introduced bias because the sample may have missed some pediatric primary care clinicians. Although a random selection method to derive the sample from the total number of potential participants was used; random differences exist between any sample and the population of interest. Sampling error could have introduced bias because the sample comprised providers from various professional backgrounds whose clinical responsibilities and professional practice differ. Not all the providers from the sample responded to the survey which accounts for a nonresponse error. People self-selected and chose to complete the survey. They may have been motivated individuals, perhaps with a special interest in developmental surveillance and screening or social determinants of health. Overall, the study’s response rate was 27.5%, n = 55. For the final analysis, the response rate was 24.5%, n = 49. Specification error could have resulted from the varying understanding and definition of constructs by the respondents. Precise definitions for the social determinants of health-related questions were not provided. The survey has not been validated. Additionally, measurement errors also include systematic biases or random variance among respondents such as personal behaviors (e.g., misreporting true attitudes or completing the survey with little attention to the questions) and clarity of questions (e.g., ambiguity in wording, variable understanding of concepts). Adjustment and processing errors result from statistical adjustments and data management and could have occurred when data were processed and analyzed, however, steps were taken to ensure that these were addressed.

continued on page 28
1.4 Discussion

Non-genetic and non-behavioral pattern factors including social, economic, and environmental influences (i.e., social determinants of health) are important in the shaping of child health and development outcomes. Social determinants of health-related screening, intervention, and follow-up may positively affect the health and development of children and families.

Pediatric primary care clinicians rated the most important factors as exposure to violence, early childhood education participation, parental mental health (including substance abuse), and housing quality. Based on ratings and current practices as described by pediatricians here, professional organizations may first want to focus on integrating validated screenings for exposure to violence, exposure to crime, and parental mental health (including substance abuse). In effect, building upon professional beliefs and perhaps, preferences. However, general developmental surveillance and screening recommendations as endorsed by the American Academy of Pediatrics are still not fully practiced by professionals in pediatric primary care settings. Additional screening requirements may be perceived as burdensome, so strategies to address these potential concerns need development by professional organizations. Certainly, barriers to monitoring for social and family factors in pediatric primary care exist. Lack of endorsed tools, time constraints, lack of knowledge about local resources, and willingness to devote professional time and practice assets are some of the barriers.

In addition, since poverty has such a detrimental effect on child health and development outcomes, a focus on family income, housing insecurity/instability, food insecurity, and parental unemployment is indicated. The American Academy of Pediatrics (AAP) past President Benard P. Dreyer stresses the need for pediatric clinicians to address poverty stating that “almost half of pediatric patients” experience economic challenges. Yet despite the importance of socioeconomic factors to child health and development, socioeconomic issues often receive limited attention from pediatric primary care clinicians. Despite its relative importance to short and long-term child health and development, just 36.8% of pediatric primary care clinicians routinely assess for socioeconomic concerns as a risk factor for poor health and development. In 2016, the AAP endorsed a new recommendation to screen children and their families for poverty. In 2015, the AAP recommended that pediatricians screen children and families for food insecurity.

Pediatric primary care clinicians need to devise practice-based systems to identify children and families with poor economic circumstances. Due to their professional understanding of the link among economics, development, and health, positioning the process within developmental surveillance and screening may be a good starting place. Practice-specific quality improvement learning projects implemented by medical students, pediatric residents, and pediatric nurse practitioner students may be a beginning point. But, of course, the process does not stop there.

Clinicians reported using a variety of tools for developmental screening including some that at least partially assess for social determinants of health. No specific social determinants of health-related screening tools are recommended in the Bright Futures (4th edition) guidelines, because sufficient evidence to endorse a specific tool is lacking. Bright Futures does note that there are short, standardized screening tools for adverse family experiences, intimate partner violence, food insecurity, prenatal alcohol exposure, and maternal depression. There are broad-based assessment and screening tools that can identify unmet basic needs and condition-specific tools to detect concerns such as maternal depression and intimate partner violence. Potentially useful tools include the WE-CARE screener, Pediatric Intake Form, SEEK parent screening questionnaire, the Edinburgh Post-Natal Depression Screening tool, the Survey of Well-being of Young Children, the Whole Child Assessment, the 2-Item Screen to Identify Families at Risk for Food Insecurity, and the age-based KySS Assessment Questions available from the National Association of Pediatric Nurse Practitioners.

[Table 4 on previous page].

continued on next page
Connecting families to resources may require assistance beyond just contact information, but also in navigating bureaucratic obstacles and other barriers. Resource information is available from NJHelps.org. On-site resource bulletin boards and brochures, as well as practice web-site based information allows access by most families. This is important as families in reduced economic circumstances may be uncomfortable approaching the clinician for assistance.

Social determinants of health affect the treatment and follow-up phases of medical care, too. Parent education efforts are affected by health literacy including limited English proficiency. The ability to obtain referred services is also affected by health literacy as well as transportation, insurance coverage, finances, language and literacy, social stigma, and neighborhood conditions.

1.5 Conclusion

Many New Jersey pediatricians recognize the importance of social and environmental factors to children’s health and development. However, some pediatricians do not monitor for the presence of such social and environmental factors (i.e., social determinants of health). With social, economic, environmental, and demographic factors influencing much of a population’s health, the impact of social determinants on child health and development is considerable. As such, it represents an opportunity for pediatricians and others in primary care to improve health and developmental outcomes for children and their families. Screening for social determinants of health in pediatric primary care settings is the first step.

Thank you to the pediatricians and other clinicians who kindly completed our questionnaire. Thank you to Sean Parnell and Misha Sharma for assistance. Thank you to Barbara Caldwell, Mercedes Echevarria, and Margaret W. Sullivan for their input into questionnaire development. Thank you to Margaret P. Diston for her editing assistance. Thank you to Rutgers School of Nursing for their partial funding of this study.

References

Mental health has been at the top of many healthcare conversations for the past few years. Thirteen years ago, my daughter was born with a chronic pseudo-obstruction that was not the top of the discussion I had with her pediatrician. It shouldn’t have been as we were doing everything to help her gain weight so she would not be malnourished and in danger of further complications. So much effort went into getting her on a research medication, finding the right titration of GJ tubes so she would grow and hopefully start feeling better. Fast forward a few years and she is now a healthy 13-year old teenage girl. However, in order to get her there, she endured many tests, inpatient hospital stays in multiple hospitals, procedures, tube feeds and research medications. When she went for her 13-year old well visit and she learned she had not grown in over a year, it was the first time in a few years she was referred to a specialist for further testing. We learned she has idiopathic short stature and nothing could be done but more tests to make sure nothing was missed. Since she had gone through so much in the first few years of her life and came through it like a champ, our pediatrician and I were surprised at my daughter’s angry reaction to tests, anxiety that something else was wrong and refusal to complete the testing. I knew something more was wrong that involved her mental health.

I was able to find her professional support, and after working with a psychologist we realized my daughter’s years with illness negatively affected her mental health. She never emotionally processed everything she had been through physically. This was a lightbulb moment for me; I felt I missed a big piece of her care. While pediatricians are tasked with taking care of a child’s physical health needs, it is imperative we don’t forget about the mental health needs a child with an illness may experience. After all, the brain is another organ and it goes hand in hand with the other parts of the body. However, when a pediatrician goes through medical school there is not much emphasis on how mental health is affected by illness. This is a shift in how society views physical and mental health. The more we recognize they go together, the more mental health becomes something that is checked during well visits as a standard part of practice. Just as we track height and weight as children grow, we should do the same for mental health. New Jersey is one of many states that has recognized this and provided pediatricians with a resource to go to when their patients need mental health support. The Pediatric Psychiatric Collaborative provides regional hubs of mental health care providers so pediatricians can safely refer their patients with any kind of mental healthcare need. This is a big step providers in 20 NJ counties in New Jersey have taken with the ultimate goal of closing the gap between physical and mental healthcare needs.

Amy Kratchman has been working with clinicians and researchers since 2008 as a family representative. She is the mother of a three children with special healthcare needs. As a Family Consultant at The Children’s Hospital of Philadelphia (CHOP), Amy co-leads numerous Family Centered Care initiatives. She collaborates with senior hospital leaders and staff to ensure that the institution’s operating plan and programmatic goals are responsive to the needs of children and families. Amy co-leads Family Partners, an innovative program developed and implemented at CHOP, to maximize the meaningful engagement of families in all aspects of the pediatric healthcare delivery system. Engaging parents and youth in research is a major focus of this work.

Pediatric Psychiatry Collaborative Regional Hubs

Legend

AtlanticHealth Hub @ Newton
AtlanticHealth Hub @ Goryeb
Hackensack University Medical Center Hub
Hackensack Meridian Hub @ Palisades
Meridian Hub @ Saint Peter’s
Meridian Hub @ Jersey Shore
Cooper Hub @ Camden
Cooper Hub @ Pennsville

For more information on joining a regional Hub in your area, email: MHC@njaap.org, call 609.842.0014 or register online at: www.njaap.org/programs/mental-health/ppc
# What’s in your glass?

Choices are great, but they can be overwhelming. This at-a-glance chart can help you understand what’s in your 8-ounce glass of milk.

<table>
<thead>
<tr>
<th></th>
<th>COW’S MILK (Low-Fat)</th>
<th>SOY</th>
<th>ALMOND</th>
<th>COCONUT</th>
<th>RICE</th>
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<td>4.5g</td>
<td>2.5g</td>
<td>5g</td>
<td>2.5g</td>
</tr>
<tr>
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<td>9g</td>
<td>8g</td>
<td>7g</td>
<td>23g</td>
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</tbody>
</table>

### VITAMINS AND MINERALS (% Daily Value)

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<thead>
<tr>
<th>Vitamin</th>
<th>COW’S MILK</th>
<th>SOY</th>
<th>ALMOND</th>
<th>COCONUT</th>
<th>RICE</th>
</tr>
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<tbody>
<tr>
<td>Calcium</td>
<td>30%</td>
<td>45%</td>
<td>45%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Phosphorus</td>
<td>25%</td>
<td>25%</td>
<td>N/A</td>
<td>N/A</td>
<td>15%</td>
</tr>
<tr>
<td>Potassium</td>
<td>10%</td>
<td>10%</td>
<td>1%</td>
<td>1%</td>
<td>15%</td>
</tr>
<tr>
<td>Riboflavin</td>
<td>25%</td>
<td>30%</td>
<td>30%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Vitamin B-12</td>
<td>20%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Vitamin A</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>25%</td>
<td>30%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Naturally Occurring | Good Source = 10% – 19% DV | Excellent Source = 20%+ DV

### PRICE

<table>
<thead>
<tr>
<th></th>
<th>COW’S MILK</th>
<th>SOY</th>
<th>ALMOND</th>
<th>COCONUT</th>
<th>RICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per ½ Gallon</td>
<td>$2.05</td>
<td>$3.37</td>
<td>$3.28</td>
<td>$4.99</td>
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</tr>
<tr>
<td>Per 8oz. Serving</td>
<td>$0.26</td>
<td>$0.42</td>
<td>$0.41</td>
<td>$0.62</td>
<td>$0.43</td>
</tr>
</tbody>
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americandairy.com
**WHAT IS LUPUS?** An incurable autoimmune disease that causes inflammation and tissue damage in all parts of the body. Lupus nephritis, which can damage and scar the kidneys and other parts of the renal system, is one of the most common and serious complications of lupus.

Childhood-onset Systemic Lupus Erythematosus (cSLE) occurs disproportionately in African Americans, Hispanic, Asians and Native Americans and these ethnicities suffer a worse outcome compared to Caucasian patients.

**Benefit of Participation: 25 MOC Part 4 Points**

This ABP-Approved Maintenance of Certification (MOC) Part 4 program is aimed at helping pediatricians on early diagnosis, effective management and improved health outcomes and health related quality of life (HRQOL) for cSLE patients. Screening techniques/tools, anticipatory guidance, referrals source and care coordination will be provided to help support the early detection of lupus, and the improvement of lupus care in the primary care setting. You will receive:

- 6-month quality improvement (QI) program
- Training on lupus screening, diagnosis, & management
- Resources for healthcare providers, caregivers/families, and patients
- Hands-on technical assistance for implementing screening and care coordination
- Opportunities to network with colleagues, experts, and community organizations

All participants in NJAAP’s Lupus Program are required to:

- Designate a 3-person multidisciplinary practice QI team
- Attend 2 half-day In-Person Learning Sessions (opportunity to earn additional CME credits) - January 16, 2018 & June 14, 2016
- Submit data for 10 patients per cycle (baseline, 2 months, 4 months, and 6 months)
- Submit bi-monthly reports on progress in achieving QI goals
- Participate in 3 (of 4) webinars (December 8th, January 10, March 7th, & May 4th)
- Complete a practice demographic survey
- Participate in on-site office visits with NJAAP QI team member
- Complete pre and post physician knowledge assessment survey
- Participate in an exit interview
- Submit attestation*

For more information about participating in the MOC Program, please email lupusnj@njaap.org or call 609-842-0014.
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Attention Pediatric Providers in Essex, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Somerset, Sussex, & Union Counties

Pediatric Alliance for Lupus (PAL)
The PAL initiative was supported by Award Number CPIMP171139 from the Office of the Assistant Secretary of Health (OASH). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OASH.

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All participants in NJAAP’s Lupus Program are required to:

- Designate a 3-person interdisciplinary practice QI team
- Attend 2 half-day In-Person Learning Sessions (opportunity to earn additional CME credits) - January 16, 2018 & June 14, 2016
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HOW IS HEPATITIS B SPREAD?
Hepatitis B is spread through contact with blood. An infected family member or caregiver can pass the virus to an infant.

A pregnant woman who has hepatitis B can pass the virus to her infant at birth, but the vaccine can help prevent the baby from getting infected.

Most people living with hepatitis B got infected as infants or young children when their immune systems were not fully developed.

WHY SHOULD MY BABY BE VACCINATED AGAINST HEPATITIS B?

- The hepatitis B vaccine can prevent a baby from getting infected. CDC recommends all babies get the first hepatitis B vaccine shot at birth and follow the vaccine schedule to get the remaining shots.
- The hepatitis B vaccine is safe and effective.
- Delaying the first dose of the hepatitis B vaccine can put your baby at risk for hepatitis B.
- The hepatitis B vaccine has helped prevent millions of infants from getting hepatitis B, which can be a deadly disease.

New Jersey Ranks Low Nationally (48th out of 51) in HBV Birth Dose Administration
The New Jersey Immunization Network, in partnership with Saint Barnabas Medical Center, Rutgers University and the New Jersey Chapter, American Academy of Pediatrics encourage you to view a new on-demand educational module on administration of the birth dose of the Hepatitis B vaccine. Topics featured in this free webinar include:

- What is Hep B and why is it a New Jersey issue?
- What are the issues with perinatal transmission? Besides the mother, how else can an infant acquire HBV?
- How are pregnant women with HBV identified and what prenatal care is recommended?
- Best practices at delivery centers to achieve universal HBV birth dose administration
- Importance of HBV testing in infants born to HBV positive mothers

This educational opportunity has been made possible through a grant from the NJ Department of Health

CDC
American Academy of Pediatrics
New Jersey Chapter
New Jersey Health Department
Rutgers
NJIN
Hepatitis B
Saint Barnabas Medical Center
Central and South America
Dedicated to the Health of All Children
MEETINGS / CONFERENCES

☐ NJAAP Annual Conference
   May 22-23, 2018
   The Palace, Somerset, NJ

☐ School Health Conference
   October 17, 2018
   The Palace, Somerset, NJ

WEBINARS

☐ Fetal Alcohol Syndrome: Identification, Treatment and Clinical & Behavioral Management
   3 Part Webinar Series (CME / CNE / Social Work approved webinar series.)

☐ Pediatric Alliance for Lupus Webinars Series
   (CME & CNE offered)
   December 8, 2017 – 12 – 1 PM
   Clinical Presentation of SLE in Children & Adolescents
   January 10, 2018 – 12 – 1 PM
   Management of SLE in Children & Adolescents
   March 7, 2018 – 12 – 1 PM
   Adolescent Health Issues & Adherence
   May 4, 2018 – 12- 1 PM
   Educational Tools to Improve Health Literacy and Self-Management of Childhood-Onset Systemic Lupus Erythematosus (cSLE)

☐ Preventing Elevated Blood Lead Levels in Children
   (CME offered)
   The New Jersey Chapter, American Academy of Pediatrics (NJAAP) in partnership with the New Jersey Department of Health has created an educational video for healthcare providers that highlights the importance of conducting blood lead level tests for children. Elevated blood lead levels is one of the most preventable pediatric environmental health issues in the United States today.

☐ Announcing Immediate Access to a Free a CME/CNE-Approved On-Demand Hep B Learning Module
   The Learning Module address key topics including:
   • What is Hep B and why is it an issue in New Jersey?
   • What are the issues with perinatal transmission? Besides the mother, how else can an infant acquire HBV?
   • How are pregnant women with HBV identified and what prenatal care is recommended?
   • Best practices at delivery centers to achieve universal HBV birth dose administration
   • Importance of HBV testing in infants born to HBV positive mothers
   To view the Module, please visit http://bit.ly/perinatalhepB. Participants can access, save, and/or print a certificate (CME/CNE) of completion immediately upon completion the course evaluation.

CME QUALITY IMPROVEMENT PROGRAMS & RESOURCES

☐ Suspected Child Abuse and Neglect Program
   CME / CNE / CE approved training programs available for PCPs, Emergency Departments and EMS providers to increase recognition of child abuse and neglect and encourage appropriate reports to CPP. (free) For more information, contact can@njaap.org for more information

☐ Integrating Infant Oral Health & Perinatal Oral Health into Routine Well Care
   CME / CNE approved office based training to integrate oral health into routine well care visits (Includes: oral health risk assessment, fluoride varnish application, payment process to Managed care organizations and list of participating Dental providers in your county) (free) For more information, contact oralhealth@njaap.org.

☐ Pediatric Alliance for Lupus Initiative
   Attention Pediatric Providers in Essex, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Somerset, Sussex, & Union Counties
   A 6-month quality improvement (QI) program is aimed at helping pediatricians on early diagnosis, effective management and improved health outcomes and health related quality of life (HRQOL) for cSLE patients. Screening techniques/tools, anticipatory guidance, referral source and care coordination will be provided to help support the early detection of lupus, and the improvement of lupus care in the primary care setting. For more information, contact Angela Chandra, Program Manager at achandra@njaap.org.

☐ Pediatric Psychiatry COLLABORATIVE
   Attention Pediatric Providers in Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union and Warren Counties
   The Pediatric Psychiatry Collaborative is available at hospital-based hubs in your area. To learn more about the collaborative that provides pediatric providers with quick access to psychiatric consultation and referrals to mental/behavioral healthcare, contact mhc@njaap.org.

Visit www.NJAAP.org often to register / learn about additional educational opportunities!
For more information call 609-842-0014 or email njchapter@njaap.org

Revised 5/17
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EIGHTH ANNUAL New Jersey CHILDREN’S Ball SPOTLIGHT on CHILDREN

Wednesday, April 25, 2018 @ 6:30 PM
The Palace at Somerset Park ~ Somerset, NJ

SAVE THE DATE!

NJAAP Annual Conference & Exhibition
Re-Stock Your Pediatric Toolbox
Tuesday, May 22 & Wednesday, May 23, 2018
The Palace at Somerset Park, Somerset, NJ

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Julie Linton, MD, FAAP | Beth Pletcher, MD, FAAP
Judith Shaw, MD, FAAP | P. Ashley Wackym, MD, FAAP
Warren Seigel, MD, FSAHM, FAAP | Peggy Eicher, MD, FAAP
L. Nandini Moorthy, MD, MBBS, MS, FAAP
Carlo Di Lorenzo, MD | Robert Murray, MD, FAAP
Patricia Schram, MD | Chief John Zebrowski
Diane Calello, MD, FAAP

Topics to Include:
Visual Diagnosis | Infectious Disease
Children of Immigrants | Genetics | Bright Futures
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Rheumatic Diseases | Gastroenterology
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The New Jersey Chapter, AAP, and NJAAP Purchasing Alliance have partnered with Positive Physicians Insurance Exchange (PPIX) and Medical Mutual Insurance Company of North Carolina (MMIC) to provide you exclusive proprietary member rates on Medical Malpractice Insurance.

For more information, visit [www.njaappurchasingalliance.org](http://www.njaappurchasingalliance.org) or call the NJAAP Purchasing Alliance at 609-378-1106