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Bilateral Pulmonary Emboli in an Adolescent with Factor V Leiden Mutation
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Discover the Superpowers of the New Jersey Immunization Registry
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The NJAAP Youth Advisory Committee
By Chair, Stephen Marcella, MD
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Turning the Page on a New Year

As we all know, 2019 has presented pediatricians from across New Jersey with its fair share of successes and challenges, and as a result, our steadfast commitment to providing comprehensive care to all children, allows for us to look in the rear view mirror and take pride in our collective efforts.

I’d like to set that subject aside in order that I might address another of equal importance.

As many may already know, after an extensive search and interview process, I, along with the entire NJAAP Executive Council are both excited and pleased to announce that Felicia Taylor, MBA, CAE has been selected as NJAAP’s new CEO. Felicia officially launched her place at the helm this past December. Under normal circumstances, this announcement would have taken place much sooner and with far more fanfare, but alas, unanticipated events precluded that from happening. So I am dedicating my space in this issue to officially introduce and welcome Felicia to the NJAAP family.

Felicia Taylor has and continues to dedicate her life to working for nonprofits, especially in fields that positively impact the health and well-being of our most vulnerable populations. Felicia comes to NJAAP from the National Association of Pediatric Nurse Practitioners (NAPNAP), a 9,000-member specialty nursing organization where she served as Director of Member Services and Engagement. Her leadership qualities span across many areas including managing the day-to-day operations of the business, hiring, developing and mentoring staff, facilitation of strategic planning retreats with the Board of Directors, leading organizational efforts in the areas of diversity and inclusion, advocating for child health and advanced practice nursing issues with legislators, financial planning and more.

Felicia has been a member of the AAP Bright Futures Project Implementation Advisory Committee since 2012. She was instrumental in facilitating discussions among the leadership (i.e., retired AAP CEO Errol Alden) at these organizations, which led to partnerships that exist today. Many of these partnerships helped raise the visibility of the organization and provided speaker exchanges, discounts to members on products and services and a joint approach to child health legislation. She has a long history of developing partnerships with industry to increase funding in the areas of sponsorship, exhibits and educational grants. Her experience, vision, and track record in membership growth, business development, and effective advocacy will no doubt prove invaluable in helping us forge new opportunities while navigating existing and yet unforeseen challenges. Given the exciting opportunities in front of us, and yes, the challenges we will face, Felicia’s experience and passion for children’s health, will serve us all well.

In her own words, “Working in pediatrics and with NJAAP has always been a dream. And now, I can say that I am beyond fortunate to be working at my dream job.”

In closing, I’d like to encourage you all to welcome Felicia and extend the same level of commitment to the growth and wellbeing of our Chapter to her. Take time get to know Felicia. Call her, email her, or better yet, stop by the NJAAP offices and welcome her in person. As has always been the case, it’s your ideas, thoughts and encouragement that has guided the growth of NJAAP and you are encouraged to continue along those same lines with Felicia.

Welcome, Felicia. We are excited to see what the future holds for all of us.
CEO's Column

Felicia K. Taylor, MBA, CAE
Chief Executive Officer
NJAAP

Leading into the future

Greetings and thank you for the warm welcome as I transition into the role of CEO of NJAAP. It is an honor to work with you to fulfill the mission of this revered organization. A special thank you to the Executive Council for selecting me to work for you as a servant leader to guide NJAAP into its next phase of growth.

The accomplishments of this organization are impressive. As I read through the website and several issues of this publication, I realized the true impact and influence of NJAAP. The work of this Chapter is demonstrated through evidence-based outcomes for child health issues in the state of New Jersey. The quality and reach of the work of this organization is a testament to the dedication of its members, volunteers and staff. This is model organization, and I can’t wait to see where it will be in 10 years.

As a New Jersey native, I am committed to making a difference in the lives of children and families in this great state. I am a parent, conscientious citizen and nonprofit executive who made a life-long commitment to work in an environment that strives to further ensure the future of all children as healthy and productive citizens. There are a multitude of issues impacting our children today; however, my passion is mental health and issues surrounding immunization adherence. NJAAP will give me an opportunity to fulfill that commitment to lead the next phase of programs, partnerships and legislative victories that will further support child health and pediatricians in the state of New Jersey.

A special thank you to Fran Gallagher for her tireless efforts, vision and leadership over the past 13 years. I would also like to recognize the outstanding staff and volunteers who work to promote health care and the needs of pediatricians. The next chapter of NJAAP will build on the solid foundation led by Fran.

It is an honor and privilege to serve you. I look forward to working with you to lead NJAAP into the future as the premiere chapter in child health.

Felicia K. Taylor
Medical Director’s Column

Steven Kairys, MD, MPH, FAAP
Chairman of Pediatrics,
Hackensack Meridian Health School of
Medicine at Seton Hall

2020 & Beyond

I would like to give another formal thanks to Fran Gallagher for her years of service to the children of New Jersey. Fran has been a passionate and highly effective voice for all of us. Her accomplishments are legion and have set a high bar for moving forward.

The Chapter’s new CEO, Felicia Taylor, has great skills and a deep record of accomplishment, and I remain assured that the transition of leadership will advance smoothly and without any disruption to programs or progress.

This transition also mirrors the start of a new decade and with it, a need to think more broadly about the needs of children and pediatricians. Focusing on these essential needs, I would like to spotlight some the themes I believe our Chapter must emphasize throughout 2020 and beyond.

1. Continued emphasis on primary care and the medical home, NCQA accreditation, and improved payment models for pediatric primary care. I still have high hopes for developing a more effective collaboration with Medicaid, one partially supported by the Nicholson Foundation. This new partnership would be directed by Dr. Larry Kleinman at Rutgers with NJAAP serving as an active participant.

2. Integrated Care for Kids (InCK). Here too, I am also hopeful that NJAAP will participate as active partner in the InCK, a national grant from CMS that would revamp the way New Jersey supports care of children covered by Medicaid, one partially supported by the Nicholson Foundation. This new partnership would be directed by Dr. Larry Kleinman at Rutgers with NJAAP serving as an active participant.

3. Continued focus on trauma-informed care and adverse childhood experiences using a strength and resiliency approach to improve outcomes for children living in toxic environments.

4. Further growth and maturation of the pediatric psychiatry collaboration so that pediatricians and pediatric specialist not only screens for mental and behavioral concerns, but also develop the capacity to manage some of these children in the medical home. We are just beginning development of telehealth so that the pediatric office may also be a site of consultation with child psychiatry. The integration between behavioral and medical health also meshes closely with trauma-informed care and develops a new system of care for these children. The continued success and growth of this collaborative effort is contingent upon payment for these new services by insurance systems.

5. Promotion of child advocacy through multiple initiatives including: pediatric residency training, ensuring immigrant health, social determinants, working closely with the Statewide Parent Advocacy Network (SPAN), continued legislative involvement, ongoing engagement with the New Jersey Immunization Information System and the VFC program, and enhanced coordination with State Departments of Health, Human Services, Education and the Department of Children and Families

6. Develop an innovative approach for ensuring a formal transition of children - especially those with special needs—moving from pediatric to adult care. Currently, we are working with the American Academy of Family Physicians to create such pilots.

As always, the goal of all of these efforts are sustainable change and payment models that incent such improvements in care. We also always need to strive to measure not only short term successes but also long term change and its effect on child outcomes.

I am optimistic that NJAAP will continue in its role of being a strong and effective advocate for all children in New Jersey and for the pediatricians who provide this specialized care.
Attention Deficit Hyperactivity Disorder and Comorbid Conditions

Introduction

Roughly one-half to two-thirds of all people with attention deficit hyperactivity disorder (ADHD) also have a second comorbid condition, ranging from depression, anxiety, obsessive compulsive disorder (OCD) and oppositional defiant disorder (ODD) to learning and language disabilities, fine and gross motor difficulties, executive function difficulties, tic disorders, or another psychological or neurological condition. In some cases, these problems are considered “secondary” to ADHD; that is, they are triggered by the individual’s frustration from coping with the symptoms of ADHD. Comorbid psychiatric disorders may complicate the clinical presentation of ADHD. In addition, up to 30% of people with psychiatric and neurological conditions such as traumatic brain injury (TBI), bipolar disorder, tics, OCD, anxiety, psychotic states, and substance use disorders also have symptoms of ADHD and similar executive dysfunction.1

Attention Deficit Hyperactivity Disorder

ADHD is a disorder characterized by a persistent pattern of inattention and/or hyperactivity/impulsivity that occurs in an academic, occupational, or social setting. Making careless mistakes, failing to complete tasks, having problems staying organized and keeping track of things, and becoming easily distracted are some of the challenges that confront patients with the disorder. Problems with hyperactivity include excessive fidgetiness and squirminess, inappropriate running or climbing, excessive talking, and being constantly on the go. Impulsivity may appear as impatience, difficulty awaiting one’s turn, blurt ing out answers, and/or frequently interrupting others. Although many individuals with ADHD display both inattentive and hyperactive/impulsive symptoms, some individuals show symptoms from only one of these groups. The prevalence of ADHD in the general unscreened school-age population is estimated to range from 4 to 12 percent.

Several genes exist for ADHD, providing evidence of its genetic origin. According to Tripp and Wickens, differences in the dimensions of the frontal lobes, caudate nucleus, and cerebellar vermis have been demonstrated, with particular focus on the neurotransmitter dopamine and its actions at the cellular and systems level. Neuropsychological testing has revealed differences in two main domains: executive function and motivation. There is also little evidence to suggest that parenting practices and family stress are important causal factors in the development of ADHD. However, these factors may influence the severity of a child’s symptoms. This is critical because it highlights the tremendously important role that parents can play in helping to promote the successful development of their child with ADHD.1

Comorbidity

Comorbidity with ADHD can occur for various reasons. First, it may be from a chance occurrence or due to the conjunction of independent risk factors. It may develop because two disorders have shared or overlapping risk factors, or because one disorder causes the Other. The comorbid condition may be a multiformal expression of one of the pure disorders, or a third independent disorder. It follows that the best approach for dealing with comorbidity depends on why a given pair of disorders tends to co-occur. The problems raised by psychiatric comorbidity cannot be resolved on an a priori basis. They require data on the nature of comorbidity between specific sets of disorders. As a result, there is no single solution to the problem of comorbidity. Rather, different solutions will be required for different combinations of disorders.4

This article highlights the comorbid disorders of ADHD and offers some practical suggestions for appropriate diagnosis, treatment, and interventions for each.

Neurodevelopmental Disorders

Intellectual Disability

Despite there being evidence that ADHD is more common in children with intellectual disability (IQ<70) and that the severity of intellectual disability increases with comorbidity ADHD, children with intellectual disability are often excluded from ADHD studies. Thus, the clinical presentation of a patient with both diagnoses is not well known. In fact, a population study estimated that hyperkinetic disorder is the most common psychiatric disorder among children with intellectual disability, though ADHD is one of the most common forms of psychopathology in children with intellectual disability. However, those with and without mild intellectual disability (IQ 50-69) demonstrated similar patterns of ADHD subtypes, total number of ADHD symptoms, and similar comorbidity with ODD, anxiety, and depression. Further, children who were diagnosed with both ADHD and intellectual disability showed an increased rate of conduct disorder and oppositional defiant disorder symptoms than with either ADHD or intellectual disability alone.5

While some studies show that children with ADHD and intellectual disability have higher rates of social skill impairment, conduct problems, aggression, and noncompliance than those with ADHD and normal IQ, community samples did not show a difference of these conditions between children with mild intellectual disability (IQ 50-69) or a cutoff of IQ 70-85. Further, another study found that children with ADHD and intellectual disability have increased rates of noncompliance, anxiety, depression, and social problems than children with only the diagnosis of intellectual disability.5 Treatment for children with ADHD and intellectual disability should include medications to address the ADHD (both stimulants and non-stimulants have shown success), and school and therapeutic interventions for the child’s specific needs.

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**Autism Spectrum Disorder**

In a large epidemiological study, 13% of youth with ADHD were also diagnosed with Autism Spectrum Disorder (ASD). ADHD is the most common comorbidity in children with ASD, with rates of 40-70% of comorbidity. In fact, diagnoses of ADHD are made approximately 2 years later in children who have known ASD versus children who do not. The ADHD symptoms of hyperactivity and impulsivity correlate strongly (r=0.56) with the restricted and repetitive behaviors of ASD. Further, family members of those with ADHD have increased rates of ASD and vice versa. Using structural equation modeling, three pathways have been used to explain ADHD and ASD comorbidity. These pathways include a pathway between inattention, verbal IQ, and social information processing difficulties, another from hyperactivity to restricted and repetitive behaviors, and a pathway from impulsivity to social information processing difficulties. While guidelines do not recommend routine use of medications to manage the core symptoms of ASD, the following are recommended for management of the comorbid ADHD symptoms: methylphenidate, atomoxetine, and guanfacine. Further, a Cochrane review showed that use of methylphenidate in children with ASD and ADHD reduced hyperactivity and impulsivity (less so attention), but had no effect on the symptoms of ASD. Medium vs. lower doses also showed an increase in clinical improvement of ADHD symptoms. Treatment for children with both ADHD and ASD should include both ADHD-specific treatment (including medications cited above), but also include multidisciplinary cohesiveness for ASD-specific treatment, with both in-school and in-home specialized therapists, aides, and practitioners, as well as medication-specific treatment for specific symptoms of the ASD, including mood stabilizers, antidepressants, or antipsychotics.

**Developmental Coordination Disorder**

Approximately 50% of children with developmental coordination disorder (DCD) have co-occurring ADHD. A combination of both diagnoses is an early predictor for further mental health problems. In fact, many times DCD is a missed diagnosis; however, this disorder results in restrictions of the patient to perform activities of daily living (ADL’s) as well as academic performance (secondary to associated dyslexia and poor handwriting). This is important to remember so that specialists become involved earlier in the treatment of this comorbidity.

**Disruptive Behavior Disorders**

**Oppositional Defiant Disorder**

When considering comorbid conditions with ADHD, disruptive behaviors are the most common, with roughly 30% to 75% representing the population of children. Oppositional defiant disorder (ODD) comorbid with ADHD almost always results in a greater severity in symptoms including aggression, outburst, ignoring requests, difficulties with peers and developmental deficits when compared to those individuals with either ODD or ADHD alone. Children with ODD and ADHD are more impaired, but effective treatments may reduce the risk of complications such as depression, conduct disorder (CD) or substance abuse. ADHD and ODD behavioral problems at a young age may predispose children to bullying involvement in early elementary school. Although treatment with a stimulant can greatly reduce symptoms synonymous with ADHD and ODD, there are still behaviors that persist with ODD. As a result, treatment should include educating the parents, or guardians with positive reinforcement, accentuating the positive, behavior modification techniques and CBT. Establishing rules and generational boundaries can be a very helpful as well.
**Conduct Disorder**

Conduct disorder (CD) refers to a range of manifestations that result in the infringement of the rights of others and the disregard for community rules. CD is normally comorbid with ADHD (1/3 of the cases), a situation that contributes to the severity of the condition. Children with both conditions have a poor prognosis and in adulthood, the sequela often includes substance abuse and antisocial personality disorder. CD and ADHD may share the same risk factors. One disorder is a risk of developing the other, or similarly, one disorder is a precursor of the other. CD alone can be rare and thus appropriate diagnosis with observation, and rating scales can be helpful to diagnosis CD since prognosis is poor for children who go on to exhibit Antisocial Personality Disorder (ASPD) as a result. Some of the cardinal features for CD include fire setting, animal cruelty, running away from home and stealing, among other things. Burke et al, in 2002 informed that a multi systemic treatment approach is key to the management of patients with CD that includes even legal instances, when appropriate. The aforementioned is of course in addition to a combination of ADHD medication and other psychotropic drugs like second-generation antipsychotics.

**Mood and Anxiety Disorders**

**Depressive Disorders**

There is a strong correlation of major depressive disorder (MDD) and ADHD. In children, this number varies from 10–30% compared to 2% for major depression alone. While depression has distinctive symptoms, such as anhedonia and cognitive dysfunction, there are many overlapping symptomatic similarities between ADHD and MDD. These symptoms include: deficits in concentration, sleep disorders, impulsivity, and restlessness. This can be a potential challenge in accurate diagnosis, as treating one disorder without addressing the other can exacerbate the severity of the symptoms. The depressive symptoms can worsen if unaddressed, as children with ADHD often go undiagnosed. There is also a possibility that dysphoric symptoms can occur as a result of the effects of medications. Up to 30% of patients who use stimulants can have effects of dysphoria not related to depression. Understanding the distinction of ADHD with MDD vs. MDD alone can often be challenging, though important, as treatment options vary between the two scenarios.

There is also a diagnostic discrepancy when discussing ADHD comorbidities and their presentations in young females compared to young males. Young females are less likely to be diagnosed with ADHD in general. This is thought to be due to females with ADHD developing coping strategies to help mask the symptoms of ADHD. In fact, it is noted that females with ADHD will have more internalizing symptoms (i.e. inattentiveness) and less externalizing symptoms (i.e. impulsiveness/hyperactivity). Biederman, et al., in a longitudinal study, followed 245 young women (123 women with ADHD and 122 women as control) in a 5-year period from early adolescence to adulthood. They concluded that 40.7% of young women with ADHD had comorbid MDD at baseline. This is in comparison to 11% of young women with MDD from the control group. After the 5-year follow-up period, it was found that 65% of young women with ADHD had MDD. This was compared with 20.5% from the control group.

It is important to note that if left untreated, these symptoms can proceed into adulthood, as similar correlations exists. In fact, in a National Comorbidity Survey Replication study, Kessler et al., found that the prevalence of MDD in adults with ADHD was 18.6% (SE 4.2) compared to 7.8% (SE 0.4) in non-ADHD respondents (OR 2.7). Further, it is hypothesized that the correlation between ADHD and depression seen in childhood progresses into adulthood, and leads to poorer long-term outcomes and a higher suicide risk.

Patients who suffer from ADHD that is comorbid with depression may benefit from attempts to treat depressive symptoms first. This treatment should include both psychotherapy, and at times when appropriate, an anti-depressant medication (with psychoeducation to the family about black-box warnings on anti-depressant use in children and adolescents).

**Anxiety Disorders**

It is found that adolescents with ADHD have a 33% prevalence rate of co-occurring anxiety. Unlike the comorbidity of MDD with ADHD, where the symptoms of MDD are fairly distinctive, recognizing a comorbid anxiety disorder is more difficult. Oftentimes, comorbid anxiety disorders are missed and children are diagnosed solely with ADHD. This is due to the misunderstanding that irritability, restlessness, and a heightened state of concern, amongst other symptoms, are caused by ADHD alone as opposed to an anxiety disorder. Halldorsdottir, et al., suggested that children with ADHD and co-occurring anxiety develop sluggish cognitive tempo and poor response inhibition. This may be due to being overwhelmed by tasks, which can lead to confusion and concurrent slow response, but are misappropriated to ADHD alone rather than recognizing the strong correlation to anxiety.

This comorbidity presents a challenge, as stimulant treatment for ADHD may worsen a patient’s anxiety. Further, CBT and other psychotherapy models are indicated as first line treatment of anxiety disorders, but these may be less effective when co-occurring ADHD is present due to the hyperactivity and distractibility interfering with the therapy. Therefore, atomoxetine is recommended for the treatment of ADHD in patients with co-occurring anxiety, so as to prevent exacerbation of anxiety that can occur with the use of stimulants.

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Bipolar Disorder

Bipolar disorder is also a consideration as a co-morbidity of ADHD. In fact, stimulant use may lead to manic decompensation. However, establishing an initial diagnosis of Bipolar Disorder that is comorbid to ADHD can be challenging, as much of the symptoms (i.e. logorrhea, pressure of speech, psychomotor instability and distractibility) can mimic symptoms of ADHD alone. It is important to understand that while the risk of comorbid bipolar disorder in children with ADHD overall is quite low, there is a much higher association of ADHD in patients with an initial diagnosis of bipolar disorder. As Van Mater discussed, up to 20% of patients with bipolar disorder are known to have ADHD as a comorbid disorder. When a patient has both ADHD and bipolar disorder, they are at an increased risk of having poorer socioeconomic outcomes in the future, including decreased employment stability and increased legal issues.19

When a patient is found to have co-occurring bipolar disorder with ADHD, stimulants should be discontinued, and mood stabilizers should be initiated. Once the mood is stabilized, re-introduction of stimulants may be considered.19 Further, the use of atypical antipsychotics can address comorbid aggression and mood dysregulation seen with bipolar disorder and ADHD. For example, aripiprazole works synergistically with stimulant therapy, which would improve both disruptive behaviors and ADHD.20

Disruptive Mood Dysregulation Disorder

Disruptive Mood Dysregulation Disorder (DMDD), which first appeared in 2013, is a condition in which children are persistently irritable, angry, or annoyed.9 According to Mulraney et al., this irritability is punctuated by intense and lengthy temper tantrums that are out of proportion to the situation. This diagnosis also grew out of concern that some children were being diagnosed with and treated for bipolar disorder without meeting the full diagnostic criteria. Chronic irritability is interspersed with fits of rage that appear with little to no provocation. They are so frequent and so severe that they become life-disrupting for both the child and his or her family. DMDD has so much in common with both oppositional defiant disorder (ODD) and ADHD that it’s sometimes hard to tell these three conditions apart. Approximately 90 percent of children with DMDD meet the criteria for ADHD, and about 80 percent meet the criteria for ODD, DMDD, ODD, and ADHD all cause irritable behavior and temper outbursts. The difference is in the rate and intensity. These behaviors are less frequent and severe in children with ODD and ADHD. In fact, 21.8% with ADHD have comorbid DMDD. Children with ADHD and DMDD have a high prevalence of ODD (89.7%) and any anxiety disorder (41.0%). Children with ADHD and DMDD have poorer self-control and elevated bullying behaviors than children with ADHD without DMDD. DMDD treatment includes symptomatic, supportive, parent training, and the use of guanfacine and other similar medications.21,22

Obsessive Compulsive Disorder

Obsessive compulsive disorder (OCD) also have ADHD. It is important to know that the treatment of ADHD with OCD as a comorbid disorder can take place simultaneously. Cognitive behavioral therapy (CBT) and the use of stimulants are considered safe and no contraindication is noted. However, patients with OCD and ADHD can also present with more serious comorbid disorders, such as bipolar disorder and tic disorders.18 This is where the use of stimulants can complicate the disease mitigation, as it can exacerbate tic disorders and bipolar disorder, and the discussion of safely introducing atypical antipsychotics should be considered.

Post-Traumatic Stress Disorder

Greater risk-taking in ADHD leads to an increase in trauma exposures; the consequence of which is a dysfunction in the frontal lobe circuits. Dysfunctional frontal lobes are a commonality involved in both ADHD and post-traumatic stress disorder (PTSD). These associations suggest a possible link between the two disorders for shared expression and symptomatology. The relative risk for PTSD in ADHD patients was 3.7 compared with normal controls without the diagnosis of ADHD and 1.6 compared with trauma controls.21 A traumatic event in the history of a child and adolescent individual is important to adequately diagnosing a patient with PTSD co morbid with ADHD. PTSD and ADHD can include similar symptoms such as sleep disorders, inattention and executive dysfunctions.11 In fact, approximately 5% of patients with PTSD have ADHD.24 ADHD can be a predisposing factor for certain trauma-stress induced disorders. Trauma can contribute to a reward deficiency syndrome (RDS), which can induce similar neurobiological diathesis similar to ADHD. Those patients with RDS will tend to self-medicate with stimulants and/or other substances. Treatment as a result should entail a careful history and assessment, making use of evidence-based trauma focused psychotherapies and psychosocial interventions in addition to stimulant psychopharmacology. ADHD treatment may have the potential to lessen fear and stress reactivity that lends to inattentiveness and impulsivity.21

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Psychotic Disorders

Schizophrenia

Many children and adolescents diagnosed with ADHD also have co-occurring schizophrenia. According to Levy, et al., discussing neurobiological disorders in the form of dichotomies is simplistic and challenged: that psychotic disorders are considered disorders of high dopamine and thus treated by dopamine antagonists, whereas ADHD is a disorder of low dopamine and thus treated by dopamine agonists. In fact, children with ADHD are 4.3 times more likely to develop schizophrenia as adults than those without a diagnosis of ADHD. Further, a genetic component is hypothesized, as a correlation is also seen in second-degree relatives of those with ADHD developing schizophrenia. In fact, 60-80% of cases of ADHD may result from genetic factors; similarly, up to 80% of cases of schizophrenia may result from genetic factors. Fifty eight percent of those diagnosed with ADHD in childhood develop schizophrenia-related psychoses in adulthood. Levy, et al. points out that in studies, those with psychotic disorders were more likely to have ADHD features than the controls. Further, in a large Swedish study (n=61,187) the risk of developing schizophrenia in those with ADHD was two times greater. Both diagnoses involve neurodevelopmental changes, though the exact relation is yet to be understood.26

Those with schizophrenia and ADHD experience difficulty with concentrating and co-occurring thought disorders. In fact, 10% of those with a diagnosis of ADHD experience psychotic symptoms. Further, in both ADHD and psychotic disorders, there is a high association seen with smoking and the use of other drugs. Both sets of patients also experience executive function deficits and a reduced capacity for emotional processing. Further, when a patient is deemed to be “pre-psychotic”, he/she is noted to also show increased levels of impulsivity, low frustration tolerance, and social functioning impairments.26,27

An interesting take as well is that people who take stimulants for their ADHD, may develop signs of schizophrenia. It is currently unclear, though, if these symptoms would have developed without the use of stimulants, i.e. via genetic and environmental factor influence. Are these people simply more susceptible to psychosis from the start? Lieberman et al. reviewed several studies on patients with schizophrenia taking stimulants. The results showed that 60% of those with schizophrenia showed no change or improvement in psychotic symptoms when taking stimulant. According to Levy et al., lower levels of dopamine in the mesocortical pathway are associated with overactive phasic dopamine signaling in the mesolimbic pathway; thus explaining how positive symptoms of psychosis (i.e. delusions and hallucinations) develop. Further, lower levels of tonic dopamine result in abnormally stimulus-dependent elevated phasic transmission. This explains how hypersensitivity to environmental stimuli develops, leading to inattention, hyperactivity, and impulsivity. Further, stimulants do not increase dopamine transmission in the mesolimbic pathway.27

When psychosis or bipolar disorder diagnosis is established in a patient with ADHD, treat the disorder first. This will clarify the contribution of treatable psychotic symptoms to the patient’s cognitive and functional impairment. If clinically significant inattention persists after treatment, consider non-stimulant treatment options, including atomoxetine or bupropion, and non-pharmacological interventions, like psychoeducation and cognitive behavioral therapy. If ADHD symptoms persist, consider a stimulant trial supported by psychoeducation for the patient and family on potential adverse events.28

Neurological Disorders

Traumatic Brain Injury

ADHD secondary to traumatic brain injury (ADHD/TBI) is one of the most common neurobehavioral consequences of TBI, occurring in 20% to 50% of individual’s post-injury. The Neurological Outcome Scale for Traumatic Brain Injury (NOS-TBI) was developed by the National Institutes of Health Stroke Scale (NIHSS) to grade injury severity after a TBI.29

Some of the most persistent problems include impairment in memory, attention and concentration, language, executive skills, social judgment, social behavior, and impulsiveness. Traumatic brain injuries can also aggravate the symptoms of ADHD or produce Secondary-ADHD. Masi and Gignac report a meta-analysis that shows strong evidence for the hypothesis that brain injury leads to ADHD (vs. the opposing thought that ADHD leads to subsequent brain injury). While the meta-analysis showed strong evidence for an association between ADHD and brain injury, with a continuing unclear directionality, it did show stronger evidence that brain injury leads to subsequent ADHD than vice versa. This has been hypothesized to be due to a dysfunction between the right prefrontal lobe, the globus pallidus, and the caudate nucleus. Impulse control is implicated from these areas, and the pathway is dominated by adrenergic (via dopamine active transporter 1) and dopaminergic (via DRD4 and DAT1-dopamine active transporter) transmission. D4 dopamine receptor defects and the overexpression of DAT are hypothesized to contribute to the ADHD phenotype, and thought to lead to impaired response inhibition.4,10 Further, patients who have ADHD and sustain mild traumatic brain injuries have an increased likelihood to have these deficits sustained in comparison to children without ADHD. Treatment for a TBI with co-occurring ADHD may include cognitive rehabilitation therapy and the use of stimulants or non-stimulant medication for impulsivity/hyperactivity or distractibility. Treatment may include other pharmacotherapies as well, depending on which symptoms the patient exhibits (i.e. If the patient shows increased depression, an anti-depressant may be used vs. increased aggression or mood lability, a mood stabilizer or second generation antipsychotic may be used).31

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Epilepsy

In many studies, ADHD is found to exist in children with epilepsy. In fact, Hermann noted in his 2007 study that 31% of children with new onset epilepsy had ADHD vs. 6% in controls. Children with epilepsy and ADHD show several social, academic, behavioral, and cognitive difficulties that come before the seizures. These difficulties show relation to neurodevelopmental abnormalities in brain structure. In fact, patients with ADHD with epilepsy have MRI's that show increased gray matter in the frontal lobe and smaller brain stem.12

In a study conducted by Wang et al., the prevalence of ADHD in children with epilepsy was 24.76% when compared to controls at 5.17%. The inattentive type was also the most prominent (14.1%). In childhood epilepsy, ADHD is associated with male sex, younger age, early first onset age, high frequency of epileptic seizures, and multiple Antiepileptic Drugs (AED). In fact, comorbid ADHD with epilepsy treated with traditional single AED's was higher than those treated with novel single AED’s, suggesting that the treatment of epilepsy with new AED’s causes less comorbid ADHD. However, the rate of ADHD was not statistically different with different frequencies of seizures. On the other hand, the results also indicated that those patients with a high frequency of epileptic seizures (seizures more than once every 3 months) had a high prevalence of ADHD.12

There are many hypotheses and studies related to the pathogenesis of epilepsy and co-occurring ADHD: brain dysplasia, the influence of epileptic seizures on the brain, epileptic discharge EEG, and the effect of antiepileptic drugs on the brain. It has been found that children with ADHD have more EEG abnormalities than children without ADHD. Furthermore, risk factors for comorbid ADHD are an early first onset age and younger age; and factors that reduce ADHD symptoms are less frequent epileptic seizures, single AED’s, and better epileptic control.12

Tic Disorders

Tic disorders (TD) and ADHD are common co-morbidities in children and adolescents, with 60% of children with Tourette’s syndrome having ADHD. Most tics are mild or moderate, responding to psychoeducation and behavioral management. Evidence supports the use of alpha adrenergic agonists, atomoxetine and stimulants for the treatment of tics and co-morbid ADHD. Severe TDS may require antipsychotic treatment, particularly aripiprazole treatment. There has been conflicting evidence of the role of psychostimulants in either precipitating or exacerbating tics. Priority should be given to the management of co-morbid Tourette’s syndrome (TS) or severely disabling tics in children and adolescents with ADHD.31

Substance Use Disorders

As many as one-half of all adolescents with substance use disorders (SUD) have comorbid ADHD. ADHD is associated with a nearly two to four times higher risk of developing an addiction for nicotine or an illicit substance such as marijuana, cocaine, and heroin among other things.14 Lee et al. reported that when compared with control subjects without ADHD, children with ADHD were twice as likely to have a lifetime history of nicotine use, nearly 3 times more likely to report nicotine dependence in adolescence/adulthood, almost 2 times more likely to meet diagnostic criteria for alcohol abuse or dependence, approximately 1.5 times more likely to meet criteria for marijuana use disorder and twice as likely to develop cocaine abuse or dependence. In addition, addictive behaviors are more common for nicotine and illicit drug use amongst children and adolescents with ADHD when compared to non-substances such as video games, and gambling.15 It becomes possible then that the reduction of frontal lobe inhibition lends itself to impulsivity and thus craving behaviors. Thaper et al.36 found that psychosocial factors such as academic upsets, difficulties in social efforts or a “laissez-faire” (permissive) parenting style resulted in an increased risk for substance use in ADHD youth populations. Intensive neural (e.g., striatal, anterior cingulate cortex) and genetic (e.g., dopamine neurotransmission) assays of probable etiological influences on ADHD and SUD should refine our understanding of their comorbidity and may signal logical targets for pharmacological interventions. Treatment strategies include a multimodal approach combining addiction and mental health interventions. In effect, addiction treatment should be undertaken as a priority when substance use is ongoing, but concomitant treatments work best after broad evaluation of the individual. Individual risk-benefit analysis, however controversial, can validate the use of stimulant treatment over non-stimulant treatment for the individual with ADHD and a SUD. Self-help groups with motivational interviewing and CBT have been shown to be helpful in combination. Further, maintenance medication for opioid and alcohol addictions are now being used with great effect in the adult population with substance use disorders. Overall, those with ADHD have a greater risk of developing a substance use disorder than those without ADHD or other co-occurring mental illness.

Additional research surrounding stimulant use for the ADHD patient with a SUD is needed, and pharmacological ADHD treatment should be managed judiciously in patients with a co-occurring SUD.17

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Approaches to Diagnosis and Treatment of Comorbid Disorders

Approximately one-half to two-thirds of patients with ADHD have a comorbid disorder. A careful initial evaluation should be made to eliminate any possible comorbid conditions. During early childhood, one will often find oppositional defiant disorder, enuresis, and language disorders as common co-morbid entities. Symptoms of anxiety and tics are most often observed in the mid-school age years. The beginning of adolescence is associated with the emergence of mood disorder, personality issues and substance use disorder. Furthermore, many children with ADHD have a specific learning disorder, intellectual disabilities or developmental disabilities, neurological and other somatic disorders. ADHD and co-morbid disorders have variable impacts on the development of the child's self-esteem and other reactive, stress induced psychological reactions that contribute to a poorer prognosis. When a child continues to struggle after one receives treatment for ADHD, the next step is to determine whether the symptoms are secondary to ADHD (and likely to dissipate if the treatment plan is fine-tuned), or if there is evidence that the symptoms are secondary to a fully-fledged comorbid disorder that requires additional treatment. Unfortunately, there is no litmus test for determining this. The best differential diagnosis begins with careful observation of where and when symptoms arise. Thus, clinicians should thoroughly screen for ADHD as well as for mood, anxiety, substance use, personality, and impulse control disorders to begin to comprehensively address all conditions and improve patients overall outcomes.

A list of mental health screening tools may be obtained from the following: Mental Health Screening and Assessment Tool for Primary Care (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/mental-health/Documents/ML_ScreeningChart.pdf). Further, online resources from the American Psychiatric Association may be found at: https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

Closing Remarks and Future Considerations

Pediatricians, nurse practitioners, physician assistants, and psychiatrists who treat ADHD should consider the following points:

• One-half to two-thirds of children who have ADHD struggle with comorbid disorders
• A careful longitudinal history with collateral information gathered from available sources can be very useful in providing the proper diagnosis of comorbid conditions
• The administration of available measurement scales, psychological and educational testing, and consultations from other specialists can be very useful in establishing a diagnosis
• There may be a need to alter traditional single diagnostic algorithms when providing psychopharmacological interventions
• The addition of psychotherapeutic and psychoeducational interventions can be very helpful in treating ADHD and comorbid conditions

• With a caring, hopeful, and helpful attitude we can help make a difference in most children’s and adolescents’ lives
• Like most other chronic medical disorders with co-occurring illnesses, ADHD with comorbidity needs further studies and research to understand the complexity of diagnosis and importance of providing effective treatment

References


continued on next page


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CME Quiz

1. Identify the accurate statement:
   a. Children with ADHD are at a decreased risk of having comorbid autism spectrum disorder.
   b. In children with autism, ADHD is diagnosed around the same age as in children without autism.
   c. In children with autism, ADHD is diagnosed approximately 2 years earlier than with children without autism.
   d. In children with autism, ADHD is diagnosed approximately 2 years later than with children with autism.

2. Dopamine increase in the _______ pathway is implicated in the positive symptoms of schizophrenia.
   a. Mesolimbic
   b. Mesocortical
   c. Tuberoinfundibular
   d. Nigrostriatal

3. Risk factors for comorbid ADHD in epilepsy include an early onset age and:
   a. Older age
   b. Younger age
   c. Better epileptic control
   d. Less frequent epileptic seizures

4. Which of the following conditions should signal to the pediatrician that the patient may have ADHD, and subsequent screening should then take place.
   a. The parents report that the child remains awake for four days in a row and reports feeling “on top of the world”.
   b. The school bus driver informs the principal that he overheard the child say that he is suicidal.
   c. The school teacher informs the parents that the child has difficulties completing assignments on time.
   d. The parents observe the child running around the backyard with a friend.

5. The preferred treatment for patients with ADHD and comorbid anxiety is
   a. SSRI
   b. Adderall
   c. Ritalin
   d. Straterra

6. When a patient with ADHD is found to have co-occurring Bipolar Disorder
   a. Patient should be hospitalized
   b. Stimulants should be continued, with possible dose increase
   c. Stimulants should be discontinued, and mood stabilizers should be initiated
   d. SSRI should be initiated

7. Young females, in comparison to males, who struggle with ADHD and comorbid depression tend to present with:
   a. Internalizing symptoms, such as inattentiveness
   b. Hyperactivity
   c. Aggression
   d. Impulsivity

8. Non-stimulants are more likely to be used in individuals with which of the following comorbid diagnosis to ADHD?
   a. Conduct disorder
   b. PTSD
   c. Bipolar disorder
   d. Cocaine use disorder

9. Parent brings in a 7-year-old boy, previously diagnosed with ADHD, complaining of continued aggression and impulsivity at home and school. Patient admits to stepping on his family dog’s tail. He reports to have anger outburst and difficulty following directions. Mom states patient chased his brother with a bat to hit him. What diagnosis is most likely to worsen the prognosis of ADHD in a patient?
   a. Learning disorder
   b. Disruptive behavioral disorder
   c. Anxiety disorder
   d. Bipolar disorder

10. Which one of the following is a commonality between patients with ADHD and PTSD?
    a. Dysfunctional frontal lobes
    b. Dysfunctional temporal lobes
    c. Dysfunctional amygdala
    d. Dysfunctional hypothalamic-pituitary adrenal axis

continued on next page
CME Quiz continued from page 14

CME Instructions
Read the CME-designated article and answer the Winter 2019 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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Understanding Consent and Confidentiality for Adolescents and Young Adults in New Jersey

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Introduction

Confidentiality protections for adolescents and young adults is of the utmost importance to pediatric providers. Provision of confidential care encourages adolescents to seek necessary health services while safeguarding their privacy. When confidentiality is ensured, adolescents are more likely to disclose information about sensitive health topics such as concerns about sexuality, substance use, and mental health. If confidentiality cannot be assured, adolescents are less likely to seek services related to sexual and reproductive health care, but no less likely to participate in risky behaviors. Parents tend to underestimate the range of risk-taking behaviors in which adolescents partake. Thus highlights the importance of protected confidential time between adolescents and a provider; a concept supported by both parents and adolescents. Open communication with parents is always encouraged and providers can facilitate such dialogue with a teenager who may be embarrassed or afraid to discuss sensitive issues. However, providers must be aware that parental disclosure may not be in the patient’s best interest. In some cases there may be a negative or even dangerous outcome from particular disclosures.

Confidentiality protections can vary based on whether or not one has achieved adult status. Young adults, ages 18 and older, may consent to their own care and are entitled to the same confidentiality protections as other adults. Minors on the other hand, can only consent for care under specific circumstances or for specific services. There are numerous state and federal statutes containing confidentiality protections. Laws authorizing minors to consent and laws protecting confidentiality for minors do not always match, although they are usually closely linked. Understanding the interplay of law and ethics is vital for the pediatric provider in the care of adolescents and young adults.

New Jersey Minor Consent Laws

In New Jersey, the age of majority is 18; anyone younger is considered a minor. Generally, minors require the consent of a parent or authorized representative in order to receive health care. While state law does not provide specific procedure for minors wishing to apply for emancipated status, New Jersey has recognized the concept of “emancipated minor” in several situations (e.g. domestic violence and AIDS housing benefits) among minors who are married, have entered military service, have a child or are pregnant, or have been declared by a court or administrative agency to be emancipated. These minors are allowed to consent for their own health care.

For adolescent minors who do not qualify to consent based on status, the mature minor doctrine may allow mature minors to consent for certain services. New Jersey does not have a specific statute or court decision adopting the mature minor exception to general medical decision making, but the concept has been accepted in other states and may provide guidance. A mature minor is an older adolescent capable of giving informed consent (i.e. understands risks and benefits and alternatives to proposed treatment and is able to make a voluntary choice among the alternatives). This concept, which can be applied generally to individuals ages 15 and older, is supported by research on adolescent brain development. When not under emotional arousal or the influence of their peers, adolescents are capable of responsible decision making. Court decisions in other states have determined that a provider should not be held liable solely on the basis of failing to obtain parental consent when non-negligent care that is not high risk, is within the mainstream of established medical opinion, and is for the minor’s benefit, is provided to a mature minor.

Under New Jersey’s health care consent laws, minors can consent to receive certain services without parental consent. The services covered by New Jersey’s minor consent laws include care for sexually transmitted infections (STIs) (testing and treatment), HIV/AIDS (testing and treatment for individuals age 13 or older), pregnancy services (including abortion and prenatal care), outpatient mental health services (individuals 16 years of age or older) excluding medication treatment, drug and alcohol abuse treatment, and care following a sexual assault including a forensic sexual assault examination. With regard to contraception services, New Jersey law does not explicitly authorize minors to consent for contraception or family planning services. However, there is no statute, regulation, or court decision that prohibits minors from consenting to such services or requires parental consent for these services. Therefore, under the mature minor doctrine or the constitutional right to privacy, it is reasonable to provide these services to minors capable of providing informed consent. Furthermore, as of 2014, Levonorgestrel formulations of emergency contraception are available over the counter to women of all ages.

Adolescents in special circumstances, such as LBGTQ minors or victims of human trafficking, are able to consent for services covered by the minor consent laws. Minors in foster care still require consent by either their parent or the Child Protection and Permanency worker unless seeking services protected by the state’s minor consent laws.

continued on next page
New Jersey Confidentiality Laws for Minors

Confidentiality protections and minor consent laws, while closely aligned, are not perfectly matched. In general, when a minor consents to their own health care they can expect confidentiality protections, however, there are exceptions. New Jersey law permits, but does not require, health care professionals to inform parents about treatment to which a minor consents. There are specific protections for health information related to HIV/AIDS, mental health, and substance abuse treatment that prevents parents or guardians from accessing a minor child's information. A New Jersey law requiring parental notification for a minor's abortion has been permanently enjoined and, thus, not in effect.16 The federal HIPAA Privacy Rule treats a minor who consents to certain health services under New Jersey law as an “individual” with control over their own protected health information.17,18 The HIPAA Privacy Rule also defers to other (state and federal) laws on whether parents have access to the minor's information when a minor is considered an individual.

Federal Confidentiality Laws

In addition to the HIPAA Privacy Rule described above, there are numerous other federal laws containing confidentiality protections. Title X Family Planning services are confidential and may only be disclosed with a minor's permission or if required by law.19 Federal Title X protections override state requirements for parental consent or notification.19 New Title X regulations are being implemented that may affect the ways in which Title X centers encourage family involvement. Your local Title X center can be found at https://njfpl.org/find-a-health-center/. Furthermore, adolescent minors receiving family planning services through Medicaid are entitled to confidentiality protections with safeguards against disclosures established in federal Medicaid law. Drug and alcohol substance abuse treatment programs receiving federal assistance must obtain consent for disclosure from the minor except under certain circumstances. Caution must be considered when health services are rendered in a school. Such services may be included in a student's education record and therefore subject to the Family Educational Rights and Privacy Act (FERPA), which allows parents the rights to their minor child’s educational records (including health records) until their 18th birthday, rather than HIPAA.20 Services provided at a school based health center by a professional employed by a health entity are covered under HIPAA rather than FERPA.20 Federally Qualified Health Centers (FQHCs), also referred to as community health centers, are required to maintain confidentiality of patient records regardless of the reason for visit.21

Confidentiality disclosures or unintentional breaches

Confidentiality cannot be absolute. Providers must understand the legal and ethical limits of confidentiality protections and be up front with patients during visits. It is important to clarify what may not be disclosed because it is confidential (e.g. HIV status), what may be disclosed based on provider discretion (e.g. when a patient is a danger to themselves or others), and what must be disclosed due to reporting requirements that override confidentiality protections. In New Jersey, there is a “duty to warn” that obligates a provider to disclose otherwise confidential information in specific circumstances.22 If a provider suspects child abuse, there is a requirement to report. In certain circumstances, intimate partner violence must be reported to law enforcement. A positive STD test result must be reported to public health authorities and partner notification may result.

Emerging challenges in confidentiality occur with provider billing and insurance claims that result in an Explanation of Benefits (EOB) statement being mailed to a policy holder (often the parent), which may compromise an individual's confidentiality. Individuals covered by Medicaid are guaranteed confidential protections. Moreover, if an individual receives services at a Title X facility or at an FQHC, they can opt to not use their insurance to avoid the risk of an EOB being delivered; services are delivered using a sliding fee scale. As a last resort, an individual can request confidential communications through the insurance company to avoid an EOB being sent to the policy holder. Most insurance providers and the NJ Department of Health have forms a patient can complete to fulfill such a request.

Parental access to patient web portals may also lead to unintentional breaches of confidentiality. Some providers may choose to deactivate, or significantly limit, parental access to their child’s web portal prior to adolescence and then provide full, confidential access to the patient on their 18th birthday.11,12

Preventive Services

Many of the preventive services recommended by Bright Futures,23 United States Preventive Services Task Force (USPSTF), and the Guidelines for Adolescent Preventative Services (GAPS),24 are protected by minor consent laws and state and federal confidentiality protections. Sometimes, a privacy concern may be clear with the reason for visit (e.g. STI screening or a pregnancy test visit), while other times these concerns may arise during a well visit. By familiarizing oneself with these protections, providers can feel comfortable performing the recommended screening for certain risk behaviors and offering risk reduction counseling and services as indicated (screening for STIs, mental health referrals, contraception, etc.).

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Legal Update: Year in Review—Increased Payor Scrutiny of Common Pediatric Services & Reimbursement Issues

Guillermo J. Beades, Esq
Frier Levit, Attorneys at Law

At the beginning of the year, we wrote an article forecasting increased payor scrutiny of pediatric practices leading to more audits and overpayment demands. Unfortunately, as the year progressed, this prognostication proved to be right as pediatric practices of all sizes faced harsh scrutiny, particularly from Medicaid and Medicaid Managed Care Organizations (“MCO”). The most audited codes were developmental testing (CPT 96110), audiometry codes (CPT 92551/2), modifier 25 and evaluation and management (“E/M”) services.

Concerning developmental testing, two (2) issues came to the forefront this year. First, the MCO Horizon New Jersey Health (“HNJH”) ceased paying developmental testing for a period of almost six (6) months beginning on or about November of last year into the spring of 2019. While HNJH has admitted to failing to pay these codes due to an internal error, it has not been quick to reimburse those payments that were erroneously withheld. Second, payors have shifted their audit tactics from a “failure to note standard instrumentation used” to now a “medically unnecessary” argument. Payors, particularly Medicaid and MCOs, are now taking the position that pediatricians are performing developmental testing “too often” and therefore are seeking large overpayment demands based on this reasoning.

Audiometry codes are being audited with a higher frequency as audits of these codes tend to identify weaknesses in coding. Most often, CPT 92552 is being attacked as being used as a “screening” code when CPT 92551 should have been used instead. The manner of documentation, machine used for the testing and other details are picked apart in an effort to identify an overpayment.

Modifier 25 and E/M codes typically go hand-in-hand and are an area of increased scrutiny as they typically signal a situation where a sick visit is being billed on the same day as a wellness visit. Again, while it is permissible to bill a sick visit on the same day as a wellness visit, auditors scrutinize medical notes to see if there is enough documentation to support the coding and billing.

Lastly, when an audit is initiated, although a certain code may be the subject of the audit, the payor will always look for other irregularities or deficiencies and cannot “un-see” what they find. The prime example of this is when auditors discover services were provided by non-credentialed providers. Medicaid and MCOs do not permit a pediatrician to bill a midlevel provider or other healthcare provider incident to their services in order to avoid credentialing. Direct supervision, even if in the same room, is never a defense. If an audit reveals that the group or pediatrician’s NPI was used on the bills but a non-credentialed provider actually provided the office visit services, 100% of the reimbursements received that day by the practice will be demanded by the payor.

While it may seem daunting to practice medicine in this age of heightened scrutiny and unfair audit practices by payors, be mindful of the many resources at your fingertips that can help you navigate these rough seas. The American Academy of Pediatrics, New Jersey Chapter is constantly monitoring changes in regulations and trends in the industry that impact pediatricians in New Jersey. Your medical malpractice insurance company provides you with legal defenses to more than just malpractice matters. Payor audits, overpayment demands, subpoenas, Board complaints and many other matters are covered by your medical malpractice carrier under your administrative rider. They cover both legal fees and expert costs and take the pressure off having to deal with auditors and investigators. Lastly, there are certified professional coders who can help you conduct self-audits and healthcare attorneys who can assure you practice is in compliance with the many state and federal laws and regulations.

With a new year on the horizon, it is important to reflect on what happened this year to learn from the experience of others with an eye towards self-improvement and protecting your practice.
Understanding Consent and Confidentiality for Adolescents and Young Adults in New Jersey

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Conclusion

Protecting the privacy of adolescents seeking care for sensitive health needs is a vital aspect of adolescent health care. Ensuring confidentiality will protect the health of young people and public health in general, and support the development and autonomy of the individual. In New Jersey, there are certain circumstances in which minors may be provided the same legal status as young adults or are allowed to provide consent for their own health care. Numerous state and federal laws support confidentiality protections in adolescents and young adults. Challenges to protecting confidentiality can occur with increasing use of technology to communicate with parents, insurance communications with policy holders, or among circumstances in which a provider may need to break confidentiality. Providers should provide necessary confidential services to adolescents when possible. If this is not possible, then they have the option to refer the individual to a provider or center where the services can be provided and confidentiality can be assured. Furthermore, providers must be up front about the limits of confidentiality with patients. Unintentional or unexpected breaches can hurt the physician-patient relationship. Lastly, providers should encourage open communication between adolescents and their parents. This approach has been shown to result in more favorable outcomes on numerous adolescent risk behaviors associated with negative health outcomes.25

References

9. E.g., Cardwell v. Bechtol, 724 S.W.2d 739 (Tenn., 1987); Younts vs. St. Francis Hospital, 469 P.2d 330 (Kan., 1970).  
18. 45 C.F.R. § 164.502(g)(3)(i)(A)  
Legislative Update: Down to the Wire

Joe Simonetta
Public Strategies Impact

Tracie DeSarno
Public Strategies Impact

After this November’s elections where all 80 Assembly seats were up and one Senate seat, in the 1st legislative district, Democrats will control the Senate by a margin of 25–15 and the Assembly by a margin of 52–28 when the 219th Legislature convenes in January of 2020. Senate President Stephen Sweeney and Assembly Speaker Craig Coughlin will continue to lead their respective houses.

As we write this, we are pleased to report that the Assembly passed legislation, A3818, that will provide for solely medical exemptions to mandatory immunizations by a vote of 45–25 and we are disappointed to report that the Senate fell short of passing the legislation. We are still hopeful that the Senate will secure the necessary votes to pass the legislation before this legislative session ends on January 13, 2020. Securing passage of this bill will require a significant grass roots effort on the part of AAP members and patients and the Chapter continues its efforts advocating for passage of this bill. Those who oppose the bill are vocal and have a sustained effort to persuade legislators that passage of the bill will violate their religious freedoms.

In October Governor Murphy announced recommendations and guidelines from the Electronic Smoking Device Task Force, which was created by Executive Order No. 84 and directed to formulate a comprehensive strategy within 21 days to protect New Jersey residents from the hazards of electronic cigarettes. These recommendations include the imposition of a ban by the Legislature on the sale of flavored electronic smoking devices and products. AAP provided information and testimony to the Task Force.

Recommendations outlined by the Electronic Smoking Device Task Force include:

**Prohibit Advertising and Sale of Covert Products**—The Task Force recommends explicitly prohibiting the advertising and sale to New Jersey consumers of products intended to conceal or disguise vaping devices as or within other products, such as clothing, accessories, utensils, or other electronic devices (such as watches). Making the advertising and sale of these items a per se violation of the Consumer Fraud Act would authorize civil penalties of up to $10,000 for a first offense and $20,000 for subsequent offenses. Alternatively, the Legislature could prohibit the sale of such items to individuals under 21 and without age verification required for the purchase of tobacco products.

**Strengthen Point-of-Sale Practices**—The Task Force recommends that the Legislature require electronic smoking device retailers to not only post signs that describe the prohibition on underage sales but also to implement point-of-sale protections such as locking up or otherwise securing electronic smoking devices and products out of reach of consumers. Consideration also should be given to requiring dissemination of information to consumers at the point of sale.

Both houses of the Legislature passed S484 which revises the State’s newborn screening program for congenital disorders by requiring the Commissioner of Health to establish a Newborn Screening Advisory Review Committee, consisting of medical, hospital, and public health professionals, scientific experts and consumer representatives, which would be authorized to make recommendations on the disorders to be screened for by the department, as well as on screening technologies, treatment options, and educational and follow-up procedures, to be used in the State’s newborn screening program. The bill requires that the committee meet annually to review and revise the list of disorders that are recommended for inclusion in the program. The bill also makes several other changes to the program, including formally designating it as the “Newborn Screening” program. The Governor will have to act on this bill by January 13, 2020.

**EDITOR’S NOTE**—S2173: Rapidly changing legislative and Chapter activity has been ongoing up to the week just prior to the printing of the Winter issue. Additionally, a crucial vote in the Senate on bill S2173 will take place just as this issue hits the mail. In summary, following a raucous Senate hearing where the largest number of pro-immunization supports from multiple mail. In summary, following a raucous Senate hearing where the largest number of pro-immunization supports from multiple representatives, scientific experts and consumer representatives, which would be authorized to make recommendations on the disorders to be screened for by the department, as well as on screening technologies, treatment options, and educational and follow-up procedures, to be used in the State’s newborn screening program. The Governor will have to act on this bill by January 13, 2020.

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Peter Brault of Glen Rock, New Jersey
1950–2020

Peter Verdi Brault MD, FAAP of Glen Rock, NJ passed away on January 3, 2020 at the age of 69 at Hackensack University Hospital after a 2 year fight against the complications of leukemia. He was born in New Bedford, MA of Richard R. Brault and Marie Virginia Brault (nee Verdi). He is survived by his parents, his loving wife of 40 years, Judith M. Brault (nee Chamberlain), and his 4 children and their spouses: John and Megan Brault; Matthew Brault and Caitlin McCormick; Rebecca Lawson and Ryan Lawson, and Andrew Brault and Dr. Megan Brault; and 11 grandchildren: Jordan, Lucas, John Peter, Owen, Ryan, Pierce, Eloise, Juliana, Connor, Brandon, and Emmett; 6 siblings: Fr. Laurence Brault, Richard Brault, Joseph Brault, Carolyne Baron, Thomas Brault and Christine Brault; and 2 brothers-in-law Dr. Robert W. Chamberlain, and James Chamberlain.

Dr. Brault graduated from Brandeis University, Waltham, MA with a Bachelor’s degree in Biology, Magna Cum Laude, Phi Beta Kappa and went on to Medical School at Tufts University, completing his internship and residency at Boston Floating Hospital, NE Medical Center, under Sydney Gellis MD. Upon graduation, he accepted a position with the U.S Public Health Service commencing work as Medical Director and Pediatric coordinator at the Paterson Community Health Center in Paterson, NJ for 38 years and pediatrician and advocate for the pediatric disabled at The Wanaque Center for Nursing and Rehab, Haskell, New Jersey, before his illness. Board Certified in Pediatrics, he was appointed to the staff as a Pediatric attending at St Joseph Children’s Hospital and courtesy staff at Barnert Hospital during that time; Associate Professor of Medicine, Seton Hall University, School of Medical Education with education duties to the pediatric residents at St. Joseph’s Children’s Hospital. Dr. Brault was active as a board member in the American Academy of Pediatrics; Chairman of the Health Advisory Committee at Paterson Head Start and received Achievement Awards from the NJ Coalition for the Prevention of Lead Poisoning, the National Health Service Corps, and Paterson Community Health Center.

Dr. Brault was also active in his church, St Leo’s Parish in Elmwood Park as member of the Liturgy Committee, Baptismal Prep Program, and Parish Council President; Church Trustee; and choir member. He also was a merit badge counselor for Ridgewood- Glen Rock District, Boy Scouts of America, an avid opera goer and music lover, traveler with wife and close friends and loved having his many grandchildren come to visit and play games with him.
Bilateral Pulmonary Emboli in an Adolescent with Factor V Leiden Mutation

Steven Kelly, DO
Rachel Graci, MD
Marc Fults, DO
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Abstract

Factor V Leiden mutation is a common inheritable condition that will predispose even heterozygous carriers to venous thromboembolism at a younger age than expected. A 15-year-old African American female who presented to emergency department with back pain and shortness of breath was diagnosed with bilateral pulmonary emboli and was found to have Factor V Leiden heterozygosity. Positive risk factors included overweight BMI and a very sedentary lifestyle. She denied smoking and oral contraceptive pill use. Lower extremity Doppler was negative for deep vein thrombosis bilaterally, and patient had no signs or symptoms of deep vein thrombosis on history and physical. Continued severe left flank pain prompted evaluation with CT scan of the abdomen and pelvis on hospital day 3 and revealed pleural effusion and a left common iliac vein thrombosis not previously found on imaging studies. Risks and benefits of the CT abdomen and pelvis in an adolescent were considered at multiple points in patient care. Factor V Leiden heterozygosity has a 1.2% prevalence in the African American population, and annual incidence is 0.5% overall. Increased weight and very sedentary lifestyle dramatically increase the risk for venous thromboembolism despite lack of other risk factors.

Keywords
Pulmonary embolism, Factor V Leiden, adolescent, hematology, sedentary

Key Points
- Factor V Leiden heterozygous, overweight BMI, and sedentary lifestyle significantly increased relative risk of venous thromboembolism.
- Factor V Leiden heterozygous patient presented with bilateral pulmonary emboli was found to have iliac vein deep vein thrombosis found on CT scan despite initially negative lower extremity ultrasound.

1.1 Introduction

1.1.1 Venous thromboembolism [VTE] is a spectrum of disease that includes both deep vein thrombosis [DVT] and pulmonary embolism [PE]. VTE occurs in the setting of Virchow’s triad, three broad categories of risk factors consisting of endothelial injury, venous stasis, and a hypercoagulable state. When compared to adults, VTE is uncommon in the pediatric population. The yearly incidence of VTE among patients <15 years-old is estimated at <5 cases/100,000 versus 100 cases/100,000 overall. However, the presence of multiple risk factors can still cause a thrombosis to occur at an age younger than normally expected.

1.1.2 Factor V Leiden mutation is the most common inherited risk factor that results in a prothrombotic state. The prevalence of Factor V Leiden mutation among patients with VTE has been estimated at 18%. This prothrombotic state is created by a resistance of factor Va to cleavage by Activated Protein C. Activated Protein C resistance was first characterized in 1993 by Bjorn Dahlback, et al in a case report examining a male with recurrent VTE first starting at age 19 and a significant family history of VTE. Investigation into Activated Protein C resistance then lead to the description of Factor V Leiden mutations. Today, the prevalence of Factor V Leiden heterozygosity in the general population of the United States is estimated to be between 3%-8%. Among Caucasian Americans and Europeans, prevalence is estimated to be 4-5%. In the African American population specifically, the prevalence is 1.2%. Similar to homozygosity for the mutation, individuals who are heterozygosity for the trait have an increased risk of VTE occurrence overall as well as an earlier age of first occurrence. Heterozygosity can increase risk up to 7x as compared to 80x for homozygosis. Individuals with Factor V Leiden heterozygosity can have upwards of a 10% risk of lifetime VTE occurrence, while the risk of recurrence of VTE has an odds ratio of 1.4.

1.2 Case Presentation

1.2.1 A 16-year-old African-American female presented to the emergency department with a history of acutely worsening chest, back, and left shoulder pain starting four days prior to admission. Her pain was described as sharp 9/10, more intense on the left side and accompanied with increasing shortness of breath. She was evaluated 3-days earlier by her primary care physician at which time she was prescribed albuterol to address her breathing. The albuterol did not provide relief and the shortness of breath continued. In the emergency department, the patient was afebrile, tachycardic, and tachypneic with 99% SpO2 on room air. She was given 2 DuoNeb treatments, 1 liter normal saline bolus, and 600mg ibuprofen. Her chest x-ray was normal. D-dimer was elevated, 2.4, which then prompted a CT angiogram that revealed multiple small bilateral PE with evidence of right heart strain. Doppler ultrasound of the lower extremities was negative bilaterally. An initial dose of Lovenox was administered in the emergency department. Following the initial dose of Lovenox, the patient was admitted to the PICU, and then transferred to the pediatrics floor for further treatment.

1.2.2 The patient had a body mass index within the overweight range for her age and height. At admission, she reported maintaining a sedentary lifestyle, stating that since the starting summer vacation most of her day was spent in bed watching television. Relevant negatives included: no recent long-distance travel, no history of smoking, and no oral contraceptive pill use. She was on no medications and had no known drug allergies. Her past medical history included...
well controlled asthma that had not required albuterol use and bilateral sensorineural hearing loss. Her birth history reported premature delivery at 26-weeks gestation followed by 4-month NICU admission, which included intubation. Her family history included a paternal grandmother with an unspecified “problem with clots” and a maternal cousin who had sickle cell trait. She was currently menstruating, which she reported as occurring regularly at monthly intervals and typically lasting 7 days. She denied any sexual activity.

1.2.3 Upon arrival on the pediatrics floor, the patient was started on a regimen of 70mg of Lovenox twice daily. The dosing of Lovenox was initially supratherapeutic, but adjusted over the course of hospital stay using anti-Xa level to 60mg then to 55mg twice daily. Hypercoagulability testing, ordered on admission, revealed that the patient was heterozygous for Factor V Leiden mutation. All other hypercoagulability testing and hemoglobin electrophoresis were negative. Other lab work including CBC with differential, ANA, ESR, CRP, PT, INR, and PTT were within normal limits at the time of admission.

1.2.4 After an uneventful PICU course and a subsequent transfer to the main pediatric floor, the patient complained of acutely worsening shortness of breath while at rest and 10/10 left flank pain. Her physical exam was significant for tachypnea and tachycardia, decreased air movement of the left lung compared to the right lung, significant left flank and left costovertebral angle tenderness, 2+ palpable pulses in upper and lower extremities bilaterally, and no edema, erythema, or tenderness of the lower extremities bilaterally. Her pain was managed with IV morphine 4mg every 3 hours as needed, but never completely resolved. She continued to have intermittent episodes of moderate to severe left flank pain exacerbated by inspiration over days 2-3 of her hospitalization. EKG and ECHO were performed and both were normal. A work-up was performed to rule out nephrolithiasis vs. renal vein thrombosis vs. renal infarct. A renal ultrasound with radiation exposure while minimally affecting the course of her treatment and thus, a CT scan of the abdomen and pelvis was not warranted. A CT scan of the abdomen and pelvis was performed later in her hospitalization as it was indicated for her continued flank pain to rule out renal etiology. Her intermittent flank pain was ultimately attributed to the pleural effusion that had accumulated on the ipsilateral side found on the CT scan.

1.3 Discussion

1.3.1 The distribution of our patient’s multiple bilateral PE was suggestive that the emboli had originated from her left common iliac thrombus. This is consistent with the Factor V Leiden paradox of increased relative risk for mutation carriers to develop DVT compared to PE. Despite the distribution of the emboli being unusual for spontaneous PE, our patient's physical exam and imaging studies did not indicate a DVT as a source for the emboli. Specifically, her lack of lower extremity pain, swelling, and erythema bilaterally and a previously performed lower extremity Doppler, which was read as negative for thrombosis bilaterally, were contraindicative of a DVT. It was not until a CT scan was performed to evaluate her continuing flank pain that a more proximal thrombosis was incidentally confirmed in the left common iliac vein. A CT scan of the abdomen and pelvis to investigate the more proximal vessels after the negative lower extremity ultrasound, would have further increased her radiation exposure while minimally affecting the course of her treatment and thus, a CT scan of the abdomen and pelvis was not warranted. A CT scan of the abdomen and pelvis was performed later in her hospitalization as it was indicated for her continued flank pain to rule out renal etiology. Her intermittent flank pain was ultimately attributed to the pleural effusion that had accumulated on the ipsilateral side found on the CT scan.

1.3.2 The relative risk of VTE reoccurrence is increased in Factor V Leiden heterozygous carriers compared to individuals negative for the mutation. The annual incidence of first VTE in patients heterozygous for Factor V Leiden mutation is estimated to be 0.5% overall. This incidence increases 1.8% following surgery, trauma, or immobilization. Prolonged sitting in the context of extended travel is classically associated with development of VTE. Our patient reported that her level of activity was mostly sedentary in nature. The amount of time that our patient reported to be sedentary on a daily basis was comparable to that of extended travel or immobility. In addition to our patient’s inactive lifestyle, her BMI of 28kg/m² increased the relative risk of VTE development by 4-10x. The degree to which she described being sedentary in combination with an overweight BMI put her at much greater risk of VTE. The patient was encouraged to exercise and eat healthy in an effort to reduce her weight and thereby minimize her two greatest risk factors for recurrent thrombus development. Given the rising prevalence of obesity and the use of electronic devices in the pediatric population, this seems to be a situation where primary care providers can provide appropriate anticipatory guidance for the primary prevention of VTE.

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Discover the Superpowers of the New Jersey Immunization Registry

The New Jersey Immunization Information System Trainers:
Barbara Alston
Joann Jablonski
Patricia Kaiser
Leanne Loewenthal

The New Jersey Immunization Information System (NJIIS) and the Vaccine Preventable Disease Program is on a mission to boost immunization rates and better protect communities against communicable disease outbreaks by spreading the word about the NJIIS’ superpowers. Discover how you can join forces to improve immunization rates and protect against vaccine-preventable diseases using NJIIS!

NJIIS is the official statewide immunization registry managed by the New Jersey Department of Health, Vaccine Preventable Disease Program. NJIIS is a free, confidential, population-based online system that collects and consolidates the vaccination data of New Jersey’s residents.

This article will focus on two of the immunization registry’s superpowers: the Scheduler Detailer and the Reminder/Recall Module.

NJIIS’ improved Scheduler Detailer provides up to date immunization recommendations based on the Advisory Committee on Immunization Practices (ACIP) approved immunization schedule, determines the appropriate vaccines for a scheduled visit and is one of your best defenses against missed immunization opportunities.

The updated Reminder/Recall Module provides a fast and easy way to contact patients that are due for vaccines with a reminder (by phone or mail) and/or recalls those who are past due for a scheduled immunization. Use these tools individually or together to ensure optimal vaccine coverage rates.

NJIIS Scheduler Detailer: Vaccine Forecasting Tool

Pediatricians interested in boosting immunization rates can utilize the NJIIS’ vaccine forecasting tool to ensure they are immunizing their patients on time every time as well as provide guidance to families about upcoming immunizations. The included immunization scheduler is a color coded chart that projects the patient’s vaccine schedule based on the date of birth and vaccination records already entered in the NJIIS. The chart shows prior vaccination dates and the earliest possible date the next round of vaccines can be administered. Office staff can also see when a vaccine series is complete. The vaccine forecasting tool updates automatically to reflect the latest ACIP recommendations.

It’s not just pediatrician offices that have the power to use the immunization scheduler; any office with access to NJIIS can view the patient’s vaccine schedule. When a patient moves to a general practice office or sees a specialist, the health care professional can view the vaccines recorded in NJIIS by previous providers. Offices utilizing this superpower can check and/or print the immunization scheduler detail chart before each visit, alerting staff that a vaccine is due. The staff can then initiate a conversation with the patient based on the forecast shown on the immunization scheduler chart.

NJIIS Reminder/Recall Module: Patient Outreach Tool

One of the most powerful ways to reach your patients is through the NJIIS’ Reminder/Recall Module. The Reminder/Recall Module offers two features that automate the process of communicating upcoming (reminder) immunizations and missed (recall) immunizations to patients.

The first feature (reminder) is a report building tool that generates a complete list of patients with upcoming and/or missed immunizations. The report includes patient names, contact information, and vaccine doses; centralizing all the information needed to conduct patient outreach in a convenient format.

The second feature (recall) generates patient-specific letters based on a customizable template. These printable letters advise patients of upcoming or past due vaccines. The letter template can be customized by the health care provider to include office information, seasonal messaging, language translations, or other population-specific languages. Mailing labels can also be generated using the Reminder/Recall Tool.

A Reminder/Recall tutorial training is available to NJIIS users, to learn the three easy steps to running a NJIIS’ reminder/recall. The on-demand webinar training can be found on the homepage of NJIIS (www.njiis.nj.gov) under the orange Enrollment/Training tab.

Join the NJIIS Community

As NJIIS trainers, we believe in the value of the NJIIS and the important role an immunization registry plays in protecting our communities against vaccine-preventable diseases. The NJIIS’ Vaccine Forecasting Tool and Reminder/Recall Module, used individually or together, can pave the way to improving vaccine coverage rates at your practice as well as across the state of New Jersey.

If you are not a current user of the registry or you haven’t utilized these new superpowers, we invite you to come on board. Join the mission to protect your community by boosting immunization rates and defending against vaccine-preventable diseases! Enrolling in the NJIIS community is easy. Go to the NJIIS homepage at njiis.nj.gov which includes information for new sites. Instructions on how to enroll a new facility can be found at https://njiis.nj.gov/docs/Instructions_for_New_Sites_Packet.pdf. Once you complete and submit the forms as directed, your local trainer will contact you.

Already a NJIIS facility? Consider supercharging your office’s strength by having more authorized NJIIS staff. Sign up office staff for an NJIIS in-person training or a read-only webinar training today!
1.3.3 Our patient was also counseled that smoking and oral contraceptive pill usage would further increase the risk of VTE recurrence. Prior to becoming pregnant, she should also be counseled on the risks of hypercoagulability associated with pregnancy. Pregnant patients with Factor V Leiden heterozygosity have a relative risk of 8.32 for developing VTE and an absolute risk of 0.8%. The greatest risk of VTE occurs in the first 6 weeks post-partum. Factor V Leiden heterozygosity is also associated with increased risks for late pregnancy loss, placental abruption, and pre-eclampsia. Aspirin and low molecular weight heparin would be safe options for prophylaxis during pregnancy.

1.4 Conclusion

1.4.1 In the case of a 16-year-old female who was found to have multiple bilateral pulmonary emboli, overweight BMI and marked sedentary life style in combination with her Factor V Leiden heterozygosity placed her at significant risk for development of VTE. In addition to Lovenox to treat her current emboli, counseling for lifestyle changes aimed at being more active as well as weight management to achieve a weight appropriate for her height are important to prevent recurrence. Continued primary care follow up is important for maintaining these lifestyle changes as well as for anticipatory guidance in the event of pregnancy or surgery.

References


Acknowledgments

Thank you to Dr. Steven Halpern, the attending hematologist for our patient while she was an inpatient.
How little or large is the impact of our touch?

Our intentions are to heal, support, comfort, and invest ourselves in our roles as caretakers.

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Our intentions are not always enough and our care does not always meet the expectation we have of ourselves, our peers have of us and our role demands of us

Continue to push forward, do not hesitate as hesitation develops fear

Ahmed Razeq MD
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The NJAAP Youth Advisory Committee

Chair, Stephen Marcella, MD
Youth Co-Chair, Ani Muralidharan

The NJAAP Youth Advisory Committee (YAC) is a youth-inspired and led initiative geared towards promoting youth involvement in the community. The mission of this diverse group of teens is to foster a two-way dialogue between the NJAAP membership and adolescents across New Jersey. The group seeks to provide pediatricians with insight into their current attitudes, trends, concerns, and perspectives. Similarly, we envision that the youth leadership will function as ambassadors to their peers by sharing the knowledge gained from interactions with NJAAP membership.

Currently, the inaugural group, is comprised of four members ranging in age from 14-21; Ani Muralidharan, Kingsway Regional High School, Gloucester County, Melissa Reifman, Northern Highlands Regional, Bergen County, Sam Regen, Robbinsville Highschool, Mercer County and Abigal Wolfe, Jefferson Township Highschool, Passaic County. The group’s pediatric champion is Stephen Marcella, MD and supported by NJAAP staffer, Krista DeFilipo, working in tandem to ensure the group remains enthused and task while also keeping the Executive Council and general membership informed on the Group’s activities.

The Youth Advisory Committee’s primary interactions with NJAAP will be through the PCORE Advisory Council. The hope is that the YAC can serve as an important resource when members or committees seek a direct input or link to perspectives on issues impacting adolescents in NJ. As an example, currently, there is an ongoing conversation about the health benefits to delaying high school start times. The group could be part of a forum for seeking reaction and input from the student population. And there are other import areas in which the YAC is already involved.

Electronic Nicotine Delivery System (ENDS) Youth Training. The ENDS training is part of a Tobacco Quit Program of the Family Health Initiatives funded by the NJ Department of Health. Led by the Southern New Jersey Perinatal Cooperative, Ani and Melissa learned about the impact and effects associated with usage of various nicotine delivery systems. Working together with the Salem County Youth Wellness Group, a flyer was created depicting the harmful effects of these devices. This flyer is available for distribution and display in pediatric offices.

This nascent group is currently working to increase YAC membership across the state. This new group is actively developing procedures and policies and developing an application process. Other organizational areas under development include, branding and recognition (designing a logo!). The Committee has created a mission statement and a code of conduct.

The brainstorming of future projects is also underway. One idea being considered is promoting the importance of adolescent well visits. This will help NJ youth develop a better understand that these visits are not just passive, one-way “check-up” but rather, a meaningful opportunity to open up channels of communication and discussions about the sundry of issues and challenges facing adolescents today.

Interested in learning more? Contact us, we welcome new members, feedback, suggestions, or even just a “hello!” To apply online or find more information, please visit njaap.org, look for the banner in the center of the page and follow prompts to click on the link for NJAAP Youth Advisory Committee.
Let’s be healthy together.

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