I have been involved with ICAAP for about ten years. The more engaged I’ve become, the more I’ve learned about the amazing things the chapter does and the incredible opportunities to volunteer in exciting initiatives, meet great people, learn, take on leadership roles, advocate, and accomplish important and meaningful things for children and families in Illinois. But beyond that, being a part of ICAAP has helped me feel empowered in the face of the intense political, environmental, and social issues facing families these days. Instead of yelling at the TV, I can do something. It will not solve everything, but it’s something and it makes me feel better. I became ICAAP president on July 1, 2018 and one of my goals is to encourage more people to join ICAAP and to become more actively involved. The more people we have working together, the more we can accomplish.

Here are just a few of the amazing initiatives that our ICAAP team, along with many volunteer pediatricians throughout the state, has been working on. I hope they inspire you to join us, but if you don’t see what you are interested in, please contact us. There’s a lot more going on, and not enough space to cover it all!
Social Determinants of Health: ICAAP has developed an active committee on the social determinants of health to oversee housing and food security initiatives. We continue to look for interested pediatricians to get involved. If you are interested, please contact Mary Elsner, melsner@illinoisaap.com.

Immigrants and Refugees: Minal Giri, MD, FAAP is leading our Refugee Immigrant Child Health Initiative (RICH), dedicated to addressing the complex needs of immigrant children. RICH seeks to improve medical homes for this population by educating pediatricians and healthcare providers and improving access to social, legal, and other vital resources. For more information, please contact Mary Elsner at melsner@illinoisaap.com or Minal Giri, MD, at minalgirimd@gmail.com.

Medicaid/CHIP Advocacy: Our Medicaid Taskforce is busy meeting with stakeholders to help providers and families navigate the complex insurance landscape to ensure that patients have access to needed care and to advocate that providers get paid for their services.

Adolescent Health: ICAAP was awarded a grant via the Illinois Department of Public Health titled Adolescent Health Provider Education. The aim of this grant is to increase adolescent well-care visits and to better address patients’ social, emotional, behavioral, and physical needs. As part of this project ICAAP will develop and disseminate CME-approved provider trainings on:

1. Teen Brain Development: Effects on Health and Behavior
2. Counseling Teens on Sexual Health and Risky Behaviors
3. Bright Futures Guidelines: Implementation for Adolescents (11-21 years)
4. Transitioning Youth to Adult Healthcare

If you’d like more information, contact Kathy Sanabria, ksanabria@illinoisaap.com.

QI/MOC4/HPV Vaccines: ICAAP successfully collaborated with the Chicago Department of Public Health (CDPH) to increase Human Papillomavirus (HPV) vaccine coverage among 100 adolescent and child health clinics around the city of Chicago, utilizing the CDC’s Assessment, Feedback, Incentives, and Information eXchange (AFIX) framework. During 2018, over 25 pediatricians and family physicians were awarded Maintenance of Certification (MOC) Part 4 or Family Medicine Certification points for quality improvement (QI) efforts. In addition, in 2018 ICAAP and the Wisconsin Chapter of the AAP collaborated on a successful HPV QI project where over 100 pediatricians received MOC Part 4 credit. Both initiatives achieved increases in patients’ HPV immunizations rates. If you are interested in learning more about QI activities, contact Kathy Sanabria, ksanabria@illinoisaap.com.

Educational Conferences/CME: ICAAP hosted a successful 9th Annual ABC Conference, You Don’t Have to be a Therapist to be Therapeutic: Building Resilience in Children, Families, Communities, and Ourselves, on November 16, 2018 in Palos Hills, IL. More than 325 professionals from different fields including medicine, education, and social work came together to advance the care of children, families, and providers impacted by toxic stress and health disparities in a trauma-informed way. ICAAP’s next annual conference is on March 8th, so mark your calendars. If you are interested in participating in future conference planning groups, please contact Dru O’Rourke, dorourke@illinoisaap.com.

Advocacy: Every year we organize our members to meet with elected officials in Springfield and lobby on issues affecting children. But we are active in advocacy throughout the year, advising on policy and teaching residents about political advocacy. A big achievement this past year was to create the Illinois Children’s Advocacy Network (ICAN4KIDS), convening the leaders of all Illinois pediatric residency program’s Advocacy rotations to share best practices and collaborate in political action on behalf of children and families. If you are interested in coming to our 2019 Lobby Day or learning more about ICAAP’s advocacy work, contact Dru O’Rourke, dorourke@illinoisaap.com. To learn more about ICAN4KIDS contact Jennie Pinkwater, jpinkwater@illinoisaap.com.

Reach Out and Read (ROR): With the help of a committed advisory board and many generous donors, ROR Illinois continues to thrive, serving over 125 ROR sites in the state and distributing over 135,000 brand new, developmentally appropriate books to low income children in Illinois. We welcome your involvement, and appreciate all donations to support this important program. For more information please contact Cindy Ogrin at cogrin@reachoutandreadil.org.
Petrak, who is a child abuse pediatrics specialist in Peoria, IL, outlined her advocacy experience working to assemble a coalition and put a bill together to change the law regarding who is best qualified to perform child sexual abuse physical examinations in the State of Illinois. Previously, although child abuse pediatricians are specially trained to perform these exams, the law as it existed stated that it is against the law for child abuse pediatricians to perform this exam. As all of us know, this is an emotionally charged clinical exam which most of us have little experience performing in our practices. In addition, emergency room physicians and providers also have limited experience as well. Dr. Petrak took us through the steps involved with crafting the bill, Illinois Sexual Assault Survivor Emergency Treatment Act (410 ILCS 70), which allows survivors to obtain care without having to incur costs and sets forth standards for that care.

Dr. Petrak began with realizing there is a problem, coming up with a solution, and then contacting the appropriate colleagues—including ICAAP—to get some guidance about how to proceed.

- **Strategic Plan Update:** ICAAP’s Executive Committee has approved an updated strategic plan for the Chapter for July 1, 2018 – June 30, 2021. The overarching goal of our strategic plan is to ensure that all children and families, as well as our members, lead healthy and productive lives and reach their maximum potential, regardless of race, ethnicity, primary language, religion, special need, socioeconomic status, sexual orientation, gender identity, or other attributes. Our updated mission statement is:

  ICAAP promotes and advocates for optimal child, youth and family well-being, and access to quality healthcare while supporting our members.

  Our specific aims include advancing:
  - The health and well-being of children and families
  - The professional and personal well-being of our members through membership activities

- The chapter as a healthy organization to optimize fulfillment of our mission

We welcome feedback from our members on ICAAP’s strategic plan. Please reach out to me, the executive committee, or staff and let us know your thoughts.

As you can see, there are many ways for you to get involved with ICAAP. Come join us, in any capacity that feels right for you. You might find, as I have, that you end up getting as much or more than you give!

For more information please call 312-733-1026, ext. 208 or email Kathy Sanabria, ksanabria@illinoisaap.com. Based upon your interests, ICAAP will point you to the proper staff person, board member, member, or resource.

**Mariana Glusman, MD, FAAP, ICAAP President**
MGlusman@luriechildrens.org

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**Highlights of the ABC Conference:**

You Don’t Have to be a Therapist to be Therapeutic

**BY JOSEPH R. HAGEMAN, MD, FAAP**

As a pediatrician, I found this most recent ABC Conference: “You Don’t Have to be a Therapist to be Therapeutic” hosted by the Illinois Chapter of the American Academy of Pediatrics (ICAAP) and held November 16, 2018 in Palos Hills, IL to be a unique and valuable experience. This conference is not about basic therapies for clinical problems like acute otitis media and urinary tract infections, although access to care is definitely addressed. The ABC conferences promote interprofessional support of children, families, and communities by advocating for children’s health, addressing behavioral/developmental health, and discussing complex health needs and their impact on patients and families.

The first keynote plenary I attended was a narrative about one clinician’s experience with the process of advocacy. I recently wrote an editorial for Pediatric Annals with the help of Dr. Phil Verhoef, a medicine-pediatrics intensivist, and Tae Yeon Kim, a medical student, both at University of Chicago, both of whom reassured me and the readers that a physician can also be active in advocacy for our patients.† Dr. Channing Petrak, who is a child abuse pediatrics specialist in Peoria, IL, outlined her advocacy experience working to assemble a coalition and put a bill together to change the law regarding who is best qualified to perform child sexual abuse physical examinations in the State of Illinois. Previously, although child abuse pediatricians are specially trained to perform these exams, the law as it existed stated that it is against the law for child abuse pediatricians to perform this exam. As all of us know, this is an emotionally charged clinical exam which most of us have little experience performing in our practices. In addition, emergency room physicians and providers also have limited experience as well. Dr. Petrak took us through the steps involved with crafting the bill, Illinois Sexual Assault Survivor Emergency Treatment Act (410 ILCS 70), which allows survivors to obtain care without having to incur costs and sets forth standards for that care.

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**FROM THE CHAPTER**

She discussed how there is much back and forth negotiation and compromise involved in this process with all of the people and organizations involved. In the end, which is really not the end, you wind up with a product which is actually just a starting point. We now have a law that was signed by Governor Rauner for which one can feel some sense of satisfaction. However, once this law is put into place, it will be important to monitor its effect on an ongoing basis and to advocate for change to make it even better. In summary, it takes a lot of persistence and patience.

We then traveled to Southern Illinois, where Anne Scheer, PhD from SIU Medical School presented an effort to impact a 50% overweight/obesity rate among children in the community. This rate compares to a 30% rate in the state. Anne conducted interviews with 5th graders to see what they eat, what “good” kids eat, and what “cool” kids eat daily. She also ate lunch with these 5th graders and observed what they ate and what they threw in the garbage. She observed what their parents packed for them for lunch as well. Finally, Anne also interviewed their parents about their financial situations, their access to grocery stores, and what they packed for their kids. Through her interviews, a form of qualitative research, she discovered this area was an example of a “food desert”.

The United States Department of Agriculture (USDA) defines food deserts as “parts of the country rapid of fresh fruit, vegetables, and other healthful whole foods, usually found in impoverished areas. This is largely due to a lack of grocery stores, farmers’ markets, and healthy food providers”. These families have limited resources so their children are eating processed food, sugar, and fats that are nutritionally insufficient for an optimal diet. The fruits and vegetables from their lunch trays end up in the garbage. All of this contributes to the children becoming more overweight and obese. This project was done with the collaboration with their individual medical homes. In addition, many of these families were split families with the kids spending part of their time with each of their parents, thus oversight of nutrition was inconsistent.

I had the opportunity to meet, listen, and learn from Robin Dodds, PhD who has degrees in education of children with special needs and is the parent of a fourteen-year-old girl with autism. She presented a talk about Parent to Parent as she is also on the board of this organization. This group is active in almost all the states in the United States, with the exception of Illinois, and she is here actively working to start a group. For more information you can visit (http://www.parenttoparent.org). Another organization, the Grahams Foundation, is active as a resource for support of parents with children with special needs including parents with babies in the neonatal intensive care (www.grahamsfoundation.org). Each support parent is trained to educate new parents about the cause of their infant’s clinical problem and how to negotiate the system.

Next was a special speaker, Sarita Shashington, who talked about the Parent Cafés, which are “safe places” for parents to share their feelings and concerns about their children who are admitted to Children’s Hospitals. Parent Cafés are a method of facilitating meaningful, reflective conversations that promote parent leadership and collaboration. The Parent Café model was developed by parent leaders as part of Strengthening Families—Illinois in 2007, and is now housed with Be Strong Families.

The last talk I attended was by Dr. Verena Schreiber, a pediatric orthopedic surgeon from NorthShore University HealthSystem, and she discussed selected orthopedic problems of children with special needs. This practical and thoughtful presentation included summaries of the diagnosis and management of spina bifida cystica, congenital talipes equinovarus (clubfoot), and developmental dysplasia of the hip.

The slides from each of these excellent presentations as well as others are available on the ICAAP website http://illinoisaap.org/conferences/abc.

REFERENCES


3. https://www.bestrongfamilies.org/parent-cafes/

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We’re in this together.

Regardless of the pressures your practice may face, ISMIE is looking out for you. Our complete medical professional liability coverage includes proprietary Risk Management programs and physician-led claims management. Learn why nearly 10,000 policyholders choose ISMIE at ismie.com/growth.
The Illinois Chapter, American Academy of Pediatrics (ICAAP) collaborated with the Chicago Department of Public Health (CDPH) on a project to increase Human Papillomavirus (HPV) immunization coverage among adolescents in Chicago. The activity, Increasing HPV Vaccine Coverage by Strengthening Adolescent AFIX (Assessment, Feedback, Incentives, and Information eXchange) is supported with funding from the Centers for Disease Control and Prevention (CDC). During the duration of the activity, 100 clinics enrolled in the Chicago Vaccines for Children (VFC) program participated and utilized the AFIX quality improvement (QI) process as the primary approach to improve HPV vaccination coverage.

Activity Summary and Methods

In 2017 and 2018, a total of 100 VFC-enrolled clinics were selected to participate in the HPV-AFIX QI project. The activity was divided into two phases with different criteria for clinic selection and varying methods to encourage participation. In phase I (2017), 50 clinics were selected based on their location within a pocket-of-need community and/ or low HPV vaccine utilization. In this context, pocket-of-need communities refer to City of Chicago neighborhoods that are experiencing high economic hardship. Economic hardship has been found to be correlated with higher cervical cancer incidence and mortality in Chicago (Healthy Chicago 2.0). During phase II (2018) 50 clinics from larger networks with high adolescent patient volume were selected. Additionally, 17 of the 50 clinics during this phase were school-based health centers.

The AFIX QI method used in the project focuses on vaccine coverage assessments and provider education to improve vaccine coverage levels. The approach consists of three learning encounters per clinic to improve HPV vaccine initiation and series completion. The initial in-person AFIX visit was conducted by a CDPH staff member and one of twelve recruited physicians serving as peer-clinician coaches. The coaches provided guidance on HPV-associated cancer data, HPV vaccine dosing guidelines, and CDC’s “Same Way, Same Day” approach for making a strong HPV vaccine recommendation. Together, the coaches and clinic staff identified QI strategies that the clinic would work to implement over the six-month project period. At check-in and follow-up learning encounters, adolescent vaccine coverage levels were re-assessed and recommendations for continued success using the QI plan were discussed. To promote medical assistant involvement in HPV vaccination efforts, a webinar series was developed for phase II. The webinar series emphasized the role medical assistants can play in recommending the HPV vaccine to patients and families. The webinars included statistical data as well as resources and talking points that medical assistants can utilize in the office setting to help increase uptake of the vaccine.

To encourage participation and emphasize the importance of improving HPV vaccination coverage, providers and allied health professionals were eligible to claim up to 6.00 AMA PRA Category 1 Credit(s)™ upon completion of all three learning encounters. In phase II of the activity, allied health professionals who completed the webinar series were also eligible to claim an additional 1.0 hour of continuing education credit by American Medical Technologists (AMT). To further incentivize provider participation throughout phase II, providers could additionally claim up to 25 Maintenance of Certification (MOC) Part 4 points via
As CDPH and ICAAP complete the remaining visits in phase II, we remain excited and eager to reach our goals of increasing HPV immunization coverage levels among adolescents throughout Chicago. As increasing awareness of the cancer-causing potential of HPV in girls and boys grows, we look forward to continued collaboration on projects using the CDC’s “Same Way, Same Day” approach to emphasize the importance of the HPV vaccine in early cancer prevention.

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This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Illinois State Medical Society (ISMS) through the joint providership of the Illinois Chapter, American Academy of Pediatrics and the Chicago Department of Public Health. The Illinois Chapter, American Academy of Pediatrics is accredited by the ISMS to provide continuing medical education for physicians.

The Illinois Chapter, American Academy of Pediatrics designates this live activity for a maximum of 6.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nurses and Nurse Practitioners can submit Certificates of Attendance to their accrediting board and should claim only the credit commensurate with the extent of their participation in the activity.

This program is eligible for 7.00 hours of continuing education credit by American Medical Technologists (AMT). Granting of credit in no way constitutes endorsement by AMT of the program content or the program’s sponsor.

Findings
The goals for the project were to increase clinic-wide HPV vaccine series initiation and completion coverage by 5% and decrease HPV vaccine missed opportunities by 5% for patients ages 13-17. As phase II wraps up at the end of 2018, data analysis and project evaluation activities are moving into full swing. Preliminary process outcomes show that on average, each clinic selected three QI strategies to focus on during the project period. The most commonly selected QI strategies targeted increasing the quality of immunization services and improving data completeness and accuracy in I-CARE, the Illinois immunization information system. These strategies included using the “Same Way, Same Day” technique for recommending HPV vaccine, designating an immunization champion, and inactivating patients in I-CARE who are no longer seen by the practice. Offering certification credit via ABP and ABFM increased physician participation in QI activities. During phase I, when this credit was not offered, 42 physicians participated in the project across 50 clinics. In phase II, when this credit was offered, 76 physicians participated across 50 clinics, nearly doubling the total number of physicians participating. CDPH and ICAAP are now analyzing how physician participation impacts progress toward implementing QI strategies and increasing vaccination coverage levels.
The Trump Administration’s War Against Children of Color

BY TODD OCHS, MD, FAAP

Historically, in order to do inhumane things to other people, especially to children, the actors must de-humanize them. The Nazis put forth the concept of “life worth living” to rationalize the murder of millions of non-Aryans. The US has not honored one treaty made with Native Americans over 300-plus years, stealing their land and killing off 90% of them from 1492 to 1900. Thousands of Japanese-Americans were involuntarily sent to internment camps during World War II. Children, on the other hand, should be innocents yet it is still possible to destroy their humanity. When the SS Exodus was turned away from America in 1942, one legislator reportedly said that the only problem with Jewish children was that they would grow into Jewish adults.

Since taking office, President Trump has sent thousands of active-duty US troops to our southern border in order to refuse asylum to Central American families fleeing governmental and gang violence, food shortages, and unavailable health care. Honduran and El Salvadoran women and children have been tear-gassed, as the President noted that the Border Patrol gassed really “tough people” trying to enter the US. Like Franklin Roosevelt in 1942, the President made unsubstantiated charges that the recent refugee caravan approaching the US contained radicals and criminals and asserted that all should be turned away. The Trump administration also proposed the “public charge” rule, which would make immigrant families choose between a path to citizenship and food, health care, and housing. The President threatened to cancel birthright citizenship for children born to immigrants and refugees (the standard in 30 other countries), as Attorney General, Jeff Sessions issued a ruling that aims to negate asylum for families fleeing gang, domestic, and governmental threats or violence.

Since 2014, more than 150,000 Central American children have sought refuge in the US

Fanning paranoia against people who are not “American” and thusly de-humanizing them allows the Department of Human Services (DHS) to snatch children from their parents and has led to the creation of some of the largest orphanages in the world.

This treatment will ultimately exacerbate the post-traumatic stress disorder in children fleeing violence after making a harrowing 3,000 mile trek to the southern US border.

According to the General Accounting Office (GAO), at the southwest border, the US DHS apprehended nearly 60,000 unaccompanied children in 2016, 41,000 in 2017, and 22,000 in the first half of 2018. Most of these children are from El Salvador, Guatemala, and Honduras. Since 2014, more than 150,000 Central American children have sought refuge in the US. On November 19, 2018, the Real News Network noted that ICE/DHS/ORR is holding 44,000 immigrants, including 14,000 unaccompanied children, in private detention centers, costing $150 per person per day.

A story in the Chicago Tribune, on November 28, 2018, exposed a detention facility in Tornillo, Texas, which is housing over 2,300 teen-age immigrants in a facility designed for 360.

A story in the Chicago Tribune, on November 28, 2018, exposed a detention facility in Tornillo, Texas, which is housing over 2,300 teen-age immigrants in a facility designed for 360. On the same date, Pro Publica published an article titled, “Families Are Still Being Separated at the Border, Months After the ‘Zero Tolerance’ Was Reversed.” DHS refers children to the Office of Refugee Resettlement (ORR), which sponsors 87 child-care facilities and fifteen transitional foster care programs across the US. There are at least eight in Illinois, with a capacity of 419 children, fifteen in New York, with a capacity of 912, twelve in Arizona, with a capacity of 1,666 children, and thirty-seven in Texas with a capacity of 4,935.

It is impossible, as an adoption and foster care pediatrician for over twenty years, to accept that placing traumatized children in orphanage-like settings would be nurturing or therapeutic, that removing children from caregivers would do anything but increase post-traumatic stress, and that institutionalizing emotionally-fragile children would not drive them into gangs like MS-13.

Is the Trump administration intentionally targeting children, or are young people just collateral damage? The fact is that any policy adversely affecting families will inevitably hurt
Representing ICAAP’s Refugee Immigrant Child Health Initiative, Dr. Nahiris Bahamón from Esperanza Health Centers speaks to reporters at the Chicago Ethnic Media Roundtable on September 27, 2018 about the forthcoming proposed “public charge” rule. Protecting Immigrant Families Illinois (PIF-Illinois) sponsored the press conference. ICAAP is a member of PIF-Illinois Steering Committee, the group that is leading efforts in Illinois to oppose expansion of the “public charge” test.

As child advocates, and as mandated reporters of child abuse and neglect, we should not just stand by and watch. These children are sons and daughters; they are victims in their countries of origin, and now here as well.

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The Pediatrician’s Lane in Gun Safety

BY JACQUELINE KORPICS, MD, FAAP

In light of recent events and the encouragement by the National Rifle Association for doctors to “stay in their lane,” this is a brief overview of what exactly the role of the Illinois pediatrician should be in terms of gun safety.

During pediatric residency training, we learn to ask about the presence of guns in the home and provide appropriate counseling when needed. While this is officially recommended and encouraged by the American Academy of Pediatrics (AAP), asking about guns and counseling about gun safety competes with the many responsibilities primary care pediatricians have to address in a short amount of time. Pediatricians may also feel uncomfortable asking due to the heated political climate, as well as concern that parents may think we are making unfair assumptions about them.

However, by not inquiring, pediatricians are dangerously assuming that none of their families have guns in their home, when in fact one in three families do... and only about one in three of these families keep all guns in their home locked and unloaded.1-4

Pediatricians need to ask. While the safest home is one without a gun, families with guns in their home should adhere to the following recommendations from the AAP:

• All guns should be locked and unloaded, with ammunition locked separately.

• Children should not have access to the keys or combinations.

• When using a gun recreationally, the safety catch should be in place at all times until just before shooting.

• Guns should be unloaded before letting them out of your hands.

• Children should not be allowed to shoot the gun until adult age.

Representing ICAAP’s Refugee Immigrant Child Health Initiative, Dr. Nahiris Bahamón from Esperanza Health Centers speaks to reporters at the Chicago Ethnic Media Roundtable on September 27, 2018 about the forthcoming proposed “public charge” rule. Protecting Immigrant Families Illinois (PIF-Illinois) sponsored the press conference. ICAAP is a member of PIF-Illinois Steering Committee, the group that is leading efforts in Illinois to oppose expansion of the “public charge” test.

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• Children should not be allowed to shoot the gun until adult age.
Parents also need to ask. The AAP’s ASK (Asking Saves Kids) campaign encourages parents to ask all other parents about any unlocked guns in their homes before sending their child over to play. This is in light of the realization that more than one in three unintentional shootings of children take place at the home of friends, relatives, or neighbors.3

One of the most important responsibilities of the pediatrician in regard to gun violence is to address trauma and screen for depression and other mental health concerns. Pediatricians need to talk with their teenage patients without the parent in the room. While there is disagreement over whether we should be universally screening for adverse childhood experiences, there is consensus about being aware of the potential trauma people have experienced and its effect on the brain, behavior, and overall health. Children with a history of trauma or mental health illness are more likely to engage in suicidal behavior or violent behaviors against others.4 The pediatrician is responsible for making appropriate referrals for high risk individuals. Adolescents who are depressed and their families should be screened for access to firearms, as these adolescents may be at a higher risk of injury and death. By doing our part in addressing trauma and mental health, we can hopefully limit the consequential self-harm, violence, and victimization, whether common-sense gun legislation and safety measures are in place or not.

The pediatrician’s most important role above all else is to advocate for children. Given that unintentional injury, suicide, and homicide remain leading causes of death, this means it is our responsibility to advocate for common-sense gun legislation and to oppose legislation to weaken current gun laws. In addition, by advocating for community resources and supporting parents, we can prevent trauma before it ever happens, and thus decrease the associated morbidity and mortality.

Some pediatricians may feel out of place or not know where to start. Organizations like the Illinois Chapter of the American Academy of Pediatrics, which works closely with organizations like Strengthening Chicago’s Youth, are here to make this process easier, providing education on current policies and how to take specific actions in Illinois. Not only do we care for victims and their families in the immediate period after a gun injury, but we also care for them for the months and many years following, as these families and survivors deal with the physical, emotional, and psychological sequelae. It is time for all of us to take action together. Pediatricians already involved in advocacy should encourage others to join them. This is our lane. We must stay in it.

To become involved, contact ICAAP and go to www.healthychildren.org for more information.

REFERENCES

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GUN SAFETY and CHILDREN

If you own a firearm, the AAP recommends it be stored unloaded, locked up (lock box, cable lock, or firearm safe), with the ammunition stored separately.

About 1/3 of the homes with children in the United States have a gun. Many are stored loaded and/or unlocked.

Every day, 78 children, teens and young adults are injured or killed by guns in the United States.

Source: CDC WISQARS database including data for all races, ages 6-31, from 2013-2016.

Children as young as 3 years may be strong enough to pull the trigger on a handgun.

The risk of dying by suicide is 4 to 10 times higher in homes with guns. If you have a teen who is at risk for suicide, remove guns and ammunition from your house.

The safest home for children and teens is one without guns.


REGISTER NOW

2019 ICAAP ANNUAL EDUCATIONAL CONFERENCE

FRIDAY, MARCH 8, 2019

NORTHERN ILLINOIS UNIVERSITY
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tinyurl.com/icaap2019
The University of Illinois at Chicago’s Division of Specialized Care for Children (DSCC) is a statewide care coordination program that serves Illinois children and youth with special healthcare needs (CYSHCN) and their families. DSCC defines care coordination as a person- and family-centered, strength-based, assessment-driven approach of empowering families to achieve their goals. This process ultimately leads to positive health outcomes, improved quality of life, and overall family satisfaction.

DSCC’s care coordination efforts focus on partnering with families and communities to help CYSHCN connect to the services and resources they need to reach their full potential. Our staff is now using a more comprehensive and holistic assessment to help our care coordination teams develop a person-centered plan for each of our families. This plan identifies valuable information about our families that can help strengthen the physician-family partnership with their medical home primary provider and foster relationships among the care team. It also helps families understand and follow their providers’ treatment plans and communicate more effectively with everyone involved in their child’s care.

CYSHCN have a higher risk for fragmented care due to the number of services they require and specialists they need for treatment. Providers’ comfort level with CYSHCN can also vary based on the types of services needed and the family’s circumstances. Effective care coordination eliminates the delivery of care in silos across providers and reduces associated healthcare costs. Most of all, it improves the patient and family experience. These benefits are consistent with DSCC’s vision statement to place CYSHCN and their families at the center of a seamless support system that improves the quality of their lives.

Our staff researched best practices in care coordination and applied DSCC’s over eighty years of experience working with children with special healthcare needs in Illinois to identify the critical characteristics of high-performing pediatric care coordination. These services must be patient- and family-centered as well as proactive, planned, and comprehensive. They also must promote self-care skills, independence, and emphasizes cross-organizational relationships. We also considered the recommendations of the Massachusetts Child Health Quality Coalitions’ Care Coordination Task Force, comprised of families, care coordinators, case managers, social workers, and providers. This task force developed a structured tool for completing care coordination needs assessments with families and identified a set of high-level domains that should be included on every structured assessment tool.

We used this research to develop a structure for our own comprehensive assessment to focus on five domains: medical, social/emotional, education, financial, and transition. Staff from across our organization worked together to create the assessment content and train their teammates. The comprehensive assessment is an ongoing learning process for our staff and families and not a single event or annual meeting. It is an information-gathering process that captures what the participant and their family wants in their life, the supports needed, and their perspective on how they want to live. It also draws on information from providers and a review of medical and other documentation.

The assessment identifies health risks, social risks, and the family’s ability to participate in their child’s care. We learn more about where our participants live, learn, work, and play so we understand how it affects their health and their ability to follow their medical home primary provider’s treatment plans. Our care coordinators and their participants then develop a person-centered plan based on what is learned during the assessment.

The person-centered plan is guided by the participant and family’s needs, wants, dreams, and desires. It includes their desired outcomes/goals, strengths, needs (both clinical and social support), the steps to achieve these goals, and the barriers and risk factors with plans to minimize them. We understand that the participant and their family know their unique needs and values better than anyone. Our person-centered planning helps DSCC care coordination teams
understand what is important to someone so they can then support what is important for them. We are focused on support rather than fixing. In other words, it’s about the person and not the process.

The person-centered plan should be shared with the family medical home primary provider so they are aware of and understand the barriers and resources the family needs to support continued health and success. Our care coordinators are asking deeper questions to help fill in the gaps between what’s discussed during medical appointments and the social determinants affecting their health and success outside of the provider’s office. We then use this information to educate both the family and the provider about the community resources and supports available for the family’s unique situation.

For example, one of our participant families recently started preparing for their son’s transition to adulthood. They want to help him achieve his highest level of independence while supporting his complex medical needs as he grows larger and more difficult to transport. Their person-centered plan focuses on the steps needed to obtain guardianship once he turns eighteen, find housing options, and make travel to their son’s various medical appointments easier for both the young man and his family. Their DSCC care coordinator and medical home care manager attended each of the young man’s primary care provider appointments to address his needs and work on transition planning together as a team.

The DSCC care coordinator referred the family to a local legal service to start the guardianship process and facilitated the paperwork needed from the medical home provider. The care coordinator made several home visits to help the family complete the application, and the medical home care manager and primary care provider completed the medical documentation.

The DSCC care coordinator and medical home care manager worked together to arrange for an Easterseals occupational therapist and durable medical equipment provider to visit the family’s home and evaluate him for a car seat and wheelchair. They also applied for the local paratransit service to give the young man rides to his medical appointments when needed. Additionally, the care coordinator and care manager attended the young man’s Individualized Education Program meetings with the family to work with the school’s transition coordinator to find suitable housing options in the community.

The partnership between the medical home care manager and the DSCC care coordinator identified and addressed the participant’s transition-related needs that were important to him as well as his caregivers. Their collaboration helped to ensure a care continuum extending into his home and community.

By implementing strategies for person-centered goals, we are driving positive change in the lives of our participants and families. This change empowers them to feel more confident and organized in the care of their child and well prepared for the transitions and changes that lie ahead. We understand that making a real difference in the lives of our participants requires a collective commitment to continue to listen, learn, and act.

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Vitamin K Refusal

BY VEENA RAMAIH, MD, FAAP

In Illinois and around the country, there is a disturbing increase in the number of Vitamin K refusals. J Loyal, et al reported a 0.6% Vitamin K refusal rate in the United States (638 refusals out of 102,878 newborns) in 2018.¹

Historically, Danish scientist Henrik Dam discovered Vitamin K in 1929 and recognized its importance in coagulation. In 1937, Waddell et al demonstrated that Vitamin K administration prevents hemorrhagic disease of the newborn (HDN).² The 1961 American Academy of Pediatrics Report of the Committee on Nutrition stated “Hemorrhagic disease of the newborn infant is hemorrhagic disorder of the first days of life caused by a deficiency of Vitamin K and characterized by deficiency of prothrombin, proconvertin and probably other factors”.³ In this 1961 report, the AAP recommended one intramuscular (IM) injection of Vitamin K at birth to prevent HDN.

This Vitamin K deficiency puts an infant at risk for Vitamin K Deficiency Bleeding (VKDB) formerly known as HDN. VKDB presents in three different stages: early (within 24 hours of birth), classical (24 hours to 14 days after birth), and late-onset (2 weeks to 14 weeks after birth).

A systematic review by MJ Sankar et al elucidating the incidence of late-onset VKDB concluded a median incidence of 35/100,000 live births.⁴ KE Choo et al reported rates of VKDB over a two-year period in Malaysia, an area where 96% of infants are breastfed and 83% are not given prophylaxis. Their rates of early, classical, and late-onset were 1/7000, 1/4000, and 1/8000, respectively.⁵

In spite of the very low incidence of VKDB, the morbidity and mortality is significant. This includes pain from lab testing and IV placement, risks from blood transfusion if warranted, hospitalization for serious bleeding such as gastrointestinal (GI) bleeding or intracranial hemorrhage (ICH), brain injury, and death. Late-onset VKDB has a 20% mortality rate as approximately 50% present with ICH. These interventions or outcomes can be avoided with one shot at birth. Vitamin K has been studied extensively and has minimal risk. In 1990, Golding and colleagues found an association between Vitamin K administration and childhood cancer from 1970.⁶ This has been refuted by JA Ross in 2000⁷ and again by the AAP Vitamin K Ad Hoc Task Force in 2003.⁸

So why are parents refusing? A 2017 survey by J Loyal et al found these primary reasons – parental perception that IM Vitamin K is unnecessary, lack of knowledge regarding the role of IM Vitamin K in preventing VKDB, concern about the preservative in the IM injection, or concern about damaging effects of pain from injection.⁹ It is interesting that the top three reasons involve misconceptions or misinformation. The fourth reason is a valid parental concern however for most parents, the risk of VKDB outweighs the risk of pain from a shot.

As parents use the internet more frequently to obtain medical information, medical providers are often placed in a position of refuting or correcting misinformation. Educating parents is an integral part of our work, however, determining the most effective method for addressing refusals can feel extremely frustrating, especially for an intervention that has been around for decades and had nearly eradicated VKDB. Even though they are often combined in the same category, Vitamin K is not the same as immunizations. Vitamin K is treating a deficiency whereas immunizations are reducing the risk of an infectious disease. That distinction is crucial in our education efforts with parents.

As medical providers for infants, an important aspect of patient care is advocacy, especially advocating for those who cannot speak for themselves. This includes advocating on behalf of the child if the parent is making a poor choice. This is very difficult for providers as we are doing our best to care for the infant’s best interest as well as maintain a relationship with families. Adults can make choices that may be detrimental to themselves as long as they are fully aware of the risks and taking the risks of their own free will. When the patient is an infant, what is our ethical and legal obligation to speak for them to prevent harm?

The spectrum of intervention ranges from educational interventions in written, video, or verbal formats to child welfare interventions such as protective custody to legal interventions such as legislation mandating Vitamin K administration.

For several years, Vitamin K refusal was included under the heading of medical neglect in the Department of Children and Family Services (DCFS) allegation system: “For the purpose of child protection services, the administration of… Vitamin K shots or pills to newborns is considered medically necessary. Calls received at the Statewide Central Register concerning a parent or guardian denying consent for the administration of these treatments shall be taken as reports of medical neglect.” On August 2, 2018, DCFS Director Walker
rescinded this statement from DCFS procedures stating that “identifying what can and should be considered ‘medically necessary’ is outside the confines of DCFS purview and judgement. It is up to the medical provider to identify Vitamin K refusal as negligent and report it as medical neglect.”

The ICAAP Committee on Child Abuse and Neglect (COCAN), of which I am one of the co-chairs, does not disagree with this decision as Vitamin K refusal is one of many forms of medical neglect and should not be singled out. We also agree that medical providers, not DCFS, determine what is medical neglect. Vitamin K refusal is time sensitive and must be addressed at the time of delivery hence there is a need for a unified approach from medical providers.

We must come together to answer three fundamental questions:

1. Does the low incidence of VKDB justify allowing refusal?
2. Does Vitamin K refusal constitute neglect?
3. What is the most effective method for reducing Vitamin K refusal?

As a start, parent education should begin prior to the child’s birth. We should engage our obstetric and midwife colleagues in these education efforts. We should work with nurseries and neonatal intensive care units to create protocols for Vitamin K refusal that include intensive education, discussion of risks, and a plan of action if refusal persists.

Below is a list of excellent resources for education on the Centers for Disease Control and Prevention (CDC) website:

- Vitamin K Shot – Essential in Preventing Serious Bleeding in Newborns  
  [https://www.cdc.gov/healthcommunication/tooltemplates/entertainmented/tips/KVitamin.html](https://www.cdc.gov/healthcommunication/tooltemplates/entertainmented/tips/KVitamin.html)
- Vitamin K Deficiency Bleeding  
  [https://www.cdc.gov/ncbddd/vitamink/index.html](https://www.cdc.gov/ncbddd/vitamink/index.html)
- Frequently Asked Questions (FAQs): Vitamin K and the Vitamin K Shot Given at Birth  
  [https://www.cdc.gov/ncbddd/vitamink/faq.html](https://www.cdc.gov/ncbddd/vitamink/faq.html)
- Protect Your Baby from Bleeds – Talk to Your Healthcare Provider about Vitamin K  
  [https://www.cdc.gov/ncbddd/blooddisorders/documents/vitamin-k.pdf](https://www.cdc.gov/ncbddd/blooddisorders/documents/vitamin-k.pdf)

Ultimately the most definitive intervention is legislation mandating Vitamin K administration. The only state that mandates IM Vitamin K over the objection of the parents is New York. Since 1993 New York statute states: “It shall be the duty of the attending physician, licensed midwife, registered professional nurse or other licensed medical professional attending the newborn to assure administration of a single intramuscular dose of 0.5 – 1.0 mg. of vitamin K1 oxide (phytonadione) within six hours of birth in accordance with current standards of medical care.” Has the time come to consider this in Illinois?

Many of us have practiced in an era where we have not seen VKDB in our lifetime. That will change as refusals increase. As medical providers, let us be proactive in our efforts to prevent the return of a disease that had been almost completely eradicated.

Please email me at vramaiah@pedsbsd.uchicago.edu with input or questions.

**REFERENCES**

10. https://www.cdc.gov/

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One of the biggest challenges for pediatric providers is the transition of care of their patients with chronic disease to the care of an adult provider. The 14th Annual Illinois Statewide Transition Conference was held October 25-26, 2018 in Itasca, Illinois. This conference, which was sponsored by the University of Illinois at Chicago (UIC) Division of Specialized Care for Children (DSCC), provided a multidisciplinary perspective for providers from the viewpoints of everyone involved, most importantly, the patient. The conference was organized by tracks including health care, employment, and education with the health care topic targeting providers, patients, and families occurring all day on Thursday, October 25. The conference plenary began with a talk by Mr. Jeff Hobbs, a young adult with quadriplegic cerebral palsy who worked hard to actively participate in high school track, cross country, and who ran half of the Chicago Marathon. His talk, which began with providers helping him ascend to the podium, was truly inspirational. After this keynote, I followed the informative health track and learned much.

One of the most helpful discussions was a mini seminar by Dr. Rachel Caskey with UIC and Kathy Sanabria with the Illinois Chapter of the American Academy of Pediatrics (ICAAP). It was a summary of a curriculum titled "Transitioning Youth to Adult Health Care for Pediatric Providers: Updated 2018." The basics of the online course included the psychology of helping each patient transition without feeling like you are abandoning your patient. It is important to begin thinking about the transitioning process around fourteen years of age and should include preparation of a portable medical summary that the patient and family can carry with them wherever they go. The curriculum also includes learning proper coding procedures to help with reimbursement. There is also a curriculum for adult providers as well as many resources for social workers, nurses, and parents. The pediatrician can also earn CME and twenty Maintenance of Certification Part 4 credits. For more information, contact Kathy at ksanabria@illinoisaap.com.

There was an excellent presentation from a multidisciplinary group from UIC about transitioning care of adolescents with Sickle Cell Disease (SCD) for patients. The transitioning process is continuous and never really ends. The curriculum included education about SCD, the therapies including transplant, and transitioning to adult care. The group included physicians, social workers, and patients.

The next presentation was about a transition of care program by internal medicine-pediatric (Med-Peds) providers and was presented by Dr. Rita Rossi-Foulkes from the University of Chicago (U of C). This program includes information on the Prioritization for Urgency of Need for Services (PUNS) list in the State of Illinois PATHways program: Illinois transition timeline. They utilize the ICAAP transition online curriculum and many resources from “Got Transition.” This program teaches medical students, residents, and young providers and includes quality improvement initiatives. The
importance of providing a portable medical summary is emphasized as well as beginning the transitioning process before thirteen years of age. This program also addresses insurance and guardianship questions, both of which come up in this process. In addition, through U of C a transition registry is created as well as a comprehensive transition skills checklist (https://transitioncare.uchicago.edu).

The Cotts Clinic for Adults with developmental disabilities at the U of C was presented which is run by a Med-Peds physician, Dr. Kamala Cotts. In this program, patients who survive with Down syndrome, cerebral palsy, autism, brain injuries, spina bifida, etc. come to this clinic for care from pediatric providers’ offices. Their clinical problems include premature aging, cardiac problems, challenges with mobility, and osteoporosis to name a few. These are clinical issues that need to be addressed usually in much older patients (like me) but become problems in these patients at much younger ages, and as a result, pediatricians find them much more challenging to address. Today, there are also many more patients with congenital heart disease and cystic fibrosis as there are more adults than children who are alive with these clinical conditions. The other issues addressed included disability, guardianship, and insurance issues after 26 years of age (http://illinoisaap.org/wp-content/uploads/Cotts-C-Track-Part-I.pdf).

Overall, this is just a sample of a thoughtful, excellent, and somewhat emotional conference for pediatric and adult providers. It was wonderful to have a day to spend time thinking about how to develop a plan to successfully transition our pediatric patients with chronic disease and conditions to our adult colleagues. The conference session handouts can be accessed at http://illinoistransitionconference.org/?page_id=168.

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**Selected Highlights of the 14th Annual Illinois Statewide Transition Conference: Youth Perspective**

**BY EMILY SANABRIA**

For any adolescent or adult, an integral part of life is figuring out who he or she is and who he or she wants to become. Forming a healthy and a developed identity through the process of exploration is essential for the overall health of any person. To do that, adolescents and young adults need certain knowledge and resources available that will help develop their self-efficacy, decision-making skills, and independence from their loved ones. This knowledge and these skills can be especially difficult to acquire if an adolescent or young adult has an intellectual, mental, or physical disability because more effort and resources may be needed to help them reach their full potential. However, the content at the 14th Annual Illinois Statewide Transition Conference, which was in Itasca, Illinois that took place this year from Thursday, October 25th to Friday, October 26th, 2018 showed attendees that with proper planning and the support of their parents, teachers, friends, and peers, a proper transition plan can be developed that allows the adolescent or young adult to achieve almost anything to which they set their minds. This conference was divided into four tracks: Health Care, Employment, Education, and Community. The purpose of the Health Care track was to give adolescents and adults with disabilities the chances they deserve to pursue and accomplish their life’s goals to the best of their ability, despite the hardships they may face each and every day.

It seemed only fitting, then, to have Jeff Hobbs illustrate the purpose of this conference as the keynote speaker. Jeff is an advocate for all people with disabilities and a motivational speaker with cerebral palsy. Jeff told a story about a girl he went on a date with in high school who seemed upset during the date. When Jeff asked her what was wrong at dinner, the girl said she missed her sister. Her sister had been away on a trip and had just gotten back. The girl was distracted and wanted to be spending time with her sister instead of Jeff. The girl ended her date with Jeff early to go to the movies with her sister. Jeff said that many people, like that girl, prefer to stick with familiar experiences. As an example, people often discriminated against him for having a disability because it made them feel uncomfortable. It is easy to point
out weaknesses in others as a self-defense for one’s own inadequacies. However, it is harder to find the true attributes that make a person worthy of being part of a community or team despite their weaknesses or disabilities. That is why for years, Jeff was denied a chance to be on sports teams in school due to them not wanting Jeff to get injured with his disability. Many coaches only focused on Jeff’s limitations, until one coach offered him a spot on the boy’s cross country team in high school. With support and knowledge from that coach, trainers, doctors, and his family and friends, Jeff was able to reach his goal of becoming the first person with cerebral palsy to run in a marathon outside of the Special Olympics, and in spite of his disabilities, he almost finished it. Jeff’s story taught me that just about anything is possible to achieve with knowledge, support from others, perseverance, and tenacity.

One fascinating session I attended focused on helping adolescents and young adults reach their full potential against all odds using the knowledge of brain development. The presentation was given by Diane Becker, who is a licensed clinical social worker. The session talked about how adolescents are facing many problems today, such as suicide or suicide attempts, mental illnesses, dropping out of school, delinquency, child abuse, and poverty. As an example, according to a review from https://www.healthypeople.gov/, which is a Federal Government Web site managed by the U.S. Department of Health and Human Services, in the year 2007, 11.3% of adolescents committed suicide, and that percentage has increased to 12.6% since then. From the year 2008 to now, the percentage of adolescents ages 12 to 17 years old with major depressive disorder has increased from 8.3% to 10.7%. Becker’s presentation also talked about how some adolescents are missing almost half a school year or they are not getting the nutrition they need due to having unstable parental relationships and households or due to being bullied at school. It mentioned that adolescents who are involved in gangs and violence are much more likely to drop out of school. It talked about how in the past five years, the number of adolescents who have visited the dentist has gone down by 3%, so oral health of these adolescents is declining.

However, an adolescent’s past does not have to define them according to Becker. That is because an adolescent brain has a lot of neuroplasticity, meaning that the adolescent brain has the ability to grow and change to adjust to its surroundings. Therefore, adolescents are easily able to learn new and healthier ways of doing activities. There was a study that Becker mentioned in her presentation about how teenagers who learned math in the way they learned best remembered more math concepts than those who were not taught in a way that worked best for them. This information suggests that adolescents have the biological ability to improve their performance in school with individualized learning techniques, and by learning healthier ways of coping.
with difficult situations that are out of their control. This presentation gave me hope that statistics about high amounts of poor mental and physical health that disables middle school, high school, and college students like myself, will decrease if adolescents have access to support and mentorship.

The presentation given by Dr. Mary Ciccarelli was a continuation on the subject of the importance of independence for adolescents with disabilities. This presentation was about how adolescents with physical disabilities often feel incompetent due to themselves and others believing they are limited with their disabilities. However, with the help of parents and providers, adolescents and adults with disabilities can get the resources they need to be independent, and to discover what they are truly capable of when they live on their own or go away to school. This can be possible if they and their parents are made aware of the services that are available for them. These resources include equipment, proper work and academic environment, accommodations, transportation, and personal care attendants, if needed. I think this information is necessary for everyone to receive, as it is directly applicable to students I know at my university, including myself, who have benefited from some of these supports.

There was also a presentation given by Dr. Carol Greenlee that I found to be empowering. The presentation was about improving the ability of health care professionals to support adolescents in their transition from adolescent to adult health care. This was an especially important topic to me since approximately 60 million adolescents are currently in the process of transitioning from adolescent to adult health care, including myself, and 25% to 30% of 12 to 26 year-olds have chronic health conditions, such as intellectual disabilities that will require a well-thought out health care plan. However, 83% of youth with Special Health Care Needs and 86% of youth without special needs do not meet the national health care transition performance measure due to lack of utilization of transition tools and lack of communication between physicians and patients. For more information on the U.S. healthcare transition performance measure, visit the Got Transition website: https://www.gottransition.org/news/index.cfm#news57

The most interesting topic within Greenlee’s presentation was improving the ability of youth and adults with and without disabilities to prioritize proper self-care and health care transition. Emerging adult patients have a strong drive for independence, which is why they tend to want adult-oriented care that includes increased independence on decision-making, responsibility, and information about health risks. I believe this should be made possible for transitioning adolescents. That is because as Greenlee said, during adolescence, neurons are constantly being myelinated. That speeds up the response of neural circuits, meaning adolescents can learn concepts, such as language, cultural tools, health care procedures, and self-care techniques more quickly. I thought Greenlee’s closing keynote was a great presentation about how and why adolescents with and without disabilities should be allowed to take more charge of their own health care with the help of competent and knowledgeable physicians and care teams. This is most applicable to emerging adults who no longer live with their families or who care for themselves at college, as I do.

Overall, I thought this conference was very well thought out. The conference contained information that will greatly help myself and adolescents and young adults with physical and mental disabilities pursue their life’s goals, discover who they are and want to become, develop independence, confidence, and decision-making skills, and reach their full potential. It was great to spend the day considering how adolescents and adults with disabilities can get the proper health care, support, and community resources they need and deserve.

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Emily Sanabria is a junior and a psychology major at Dominican University in River Forest, Illinois, in the process of transitioning to adult care. She is also a former Immunizations Program intern at the Illinois Chapter of the American Academy of Pediatrics (ICAAP).
The second edition, based on a comprehensive scientific review, reflects new knowledge about immediate and long-term health benefits from physical activity, as well as new evidence that physical activity can help manage chronic conditions that many Americans have.

“The American Heart Association has long recognized physical activity as a proven way to lower chances of heart disease and live a longer, healthier life. Our organization is committed to developing programs and advocating for polices that make it easier for everyone to get more physically active, regardless of where they live,” said Ivor Benjamin, M.D., American Heart Association president. “In 2008, the American Heart Association adopted the Physical Activity Guidelines and again we are proud to lead the call for health groups across the country to view these guidelines as beneficial to both public health and a worthy tool for clinicians.”

Notable updates:

- The previous guidelines stated that only 10-minute bouts of physical activity counted toward meeting the guidelines. This requirement has been removed because all activity counts.
- There are immediate health benefits, attainable from a single bout of activity, including reduced anxiety and blood pressure, improved quality of sleep, and improved insulin sensitivity.
- There are more long-term benefits from physical activity, including improved brain health, reduced risk of eight types of cancer (previously two), reduced risk for fall-related injuries in older adults, and reduced risk of excessive weight gain.
- Physical activity helps manage more chronic health conditions.
  - It can decrease pain for those with osteoarthritis, reduce disease progression for hypertension and type 2 diabetes, reduce symptoms of anxiety and depression, and improve cognition for those with dementia, multiple sclerosis, ADHD, and Parkinson’s disease.
  - There are new key guidelines for preschool children to be active throughout the day to enhance growth and development.

For more information about the latest Physical Activity Guidelines for Americans visit [www.health.gov/paguidelines](http://www.health.gov/paguidelines).
How to Code for Flu Vaccine, Administration in 2018-2019 Season

CODING CORNER, BY BECKY DOLAN, MPH, CPC, CPEDC
FROM THE AMERICAN ACADEMY OF PEDIATRICS
DIVISION OF HEALTH CARE FINANCE

It’s that time of year again when patients will need their annual influenza vaccine. Some will combine with another service, while others will come in solely for the vaccine. Keep the following in mind for the upcoming season:

- If administering a quadrivalent vaccine, be sure to use the appropriate quadrivalent code and not the trivalent code.
- Live attenuated inactivated influenza vaccine (LAIV4, Flumist) is an option.
- Remember to note:
  a. trivalent vs. quadrivalent
  b. preservative vs. no preservative
  c. dosage
  d. route of administration
  e. any other distinctive feature of the vaccine (e.g., cell cultured, antibiotic free)

It is important to know the specific vaccine product being ordered and administered in your office. When administering the vaccines, be sure the patient meets the age requirement.

Code descriptors in the table are listed by “quadrivalent” or “trivalent” to differentiate the products. (The Academy does not promote one vaccine product over another, and the list may not include all products.)

As with all vaccines, report a vaccine product code in addition to the appropriate immunization administration (IA) code.

Immunization administration codes

If the patient receiving the influenza vaccine is 18 years of age or younger and receives counseling from a physician or other qualified health care professional (e.g., nurse practitioner), report 90460 for either the injection or intranasal.

90460 – Immunization administration through 18 years of age via any route of administration, w/counseling by physician or other qualified health care professional; first vaccine/toxoid component

However, if both of the above criteria are not met, the immunization administration code reported must come from the 90471-90474 series. Clinical staff (e.g., R.N., L.P.N.) do not meet the criteria for other qualified health care professional per CPT guidelines.

90471 – IA; one vaccine (single or combination vaccine/toxoid)

+90472 – IA; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to 90460, 90471 or 90473.)

90473 – IA; one vaccine (single or combination vaccine/toxoid)

+90474 – IA; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to 90460, 90471 or 90473.)

Other considerations to keep in mind when reporting codes 90471-90474:

- If you administer an injection of the influenza vaccine only, report 90471.
- If you administer the intranasal influenza vaccine only, report 90473.
- If you administer an influenza vaccine in addition to other vaccines, report the influenza injection with 90472 or the intranasal with 90474.

Note that code 90471 or 90473 cannot be reported in conjunction with 90460. Therefore, if during a single encounter, a patient receives multiple vaccines and there is counseling on all but the influenza vaccine, report 90472 or 90474 in addition to 90460 and 90461 as appropriate.

The International Classification of Diseases, Tenth Revision, Clinical Modification code for the influenza vaccine is Z23.

Vignettes

A 12-year-old is seen for her well-child check and vaccines. She receives tetanus, diphtheria and acellular pertussis (Tdap), human papillomavirus (HPV) and meningococcal vaccines in addition to the intranasal influenza vaccine. The physician counsels on all of the vaccines. Report the following IA codes:

90460 x4 (tetanus component; meningococcal; influenza; HPV)

90461 x2 (diphtheria and pertussis component)

To code for the same scenario as above except that the...
It is important to remember that reporting an evaluation and management service in addition to immunization administration codes will depend on several factors. This becomes an issue when patients present outside of their routine well check to receive vaccines. Many practices set up flu clinics where patients can receive their annual influenza vaccines and are seen solely by clinical staff.

For more information on how to bill for vaccine-only visits, particularly those involving only clinical staff, visit http://bit.ly/2sGgYrk (log-in required).

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</tr>
<tr>
<td>90674</td>
<td>Flucelvax Quadrivalent</td>
<td>Seqirus</td>
<td>Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative- and antibiotic-free, 0.5 mL dosage, IM</td>
<td>≥4 years</td>
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<tr>
<td>90682</td>
<td>Flublok</td>
<td>Seqirus</td>
<td>Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative- and antibiotic-free, IM</td>
<td>≥18 years</td>
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<td>90685</td>
<td>Fluzone Quadrivalent</td>
<td>Sanofi Pasteur</td>
<td>Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.25 mL dosage, IM</td>
<td>6-35 months</td>
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<td>Seqirus</td>
<td>Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.5 mL dosage, IM</td>
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</tr>
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<td>≥6 months</td>
<td></td>
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<td>Fluarix Quadrivalent</td>
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<tr>
<td>FluLaval Quadrivalent</td>
<td>GlaxoSmithKline</td>
<td>≥6 months</td>
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<td>Sanofi Pasteur</td>
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<td>6-35 months</td>
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<tr>
<td><strong>Trivalent</strong></td>
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<td></td>
<td></td>
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<td>Afluria</td>
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<td>Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, 0.5 mL dosage, IM</td>
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<td>90658</td>
<td>Afluria</td>
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<td>≥18 years</td>
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</table>
The Magnitude of the Opioid Epidemic in Women of Reproductive Age and Their Newborns in the State of Illinois and What We Can Do to Help

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Opioid use in pregnancy has increased drastically in recent years resulting in a significant increase in maternal morbidity and mortality. Data from the Illinois Department of Public Health show that maternal opioid use has increased by 5.9% per quarter and 116% overall between 2011 and 2015. The rate of opioid related poisoning deaths of women of reproductive age in Illinois increased 175% from 2008 to 2017. Pregnancy-associated death rates within one year of pregnancy related to opioid poisoning increased almost six-fold between 2008 and 2016.

The rise in opioid use during pregnancy has also lead to a significant increase in neonatal abstinence syndrome (NAS), the “collection of signs and symptoms that occur when a newborn prenatally exposed to prescribed, diverted, or illicit opiates experiences opioid withdrawal”. The rate of NAS has increased 52% in Illinois between 2011 and 2016. In 2016, there were 2.7 recorded cases of NAS per 1,000 live births in Illinois. Morbidities associated with NAS include lower birth weight, feeding difficulties, respiratory insufficiency, seizures, and longer hospital length of stay.

To address this worsening problem, the Illinois Perinatal Quality Collaborative (ILPQC) launched the Mothers and Newborns affected by Opioids (MNO) obstetric and neonatal quality improvement initiative to build hospitals’ quality improvement capacity to improve health outcomes of mothers with an opioid use disorder (OUD) and their opioid-exposed newborns (OENs). There are 107 hospitals across Illinois (including a few around St. Louis, Missouri serving women and newborns in Southern Illinois) participating. The MNO-neonatal teams are working on key strategies for improvement that highlight opportunities for pediatric providers to improve outcomes for OENs in the following areas:

1. Strengthen Family/Care Team Relationships

Providers can work to increase maternal and family participation in the care of the OEN. First, we can educate ourselves on the science of addiction as a chronic disease or illness and be cognizant to rework attitudes to minimize stigma and bias towards women with OUD and OENs. Second, we can work with the care team to educate and support a mother with OUD to engage her in the care of her OEN. This includes holding, calming, on-demand feeding, skin-to-skin contact, rooming-in, and reducing stimuli such as noise and bright lights.

2. Standardize Identification and Assessment of OENs

It is important to work with pregnant women and their obstetricians to develop a plan for prenatal, labor and delivery, and postpartum care which includes plans for care for the OEN. OENs typically become symptomatic two to five days after delivery. As providers, we can familiarize ourselves with toxicology testing options and establish unbiased guidelines to identify newborns to be tested. We can educate ourselves and become involved with the assessment and management of NAS. It is essential that your newborn nursery has structured guidelines for assessment and management of these infants and that the mother and baby be thought of as a maternal-infant dyad.
Finnegan Neonatal Abstinence Scoring System (FNAST) and the Eat, Sleep Console (ESC) care tool are available resources.12

3. Optimize Treatment of OENs

Non-pharmacologic management is the first step in the management of NAS.9-11 This begins with maternal education before delivery and continues after delivery with implementation of a non-pharmacologic care protocol including rooming-in, skin-to-skin contact, holding, swaddling, feeding on demand, non-nutritive sucking, clustered care, and a quiet environment.9-11 Newborn assessment is performed serially every two to four hours. If it is determined that pharmacologic therapy is necessary, standard guidelines approved by the pharmacy, therapeutics committee, and the providers should be followed closely.9-11 Lastly, establish feeding guidelines that promote breastfeeding when appropriate and provide for nutritional alternatives when mothers should avoid breastfeeding.

4. Coordinate and Communicate Safe Discharge

In-hospital providers should work to ensure a plan for safe discharge with the mother, family, and care team. We should partner with primary care providers and community organizations to provide ongoing support of the maternal-infant dyad and to facilitate the transition. Making the transition from hospital to home with a newborn is challenging when the mother and infant are otherwise healthy and this transition can be much more challenging with maternal OUD and other complex health and social needs.12

The ILPQC provides a quality improvement infrastructure and resources which include collaborative learning opportunities, rapid response data to monitor improvement over time and in comparison to other hospitals, and individualized quality improvement support to help hospitals achieve their improvement goals. This enables hospitals to facilitate sustainable system changes that improve outcomes for mothers and newborns. Check with your local/affiliated hospitals to see if they are one of the over 100 hospitals participating in this statewide quality improvement initiative. The www.ilpqc.org website includes valuable resources including collaborative call recordings and toolkit resources. Contact info@ilpqc.org to get involved.

REFERENCES


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while behavior symptoms may include irritability, anxiety, and depression. It is important to share these symptoms with parents, as many of these symptoms may mask themselves as other issues and may go unnoticed and untreated for weeks.

**Pathophysiology of True PCS**

Post-concussion syndrome is contributed to by both psychologic and physiologic factors. Psychogenic/psychologic factors can include fear of the injury, social isolation, fear of losing their role, fear of being perceived as “weak,” and loss of identity. Psychological contributions may be based on one’s coping style, misattribution of unrelated or normal symptoms to a concussion, anxiety, sensitivity, life stressors, and/or pre-existing psychiatric history. Physiologic factors include persistent neurometabolic and neuroinflammatory changes that may promote the physical and cognitive symptom experience.

The bottom line is that with concussion, the injury itself can be the precipice of a series of complicated health issues, both physical and psychological. These factors can contribute to greater struggles for the patient and should be taken into consideration during follow-up appointments. Bringing parents’ attention to these potential symptoms will allow them to recognize them earlier, thus leading to improved outcomes.

**Factors that Can Prolong Recovery**

The existence of some comorbidities or genetic predispositions have been demonstrated to increase an individual’s risk for a prolonged recovery from concussion. These include migraine, ADHD, mood disorder, and other psychiatric illnesses. Additionally, the presence of other injuries can prolong symptoms after concussion. Depending on how the injury was obtained, some individuals with concussion will also experience cervical strain. Cervical strain can cause cervicogenic headaches, cervicogenic dizziness,
and in some cases visual disturbance and vague cognitive symptoms such as feeling foggy or disconnected.

Some individuals with concussion will display vestibulo-ocular dysfunction which may continue after the acute concussion otherwise resolves. This is often clinically manifested as gait imbalance, dizziness, motion and environmental sensitivity, screen intolerance, and difficulty with eye tracking and reading. In some cases, vestibular dysfunction can be persistent for months or even years post-concussion without proper treatment.\(^5\) If a patient experiences repeat injuries during the recovery period, considered a period of biochemical vulnerability, there is a compounded chemical change, extended cognitive change and symptoms are often exacerbated.\(^6\)

**Treating PCS: Over or Under Rest?**

Concussion has been traditionally treated by prescribing total cognitive and physical rest. This is based on the concept that activity draws oxygen and glycojen away from injured neurons, increasing the energy crisis.\(^7\) However, emerging research supports that moderate levels of cognitive activity during early recovery may be best for symptom recovery and strict rest may actually result in higher symptom burden and longer symptom duration as compared to gradual return to cognitive activity in the first five days following concussion.\(^8\)\(^,9\)

**Diagnostics**

Developing a customized treatment plan for patients diagnosed with PCS is critical to their recovery. A treatment plan will be individualized for the patient and should be based on what is surmised to be the cause of prolongation of symptoms. Patients may be referred to a neurologist, cognitive therapist, and/or physical therapist as part of their treatment plan.

**Physical Therapy**

If there is a concern for cervical or vestibular involvement, pediatricians should consider referring patients to a physical therapist. Physical therapy evaluations may find reduced range of motion of the neck, tenderness to trapezius, paraspinal or suboccipital palpation, poor cervical proprioception, and/or reproduction of symptoms with cervical manipulation. On vestibular exam, a PT may find exotropia, convergence insufficiency, intolerance to vestibulo-ocular reflex, nystagmus, traumatically-induced benign paroxysmal positioned vertigo, hypo- or hypermetric saccades, and/or gait imbalance to indicate vestibular dysfunction.

**CT and MRI Scans**

Pediatricians may also consider a CT in a patient with prolonged symptoms or atypical recovery to rule out a skull fracture or intracranial bleed. Though not typically used in the diagnostic work-up of patients with prolonged symptoms, an MRI of the brain can be considered to rule out other injuries or abnormalities.

**Neuropsychologic Testing**

Neuropsychologic testing may be recommended for individuals that have persistent cognitive complaints, either themselves or noticeable by their parents. This testing can be useful to see if there are any changes that are unexpected for that individual’s age and education.

**Behavioral Optometry**

A referral to behavioral optometry may be recommended for select patients that plateau with vestibular physical therapy and may require more specialized attention by a behavioral or developmental optometrist. These specialists may prescribe tinted or prism glasses or more intensive vision therapy to correct remaining ocular deficits that remain after physical therapy.

**Cognitive Rehabilitation**

Cognitive rehabilitation may be indicated and can be useful in individuals with prolonged cognitive symptoms following concussion. Treatment by mental health experts (psychiatry/psychology) is often an important part of PCS,
and a low threshold for referral is recommended. Some patients suffer from exacerbations of preexisting psychiatric conditions such as anxiety or depression while some patients have de novo mood disturbance from concussion, and many patients have difficulty with adjustment disorder due to the loss of function, athletic or physical participation, or social involvement their injury may have caused. Again, talking through these issues with parents ahead of time will help identify symptoms and early intervention.

Pharmacologic Treatment

Depending on the symptoms and their response to non-pharmacologic interventions such as psychology or physical therapy, pharmacologic treatment may be indicated. A provider may consider treatment for sleep initiation and maintenance (melatonin, amitriptyline, gabapentin), headache (gabapentin, nortriptyline, topiramate, or baclofen depending on the type of headache), and mood (SSRI or SNRI). Stimulants such as methylphenidate have been used off-label in this population for complaints of cognitive fatigue and difficulty with concentration, but there is limited evidence and should be used with caution.

Exercise

Mounting evidence supports the physiologic and recovery benefits of exercise and recommends a graded and progressive exercise program for patients with post-concussion syndrome.\textsuperscript{10}

Post-concussion syndrome symptoms can vary drastically from individual to individual depending on the severity of the concussion and other complicating issues, including previous diagnoses. While PCS is often difficult to diagnose, identifying patients experiencing prolonged concussion symptoms early on is critical to their recovery. While some patients will recover with minimal treatment, others may require complex multidisciplinary care and a keen eye to lead them to a path of recovery.

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2. Rose SC, Fischer AN, Heyer GL. How long is too long? The lack of consensus regarding the post-concussion syndrome diagnosis. Brain Inj 2015;14:1-6

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Helmets can help prevent concussions and head injuries. Wear your helmet!
Family Guide to Medicaid Managed Care Appeals

Providers are encouraged to share this information with their patients/families who need assistance with Medicaid appeals.

Step 1 - Get a prescription from your child’s doctor for a recommended, medically necessary treatment. For example, a developmental evaluation or a therapy service require a prescription.

A prescription is also needed for durable medical equipment as well as for some supplies or over-the-counter medications for children.

Step 2 - Contact your child’s care coordinator by calling the toll-free number on the back on the insurance card.

Important – if your child does not yet have a care coordinator, you can request one by calling the same toll-free customer service number.

• Tell the care coordinator that Dr. X______, has prescribed the following service ___________ at the last office visit.

• Ask for a written/hard copy referral to a provider of this service who is “in-network” with the health plan. This document lists all of the Health Choice Illinois plans, and the toll-free member services number for each: https://www.illinois.gov/hfs/SiteCollectionDocuments/CONTACTInformationforHealthPlansforMembers8718.pdf

Step 3 – If you receive a written list of in-network therapy providers (or download and print out a list from the health plan’s website) you will need to call each one and request an appointment for your child. You need to keep a record of each call which you make and the response which you receive;

1. Provider name
2. Telephone number
3. Date and time of your call
4. Name of person you spoke with
5. Outcome of your call (for example: my child got an appointment, I was told that there is a waiting list, I was told that provider does not accept Medicaid, I was told that provider is no longer “in network” with the health plan, other)

Step 4 – If the care coordinator informs you that the health plan does not have a provider for the prescribed services, or that you can only be referred to a provider who has a long waiting list (or any other reason that your child cannot receive the prescribed service), then you will need to file a grievance with the health plan according to the rules in your Member Handbook.

Step 5 – If you do not have a member handbook, you can ask the Care Coordinator to send one to you in any language and/or format required. You can also look at the Member Handbook on the health plan’s website.

Step 6 – If you do not agree with the decision which the health plan made in response to your grievance, then you can file an appeal with the Illinois Department of Healthcare and Family Services. Here is information regarding how to do this: https://www.illinois.gov/hfs/SiteCollectionDocuments/MCOGrievanceAndAppealsProcess.pdf

Be sure to keep copies of all documents related to your grievance and/or appeal.

Please contact The Arc of Illinois Family to Family Health Information Center and 866-931-1110 or Illinois Life Span Program at 800-588-7002 if you have any questions or need more information.

ICAAP Thanks ...

American Academy of Pediatrics (immunization)
American Heart Association
Voices for Healthy Kids (physical education/obesity prevention)
Anonymous Donor (adolescent health)
Autism Speaks (autism)
Centers for Disease Control and Prevention (immunization)
Chicago Department of Public Health (immunization)
Illinois Department of Public Health (adolescent health)
Illinois Public Health Institute (breastfeeding/physical education)
Otho S. A. Sprague Memorial Institute (obesity/housing)
I am sitting at my desk in my office at University of Chicago, working on NICU quality improvement projects, editing, writing, and helping medical students, residents, fellows, nurse practitioners, faculty, and NICU and PICU nurses with papers and research projects. Hey, my brain is working! That classical music is really relaxing from an iPad and an app (WFMT) and it gets me thinking…it was five years ago when I stepped out of the pool at Northwestern with what I thought was costochondral discomfort related to my regular swimming—seven days a week for about half an hour. I woke up one and a half days later after I was extubated in the Intensive Care Unit at Evanston Hospital (North Shore University Health System, Evanston, IL). I had suffered a “heart attack” with coronary vasospasm and ventricular fibrillation, which required five shocks before I converted.

Every day I am grateful to the physician who happened to be in the locker room where I collapsed. I am also thankful for the lifeguards, paramedics, Emergency Department nurses, and physicians for performing “optimal” cardiac compressions1 to maintain my coronary and cerebral blood flow. As a result, I could continue to make small contributions to the literature while teaching pediatrics to students, residents, and fellows, in addition to doing my editing of Pediatric Annals, NeoReviews, and Neonatology Today, do some career choice counseling, learn new things, all the while trying to be a good husband, father, and grandfather.

As physicians, whether we come to a point in our professional lives when we make conscious decisions not to continue practicing clinical medicine or the decision is made for us, we face a major change in the orientation of our professional lives and it is important that we realize that we have many other skills that will enable us to continue to be productive physicians. In the “old days,” when we felt burned out or we felt down or depressed, we sometimes talked with our chairs or section chiefs and we got a sympathetic ear and sometimes got some help. But we were pretty quiet and basically dealt with our feelings and ups and downs as these were expected. As physicians we were expected to always be at the “top of our game.”2

More recently, there has been more open discussion about physician burnout and wellness. In my conversations with Dr. Hilary McClafferty, a pediatric emergency physician and integrative medicine physician who is the first author on the clinical report "Physician Health and Wellness” from the AAP Section on Integrative Medicine and Committee on Practice and Ambulatory Medicine which was published in Pediatrics in 2014, she tells me that she has had the opportunity to speak at a number of meetings and forums with practicing pediatricians.3 When she begins to discuss burnout and career challenges, and then opens the discussion, there are always pediatricians who volunteer career challenges in their professional lives (personal communication, Hilary McClafferty, 2017).

It is important for each of us to do regular self-assessments of the balance between the positive and negative aspects of our professional lives as we move forward in our careers. It is also equally important that we do the same assessment with our personal lives. Once we have accomplished both of these assessments, we then need to assess the balance between our professional and personal lives.3 (Figure 1).

McClafferty and colleagues have outlined a helpful approach for pediatricians to minimize the negative effects of the chronic stress we experience in our professional lives which have been demonstrated to lead to impaired immune function, inflammation, elevation of cardiovascular risk factors, and depression. These include focusing on nutrition, regular exercise, mindfulness, and effective stress management.3

Dr. Neil Baum outlines 10 suggestions to help us achieve and maintain a balance between our personal and professional lives:2
either voluntarily or involuntarily. Your adjustment period and transition as you “reinvent yourself professionally” will be a bit smoother. This I can tell you from personal experience as forced retirement is a challenging and potentially depressing experience.

For further inspiration I recently learned about Leon Fleisher, who is now a 90-year-old pianist, conductor, and teacher who came to Ravinia in Highland Park, IL to play a piano recital. Mr. Fleisher was a prodigy who began playing the piano at age five and developed finger dystonia of the 4th and 5th fingers of his right hand at age 36. This is the same age I developed cervical dystonia and had to stop practicing as a neonatologist. He “reinvented” himself as a composer, teacher, and conductor and eventually began getting Botox® injections that enabled him to resume playing the piano.4 Fifty-four years later he is still playing the piano professionally and conducting. Presently he is the Andrew Mellon Chair of Piano at the Peabody Institute of the Johns Hopkins University. My Botox® injections for the recurrence of my cervical dystonia, which returned a year ago, have enabled me to write and teach with more efficiency, limited my chronic pain to a two to three out of ten, and have generally improved my quality of life.

In summary, we as physicians need to be more mindful and sensitive in taking care of ourselves mentally and physically to enable us to find a reasonable balance in our professional and personal lives. By caring for ourselves, it will be better for us, for partners and family, and for our patients and their families.

REFERENCES

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Commercial/multifamily mortgage origination volumes during the second quarter of 2012 were up 25 percent from second quarter 2011 levels, and up 39 percent from the first quarter of 2012, according to the Mortgage Bankers Association. Why not take advantage of HealthCare Associates Commercial Real Estate loan options and lock in long term low fixed rates?

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