It is hard to believe that we have begun 2018. As I prepare to write this article, I am once again in awe of the amazing work that is taking place at ICAAP. In the second half of 2017, ICAAP continued to advocate for the health of children and worked tirelessly to support clinicians in caring for children and their families. I would like to take a few moments to share with you some new initiatives of the last six months.

**IMMIGRANT HEALTH**

In August 2017, ICAAP launched a Refugee Immigrant Child Health Initiative (RICH1) to address the complex needs of immigrant children in Illinois. RICH1 seeks to improve medical homes for this vulnerable population and to increase access to medical, social, legal, and other vital resources. RICH1 provides resources for physicians, facilitates collaboration, promotes advocacy, and creates immigrant-friendly health care spaces.

**HEALTH EFFECTS OF CLIMATE CHANGE**

Over the past year, ICAAP created a group of interested staff and pediatrician volunteers to serve on a climate change work group for the Chapter. CME-approved live and enduring educational webinars were developed as well as work leading to written provider education and a conference in collaboration with the Chicago Physicians for Social Responsibility.

**IMMUNIZATION COMMUNITY OUTREACH/PUBLIC EDUCATION**

This year for the first time ICAAP participated in five community public education events throughout the state of Illinois. The immunizations team exhibited at community health events in Aurora, Robbins, Bartlett, Springfield, and Arlington Heights reaching over 1,300 community members.

**COMPASSION FATIGUE**

Compassion fatigue is an occupational hazard that comes from working with children, families, and even colleagues who have been affected by...
Adverse Childhood Experiences, trauma, and toxic stress. The ICAAP Child Development team and our dedicated physician subject matter experts developed a training session titled The Cost of Caring: When Their Issues Become Our Stress, that addresses the need for self-reflection and self-care of the provider, before the provider can approach therapeutic interventions for children and families. The learning objectives for the training include: 1) Distinguish the difference between burnout and compassion fatigue and why this difference is important; 2) Examine the science behind and process of stress and compassion fatigue for all “helping professions”; and 3) Recognize the specific impact of compassion fatigue on our work and other parts of our life.

PROFESSIONAL EDUCATION

The ICAAP Continuing Medical Education (CME)/Quality Improvement (QI) program coordinates, monitors, and evaluates ICAAP’s CME, QI, and Maintenance of Certification (MOC) efforts and activities to ensure quality and consistency in the content development and design process as well as to provide oversight for CME accreditation. ICAAP’s CME/QI Planning Committee and staff recommend direction for the program in consideration of sound educational practices based on the principles of adult learning theory. To register for ICAAP’s eLearning platform visit, https://icaap.remote-learner.net and create an account. Visit the Course Catalog at the end of this newsletter where you can read about educational offerings. Throughout 2017, ICAAP’s CME program provided more than 2,200 learners with CME or CE credit.

STRATEGIC PLANNING

In the fall of 2017, more than 25 ICAAP physician leaders and staff began discussions that will lead to a three-year strategic plan for ICAAP. We look to advance advocacy, programming, and education in innovative ways that will further strengthen our ability to care for children, their families, and the clinicians who care for them.

These new initiatives were on top of the platform that makes ICAAP great. We continued to strengthen our programs that you are already familiar with including: Bright Smiles from Birth, child development, immunizations, school health, children with chronic illnesses and disabilities, obesity prevention and management, medical home initiatives, transitioning youth to adult healthcare, and Reach Out and Read.

I wish you and your families a happy and healthy 2018!

Alison S. Toth, MD, FAAP, President
Associate Professor of Pediatrics
Pediatric Emergency Medicine, University of Chicago
atothy@peds.bsd.uchicago.edu

You Don’t Have to Be a Therapist to be Therapeutic
Facilitators will provide insights into what communities and individuals can do to build supportive, healing, and nurturing environments for children and families, understanding that risk factors for Adverse Childhood Experiences (ACEs), trauma, and toxic stress are not predictive factors, because of protective (resilience-building) factors. This session includes lecture and interactive participation into building resilience. Participants will learn about the science of resilience, understand the three E’s of traumas, discuss the 7 C’s of resilience, and strategize your role in building resiliency.

The Cost of Caring: When Their Issues Become Our Stress
This session addresses the need for self-reflection and self-care of the provider. Participants will distinguish the difference between burnout and compassion fatigue, examine the science behind and process of stress and compassion fatigue for “helping professions”, recognize the impact of compassion fatigue on our work and other parts of our life, use the self-care inventory and debrief results, and strategize ways to develop skills for self–care.

For training fees, please contact Juanona Brewster, MDIV, MTS, MJ, Senior Director, Child Development Initiatives jbrewster@illinoisaap.com or 312/733-1026 x (203).
While you’re caring for your community,

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Our passion protects yours
ICAAP is offering two free CME-approved one-hour enduring webinars for physicians, health care providers, and those interested in the effects of climate change on their patients' health. These are available on ICAAP's eLearning platform. Go to ICAAP's e-Learning site at https://icaap.remote-learner.net and click create an account at the top right. Once you have registered an account, navigate to the course catalog and click “Health Effects of Climate Change” to access the webinars. Questions may be directed to Anna Carvlin, MPH acarvlin@illinoisaap.com or Kathy Sanabria, MBA ksanabria@illinoisaap.com

**Presenters:** Samuel Dorevitch, MD, MPH and Elena Grossman, MPH with the Building Resilience Against Climate Effects (BRACE) Project, University of Illinois at Chicago, Environmental and Occupational Health Sciences, School of Public Health.

**WEBINAR 1***

*Preparing Pediatric Providers to Address Health Effects of Climate Change: Heat-Related Illness, Asthma, and Allergies* focuses on climate change’s impact on air quality, respiratory health, and heat-related illnesses.

**Learning Objectives:** At the conclusion of this educational activity, participants will be able to:

1. Summarize the impacts of a warming climate on respiratory health
2. Apply principles of climate change communications in explaining to patients and their parents the connection between climate and heat-related illness and respiratory health
3. Identify sources of reliable heat and air quality data in the Midwest
4. Describe the various types of heat stress illnesses, their diagnosis, treatment, and prevention, including guidelines for outdoor physical activity during extreme heat

**WEBINAR 2***

*Preparing Pediatric Providers to Address Health Effects of Climate Change: Vector-Borne Diseases, Public Health Implications from Floods, and Mental Health Concerns* focuses on climate change’s impact on vector borne illnesses, extreme weather events, and mental health.

**Learning Objectives:** At the conclusion of this educational activity, participants will be able to:

1. Summarize the impacts of climate change on vector-borne diseases and extreme weather events
2. Identify sources of reliable precipitation and vector-borne disease data related to climate change in the Midwest
3. Describe the health impacts of floods
4. Describe the mental health consequences of extreme weather events
5. Apply principles of climate change communications in explaining to patients and their parents the connection between climate change, flooding, vector-borne diseases, and mental health

*The Illinois Chapter, American Academy of Pediatrics designates this enduring activity for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The Illinois Chapter, American Academy of Pediatrics is accredited by the Illinois State Medical Society (ISMS) to provide continuing medical education for physicians.
We are pleased to summarize some of the excellent talks and information that was provided by the speakers during the ICAAP ABC conference held November 17, 2017 at Moraine Valley Community College in Palos Hills, IL. The conference was entitled, *Lives in the Balance: Caring for Children with Special Needs, Their Families, Their Communities and Ourselves in These Precarious Times.*

The conference started with an excellent presentation by Erica Smith about using trauma-informed principles to build resilience during which she reviewed the trauma and toxic stress that some of our patients and their families endure and how we can help them deal with these issues. She also emphasized the effects of dealing with this trauma as health care professionals, the development of compassion fatigue and burnout and how we need to learn to protect ourselves. Erica summarized the physical and emotional manifestations of compassion fatigue and burnout that we may experience and cited a study in physicians in which this was manifested in 26 of 27 clinical specialties.¹ Tait Shanafelt, MD, a hematologist and physician–burnout researcher at the Mayo Clinic, said in a presentation at a New England Journal of Medicine Catalyst event last June, “Today’s medical practice environment is destroying the altruism and commitment of our physicians. We need to stop blaming individuals and treat physician burnout as a system issue, if it affects half our physicians, it is indirectly affecting half our patients.”² It was also mentioned in this and other discussions, that exposure to secondary trauma which results in compassion fatigue and burnout can also affect the quality of care we give our patients and their families³; it may also affect our professional performance.⁵ In another related article, Dr. Shanafelt stated the following:

**Burnout is often the result of three components:**

- **Depersonalization:** Treating people as though they’re objects rather than human beings
- **Emotional exhaustion:** Losing enthusiasm for your work
- **Low personal accomplishment:** Feeling you’re ineffective in your work, whether or not that is an accurate perception

“All of us have those feelings to some frequency and some severity,” he said. “But when they come too often and to too severe an extent, they can begin to undermine your effectiveness in your work.”⁶

“This syndrome differs from the global impairment of depression,” he said. “It primarily relates to your professional spirit of life, and it primarily affects individuals whose work involves an intense interaction with people—so professions such as teachers, social workers, police officers, nurses and physicians.”⁷

— Dr. Tait Shanafelt

It has just been in the past couple of years that discussion about compassion fatigue and burnout as well as 300-400 physician suicides per year in the US are becoming issues to address more visibly.⁷ Addressing physician wellness is new in medical schools and residency programs and the major point is, we have to start somewhere with “Physician heal thyself” which is a timeless quote.⁸ After all, our culture’s approach has historically been to just deal with it and move on… which we also realize no longer works very well with the burnout rate being acknowledged to be as high as it is. We also need to help ourselves so we can continue to take good care of our patients and their families.

Continuing on, during the mid-day key note address, Dr. Eddie Pont, a community pediatrician for over two decades and chair of the ICAAP Committee on Government Affairs, gave an excellent keynote speech that reflected the intersection of politics and medicine. His presentation was entitled *Advocacy: Everything is Impossible, Until It’s Not.* Dr. Pont interspersed stories of his experience with priceless strategies for efficient advocacy. He stressed the importance of narrative and persistence. Dr. Pont also shared one of his most ingenious moves in Springfield. Waiting in the capital building to speak with his legislator, he happened upon a school group, meeting with the same lawmaker. Dr. Pont offered to take a picture of the group on the legislator’s phone, ensuring his own face time prior to the phone’s return. He made advocacy seem accessible and crucial in our current climate.

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It has just been in the past couple of years that discussion about compassion fatigue and burnout as well as 300-400 physician suicides per year in the US are becoming issues to address more visibly. Addressing physician wellness is new in medical schools and residency programs and the major point is, we have to start somewhere with “Physician heal thyself” which is a timeless quote. After all, our culture’s approach has historically been to just deal with it and move on… which we also realize no longer works very well with the burnout rate being acknowledged to be as high as it is. We also need to help ourselves so we can continue to take good care of our patients and their families.

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The conference then split into three tracks to focus on Autism, Behavior and Complex Care (ABC). The complex care track of the conference consisted of three presentations covering a wide variety of issues that providers for and patients with medical complexities face in their daily lives.

Keeping with the theme of stress management, the first presentation was titled When Our Families Are Stressed, How a Primary Care Medical Home Works to Decrease Stress in Our Families and our Team. This presentation highlighted the success of the medical home model program, which began in 2005 at La Rabida Children’s Hospital: Premier Kids. The director of the Premier Kids Program, Dr. Edith Chernoff, along with the Medical Home Program Manager, Pam Northrop, eloquently described the program which incorporates a multidisciplinary team of two pediatricians, a registered dietitian, a social worker, a family advocate, two developmental therapists, two nurse case managers, a program manager, and a dedicated volunteer. This program seeks to address the various stresses that parents and children with complex medical needs endure, such as dealing with insurance companies and the transition to managed care as well as managing medications, supplies, services and resources from various providers. Their interdisciplinary team seeks to address these needs through education on advocacy, assistance with health systems navigation, a supportive culture, outreach to the community to share resources, and exploration of new solutions.

The second presentation in the complex care track addressed an often overlooked element of health of children with medical complexities, dental care. In a presentation entitled, Oral Health Considerations for the Child with Medical Complexities, given by Robert E. Rada, DDS, Dr. Rada addressed how children with complex medical conditions are at greater risk for developing dental disease and this risk is compounded by the dearth of dental providers who specialize in caring for this population. Dr. Rada stated that there are “5000 pediatric dentists in the United States” and “11.2 million children with special health care needs” in the United States. He described that dentists report feeling, “less prepared to treat persons with cognitive and sensory limitations compared to children ages 0 to 5.” Dr. Rada encouraged better training at the pre-doctoral and postgraduate levels that focuses on caring for children with medical complexities.

The final presentation addressed a growing area of focus for children with special healthcare needs, the transition to adult care. Drs. Jessica Gold, Kamala Gullapalli Cotts, and Parag Shah presented the current state of programs focusing on transition to adulthood in their presentation entitled, Reach for the Stars: Maximizing Health and Ability for Adolescents and Young Adults with Chronic Childhood Conditions. Due to the increasing life expectancy of individuals with developmental disabilities, more focus needs to be placed on the process of transitioning people to adult systems of care. The presenters estimated that “more than 90% of children born today with a chronic or disabling condition will live more than 20 years.” However, adolescents with chronic childhood illnesses often aren’t prepared for their adult futures and face a high unemployment rate, high dropout rate, limited day programs and dependency on SSI or Medicaid. The need for more structured programs to aid in the transition process to adulthood has been stated as a priority by the AAP, AAFP and ACP. The presentation covered three possible models of transition care including a clinic dedicated solely to healthcare transition housed within a pediatric hospital, a healthcare transition consult service, and a clinic dedicated to adults with developmental disabilities. Its overall goal was to provide the audience with multiple ideas on how to address transition care.

Finally, the closing address of the day entitled, The Cost of Caring: Refueling When We Are Spent was presented by William E Gordon, DMiD, MDiv. Dr. Gordon’s primary role is in team building and he works with medical professionals. In his discussion he summarized the major issue, which is, we tend to “care too hard” and this results in us “running out of gas” physically and emotionally. He discussed the physical and emotional signs of compassion fatigue and burnout and provided us with 10 suggestions to help us heal and rebuild our resilience.

The authors thank the planning committee, presenters, and ICAAP staff who all ensured an inspirational and successful conference. The slides from these presentations are available at www.illinoisaap.org/abc.

REFERENCES


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Jessica Gold, M.D. – Jessica.Gold@uchospitals.edu
Joseph R. Hageman, M.D. – jhageman@peds.bsd.uchicago.edu

The H. Garry Gardner Memorial Lecture will feature Dr. Robert Sege speaking on Teen Suicide.

The conference will offer 7.75 hours of CME content. Topics include:

· Overuse Injuries in Young Athletes
· Adolescent Mental Health Issues
· Vaccine Hesitancy and Refusal

The 2018 Conference will also include a live MOC Part II activity on Pediatric Asthma Care. Participants will be required to complete a pre-test and post-test, review the course bibliography, attend the live educational sessions at the conference, and complete an evaluation of the activity to receive 20 MOC Part II points.

For more information on the conference and MOC activity, please contact Dru O’Rourke at dorourke@illinoisaap.com.

The Illinois Chapter, American Academy of Pediatrics is accredited by the Illinois State Medical Society (ISMS) to provide continuing medical education for physicians. The Illinois Chapter, American Academy of Pediatrics designates this live activity for a maximum of 7.75 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Yes You Can: Report from the 2017 AAP Legislative Conference

BY SADIE LAPONSIE, MD, FAAP AND DEANNA BEHRENS, MD, FAAP

“Health care delayed is health care denied.”
– Fernando Stein, MD, FAAP, President of the American Academy of Pediatrics

“Hope is not a strategy.”
– Mark Del Monte, Senior Vice President, Advocacy and External Affairs at American Academy of Pediatrics

Motivated by concern for the state of children’s health care, we joined almost a dozen representatives from Illinois to attend the American Academy of Pediatrics (AAP) Legislative Conference in Washington, D.C. last April to strengthen our skills as advocates for child health. Given the current political climate and risks to child health including threats to access to healthcare, vaccine policy, climate change, and gun violence a record 220 pediatricians participated this year—with a substantial waiting list for the program. Participants came from everywhere and included medical students and seasoned attendings, outpatient clinicians and intensivists, and even a few concerned parents.

Even before the conference started, we were tasked with making appointments with our Members of Congress (MOC). Becoming comfortable with contacting our MOCs and learning how to communicate with them and their staff was one of the most valuable things we learned how to do. A few of us had been to the conference before, and so helped guide the coordination of tasks. Most of us though, were enthusiastic first-time attendees drawn together by a desire to fight against real threats to child health that have come to the forefront this year. This task united us as a group and we formed relationships, professional and personal, that have and will persist.

While the culmination of the conference was the visit to Capitol Hill to advocate for a clean extension for the Children’s Health Insurance Program (CHIP) and protection of Medicaid, we also reviewed a variety of AAP advocacy priorities. Breakout groups led by fellow pediatric experts focused on issues such as immigrant health, vaccine policy, global health, the opioid epidemic, and child nutrition programs. In addition to covering specific policy issues, conference sessions taught us to build advocacy skills that can be used at any level: local, state, and federal. It is important to identify potential allies and potential threats; form coalitions; and have a clear, concise, and consistent message. We want to

continued on page 9
With so many important issues before them, legislators may not have expertise in health care issues. As the conference progressed, we were armed with the certainty that we are the experts in child health, and that policy makers want to hear from us.

One way to forge relationships and reach a large number of people is via social media. Many of us shared experiences throughout the conference and kept tabs on what others were learning via #AAPLegCon. Most of us were new to the platform and joined an incredibly welcoming, interactive, and informative community of pediatric advocates on Twitter known as #tweetiatricians. We have found social media to be a fun and effective way to communicate and amplify each other’s voices. When the AAP conference was in Chicago this past September, we met a lot of these engaged and impassioned providers in real life and solidified friendships that started at the Legislative Conference or on Twitter. It can even be a powerful tool for engaging lawmakers; our group used Twitter to schedule a meeting with Congressman Mike Quigley’s office. With so many important issues before them, legislators may not have expertise in health care issues. As the conference progressed, we were armed with the certainty that we are the experts in child health, and that policy makers want to hear from us. While facts and statistics are important, stories also matter. Whenever we contact our legislators and their staff about an issue, we ask how we can help and have a patient story ready to share. It can have an enormous impact. When voting against the ACA repeal bills, Senator Lisa Murkowski gave direct examples of patient stories that influenced her decision.

On the final morning of the conference, we had the opportunity to meet with our members of Congress and put into action all that we had learned. Over 200 pediatricians gathered on the rainy lawn outside the Capitol and had the honor of being addressed by Representative Jim McGovern (Massachusetts), Senator Ron Wyden (Oregon), and Senator Tim Kaine (Virginia) before scheduled meetings with representatives. All three legislators thanked us for coming to the Capitol to advocate for the needs of children. Each shared their own stories, tips, and encouragement.

Emboldened by the conference and armed with fact sheets about CHIP and Medicaid, we met with staff of both Senator Dick Durbin and Senator Tammy Duckworth before dividing to meet with the offices of a half-dozen Representatives from across the state. Being on the Hill, speaking about issues that matter for kids, and meeting with the people who make decisions about these issues was a powerful moment. We should never hesitate to call upon our members of Congress about issues we can affect.

As pediatricians, we are the experts in child health. We see the effects of public policy on our patients every day in the clinic and hospital. Our voices are respected in our institutions and communities. The skills learned at the AAP Legislative Conference empower attendees to be engaged and effective child health advocates, turning knowledge and passion into tools for change.

The 2018 AAP Legislative Conference is scheduled for April 8–10, 2018. Any interested members of the ICAAP are encouraged to attend, including generalists, specialists, and trainees. The conference is expected to fill to capacity again this year. Limited scholarships are available for trainees and through several AAP sections. Please visit https://shop.aap.org/2018-legislative-conference/ to learn more.

As a reminder, as of the writing of this article, CHIP still has not been renewed. Please call your MOC at 202-224-3121 and demand renewal of this vital legislation.

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Data from the 2016 National Survey of Children’s Health (NSCH)

Data from the 2016 National Survey of Children’s Health (NSCH) funded and directed by the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA/MCHB) are now available on the Data Resource Center (DRC) website! (http://childhealthdata.org/learn/NSCH) National, state and child subgroup findings on key measures from the 2016 survey are now available on the DRC’s NSCH interactive data query. All Title V National Performance Measure (NPM) and National Outcome Measure (NOM) findings are available as well as findings on topics representing the range of those addressed in the 2016 NSCH: children’s physical and mental health status (including health conditions and functional difficulties); health insurance, health care access, use, and quality (e.g. medical home; transition to adult health care); family health and activities; neighborhood characteristics; and age-specific content on school and learning. Data are available at the national level for a range of child subgroups. Where sample sizes are sufficient, data are also available at the state level for child subgroups within each state. Title V measures can also be viewed across all states in our NPM and NOM hot-spotting tables. Downloadable datasets and accompanying codebooks will be available at a later date; for questions on this, please contact us at info@cahmi.org.

There were several key changes in the administration of the 2016 NSCH. Most importantly, the 2016 NSCH represents an integration of past years of the NSCH and National Survey of Children with Special Health Care Needs. The new NSCH was also designed to be fielded annually from 2016 onward, but with smaller samples sizes each year than in prior years of the survey. Additionally, the 2016 NSCH was administered via web- and mail-based (paper) instruments, as opposed to via telephone. To assist in your use of the data, the Data Resource Center provides several “learn about the survey” documents, including:

- The full-length 2016 NSCH survey instruments
- An interactive and PDF guide to the 2016 NSCH’s topics and questions
- A guide to the 2016 NSCH’s NPMs/NOMs content changes
- A diagram of the 2016 NSCH’s sampling and administration
- 2016 NSCH Fast Facts
- Impact of Missing Values
- Data Suppression and Display criteria

What Can Pediatricians Do to Reduce Risk of Childhood Cancer, Autism, ADHD, and Lower IQs?

BY JEAN-MARIE KAUTH, PHD AND SUSAN BUCHANAN, MD, MPH

Did you know that rates of childhood leukemia are steadily increasing?¹ That now, one in 42 boys develops autism?² That children in the top fifth of exposure to chlorpyrifos, a common pesticide, test seven IQ points lower than children in the bottom fifth of exposure?³ That many major chronic diseases in children are linked to environmental exposures and can be prevented?¹ ⁴ ⁵ ⁶ The Centers for Disease Control and Prevention (CDC) has shown that while most pediatricians would like to educate patients about environmental health hazards, they are not necessarily well prepared to do so.⁷ The CDC recommends practitioners contact their Pediatric Environmental Health Specialty Unit (PEHSU) for help in advising patients well.⁸ ⁹ In Illinois, our PEHSU, funded by the US Environmental Protection Agency (EPA) and the Agency for Toxic Substance and Disease Registry (ATSDR), is the Great Lakes Center for Children’s Environmental Health at the University of Illinois at Chicago School of Public Health.¹⁰ They are available for outreach, education, and consultation with healthcare providers and concerned parents. The hotline number is 1-866-967-7337, and the national PEHSU website can be found at www.pehsu.net.

Furthermore, the CDC points out that physicians are not always comfortable discussing environmental health with patients:

Taking an environmental history is essential for healthcare providers to understand patients’ exposure risks and help reduce them, but most physicians and other healthcare providers are not taught the importance of an exposure history during their medical education. For example, responses to a survey of members of the American College of Obstetricians and Gynecologists in 2014 reported that:

- Only one in fifteen physicians have received training on environmental exposures.
- Half of the respondents rarely take an environmental health history.

“Most providers think to warn parents about the dangers of lead in older homes and mercury in fish, but they might not ask about exposures to pesticides, endocrine disruptors, and chemicals in personal care products. It is important to educate parents about common environmental health risks that can lead to cancer, autism, ADHD, and lost IQ points in children. Simply exposing parents to the information may have benefits, but asking a few more questions on health histories accomplishes even more. Parents usually trust their pediatricians, who are often their very best source of information about how to protect their children.”

– Jean-Marie Kauth, PhD and Susan Buchanan, MD, MPH

• Less than 20% counsel patients about environmental exposures common in pregnant women in the United States.

However, 78% of respondents did agree that counseling patients about environmental health hazards could prevent exposures.⁷

Additionally, while providers likely warn parents about the dangers of lead in older homes and mercury in fish, they might not ask about exposures to pesticides, endocrine disruptors, and chemicals in personal care products. The AAP specifically states that because of the link between pesticides and cancer, neurobehavioral and cognitive deficits, asthma, and birth defects, pediatricians should do the following:

1. **Acute exposures**: Become familiar with the clinical signs and symptoms of acute intoxication from the major types of pesticides. Be able to translate clinical knowledge about pesticide hazards into an appropriate exposure history for pesticide poisoning.

2. **Chronic exposures**: Become familiar with the subclinical effects of chronic exposures and routes of exposures from the major types of pesticides.

**FOR YOUR PRACTICE** continued on page 12

3. Resource identification: Know locally available resources for acute toxicity management and chronic low-dose exposure.

4. Pesticide labeling knowledge: Understand the usefulness and limitations of pesticide chemical information on pesticide product labels.

5. Counseling: Ask parents about pesticide use in or around the home to help determine the need for providing targeted anticipatory guidance. Recommend use of minimal-risk products, safe storage practices, and application of Integrated Pest Management (IPM) (least toxic methods), whenever possible.

6. Advocacy: Work with schools and governmental agencies to advocate for application of least toxic pesticides by using IPM principles. Promote community right-to-know procedures when pesticide spraying occurs in public areas.

There are actions providers and parents can take. Asking at least a few more questions about environmental health raises the issue for both parents and providers; an excellent environmental health history is available at NEEF (National Environmental Education Foundation). See the list of resources below for a wide range of helpful sources including links to toolkits for clinicians, CME courses in environmental health, and practical advice from the USCF Program on Reproductive Health and the Environment, the EPA, and the Midwest Pesticide Action Center.

In addition, pediatricians can share information directly with parents, such as this list of concrete actions for avoiding exposures.

**TOP TEN WAYS TO HELP PROTECT CHILDREN FROM ENVIRONMENTAL EXPOSURES**

The American Academy of Pediatrics has determined that we can help prevent disease and disability in children by limiting their exposure to pesticides and other chemicals found in everyday life. Here are some things providers can counsel parents to do:

1. Choose non-toxic and environmentally safe chemicals, eliminate landscape pesticide and fertilizer use; do not use pesticides inside or on pets, and dispose of toxic chemicals safely.

2. Reduce exposure to pesticides by choosing organic foods or washing thoroughly. Choose free-range meat and avoid eating processed, charred, or well-done meat.

3. Remove shoes before entering the home, and if exposed to chemicals, wash work clothes separately from family laundry.

4. Filter home tap water and carry and store in stainless steel, glass, or BPA- and phthalate-free containers. Microwave food and beverages only in ceramic or glass. Avoid canned goods and #1, #3, and #7 plastics.

5. Make informed choices about purchases by consulting the Household Products Database (USDHHS 2016). Foam items bought before 2005 should be inspected; anything ripped or breaking down should be replaced; be careful when removing old carpeting and padding. Inquire about fire retardants. Use a HEPA filter on vacuums.

6. Cut down on fossil-fuel consumption by turning off lights, driving a fuel-efficient car, and walking and biking when possible.

7. Avoid tobacco.

8. Limit cell phone use, check home radon levels, and weigh risks of medical tests against diagnostic benefits.

9. Wear protective covering and sunscreen.

10. Become an active voice in his or her community. Individuals have the power to affect public policy by letting policymakers know that they strongly support environmental cancer research and measures that will reduce or remove from the environment toxins that are known or suspected carcinogens or endocrine-disrupting chemicals. Individuals also can influence industry by selecting non-toxic products and where these do not exist, communicating with manufacturers and trade organizations about their desire for safer products.

You can find flyers and posters for patients at the Poisoning Children Blog and Green Kids Doc Blog. All information is firmly based on peer-reviewed literature, best practices, and/or the experience of the Great Lakes Center for Children’s Environmental Health.
Making a Strong Recommendation: Addressing the HPV Vaccine with Patients

BY OLIVIA PHILLIPS, ICAAP IMMUNIZATIONS PROJECT COORDINATOR; KATHY SANABRIA, MBA, ICAAP ASSOCIATE EXECUTIVE DIRECTOR; AND MARIELLE FRICCHIONE, MD, CDPH IMMUNIZATIONS DIRECTOR

In the Spring/Summer 2017 issue of Illinois Pediatrician, The Illinois Chapter, American Academy of Pediatrics (ICAAP) announced collaborating with the Chicago Department of Public Health (CPDH) on the Increasing Human Papillomavirus (HPV) Vaccine Coverage by Strengthening Adolescent Assessment, Feedback, Incentives, and Information eXchange (AFIX) activity supported by funding from the Prevention and Public Health Fund (PPHF) through the Centers for Disease Control and Prevention (CDC). The goal of the project is to increase HPV vaccination rates among 100 clinics enrolled into the Vaccines for Children (VFC) program around the City of Chicago utilizing the AFIX quality improvement (QI) process.

METHOD

The project is divided into two phases. Phase I was a pilot and consisted of working with 50 clinics in 2017. At the start of 2018, an additional 50 clinics will begin receiving initial in-person AFIX visits. During the in-person visits, a CDPH staff member is accompanied by one of twelve recruited clinician faculty to contribute to the discussion and provide peer-to-peer guidance informing providers, medical assistants, and other clinic staff of the CDC’s guidance to recommend
the HPV vaccine using the “Same Way, Same Day” approach when discussing the HPV vaccine with patients and their families. The suggested improvement goals for the project are to increase clinic-wide HPV vaccine series initiation and completion rates by 5% and decrease HPV vaccine missed opportunities rates by 5% for patients aged 13-17. Faculty and clinics use data provided by CDPH from the I-CARE registry to drive improvement throughout this project as follows:

- Baseline HPV vaccination series initiation, completion, and missed opportunities will be reviewed by CDPH staff and faculty during AFIX visits with participating clinic staff, who will then select and implement quality improvement strategies to improve HPV vaccination series initiation and completion.

- Approximately 2-3 months after the initial AFIX visit, a check-in session either in-person, over the phone, or web-based will be conducted by the assigned peer clinician to review interim HPV vaccination series initiation and completion rates with participating clinic staff. Clinic staff will then work to improve or modify if necessary, quality improvement strategies to improve HPV vaccination series initiation and completion.

- Approximately three months after the midpoint follow-up, a second follow-up will occur over phone, in-person, or via web by the peer-clinician to review HPV vaccination series initiation and completion rates.

“SAME WAY, SAME DAY” APPROACH

Throughout the course of routine well-child visits, the CDC strongly encourages providers to “Recommend the HPV vaccine the same way and the same day you recommend the Tdap and meningococcal conjugate vaccines.” For example, start your vaccine discussion with the parents of preteen patients by saying: “Your child needs three shots today—meningococcal, HPV, and Tdap vaccines.” The “Same Way, Same Day” approach couples the HPV vaccine with recommended scheduled immunizations during the well-child visit, hence, not creating separation or presenting the vaccine as optional.

RESOURCES AND SUPPORT

In an effort to destigmatize and address rumors regarding the HPV vaccine, prior to beginning AFIX visits, participating peer faculty were provided comprehensive training from resources coordinated to correspond with the CDC’s recommendations. Each material supports and stresses the importance of the HPV vaccine in combatting HPV-related cancers, in addition to addressing vaccine-related concerns.

The following resources are utilized by CDPH and peer faculty throughout the course of the HPV-AFIX project, and can be used by pediatric and adolescent providers in general, to support increasing HPV coverage levels:

TIPS FOR PROVIDERS: TALKING ABOUT VACCINES

- Documenting Parental Refusal to Have Their Children Vaccinated (http://bit.ly/2lvTWi8)
- Motivational Statements about HPV Vaccination (http://unc.live/2jrE0O7)
- Announcements Versus Conversations to Improve HPV Vaccination Coverage: A Randomized Trial (http://bit.ly/2gYWqV8)
- Talking to Parents about HPV Vaccine (http://bit.ly/2qJWqj4)
- Top 10 List for HPV #VaxSuccess (http://bit.ly/2pfaWq)

In the United States, HPV is the most common sexually transmitted infection, accounting for over 6.2 million new infections yearly. With the state of Illinois having the 6th highest incidence rate for cervical cancer in the United States and the City of Chicago being at-risk for increased HPV-related cancers among vulnerable populations; the HPV vaccine is one of the best forms of prevention alongside proper contraceptive use and comprehensive sexual education materials and programs. Each provided resource aids CDPH staff and peer faculty members with emphasizing the importance and impact of the HPV vaccine among adolescents and teens.

As the CDPH Immunization Program and ICAAP continue to partner on projects dedicated toward increasing HPV vaccination rates throughout the City of Chicago, health care providers can work to increase HPV vaccination rates among children and teens within their own practice making use of the “Same Way, Same Day” approach. A suggestion on
incorporating the method within your practice can include introducing medical assistants and other staff members to educational materials during daily, weekly, or monthly meetings. Building upon the importance of the HPV vaccine and handling patient concerns can lead to increased coverage levels and lessen concerns to decrease stigmatization surrounding the vaccine.

CDPH and ICAAP are excited to continue to work towards the goal of increasing coverage levels among adolescents and teens; however, as HPV rates continue to rise across the U.S., it is important that pediatric and adolescent providers collaborate using the strongly encouraged “Same Way, Same Day” approach, keeping in mind your recommendation matters!

For more information on discussing the HPV vaccine with patients and families visit the CDC’s web site, https://www.cdc.gov/vaccines/partners/teens/matte.html.

REFERENCES
Dr. Kavitha Selvaraj, a fellow in Academic General Pediatrics and Primary Care at Ann & Robert H. Lurie Children’s Hospital of Chicago, co-led the development of the QI project with Dr. Mary Dobbins. Dr. Barbara Bayldon, recent past president of ICAAP and the Section Head of Primary Care at Lurie Children’s Hospital, served as the QI project leader. The specific aims of the learning collaborative were:

1. To increase documentation of screening for one specific psychosocial stressor or mental health disorder in children with overweight or obesity by 20%.

2. To increase documentation of a management plan for those patients who screened positive for the chosen psychosocial stressor or mental health condition by 20%.

Pediatricians interested in participating outnumbered capacity. Project leaders encouraged participants to choose a screening topic that was new to them. A total of 23 pediatricians participated from 17 clinics, private practices, federally qualified health centers, and hospital clinics, with a Medicaid population ranging from 20-100%. Screening topics and screening tools chosen by pediatricians for this project were as follows:

<table>
<thead>
<tr>
<th>Stressor Chosen</th>
<th>Screening Tool Chosen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety/depression</td>
<td>Psychological Services Center (PSC) for ages 5-11; Patient Health Questionnaire (PHQ)-9 for ages 12-17</td>
</tr>
<tr>
<td>Anxiety/depression</td>
<td>PSC 35</td>
</tr>
<tr>
<td>Bullying</td>
<td>4-Question Screen</td>
</tr>
<tr>
<td>Depression</td>
<td>PHQ</td>
</tr>
<tr>
<td>Depression</td>
<td>PHQ2/PSC</td>
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<tr>
<td>Depression</td>
<td>PHQ-9</td>
</tr>
<tr>
<td>Depression</td>
<td>PHQ-A/PHQ2 (2-Question Screen)</td>
</tr>
<tr>
<td>Depression</td>
<td>PHQ-9</td>
</tr>
<tr>
<td>Depression</td>
<td>PSC-17</td>
</tr>
<tr>
<td>Depression</td>
<td>PSC-17, PHQ9</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>2-Question Screen</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>2-Question Screen</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>Hager</td>
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<td>Food Insecurity</td>
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<tr>
<td>Food Insecurity</td>
<td>2-Question Screen</td>
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<td>Food Insecurity</td>
<td>2-Question Screen</td>
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<tr>
<td>Food Insecurity</td>
<td>Hager</td>
</tr>
<tr>
<td>Parent Stress</td>
<td>Safe Environment for Every Kid (SEEK)</td>
</tr>
<tr>
<td>Housing Instability</td>
<td>HealthLinc Instrument, adapted from Health Leads</td>
</tr>
</tbody>
</table>

In addition, participants were required to complete ICAAP Continuing Medical Education (CME) Screening for Psychosocial Stressors and Mental Health Disorders in Children with Overweight and Obesity (developed specifically for this project), presented by Dr. Selvaraj, and Understanding and Assessing Psychosocial Factors Associated with Childhood Obesity presented by Drs. Garry Sigman and Denise Styer.

ICAAP conducted four monthly collaborative sessions for the QI project. The topics and guest presenters for the learning sessions included Becoming a Trauma Informed Practice with clinical psychologists Drs. Colleen Cichetti and Claire Coyne; Depression Management in Pediatric Primary Care with child psychiatrist and pediatrician Dr. Mary Dobbins; and Troubleshooting & Barriers with Dr. Stan Sonu. Dr. Dobbins also provided consultation with project participants to assist with practice implementation of mental health screening and management.

For QI purposes and to also receive MOC credit approved by the American Board of Pediatrics for this project, participants reviewed ten charts at baseline and then every thirty days for two cycles.

Key Clinical Activity (KCA) 1 was Assessment of Screening for Psychosocial or Mental Health Disorder. All participants achieved the 20% target improvement from baseline chart review to the Cycle 1 chart review, and some participants increased even further in the final chart review cycle.

KCA 2 was Management Plan Developed. All participants achieved the 20% target improvement from baseline chart review to the Cycle 1 chart review, and some participants increased even further in the final chart review cycle.

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Dr. Audrey Brewer of Lawndale Christian Health Center screened for depression using the PHQ-9 tool. Dr. Brewer said the project “underscored the value and importance of incorporating screeners more regularly.” In addition, she noted that:

"The project helped me recognize the importance of doing a better job taking time to address these issues. Sometimes parents just want someone they can rely on and trust to listen, to give them space where they can express how they’re feeling, and to have a relationship where they can work with the pediatrician to figure out best next steps."  
– Dr. Audrey Brewer

They would incorporate the training into everyday practice. Dr. Selvaraj noted:

"When we were initially developing this project, I was concerned that asking pediatricians to incorporate a new psychosocial screening process into their clinic flow might be a burden on their already busy workload. However, I was blown away by the enthusiasm, dedication, and interest that the participants brought with them."
– Dr. Kavitha Selvaraj

Overall, participants provided very positive feedback on the project, rating the experience 4.5/5 on overall satisfaction. In addition, 83% of participants indicated they would incorporate the training into everyday practice. Dr. Selvaraj noted:

“We have to keep going back to why we do what we do: advocating for our patients, for children, for those who can’t speak for themselves, and to not lose hope if [we] run into different obstacles."
– Dr. Audrey Brewer

Funder Acknowledgement:

Identification and Management of Psychosocial Stressors and Mental Health Disorders in Children with Overweight and Obesity was part of a larger quality improvement and CME initiative, Promoting Health: Raising the Standard of Care for the Management and Treatment of Childhood Obesity in Illinois supported by a grant from the Illinois Department of Healthcare and Family Services and the Sprague Memorial Institute.

REFERENCE


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LISTENING IS ACTIVE, HEARING IS PASSIVE

Treating factory workers and opera singers, Dr. Tomatis developed a method to stimulate the interconnections between the ear and the nervous system delivered through headphones with specialized machines. This method, Audio-Psycho-Phonology (APP), uses filtered music specific for the frequencies found deficient in the person’s hearing evaluation. A program of listening is developed to re-train the ear and the development of listening from the fetal stage through birth and the development of language. The Tomatis Method is looked at more closely in the article, “The Efficacy of the Tomatis Method for Children with Learning and Communication Disorders: A Meta-Analysis”. ¹

Since listening begins in utero when the fetus becomes aware of the sounds and frequencies in the fluids of the mother’s body and her voice, APP engages this developmental listening process by filtering the mother’s recorded voice, reproducing how sound is heard in utero, and deepening the effect of the listening re-training changes.

More recent work by Fukui and Toyoshima in 2008 suggests that the medical potential of music is vast, stating:

“We propose that listening to music facilitates the neurogenesis, the regeneration and repair of cerebral nerves by adjusting the secretion of steroid hormones, ultimately leading to cerebral plasticity. Music affects levels of such steroids as cortisol (C), testosterone (T) and estrogen (E), and we believe that music also affects the receptor genes related to these substances, and related proteins.” ²

Dr. Alfred Tomatis, a French otolaryngologist from the Nicoise region of France, did seminal research in the 1950s involving listening and the brain. In 1957 The Sorbonne acknowledged “The Tomatis Effect” which states that the voice reproduces only the sounds the ear hears. Dr. Tomatis’ research also found that hearing is primarily through bone conduction not through the ossicles, that it is possible to re-train the ear by stimulating the muscles of the middle ear, and right ear dominance is essential for language development and learning with faster neuronal pathways to left hemispheric language centers. We now know that higher frequencies charge the brain’s cortex giving us energy, lower frequencies stimulate the vestibular system and are felt by the body, and sound affects our emotions. Our ear regulates alertness and attention, the coordination of posture and movement, and is so much more than simply an organ of hearing.

LISTENING

Listening. It is attuning to and interpreting sound information with our whole body.

Our ability to focus, switch our attention, ignore background noise, and modulate the intensity of our incoming perceptions all contribute to good listening.

This system is also important in regulating our anxiety. If an adult or child is overwhelmed by stimuli they can’t organize perception. They may withdraw, get argumentative, or poorly regulate their affect and behavior (i.e. becoming easily frustrated, especially with an internal perception of not being successful), and suffer poor coordination of their body or a poor sense of their body in space. The auditory and vestibular functions are central in the complex integration of all sensory modalities and use the Three Integrators—Vestibular, Ocular, and Cochlear systems and then with the cerebellar system

integrates all of the sensory information coming into us, coordinating it with motor movements of the body and eyes.

Audio-Psycho-Phonology has been found helpful with Learning Disorders, ADD/ADHD, Autism Spectrum Disorders, Anxiety Disorders, Depression, Dyslexia, Memory, Vocal Re-Education of Singers, Foreign Language Learning, Parkinson’s Disease, and early Dementia. Audio-Psycho-Phonology continues Dr. Tomatis’ research at Mozart Brain Lab in Sint-Truiden, Belgium.

“Just because a hearing test is normal, doesn’t mean listening is intact.”

–Dr. A. Tomatis

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continued on page 19
"In the prevention of Alzheimer’s disease and dementia, hormone replacement therapy has been shown to be effective, but at the same time, side effects have been documented, and the clinical application of hormone replacement therapy is facing a serious challenge. Conversely, music is noninvasive, and its existence is universal and mundane. Thus, if music can be used in medical care, the application of such a safe and inexpensive therapeutic option is limitless."

In conclusion, the body of research begun by Dr. Tomatis grows to this day, showing improvement in auditory processing skills, social engagement, cognition, memory, depression, and possible effects on levels of dopamine. A good summary article to learn more is “An Historical Commentary on the Physiological Effects of Music: Tomatis, Mozart and Neuropsychology” by Billie Thompson, Ph.D. and Susan Andrews, P.D. 2000.

REFERENCES

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Sharron Coeurvie, BSN, BCIP, APP has been in private practice since 1989. She is Board Certified in Integrative Pediatrics and works with the family system through the body/psyche including assessments for environmental illness that may be affecting a person’s health. Her website is https://listendotdotdot.org/

Taking the Time to Say Goodbye

BY JOSEPH R. HAGEMAN, MD, FAAP

During the 30 years I practiced taking care of critically ill infants and children when a patient of mine passed away and once things quieted down, I always made it a point to go back after reviewing the record to examine them and to say good bye. The examination was just to make sure I took the time to try to gather all of the clinical information, especially in situations when the reason for the decompensation or arrest was not clear. This review was sometimes helpful with the post-mortem examination to define the etiology for the arrest.

One case of a young adult male sticks out in my memory. He came to the Evanston Hospital emergency department one winter evening in cardiac arrest. We worked to resuscitate him for a long time but were unsuccessful. We had drawn blood for tests and I got the results of the electrolytes: Na+ 123 mEq/L, K+ 7.8 mEq/L. As I went back to re-examine him and review the history, he had an excellent tan but had not travelled on vacation. I called our pediatric endocrinologist and subsequently was able to make a diagnosis of Addison’s disease. In this case, going back helped make a diagnosis.

The other reason I would always go back was to say good bye to each infant or child. This was for my own psychological well-being. I felt that I would spend a lot of time sitting at the bedside with these critically ill infants. For those who are familiar with Bree Andrews, Jaideep Singh, and Bill Meadow’s NICU intuition outcome predictability research, I also felt that I got a sense of how the baby was doing and what I thought their long-term outcome was going to be if they survived. I also felt that I got a sense of their “life force” and at times when they still had the “desire” to survive or when they no longer did. In the situations when, after discussions with their family, we decided to withdraw support I would make a point to sit and talk with the baby after they passed away. In situations when our resuscitation was unsuccessful, after I talked with the family, I would go back to the baby’s bedside to say goodbye.

More recently, McClafferty and colleagues have developed a curriculum for physician wellness; physician authors like Sameer Vohra have begun to communicate their own feelings about dealing with the death of their patients. As I have stated in communications in the form of “blogs,” I still carry feelings about patients and their families that I cared for 30 years ago, survivors and non-survivors. There are families who I still see around our community or in the hospital and each time, there is a rush of these feelings, sometimes unresolved. As physicians, we will carry those feelings with continued on page 20
us. However, nowadays there are better ways psychologically for us to deal with these feelings than previously when we would just have to deal with them on our own.3–5

When Hilary McClafferty—now an active integrative medicine physician at the University of Arizona—came to give grand rounds at the University of Chicago, she and I talked, as she had been a pediatric resident at Children’s Memorial and rotated through the NICU when I was an attending. I have also become more involved with integrative medicine. I learned mindful meditation and guided imagery to deal with my cervical dystonia and chronic neuropathic pain. Once I had a chance to review Hilary’s curriculum for physician wellness, I sent her my blog and we talked for a long time about aspects of physician wellness. I asked her if she would be willing to review my blog and this article and give her thoughts. I hope you will find Hilary’s commentary below as insightful and helpful as I did.

COMMENTARY

BY HILARY MCCLAFFERTY, MD, UNIVERSITY OF ARIZONA INTEGRATIVE MEDICINE

My passion and energy for the work in physician wellness comes from a very personal place of feeling utterly burned out and seeing the signs and symptoms in my colleagues and being so baffled that no one was saying anything about it. I think it takes telling your story for other physicians to allow themselves to let down their guard.

A big part of our mission with the work in physician wellness is to normalize self-care—a large part of which is dealing with difficult emotions in the moment and afterward—in ways that promote emotional processing and at the same time remind us why we do what we do, and how we can be effective healers without constantly running on empty. I would also like to mention a new article by Joseph Bokum Lee, one of the University of Chicago’s pediatric/policy residents, who recently published an illustration of how residents find ways to deal with feelings of burnout.8

There are initiatives underway nationally in physician wellness that are critically important, and our link to integrative medicine informs the idea that if the teacher can internalize the lessons of wellness, the benefit is twofold. Once for their own health, and again in their impact as teachers on the young patient and their family.

The “permission” to grieve, acknowledge loss, connect with patients in a deep way, and allow this to enrich our lives as physicians must start from the top in the medical hierarchy—with experienced and insightful physicians who are confident in their wisdom and able to teach the next generation of physicians to be kinder to themselves and view that as a strength rather than a failing.

REFERENCES


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Hilary McClafferty, MD
University of Arizona Integrative Medicine
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ICAAP eLearning Course Catalog: January 2018

ICAAP is pleased to provide the following web-based CME-approved educational offerings. Some activities are approved for MOC Part 2 and 4 credits.

To register for ICAAP's eLearning platform, visit https://icaap.remote-learner.net/ and create an account. Then visit the Course Catalog where you can access all of the educational trainings ICAAP offers. For questions, Kathy Sanabria, MBA, Associate Executive Director, ksanabria@illinoisaap.net.

Asthma Management Part 2 Activity:

**Diagnosis and Management of Pediatric Asthma Care: Knowledge Assessment and Learning**

This Continuing Medical Education (CME) and Maintenance of Certification (MOC) Part 2 activity improves the diagnosis, management, and delivery of high quality asthma care within the medical home. This initiative appeals to state and national pediatric primary care providers that have high rates of asthma seen in their patient populations. The self-assessments, trainings, and resources provided address 1) asthma epidemiology, pathophysiology, and natural history (including allergen triggers and asthma predictive index); 2) asthma diagnosis and classification; and 3) best practices for asthma treatment based on the National Heart, Lung, and Blood Institute Guidelines for the Diagnosis and Management of Asthma. The activity also focuses on asthma-related content covered in the American Board of Pediatrics (ABP) board certification exam.

15 AMA PRA Category 1 Credits™, 20 MOC Part 2 Points
(Next live training date February 23, 2018 in Naperville, IL in conjunction with ICAAP annual conference.)

$250 members; $300 nonmembers

**Medical Home Webinar:**

**Building Family Professional Partnerships**

Describes the importance of incorporating family feedback into practice in order to improve care of patients.

1 AMA PRA Category 1 Credits™, Free

**Obesity Prevention Training Modules:**

**Connecting Patients to Community Resources**

Provides learners with information regarding how to link practices to community resources and how to assess and counsel patients and their families on improving their access to resources related to pediatric obesity.

1.25 AMA PRA Category 1 Credits™, Free

**Nutrition for Obesity Prevention and Treatment**

Includes practical applications to improve providers' ability to effectively assess and counsel about nutrition. Improves the competency, skills, and professional performance of pediatric healthcare professionals by 1) increasing their knowledge of nutrition as it relates to childhood obesity, and 2) improving their ability to effectively assess and counsel patients and their families about nutrition, identify and address common barriers to nutrition counseling, and use and access tools and guidelines on nutrition.

2.75 AMA PRA Category 1 Credits™, Free

**Physical Activity Guidelines and Counseling for Children and Adolescents**

Provides learners with practical information regarding physical activity as it relates to pediatric overweight/obesity and common barriers, along with strategies to counsel patients and their families on improving overall health through physical activity.

1.25 AMA PRA Category 1 Credits™, Free

**Screening for Psychosocial Stressors in Children with Overweight and Obesity**

Outlines the relationship between psychosocial stressors and childhood obesity. Discusses AAP's call for universal screening of depression in adolescents as well as targeted screening of toxic stress in at-risk populations.

1.25 AMA PRA Category 1 Credits™, Free

**Understanding and Assessing Psychosocial Factors Associated with Childhood Obesity**

Discusses mental health issues/disorders as they relate to pediatric overweight/obesity. Topics covered include the role of the family and health care provider, reducing weight stigmatization, psychopathology, psychosocial screening, and psychotropic medications. Coding tips are provided.

1.25 AMA PRA Category 1 Credits™, Free

**Evaluation and Management of Hyperlipidemia in Children**

Presents the rationale for screening and treatment for lipid disorders in children. Three case studies are discussed to illustrate objectives.

1.25 AMA PRA Category 1 Credits™, Free

**Building Healthy Habits with Families in Your Practice Trainings and MOC Part 4 Activity**

Through this web-based improvement activity, pediatricians in primary practice will improve frequency of performing assessment of weight status, healthy lifestyle counseling, and clinical care actions based on identification of overweight/
Obesity. Improvements in care will be achieved through benchmarking and implementation of changes in practice. Participants are guided by CME in patient counseling and linking patients to community resources.

20 MOC Part 4 Points approved by ABP

$275 members; $300 nonmembers

Tools to Empower Adolescent Moms and Child Development Training Modules:

Developmental Screening and Referral
Covers major concepts related to developmental delay, surveillance, screening, and referral. It describes the benefits of early identification and intervention and highlights validated screening tools to screen infants and toddlers for developmental delays. Participants will learn about efficient office procedures for screening and referral, as well as ways to engage parents/caregivers.

1.25 AMA PRA Category 1 Credits™, Free

Identifying Perinatal Maternal Depression During the Well-Child Visit
Covers major concepts related to maternal depression and its impact on children and families. It describes risk and protective factors relating to maternal depression and highlights professional expectations as part of the Perinatal Mental Health Disorders Prevention and Treatment Act. Participants will learn about efficient office procedures for screening and referral, as well as ways to engage families.

1.25 AMA PRA Category 1 Credits™, Free

Intimate Partner Violence (IPV) and Its Effects on Children
Covers major concepts related to intimate partner violence (IPV) and its impact on children and families. It describes symptoms to look for and techniques for implementing surveillance and anticipatory guidance for IPV as part of well-child visits. Participants will learn about communications and practice strategies, as well as identifying available resources to help children and families.

1.25 AMA PRA Category 1 Credits™, Free

Social, Emotional, and Autism Concerns
Covers major concepts related to social-emotional development and behaviors, and autism spectrum disorders. It describes signs and red flags to look for, and tools for screening as part of well-child visits. Participants will learn about efficient office procedures for screening and referrals, as well as ways to engage families.

1.25 AMA PRA Category 1 Credits™, Free

Incorporating Bright Futures into Primary Care Practice
Covers major concepts for incorporating Bright Futures well-child guidelines into every day practice.

1.25 AMA PRA Category 1 Credits™, Free

Transitioning Youth to Adult Health Care Courses

Transitioning Youth to Adult Health Care for Internists and Family Physicians Training
This web-based course targets primary care providers in an adult health care setting, to provide pediatric primary care medical homes with the information, tools, and resources to help patients and their families make a smooth transition to adult health care, and to help practices measure and improve transition care and planning.

10 AMA PRA Category 1 Credits™

$350 members; $450 nonmembers

Transitioning Youth to Adult Health Care for Pediatric Providers Training and MOC Part 4 Activity
The goals of the Transitioning You outh to Adult Health Care Pediatric Course Updated is a web-based course to equip pediatric primary care medical homes with the information, tools, and resources to help patients and their families make a smooth transition to adult health care, and to help practices measure and improve transition care and planning.

15.00 AMA PRA Category 1 Credits™

25 MOC Part 4 Points approved by ABP

$275 members; $300 nonmembers

Note: Free offerings are currently or were developed with support from grant funding and are sustained on ICAAP’s LMS per arrangements with funders. These offerings provide added value to members and their clinic staff.

For more information about course offerings, please contact Kathy Sanabria, MBA, Associate Executive Director, ksanabria@illinoisaap.com.

The Illinois Chapter, American Academy of Pediatrics designates each enduring material for the number of AMA PRA Category 1 Credits™ listed above. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The Illinois Chapter, American Academy of Pediatrics is accredited by the Illinois State Medical Society (ISMS) to provide continuing medical education for physicians.
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