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Welcome 2021! I am delighted that my first President’s Column coincides with the beginning of a new year. We are all sorely in need of some relief after what will go down in history as “The Year of the Pandemic”.

As I write this, we are beginning the first of the COVID vaccinations, our businesses and schools are developing strategies to both reopen and stay open, and we are again seeing Affordable Health Care being championed on the national stage. Although we are certainly not in the clear yet, there is finally some light at the end of the dark, seemingly endless tunnel of 2020. What next?

The pandemic has in essence been a profound “reset” - not only for the practice of medicine, but also for our institutions, our economy, our society, our global community, the environment, and certainly for us as individuals. The grave and unprecedented crisis has provided a great and unprecedented opportunity to reshape our world and ourselves into a “New Normal”, moving forward to the world as it could be instead of merely back to the world as it was. What are our lessons learned, and what do they mean for our actions moving forward?

First and foremost, we have learned that children (and their families) need us now more than ever. Let us always remain inspired and guided by the reason we chose Pediatrics as a profession in the first place, the well-being of children. Children are truly the future of our society - and the care we give them today helps to provide them with the brightest future possible.

Children are also the marker of the health of a society. The pandemic has both highlighted and exacerbated areas of social injustice, health disparities, racism and bias - especially exposing our cultural dependency upon schools to provide many of the basic needs for our children (including food and “daycare” for working parents). As a society, we have also learned that our health can be affected by the actions of others – be it a neighbor at the grocery store or a stranger on the other side of the world. Living in the context of a national - international community, we now recognize that public opinion has become a significant cultural factor affecting health and healthcare practices.

Subsequently, the “New Normal” will continue to expand upon our current combination of medical practice, health education, and advocacy, albeit perhaps with somewhat different emphasis. Medical practice will emphasize family engagement and education, safety, ongoing assessment for socioeconomic stressors and supports, “catch-up” in immunizations and well-child care, vigilance for developmental and mental health concerns, intensified efforts treating chronic conditions, and expanded models of care (e.g. trauma-informed care, telehealth). Educational efforts will emphasize health literacy (including the identification of appropriate resources) and social messaging. Advocacy efforts will include both professional (e.g. access to care, workforce adequacy and well-being) and social issues.

As pediatricians, we actually find ourselves uniquely situated to help shape a “New Normal”. Child development and parental guidance are the very foundations of our specialty. We continue to integrate mental health care into our practices, but also promote mental health by
converting “toxic” stress to “tolerable” through the supportive relationships we develop with our patients and their families. We have access to up-to-date and accurate information regarding the pandemic and other health issues, and access to a multitude of professional resources. We are the medical experts, and we have credibility.

However, there are limitations to our individual time and efforts. This is where ICAAP provides assistance. We review vast amounts of medical information and practice guidelines provided by the AAP, then provide summaries for you on our website and through our weekly e-mails, “ICAAP-lets Update”. (We provide a variety of educational activities as well.)

If you would like to extend your reach outside of your practice setting, we have over 20 state-wide committees and initiatives, addressing a variety of issues (including COVID guidelines for practices, immunization campaigns, anti-racism efforts, immigration, housing, and the reopening of schools- just to name a few from the past 6 months). If you would like to develop your civic / advocacy efforts, our Governmental Affairs Committee coordinates efforts with our lobbyists and our annual Legislative Advocacy Day at the Illinois State Capitol building. Member input informs our work and advocacy efforts. We also represent our membership in monthly conversations with our District Chairperson, who serves on the board of the AAP.

Please remember that, “Nobody can do it all, but everyone can do something.” Take care of yourselves and take heart in knowing that no matter your stage of career or training, level of expertise, or type of practice, there is a place for you in creating the “New Normal”.

Here’s to the world as it could be!

Best,

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Illinoisans have been signing up for Healthcare.gov plans that start in 2021 mostly at the same clip as for 2020, per recent federal data.


Source: Healthcare.gov
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For COVID-19 resources, visit ismie.com/covid-19.
Highlights from the 2020 ICAAP Immunizations Conference

BY SUZI MONTASIR, MPH, ICAAP IMMUNIZATIONS CONSULTANT

On October 6, 2020 ICAAP held its first annual Immunization Conference and provided it virtually. The content included review of the latest updates to the Advisory Committee on Immunization Practices (ACIP) recommendations, addressing vaccine hesitancy, declining immunization rates during COVID-19, strategies for increasing influenza vaccination, the role of social media and immunizations, and an update on COVID-19 in Illinois. Below are highlights from the conference’s phenomenal speakers.

First up was Dr. Kenneth Haller. His talk highlighted the reasons why parents refuse or delay vaccines and how to address them. Reasons include: complacency (most parents today have no experience witnessing vaccine-preventable diseases, so the risk doesn’t feel real), factors associated with convenience (e.g., frequency of visits to provider), and dis-information circulating by groups that are savvy with messaging and providing information based in association vs. causality (e.g., MMR and autism).

According to the AAP, only 3% of parents refuse all vaccines and 47% of parents accepted vaccines after initially refusing them, so it’s important providers build a trusting relationship and make strong recommendations. Pro-vaccine providers can create harm by inadvertently insulting parents and not respecting their thoughts. This is why it’s so important to remember that families are coming from a different knowledge base than providers and are hearing things based in media that they think are fact-based.

So, what can providers do?

- Practice the 8 skills of masterful physicians.
- Create trust and assume parents love their kids — their questions around vaccination are coming from a good place.
- Acknowledge fear is healthy and try to agree with what parents share when you ask why they are hesitating. For example, “I hear that you want the best for your child. I want the same.”
- At the first check-up, give a roadmap of encounters for the coming year and see what questions they have.
- Make it personal — talk about what you’ve seen in terms of vaccine-preventable illness. You can also make comparisons. For example, in comparing the flu to a car accident, ask parents if they still plan to put their child in a car seat.
- Role play scenes with your peers — it helps to practice the ups and the downs of how the conversation will go.
Up next was Jennifer Burns, CPNP, to talk about influenza. Jennifer reviewed how influenza appears as yearly epidemics, with sporadic pandemics (the last one in 2009) with 5-20% of the U.S. population being infected each year. In reflecting on the 2019-2020 season, Jennifer shared the following:

- The severity of the 2019-20 influenza season was classified as moderately severe, with the most pediatric deaths since 2017-2018.
- Influenza B circulated early, so providers should be prepared in case this happens again.
- Jennifer reminded attendees that it’s important to vaccinate throughout the whole flu season. Because there is no preferential ACIP recommendation between types of vaccine, give what you have/what patients want. She also shared the following updates for 2020-2021.
  - The AAP and AAFP recommend the use of IIV rather than LAIV but note that LAIV should be used if patients would otherwise not receive vaccination. Flu mist can only be given to patients aged 2-49. There are several contraindications, but new this year is that it shouldn’t be given to those that have cerebral spinal fluid leaks, cochlear implants, asplenia, or sickle cell disease because some adverse events have been reported.
  - Age Expansions: for Afluria Quadrivalent (IIV4) — those 6 to 35 months should receive 0.25mL. Those 36 months and older should receive 0.5 mL. For Fluzone Quadrivalent (IIV4) — infants 6 to 35 months can receive either 0.25mL or 0.5mL; those older than 36 months should get 0.5mL.

Finally, as we try to avoid a “twindemic,” Jennifer talked about how providers are getting creative while taking extra safety precautions. Approaches include outdoor flu clinics, wearing masks and goggles (or face shields), and encouraging families to sign-up. A challenge this season will be differentiating between flu and COVID-19, as symptoms are similar. One thing that seems to be a clear differentiator is the loss of taste or smell for those with COVID-19 disease.

It’s estimated we’ll need at least 70-80% of the population to have antibodies to COVID-19 in order to achieve herd immunity.

Dr. Tina Tan then took the stage to talk about declining immunization rates and the current pathway for vaccine development as we reserve hope for a COVID-19 vaccine. Unfortunately, one of the unintended consequences of COVID-19 has been a great decline in vaccinations. When COVID-19 hit, there was a dramatic decline in vaccinations across all ages. In Illinois, rates for children under two dropped by 25-30% in March 2020 and continued to drop in the following months. Some data has shown that well-child visits dropped from 50-70%. There has been some recovery as time has gone on; however in the age group of two to eighteen, there has been almost no recovery after the significant decline in March, meaning there is risk for outbreaks in vaccine preventable diseases as the number of unvaccinated children rise. In response to this, the AAP developed the Call Your Pediatrician Campaign.

Dr. Tan then shifted gears to vaccine development. In summary, most vaccines take ten to twenty or more years to develop; yet the goal for a COVID-19 vaccine is twelve to eighteen months. While this may seem alarming, there are a few reasons why it’s possible. One is new technology — the genome of the virus was already sequenced before the pandemic was declared. Additionally, scientists were able to do animal studies very quickly so that clinical trials could be started in a matter of months. As clinical trials

When COVID-19 hit, there was a dramatic decline in vaccinations across all ages. In Illinois, rates for children under two dropped by 25-30% in March 2020 and continued to drop in the following months.
move forward in the United States, there are common challenges to note. For example, all trials are having trouble enrolling Hispanic/Latinx and Black participants and (at the time of the conference) none of the trials have studied the vaccines in pregnant or breastfeeding women and very few, if any, have included children. Dr. Tan closed in sharing that we know the vaccine will be critical, but we’ve got a ways to go even once the vaccine is available. It’s estimated we’ll need 70-80% of the population to have antibodies in order to achieve herd immunity. Additionally, there is preliminary indication that immunity only lasts four to six months, meaning vaccination for COVID-19 may need to occur on an annual basis. A vaccine for children will take even longer, given the lack of clinical trials enrolling children to date.

Dr. Craig Batterman then covered what’s new in 2020, with respect to ACIP vaccine updates:

- **Hepatitis A** — revised to include recommendation that all aged two through eighteen years who have not previously received Hep A should receive catch-up vaccination and complete a two-dose series.
- **Meningococcal** — booster doses are now officially recommended for those ten years and older who are at increased risk from MenB infection.
- **MenACWY** — clarity regarding adolescent vaccination

A vaccine for children will take even longer, given the lack of clinical trials enrolling children to date.

- **Diphtheria, Tetanus, and Pertussis** — clarity has been added to the note for catch-up vaccination. Vaxelis is a newly approved combo vaccine for DTaP, but with more complicated guidance on how to use in the series. Refer to the package insert for details.
- **TDAP** — the note has been updated to allow either Td or Tdap as an option for decennial tetanus booster doses and catch-up series doses in persons who previously received Tdap. The note now reflects recent updates to the clinical guidance for children aged seven through eighteen years who received doses of Tdap or DTaP at age seven through ten.
- **Haemophilus influenzae type b** — an update has been made to the notes section including a new bullet that catch-up vaccination is not
recommended for previously unvaccinated children aged five years or older who are not at high risk.

- Hep B — the vaccination schedule note was revised to add clarity, but the recommendations remain the same. A “special situations” section has been added which contains information regarding populations for whom revaccination might be recommended. For detailed revaccination recommendations, see the HepB MMWR publications.

- Influenza — the note has been updated to reflect recommendations for the 2020–21 season and the “routine vaccination” section was reformatted to more clearly outline whether one or two doses are recommended.

- Polio — detail has been added on which oral poliovirus vaccine (OPV) doses may be counted toward U.S. requirements. See Guidance for Assessment of Poliovirus Vaccination Status and Vaccination of Children Who Have Received Poliovirus Vaccine Outside the United States.

- Human papillomavirus (HPV) — the only change is the addition of clarification in Table 1 of the schedule; an asterisk has been added to the blue bar for children ages nine to ten years to indicate that for this group, the HPV vaccine series can be started at the clinician’s discretion.

With so many people against immunizations on social media, providers can be the voice of reason and counter disinformation. It is also a great way to connect with others using the same hash tags (e.g., #FluBeforeBoo or #tweetiatrician).

If new to social media, Dr. Behrens recommends choosing one platform to invest energy. First, choose the platform to match your target audience: parents and grandparents are on Facebook; teens are on Instagram, TikTok, and Snapchat; and colleagues are on Twitter. For those worried about anti-vaccination groups, note that this usually only occurs when posts receive many, many views (e.g., if post goes viral). There is a wonderful organization called Shots Heard Round the World (Shots Heard) whose mission is to help protect social media pages of health care providers and practices. In addition to providing tools, Shots Heard will help counter anti-vaccine posts with accurate information. As mentioned, Dr. Behrens believes Twitter is the most useful platform to connect with colleagues. Pediatric providers should follow @AmerAcadPeds; @IllinoisAAP; @ACPInternists; @CDCgov; @aafp; your favorite newspapers; your congresspeople; your school; your hospital; etc.; then others that match your interests.

Tips for setting up Twitter and composing tweets:

- Some people keep separate personal and professional accounts; it’s important to list your credentials in your username or handle if you want a professional presence.

- Write a brief profile, including a picture - you may get more interest with a professional one.

- Use proper hashtags and cite your sources.

- Be aware that anything you post is posted forever, so you may need to check your institution’s policies on social media.

IDPH is planning for a state-wide mass vaccination campaign where the goal is to have 80% of the population vaccinated once there are COVID-19 vaccines.
Dr. Ngozi Ezike, the conference keynote speaker, then shared her perspective on the current state of COVID-19 in Illinois and efforts of the Illinois Department of Public Health (IDPH). In working to reduce the spread of COVID-19, IDPH is focused on messaging the “3 Ws (wear a mask, wash your hands, and watch your distance), with the addition of “wage war against influenza and get a flu shot.” Additionally, they have a continued focus on testing, which Illinois has done well with, putting the state third in the country in terms of number of tests conducted. There are currently eleven community based testing sites, where testing is done for free, without symptoms and without a doctor’s referral. Please check the IDPH website for current information. dph.illinois.gov/covid19

In focusing on the future, IDPH is planning for a state-wide mass vaccination campaign where the goal is to have 80% of the population vaccinated once there are COVID-19 vaccines. In terms of how this will be accomplished:

- Vaccine providers will be required to enroll in the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE). Additionally, providers will be required to agree to Centers for Disease Control and Prevention (CDC) guidance on administration, storage, and handling.
- Allocation will be based on the jurisdiction’s population size and disease burden, while ensuring equity, and providers will be allocated vaccine as it becomes available.
- The vaccine will be delivered via the Vaccines for Children (VFC) model, meaning direct shipment to providers (subject to revision based on logistics).

Early on when vaccine availability will be limited, phases of prioritization will be used. Because 80% of the population will need to be vaccinated, vaccination will take place over many months and may unfold in phases as more vaccine becomes available. Monitoring for adverse events will be very important and vaccine distribution for common vaccine-preventable disease should not alter from routine procedures. In closing, Dr. Ezike reminded everyone of the considerations of an effective rollout, including the challenge around vaccine mistrust and children not being included in clinical trials, yet.

REFERENCES

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In 2021, ICAAP will be hosting a live immunizations webinar series and virtual Immunizations Conference (Fall 2021). Check ICAAP’s Events page on our website for the training schedule and to learn about other professional education offerings for members and pediatric healthcare providers. www.illinoisaap.org
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Addressing Racism and Implicit Bias in Child and Adolescent Health Through Action

BY: OLYVIA PHILLIPS, ICAAP PUBLIC HEALTH ACTIVITIES MANAGER AND JENNIE PINKWATER, ICAAP EXECUTIVE DIRECTOR

In August 2019, the National American Academy of Pediatrics (AAP) released the first ever policy statement on The Impact of Racism on Child and Adolescent Health. Healthcare providers continue to point out racism as a social determinant of health, with the policy statement making it clear that racism has a "...profound impact on the health status of children, adolescents, emerging adults, and their families." The AAP policy statement has served as a catalyst for providers and organizations to continue to push toward racial equity and equality, especially in care settings.

Following in the direction of the National AAP, the Illinois Chapter, American Academy of Pediatrics (ICAAP) has mobilized Illinois pediatric providers to develop the Anti-Racism and Implicit Bias Taskforce. The Taskforce was developed in response to the need to dismantle structural racism and improve the lives and health of children and families. This year has been tumultuous, from the onset of the COVID-19 pandemic to the lives lost due to systemic inequities and racism, these things and more are health-impacting factors that can lead to poor health outcomes for children and families. In response to these areas, ICAAP's Anti-Racism and Implicit Bias Taskforce is committed to developing responses using education and advocacy by our pediatric members and leadership.
Some of the activities of ICAAP’s Anti-Racism and Implicit Bias Taskforce include:

- Developing educational content for ICAAP events and offerings that provide education on racism and its history in medicine, biases, and normalizing “uncomfortable” topics such as addressing medical bias.
- Creating mentorship opportunities for early health professionals.
- Collaborating with community organizations and partners committed to anti-racism and decreasing implicit bias.
- The activities specified above have been a direct result of ICAAP’s Taskforce subgroups that were developed as a way to organize member efforts. The subgroups are Education and Leadership/Membership.

The Education subgroup focuses on the development and support of anti-racist educational opportunities for pediatric providers, residents, medical students, and staff with a focus on:

- Education on racism and its history in medicine, with a focus on anti-Black racism.
- Recognizing and addressing biases, privileges, and positionality in order to reframe the interactions and roles pediatricians play in medicine and society at large.
- Normalizing “uncomfortable” conversations which address the subtle and overt racism and inequity within medical institutions that harm pediatric colleagues, patients, and their families.

The focal point of the Leadership/Membership subgroup is to amplify diverse and inclusive voices and ideas with ICAAP, its leadership and the pediatric workforce overall. The goals include:

- Create safe spaces and support networks for pediatric providers.
- Increase diversity and inclusion in ICAAP leadership and membership.
- Promote pipeline programs among our membership.

The work of each subgroup informs the action and activities of the Taskforce as a whole.

As stated in ICAAP’s Statement on Racism released by ICAAP’s Immediate Past President, Dr. Mariana Glusman:

“ICAAP is committed to doing our part to consciously and intentionally incorporate these actions, and a racial equity lens, into the work that we do; from our advocacy efforts on health care access, to our various initiatives including housing, immunizations, and Reach Out and Read; from our clinical educational programs to our efforts in practice transformation; and from our membership activities to our staff and leadership training and recruitment.

These times have been filled with anguish, for some even more than for others. But we have a unique opportunity as part of ICAAP — we can use our network to foster equity and justice, and to fight against racism of all kinds.”

This is what ICAAP’s Anti-Racism and Implicit Bias Taskforce is built upon, leveraging our networks and resources to dismantle racism and increase equity and justice for children and their families.

If you are interested in learning more or being a part of the ICAAP Anti-Racism and Implicit Bias Taskforce, please email Olyvia Phillips, ICAAP Public Health Activities Manager, at ophillips@illinoisaap.com.
ICAAP Telehealth Survey Results Will Guide Chapter Work in Telemedicine

In September of 2020, ICAAP conducted a survey of members on Baseline Telehealth Services and Barriers. The goal of the survey was to obtain information about how members and practices are utilizing telehealth in the current environment, barriers to providing services via telehealth, and plans to offer telehealth services in the future. Survey results will be used to guide ICAAP’s work to support telehealth efforts and ensure children in Illinois have access to care.

The survey was completed by 76 ICAAP members (4.2% of membership) representing a wide variety of practice types, including independent practice (24%), group practice (29%), hospital-based pediatrics (12%), and FQHCs (6%). Most of the respondents practice in a suburban setting (68%).

Regarding providing telehealth services, the survey found that 88% of respondents did not provide telehealth services prior to March 2020 and 96% of respondents have been providing telehealth services during the pandemic. Additionally, 83% of respondents indicated they plan to continue providing services via telehealth after the pandemic. The majority of services being provided via telehealth are sick visits and follow-up/medication management visits; very few respondents indicated they are providing well-child visits via telehealth. All respondents replied that telehealth services are only being provided for existing patients.

Respondents were asked to identify what has worked well with telehealth and indicated convenience (82%), eliminating patient barriers to in-person barriers (79%), reduced travel time (63%), and improved access to care (58%). Things that have not worked well with telehealth included internet challenges (83%) and poor audio/video quality (76%). Additionally, 48% of respondents indicated feedback from patients/families on telemedicine visits was mostly positive. Most concerns from families were internet access (45%) and technology (34%).

A key concern that many respondents noted was sustainability and ensuring adequate payment for providing services via telehealth. ICAAP will continue to monitor this aspect of telehealth and advocate for its members.

ICAAP appreciates its members taking the time to complete the survey and provide chapter staff and leadership with valuable information to guide our telehealth work.

“The telemedicine is still underutilized compared to what it could do. There is a learning curve for the consumers (outside of the early adopters) as well as our staff. I think as we create learning and first and second experiences, it will be requested more routinely. We are actively working on that process in our health system.”

“Seeing a patient in their home allows me a window into their world that I did not have before.”
Pediatricians Stand Up for Children Facing Housing Insecurity

BY TIM HERRING, COORDINATOR, HEALTH EQUITY INITIATIVES, ILLINOIS CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

Across the U.S., families comprise over one-third of the population experiencing homelessness. The majority of these family members are children, more than half of whom are less than six years old. In fact, infants are more likely than any other age group to stay in shelters. On a state level, the Illinois State Board of Education reported 53,696 students experiencing homelessness during the 2018-19 school year. The deep racial inequities of Illinois’ housing sector are also borne out in data from Chicago, where 81% of students experiencing homelessness in Chicago Public Schools that year were Black, despite Black students representing only 37% of citywide enrollment.

The toxic stress of Adverse Childhood Experiences (ACEs) is known to place individuals at risk for learning and behavior-related problems, mental illness, and long-term physical illnesses. Childhood experiences of homelessness and housing insecurity are associated with increased numbers of ACEs, and could reasonably be considered adverse experiences on their own. The effects of housing insecurity compound over time and with repeated instances. Even being born to a parent who experienced housing insecurity during pregnancy may later affect health outcomes for that infant.

Illinois pediatricians recognize that housing insecurity is a socioeconomic barrier to good health. As Dr. Markeita Moore, MD, FAAP, Chair, ICAAP First Steps Education Workgroup said, “We must improve our screening processes and have referral resources on hand. ICAAP’s cross-sector education provides much-needed background on housing in Chicago, screening guidance, cultural sensitivity, clinical guidelines, and referral resources for housing insecure children.” Nearly 91% of ICAAP pediatricians surveyed indicated a desire to increase their knowledge about housing systems and housing resources for their patients. Members
also expressed a belief that cross-sector health and housing training and collaboration could eliminate gaps in care and improve linkages between systems.

For this reason, ICAAP established the First Steps: Improving Child Health and Housing (First Steps) initiative. The initiative seeks to prevent and mitigate health risks related to housing insecurity for children aged zero to six years old and pregnant persons in Chicago. While the initiative currently focuses on Chicago, future statewide advocacy opportunities are anticipated. The target population was selected due to recent research indicating the various ways in which experiences with housing insecurity can negatively impact the health of young children immediately and throughout their lifetimes.

The First Steps initiative seeks to prevent and mitigate health risks related to housing insecurity for children aged zero to six years old and pregnant persons in Chicago.

To address the significant health impacts of housing insecurity, First Steps began working on policy and system level changes in housing and health care through three multi-disciplinary workgroups led by ICAAP members:

- Housing Capacity Workgroup, chaired by Dr. Deanna Behrens, MD, FAAP, Advocate Children’s Medical Group – Park Ridge, which pushed for the prioritization of children and families in the housing system.
- Data Advisory Workgroup, co-chaired by Drs. Anna Volerman, MD, FAAP, UChicago Medicine and Amanda Osta, UI Health, which made recommendations on pediatric screening for housing insecurity and what child data should be collected by Chicago housing agencies.
- Education Workgroup, chaired by Dr. Markeita Moore, MD, FAAP, Advocate Children’s Medical Group, Evergreen Pediatrics, which oversaw the development of cross-sector training and tools for pediatricians, as well as for housing case managers and shelter staff.

In the Education Workgroup specifically, the group's health care and housing experts created A Primary Care Primer on Housing Insecurity in Children, a comprehensive educational module that covers an overview of the Chicago housing system, practice site and physician cultural sensitivity, patient communication and identification of risk, clinical guidelines, referral options, and ICAAP’s accompanying physician referral tool.

A Primary Care Primer features presentations from Dr. Moore, Dr. Barbara Bayldon of Ann and Robert H. Lurie Children’s Hospital of Chicago, and Johnna Lowe from the Corporation for Supportive Housing (CSH). A separate module was created by Dr. Margi Scotellaro, MD, FAAP, from Rush University Medical Center on the topic of mandated reporting standards related to housing insecurity. A referral tool, created by Dr. Stephanie Liou, MD, from UChicago Medicine, provides a streamlined flowchart of housing referral resources for physicians to use for patients who are literally homeless and who are about to lose their homes. The Education Workgroup recently piloted the education and the referral tool.

A recording of the webinar, along with downloadable PDF versions of the slideshow and referral tool, are available on ICAAP’s First Steps website https://illinoisaap.org/child-health-housing/.

Aside from its cross-sector education, ICAAP member pediatricians recently launched the Collaborative on Child Homelessness – Illinois (Collaborative) with housing partner Facing Forward to End Homelessness to build a strong, unified voice to elevate the needs of children and families in the Chicago housing system. In doing so, ICAAP folded the operations of the Housing Capacity and Data Workgroups into this collective body, which comprises approximately 35 housing, health, and early childhood organizations and government agencies. As a group, the Collaborative aims to make housing policies and systems more responsive to the needs of children and to promote systems integration between the health and housing sectors.
These partnerships represent a unique opportunity to serve our patients experiencing housing insecurity. ICAAP physician champion Dr. Nancy Heil, MD, FAAP says of her work with the Collaborative, “member organizations have worked for years to eliminate housing insecurity and literal homelessness. Together we are striving to improve the chances that children will grow up in stable housing, so that they are more able to reach their best potential.”

One of the Collaborative’s notable accomplishments to date is its Maternal and Child Health and Housing Proposal to the Chicago Continuum of Care, which calls for the prioritization of infants under twelve months and individuals who are pregnant or have delivered a baby in the last twelve months for rapid rehousing. The proposal also calls for tracking all individuals in Chicago’s homeless service system who are pregnant. A vote is expected on the proposal before the end of the year.

The Collaborative is an opportunity for pediatricians throughout the state to advocate for the needs of children and families experiencing homelessness. Illinois pediatricians have a unique ability to provide evidence-based medical testimony that can help change the life trajectory of children and bring housing stability to more families in these uncertain times by supporting local, state, and federal policies that lead to increased availability of low-income, transitional, and permanent housing.  

To become an Illinois housing advocate for children, please email Mary Elsner, Director, Health Equity Initiatives at melsner@illinoisaap.com.

First Steps: Improving Child Health and Housing is supported by a grant from the Otho S. A. Sprague Memorial Institute

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Reach Out & Read Illinois: How Diverse Children’s Books can make a Real Impact in the Clinic

Reach Out & Read Illinois uses children’s books as a tool during well-child visits to improve early literacy, family bonding and building a strong foundation for early health and wellness. Distributing quality children’s books is a cornerstone of the Reach Out & Read (ROR) program. One of our longtime clinic partners, Friend Health, expressed a need for more diverse books for the clinic. The following is a conversation between Dr. Anne Gearhart and Derrick Ramsey, co-founder of a local nonprofit, Young, Black & Lit, about the importance of diverse books inside our clinics.

Dr. Gearhart, how long have you been implementing Reach Out & Read?

I started as a participant in ROR in 2012. When I moved to Friend Health in 2017, I became the Coordinator of the ROR Program here. Friend Health has been operating on the south and west sides of Chicago for twenty years serving primarily the African American and Latinx communities there. In a typical year, we provide primary pediatric care to over 10,000 children.

Why did you feel the need to diversify your Reach Out & Read book selection?

It is extremely important for our young patients to see themselves in the stories they read. The selections we had were woefully inadequate in this realm. For the past twelve months, I had been searching for an organization to help fulfill this need — even working with the national ROR book committee to improve the selections that are made available to ordering clinics. Young, Black & Lit (a nonprofit organization that Reach Out & Read Illinois connected us to) offered the exact solution I was looking for!

Derrick, why did you develop Young, Black & Lit?

Young, Black & Lit was developed to increase representation and access to children’s books featuring Black characters. Study after study has shown that increased access to books in the home has a significant impact on children’s reading achievement. In a world that too often undervalues the beauty and brilliance of Black children, Young, Black & Lit aims to change the narrative. We are an organization that is rooted in love: love of children, love of reading, and love of Black culture. Young, Black & Lit makes it easier for children to access quality books featuring Black characters by removing the cost and doing the research to find books that affirm the varied experiences
of Black children; building at-home libraries, self-esteem, and life-long readers one book at a time.

**Why were you excited about Reach Out & Read and being able to reach young kids birth – age five?**

When we analyze the statistics for early learning, the results are staggering. Thirty-seven percent of children arrive at kindergarten without the skills necessary for lifetime learning. Eighty percent of preschool programs serving low-income populations have no age-appropriate books for their children. The work that Reach Out & Read does is critical to impacting young learners early and getting them engaged in reading.

As we look to put books into the homes of K-3rd grade students through our Lit Year program, a partnership with Reach Out & Read is a natural fit. We've loved to expand the access to building home libraries for pre-K students as well. With a natural touchpoint, Reach Out & Read is an ideal partner to help us expand our reach.

**“I have already seen the look of recognition and joy when sharing the books with our patients.”**

**Dr. Gearhart – how have you liked having these books?**

Derrick delivered several boxes of incredible titles directly to our clinic location. I have already seen the look of recognition and joy when sharing the books with our patients. One of our MAs, Ashley Murray, was also overjoyed to see the new titles and eagerly stocked the shelves. She has continued to give great feedback to me about the selections.

**Derrick – how can more pediatricians work with you?**

The medical community can support our organization in quite a few ways. First, they can make a donation to our organization by visiting youngblackandlit.org/donate. Second, they can purchase books from our bookstore. All donations and purchases go to support our mission of getting free, new books to children. Third, they can partner with us to bring high-quality books to their offices for their patients and their patients’ families to enjoy through their local Reach Out and Read partners or directly. Finally, advocate and evangelize. Spread the word. We are a small grassroots organization. We've grown to where we are today through people sharing our work and telling their networks.

**As we look ahead to 2021, what are your biggest challenges?**

**Dr. Gearhart:** Our biggest challenge is always fundraising. We have some dedicated personal donors and Friend Health always supports our efforts as well. However, we distribute books to only about one-quarter of our visiting patients due to a lack of funding. My goal going forward would be to increase that percentage of children who receive a quality, culturally-appropriate and inclusive book at every well-child visit to 100%.

**Derrick Ramsey, Young Black & Lit:** Young, Black & Lit just rolled out its Lit Year Program which provides one new book per month for the 2020-21 school year plus an additional five books for the summer (a total of fifteen new books) to students at participating schools who qualify for the free/reduced lunch program. The Program is starting with kindergarteners who will remain in the Lit Year Program through 3rd grade. Research shows that students who were not proficient in reading by the end of third grade were four times more likely to drop out of high school than proficient readers. A significant way to improve the reading achievement of children is to increase their access to print. Lit Year Program participation ensures that each child will have at least 60 books in their at-home library by the end of 3rd grade.

Reach Out & Read Illinois is committed to fundraising and purchasing more diverse books for our clinics in 2021 – to learn more or make a donation to these efforts, visit reachoutandreadil.org.

To learn more about Young, Black & Lit and support their efforts, please visit youngblackandlit.org and follow them on social media - Facebook: @youngblackandlit Instagram: @youngblacklit.
Migraines in Children and Special Considerations During a Pandemic

BY LESLIE FINKEL, MD
PEDIATRIC NEUROLOGIST
NORTHSHORE NEUROLOGICAL INSTITUTE
NORTHSHORE UNIVERSITY HEALTHSYSTEM

Migraines can be a debilitating and intrusive part of a child’s day. In a landmark study looking at 9,000 children, the prevalence of migraine at age seven was 1.4% and went up to 5.3% at age fifteen. Migraines are the most frequent type of primary headache and are seen in slightly over one-fourth of older teens. Children and adolescents with a family history of migraine are at a higher risk of developing migraines and migraines possibly emerge at a younger age in children with parental history of migraine. Female sex is also another probable risk factor. A history of migraine variants in younger children such as abdominal migraine, motion sickness, cyclic vomiting, and benign paroxysmal vertigo of childhood are also important to keep in mind. Proper diagnosis and treatment are essential to ensuring adequate quality of life and an effective management plan.

This article will review lifestyle management of migraines and look into specific lifestyle interventions that are relevant during a pandemic with many children learning virtually and feeling more isolated from their peers. There are four key lifestyle factors to address during a visit for recurrent headaches: sleep hygiene, screen use, nutrition (including diet and exercise), and mood concerns. This article will also touch on non-medication interventions that can be beneficial for recurrent headaches.

The evaluation of children and adolescents with headaches always starts with a thorough history and examination. The overall description and lack or presence of systemic symptoms can help guide the physician to determination of primary or secondary nature of headaches. Red flags such as new-onset headache, absence of family history of migraine, abnormalities on the exam, and occurrence of seizures prompt further evaluation for a potential space-occupying lesion, but neuroimaging is not indicated on a routine basis in children with recurrent headaches and a normal neurologic exam. There are a paucity of studies that evaluate routine lab work or lumbar puncture in reference to recurrent headaches so no specific recommendation is given, and an EEG is not indicated as part of the evaluation of recurrent headaches.

Lifestyle modifications, as discussed below, are a critical part of pediatric headache prevention. Although medications have a role in management of recurrent headache, the Children and Adolescent Migraine Prevention Trial demonstrated no significant

<table>
<thead>
<tr>
<th>RECURRENT HEADACHES</th>
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<tr>
<td>Four Key Lifestyle Factors</td>
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<tr>
<td>1. Sleep Hygiene</td>
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<tr>
<td>2. Screen Use</td>
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<tr>
<td>3. Nutrition</td>
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<tr>
<td>4. Mood Concerns</td>
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difference in reduction in headache frequency or disability in child/adolescent migraine with Amitriptyline, Topiramate, or placebo. This randomized, double-blind, placebo-controlled trial helps to underscore the importance of lifestyle modifications.

**Sleep Hygiene**
Sleep hygiene is critical. One large-scale study of adolescents found that poor sleep was the most common headache trigger. Staying on a consistent sleep schedule and making sure children have an adequate amount of sleep each night is a necessary part of headache management. Differentiating what time the teenage patient actually falls asleep, and not what time they go into their bedroom, is a helpful piece of information to guide the conversation.

There can be a disconnect with the amount of time a family thinks their child is sleeping and how much actual sleep the child is getting. It can often be beneficial to review the American Academy of Pediatrics guidelines for sleep with families as there may be uncertainty regarding the duration of sleep needed.

<table>
<thead>
<tr>
<th>Age</th>
<th>Sleep Hours Per 24 Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 years old</td>
<td>11-14 (including naps)</td>
</tr>
<tr>
<td>3-5 years old</td>
<td>10-13 (including naps)</td>
</tr>
<tr>
<td>6-12 years old</td>
<td>9-12</td>
</tr>
<tr>
<td>13-18 years old</td>
<td>8-10</td>
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</tbody>
</table>

**Screen Use**
Prolonged screen use has always been a topic of conversation related to headaches, but what effect does that have on children when their entire day is on a screen? Extended hours of screen use have been associated with neck pain. There are conflicting answers as to the amount of screen time that can cause neck pain, but it may be beneficial to educate children and adolescents on proper posture and the ergonomics of screen use. Children should not need to bend their neck to view the screen and the keyboard and mouse should be directly under the fingers when elbows are bent at about 90 degrees. Taking breaks, adjusting glare and brightness for comfort and having feet firmly on the ground can also be helpful tips. Utilizing our physical therapy colleagues to perform myofascial pain release for musculoskeletal pain is also a consideration when possible. There is no specific set protocol used for physical therapy to treat headaches and the therapist will help create a plan based on the patient’s area of tenderness and specific needs.

Screen use is not only related to headaches, but screen use also impacts sleep. Although difficult to show definite causality, the majority of available studies show consistently that poor sleep is correlated with increased duration of screen use. With varying schedules due to e-learning and hybrid models, it is crucial to stress maintenance of a bedtime routine and allow for time before bed to decompress. In addition, avoidance of caffeine overconsumption and avoidance of caffeine consumption late in the day can help one fall asleep more quickly in the evening and avoid caffeine withdrawal headaches.

**Nutrition**
Exercise and diet are also crucial to headache management. It is important to find creative ways to exercise when gyms are closed, and children are often not enrolled in their typical school sports. Studies also suggest an association between obesity and migraine in children and adolescents.

**Mood Concerns**
Comorbid mood conditions are seen with chronic headaches, although exact prevalence is not known. The pandemic has created additional stressors for children and adolescents. Whether that is from being affected by world news, having a parent or family member that is an essential worker, or feeling isolated from friends. We cannot overlook how children and adolescents are processing the changes in the world. Screening and appropriate referrals are part of the successful treatment of headaches.

**Non-Medication Interventions**
Mind body awareness practices have been well described as a treatment modality for migraines even in the absence of comorbid mood concerns. Cognitive behavior
therapy, including biofeedback, has been supported in the literature as part of the headache treatment protocol combined with amitriptyline or with relaxation training.\textsuperscript{17, 18} Biofeedback involves using sensors to show the participant how to control body functions, such as skin temperature and muscle tension in order to enable one to learn how to change physiologic activity for the purpose of improving health and performance.\textsuperscript{19, 20} This can take multiple sessions to learn and practice at home so a motivated patient is key to this intervention. Now that therapy is more available via telehealth, I am hopeful that these modalities will become increasingly more accessible.

Lifestyle modifications and the interventions discussed as the initial step to manage primary headaches have significant overlap (i.e. screen use affects sleep and sleep can affect mood). Addressing lifestyle changes are the foundation of successful headache treatment in children and adolescents. The current pandemic and the changes in our world make it even more crucial to go back to the basics when trying to manage headaches. Special considerations for each child should be taken to elucidate what may be triggering their headache and what can be done to alleviate pain when trying to mitigate primary headaches.

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The University of Chicago Pediatric Injury Prevention Program wishes you a joyful and safe holiday season. We have prepared a small list of the many safety topics that may impact you and your family this holiday season.

**Travel**
- Always keep every person in the vehicle restrained. Nationwide, unrestrained passengers accounted for 47% of fatalities in 2018.\(^1\)
- Bring your own car seat if you will be ride-sharing or taking a taxi. While many companies offer to loan car seats, there is little chance they will properly fit your child as well as the child’s own seat.
- If purchasing car seats online, double check to make sure the seat is certified for use in the United States. There have been sellers advertising Asian and European seats which do not meet US safety standards.\(^2\)
- During air travel the safest practice is to secure the child in a Federal Aviation Administration (FAA) approved car seat in their own seat on the plane.
  - To find if your child’s car seat is FAA approved look for the sticker on the side of the car seat that reads, “Approved for use in Aircraft.”
- Perform general winter maintenance on your vehicle before winter weather hits.\(^3,4,16\)
  - Test the charge of your vehicle’s battery and replace any that show low charges.
  - Many auto part stores offer battery testing and charging for low or no cost.\(^5,6\)
  - Check fluid levels: oil, coolant, and windshield wiper fluid are easy to check and refill.
  - Ensure all tires are properly inflated to the recommended levels which can be found on the outer rim of most tires.
- Slow down. Speeding is involved in over 39% of Illinois traffic-related fatalities.\(^7\)
- Limit driving in inclement weather especially among young or inexperienced drivers.
- Keep a safe distance from snowplows as they have extremely limited vision.\(^4\)
- Prepare an emergency kit for your vehicle that includes cold weather supplies such as matches, a blanket, flares, jumper cables, water, a first-aid kit, and non-perishable food.
- Children should not wear bulky, thick, or puffy coats while they are secured in car seats or booster seats. They create dangerous gaps in the harness or seatbelt and can cause children to be ejected during a motor vehicle crash.
  - To keep children warm try preheating the vehicle or tucking a blanket over the child after the child is strapped in.

**Holiday Shopping**
- Pay special attention to the age recommendations for children on the packaging. The recommendation considers the risk of choking, sturdiness, and skills involved for proper play.\(^8\)
- Think of the maturity level of the child when buying each present.
• “Will the child play with this safely and as intended?”
• For video games, double check the age recommendations and the content warnings.
  • In-game voice chat should only be used with parental supervision.
• Purchase safety equipment such as helmets and kneepads when shopping for bicycles, skateboards, or other similar items.
• Shopping online is recommended this year to lower the risk of Covid-19.²⁹
  • When making online purchases, look for reviews of the seller to protect yourself against counterfeit or unsafe products.

Safety Inside the Home
• Illinois Poison Center is available 24 hours a day for any possible poisonings.²⁰
  • (800) 222-1222
• Encourage family to lock up medication, alcohol, and cleaning supplies.
• Some decorative holiday plants are toxic including holly, poinsettias, and mistletoe.²⁰
  • Consider using artificial versions if small children will be present.
  • Keep the plants out of reach.
• Scan the household for possible choking hazards. A good rule of thumb is if something fits inside of a tube of toilet paper it is a choking hazard.²¹
  • Batteries in remotes and toys.
  • Toys designed for older children.
  • Decorations
  • Plastic bags
  • Ice cubes
  • Certain foods like grapes, radishes, and hotdogs.
• Secure furniture to the walls. Especially anything tall, narrow, or top heavy.
• Do not place televisions on top of unstable or tall furniture.²²
  • Old-style cathode-ray tube (CRT) televisions are especially dangerous due to their weight.
• Trim or secure cords that are possible strangulation risks such as pull strings for blinds, computer headphones, and hanging bags.
• Set your hot water heater’s maximum temperature to 120 degrees Fahrenheit.¹³
  • A child’s skin will scald much more easily and quickly than an adult’s.
• Always use a bath thermometer when bathing infants and toddlers, especially in unfamiliar tubs.
  • Keep the water at around 100 degrees Fahrenheit.
• Keep all doors to restrooms and bathing areas shut and secure from children.
  • Consider putting up reminder signs to shut and secure the door.
• Take out the bath stopper and keep it somewhere inaccessible to children.
  • This will not let water pool up if a child sneaks in the tub and can prevent drowning.
• Move climbable objects away from windows to lessen the risk of falling out of a window.
  • Some windows push out very easily.
  • Screens will not stop a child from falling.
Fire Prevention

- Be careful when hanging decorative lights. Some lights are only for indoor use or only for outdoor use. Use them in their correct areas.

- Do not overload power strips and power outlets and keep flammable material away from any plugs.

- Do not daisy-chain extension cords together and use extension cords in the areas for which they are designed.

- Do not use metal staples or nails to hold up lights or extension cords as the metal can damage the cords.

- Candles are responsible for over half of all winter fires.

  - Keep candles in a stable candle holder and away from any flammable material.
  - Never use candles as decorations on plants or trees.

- Give space heaters space. Do not have any clutter nearby space heaters.

  - When choosing a space heater, opt for one with auto-shut off for tip-overs and with thermostat control.
  - Do not use extension cords with space heaters.

- Do not use your stove or oven as a heating source.

- If food is cooking, stay in the kitchen.

- Do not cook while drowsy or have consumed alcohol.

- Set timers to remind you to check on your food.

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Winter and influenza season are here. COVID rates within the United States (US) are currently climbing again with seemingly no end in sight. With hundreds of articles, news reports, and podcasts flooding our inboxes and daily conversations, it may be useful to have a clear picture of what is important from a pediatric perspective. The following is an overview of COVID and influenza as of early December 2020, including reminders for both health care professionals and families for how to stay safe and healthy.

**Current pertinent Illinois statistics:**
- Illinois COVID-19 cases <20 years of age: 119,711
- Illinois MISC cases: 31-50
- Illinois COVID-19 deaths <20 years of age: 9

**Current pertinent national statistics:**
- US COVID-19 cases <18 years of age: 1,184,252
- Estimated US 2019-2020 influenza cases with symptomatic illness <18 years of age: 12,505,934
- Estimated US 2019-2020 influenza related deaths <18 years of age: 43

Given the striking nature of the data, the following is a brief reminder of the simple daily tasks we need to be practicing, discussing, and encouraging our patients and families to do:

- Recommend social distancing. What does six feet actually look like? A yoga mat, dairy cow, adult bike, or three seat sofa...you get the idea.
Encourage Flu Vaccine

Get the influenza vaccine. Approach the “flu shot” conversation with an open mind. Try to listen and prioritize motivational interviewing over “educating.”

Plenty of local business are offering discounts and advertising specific coverage of influenza vaccine cost. Consider using this information as an additional incentive to encourage families to get vaccinated.

While the mortality of the pediatric population with COVID-19 compared to older patient populations...
remains low, it is important to consider the previous effects of influenza on children. As we progress into the remainder of 2020 and start of 2021, clinicians and health care providers should be proactive and remain informed on new findings regarding COVID-19.

This Table helps describe the characteristics of seasonal influenza viruses versus SARS-CoV-2. Other issues to look out for:

- Studies including the pediatric population and COVID vaccination
- Studies identifying what post-COVID infection means for immunity v. non-immune status

**Characteristics of Seasonal Influenza Versus SARS-CoV-2**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Seasonal influenza viruses</th>
<th>SARS-CoV-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route of transmission</td>
<td>Droplet e.g. cough, sneezing and/or speaking</td>
<td>Droplet (airborne, fomite, and fecal-oral possible but less significant)</td>
</tr>
<tr>
<td>Overall infectivity</td>
<td>Less contagious</td>
<td>More contagious</td>
</tr>
<tr>
<td>Incubation period</td>
<td>1-4 days (median 2 days)</td>
<td>2-14 days (median 5 days)</td>
</tr>
<tr>
<td>Pediatric risk factors for severe disease</td>
<td>Children &lt;5 years of age (especially under 2), racial or ethnic minority status, neurologic conditions, immunocompromised and chronic pulmonary conditions</td>
<td>Immunocompromised, cardiopulmonary disease, obesity, diabetes and hypertension</td>
</tr>
<tr>
<td>Clinical presentation</td>
<td>Fever, cough, sore throat, rhinorrhea, congestion, myalgias, headache, fatigue and emesis with peak in first 3-7 days</td>
<td>Fever, cough, sore throat, malaise and myalgias with peak possible in week 2-3 of illness (may be asymptomatic)</td>
</tr>
<tr>
<td>Pediatric case-fatality rate</td>
<td>0.8% (2019-2020 data)</td>
<td>&lt;0.1%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Nucleic acid amplification and antigen-based assays from respiratory samples</td>
<td>Nucleic acid amplification and antigen-based assays from respiratory samples Serologies</td>
</tr>
<tr>
<td>Pediatric treatment</td>
<td>Oseltamivir (Tamiflu): drug of choice for children ≥2 weeks</td>
<td>Remdesivir: for children aged ≥12 years and weigh ≥40 kg; available for younger children (and those weighing &lt;40 kg and &gt;3.5 kg) through an FDA emergency use authorization</td>
</tr>
<tr>
<td></td>
<td>Zanamivir: for children ≥7 years</td>
<td>Case based/ individualized treatment considering alternate antiviral or immunomodulatory treatment</td>
</tr>
<tr>
<td></td>
<td>Peramivir: IV for children ≥2 years</td>
<td>Supportive care</td>
</tr>
<tr>
<td></td>
<td>Baloxivir: early outpatient treatment for children ≥12 years</td>
<td></td>
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<tr>
<td></td>
<td>Supportive Care</td>
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</table>

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Building Community Trust Key in Delivering COVID-19 Vaccine

Addressing healthcare disparities will help bolster trust in a COVID-19 vaccine, a panel of healthcare leaders said Thursday [December 10, 2020].

Steve Nelson, CEO of the DuPage Medical Group, said during a webinar hosted by Crain’s Chicago Business that the healthcare industry needs to reconsider how it delivers care. For years, he said most providers have focused funding on hospitalizations and doctor visits, instead of addressing things that “actually drive people’s health” like mental health, food stability and housing.

“It’s disappointing to me that the biggest indicator of your health status right now is your credit score and your zip code, as opposed to a lot of other things that it should be,” Nelson said.

Disparities also play into the long-term skepticism that many in Black and Brown and other underserved communities have on healthcare, said Suzet McKinney, CEO and executive director of the Illinois Medical District.

She said historical events like the Tuskegee experiments in Alabama still create deep distrust in vaccines, and healthcare providers must do a better job of connecting with communities, which includes recruiting community leaders and "ambassadors" to help promote the COVID-19 vaccine and the healthcare industry.

“First and foremost, (they can) dispel some of the myths that surround vaccination, but also educate residents and stop the spread of COVID by being ambassadors for the COVID-19 vaccine, which we also, in turn, hope will assist our public health officials and our government officials in ensuring that this vaccine gets into the communities where it is most desperately needed,” McKinney said.

Dr. Tom Shanley, president and CEO of Ann & Robert H. Lurie Children’s Hospital of Chicago, said leaders need to focus on the “three C’s” as they prepare to administer COVID-19 vaccines: complacency, convenience and confidence.

While he does not think people will be too complacent to skip the vaccine, he echoed McKinney’s comments that any vaccination plan must make it convenient for residents to receive the shot, which includes going into the underserved communities and offering free or low-cost vaccinations.

Healthcare leaders must also create the right messaging to inform the public about the safety of the vaccine and bolster their confidence in it, Shanley said.

“So I think we’ve got to address those three C’s to make sure that we really do maximize our ability to reverse the trend of the pandemic as the vaccines will hopefully be able to do,” he said.

Note: Health News Illinois is a statewide healthcare news subscription service. For more information, contact tstumm@healthnewsillinois.com.
COMPREHENSIVE PEDIATRIC CARE

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Parental Attitudes to Vaccination Survey Region 7 (West Chicago Suburbs)

BY LOUISE LIE, EPIDEMIOLOGIST; SUSAN STACK, COMMUNICATIONS COORDINATOR; STACY ZENG, COMMUNITY HEALTH PLANNER; MARIJA HEGEL, COMMUNITY HEALTH INITIATIVES COORDINATOR; MICHAEL ISAACSON, ASSISTANT DIRECTOR COMMUNITY HEALTH; AND KATELYN YOSHIMOTO, VICE PRESIDENT OF JASCULCA TERMAN STRATEGIC COMMUNICATIONS

Background

Kane County Health Department (KCHD) was awarded a three-year grant through the Illinois Department of Public Health (IDPH) in April 2019 with the goal of addressing vaccine hesitancy in Region 7 (West Chicago suburbs) through a targeted communication campaign. Region 7 includes the counties of DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, and Will.

Grant activities in the first year were focused on research activities that would be used to guide and create targeted messaging to vaccine hesitant parents. Research activities included a parental survey and further examining identified themes by parental focus groups.

Parental Attitudes About Vaccination Survey Findings

Utilizing the 2018-2019 Illinois State Board of Education (ISBE) Student Health Data, schools in Region 7 with less than 95% MMR coverage rates were identified. One hundred twenty-two schools were identified from this data. These schools were selected for participation in this survey since the probability of engaging with vaccine hesitant parents would be higher than in schools with...
100% compliance. Each school was contacted and asked for their assistance in distributing a survey link to parents who could voluntarily participate in the survey. The survey was also made available in Spanish. The survey finding would then be used to provide data to inform and direct the immunization communication campaign.

The validated Parental Attitudes About Childhood Vaccines Survey (PACV) created by Opel et al. was used for our research. The PACV survey was created as a tool to measure vaccine hesitancy. The survey could be scored, and respondents evaluated on a vaccine hesitancy scale. Additionally, the survey was used to identify key themes and concerns of parents specific to Region 7.

One hundred forty-four Survey responses were collected and represented sixteen schools in the region. Respondents to the survey were overwhelmingly female (74.7%), married/living with a partner (87.3%), white (78.5%), financially stable (81.6% household income of more than $75,000) and college educated (83.1%). Each response was scored, and each respondent given a vaccine hesitancy score from zero (no hesitancy) to one hundred (complete hesitancy). The mean vaccine hesitancy score of respondents to this survey was 24.

While the majority of respondents to this survey indicated an acceptance and trust in the safety of vaccines by scoring zero to ten on the 100-point scale, a range of vaccine hesitancy scores could be seen thus demonstrating the vaccine hesitancy continuum (see figure 1). Vaccine hesitancy should not be viewed as a binary decision, but it should be acknowledged that many parents have concerns and questions that could make them susceptible to influence either to vaccinate or to not vaccinate. Twenty percent of respondents admitted to having delayed a shot, while 19% admitted to having declined a shot (not including flu vaccines). When asked if they were to have an infant today, would they want them to get all their recommended shots; 84% responded that they would want them to receive all their shots.

When ranking vaccine concerns, the number one concern of parents was that they felt it was better for children to get fewer vaccines at the same time.

<table>
<thead>
<tr>
<th>Overall ranking of vaccine concerns</th>
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<tbody>
<tr>
<td>It is better for children to get fewer vaccines at the same time</td>
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<tr>
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<tr>
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<td>Concern that a shot might not prevent the disease</td>
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<td>Children get more shots than are good for them</td>
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<tr>
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<tr>
<td>Confidence in shot schedule</td>
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<td>Belief in illnesses that shots prevent being severe</td>
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**Figure 2**

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**Overall ranking of vaccine concerns**
The I Protect Campaign

KCHD selected Jasculca Terman Strategic Communications to create and manage the communication campaign. Utilizing the survey findings together with insights learned from parent focus groups the campaign strategy was developed. The I Protect campaign aims to empower parents by presenting factual information to allow parents to feel informed and in control of their vaccination decision. The campaign presents five “personas” that connect facts to a relatable narrative. The campaign is social-media-based and utilizes a microsite (https://www.iprotectil.com) to direct users to trusted information sources.

Provider Involvement

The social media campaign has been created in a way that makes it easy for coalition partners, community agencies, and health care providers to share our messaging to your social media platforms, newsletters, and other communication channels. The success of this campaign relies heavily on our messaging being

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Figure 3

<table>
<thead>
<tr>
<th>Trust Variable</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>I trust my doctor</td>
<td>80%</td>
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<tr>
<td>I trust the information I receive about shots</td>
<td>75%</td>
</tr>
<tr>
<td>Trust government regulations are in my best interest</td>
<td>75%</td>
</tr>
<tr>
<td>Trust that big pharma puts safety concerns before profits</td>
<td>25%</td>
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widely spread. We ask you to please join us in sharing our campaign with your patients and colleagues. A toolkit has been provided at https://bit.ly/3eYMPLW that contains social media posts, videos to download, fliers, and newsletter templates for your convenience.

Conclusion
Across the United States, we have seen a worrisome decline in the number of childhood vaccines that have been given during the COVID-19 pandemic.\(^2\) Aside from COVID-19 concerns, we know that vaccine-hesitant parents represent an important demographic adversely impacting vaccine rates. In order to increase vaccine uptake, we need to be sure that any parent on the vaccine hesitancy continuum is offered resources to empower their decision making and in doing so influencing them to choose to vaccinate their child. The I Protect campaign aims to connect parents to facts in a narrative that they can relate to.

Through this survey we have learned that presenting parents with factual vaccine information from reliable sources allows them to feel that they are in control of the decision-making process regarding vaccination of their child. Doctors are well-trusted sources of this information. While it may not be always possible to address every concern or question that a parent has at a clinic visit, we hope that the I Protect campaign may be a useful tool to you, to provide your patients with this information.

REFERENCES

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**Campaign Assets**
Help us to spread our campaign

1. **The Microsite**
   www.iProtectil.com

2. **Shareable Videos**
   See toolkit

3. **Sample text for newsletters or blogs**
   See toolkit

4. **Social Media**
   Follow I Protect IL on Facebook, Instagram and Twitter.

5. **Coalition Toolkit**
   http://docs.google.com/document/d/1xuNIkvw3YyEwg7xIWQi61x66IWQJ1BTKw7tdxQ0/edit?usp=sharing
A Hospitalist’s Perspective on Asthma Prevention

BY MARTIN DUNCAN, MD, FAAP, PEDIATRIC HOSPITALIST AT ANN & ROBERT H. LURIE CHILDREN’S HOSPITAL OF CHICAGO

Winter in Illinois can mean many things. Traditionally we think of softly falling snow, lights, candles, and bitter cold warmed by the cheer of the holidays. However for those of us in pediatric hospital medicine, the winter season also comes with another familiar face: admissions for acute asthma exacerbations.

Among children, asthma represents the third leading cause of preventable hospitalization and is the leading cause of health-related school absenteeism. In Illinois specifically, the prevalence of asthma reported in the 2016 Illinois Department of Public Health (IDPH) “Illinois Childhood Asthma Surveillance Report” was 9% among all children, with wide disparities ranging between 6% and 19% prevalence when considering ethnicity and socioeconomic status.

As any student of medicine knows, an ounce of prevention is worth a pound of cure; particularly when that cure arrives in the form of a multi-day hospitalization requiring high-flow or even positive pressure ventilation. Over the years that I have worked at Lurie Children’s in units ranging from the PICU to the observation unit, I have seen some common themes arise when a child is admitted in status asthmaticus. These areas can present opportunities for intervention and prevention before the child ever arrives in the hospital. Here are a few reminders and recommendations to consider based on common issues that seem to come up every winter:

1. When reviewing your patient’s level of asthma severity and control, check in with their parents to assess their understanding of their child’s asthma management. If possible, take time to do teachback. Time and time again, I have been surprised by what some parents consider to be “well-controlled.” I can’t count how often I’ve had a parent tell me they’ve had no problems with asthma, and their child only uses their rescue inhaler “a few times per week.”

2. It may go without saying, but make sure your patients have a metered-dose albuterol inhaler (MDI) with a spacer and appropriately-sized mask (if needed). MDIs have been proven to be as effective as a nebulizer machine, and in the era of COVID-19 are preferred due to the increased likelihood of nebulizers spreading infection due to the aerosol generation.

3. However, it is very common for us to admit patients who either only have a nebulizer at home, have an inhaler but lack the spacer, or have outgrown (or lost) their mask. Refill all of their prescriptions and provide extra albuterol MDIs with spacers. Time and time again, we see patients who are admitted and have been off of their controllers for weeks, if not months prior. Sometimes the patient will have had a simple precipitating URI but have lost their spacer, or left their only inhaler at a relative’s house.

4. Make sure they have an asthma action plan and review the medications and steps with your patient and their parents. Simple misunderstandings are
a common cause of medication non-adherence, particularly when involving multiple inhalers. One of the most unfortunately common scenarios I’ve encountered is families only using their controller medication when their child is having an exacerbation while diligently giving albuterol every day. While you are at it, double-check the dosage of their medications on the plan. For example, the Global Initiative for Asthma (GINA) and National Asthma Education and Prevention Program guidelines recommend albuterol ranging from four to ten puffs anywhere from every twenty minutes to every four hours depending on the severity. At Lurie, for patients in the “yellow zone” we recommend four puffs every four hours for patients under 20kg, and six puffs every four hours for patients over 20kg.

5. Schedule follow-up visits. Even if the asthma is well-controlled, the AAP recommends visits at three to six month intervals to assess control and adjust medications. This is also the perfect time to make certain they have gotten their annual flu shot, review medications, update their asthma action plan, and reinforce proper MDI and spacer technique.

6. Lastly, prevention starts at home. Teaching parents to recognize and reduce common asthma triggers found in the home can reduce the odds of asthma exacerbations. Tips and checklists for identifying and reducing asthma triggers can be found on the CDC website or accessed here: (https://www.cdc.gov/asthma/pdfs/home_assess_checklist_P.pdf). A condensed tip sheet that covers all of this and more is available from the AAP Medical Home Program on Asthma, Allergy, and Anaphylaxis online at this link: (https://www.aap.org/en-us/Documents/medicalhome_resources_keypointsforasthma.pdf). National and international guidelines cited are available free of change in PDF form via the links in the reference section, including the GINA 2020 report.

This winter season, take advantage of your patients’ next follow-up visit, well-child check, routine immunization, or sick visit. Just a few focused interventions and a bit of anticipatory guidance can make the difference to help prevent or shorten their next admission, and most importantly, keep them home for the holidays.

Martin Duncan is a pediatric hospitalist at Ann & Robert H. Lurie Children’s Hospital of Chicago and a clinical instructor of pediatrics at the Northwestern University Feinberg School of Medicine.

REFERENCES


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What if we could find a way to communicate with our patients and their caregivers in a way that would elicit more meaningful information and result in better outcomes? Or at the very least, provide them with the information they need to make better decisions regarding their health? And what if we had a tool that would help reduce the stress that is felt by both healthcare professionals who would like to have all the answers but frequently don’t, and patients who feel unwell and uncertain?

“A scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering. Along with scientific ability, physicians need the ability to listen to the narratives of the patient, grasp and honor their meanings, and be moved to act on the patient’s behalf.” This is the idea of Rita Charon, MD, PhD from Columbia University, who founded Narrative Medicine as a way to help healthcare professionals deliver better, more compassionate care to their patients.

This idea was embraced by Drs. David Thoele and Marjorie Getz from Advocate Children’s Hospital (ACH) who formed a Narrative Medicine program in 2013. Their mission? “We tell stories, listen closely, write and share to facilitate healing, re-humanize healthcare, and increase capacity for empathy and self-reflection.” Members of the Narrative Medicine program include doctors and other healthcare professionals, patients, and caregivers. The group holds meetings twice a month with meditations, writing exercises and sharing; conducts writing workshops; and teaches the 3 Minute Mental Makeover as a tool for medical providers and patients dealing with stress. In this way, participants practice how to tell their own stories, as well how to receive other peoples’ stories.
In the spring of 2020, due to the Coronavirus pandemic, the monthly meetings became virtual via Zoom. While everyone missed the in-person meetings, this shift allowed the program to expand and include people across the United States who otherwise wouldn’t be able to participate. That is when I formally joined the group, and it’s one of the best things I’ve done!

As part of ICAAP’s COVID19 response, we’ve also looked for ways to help alleviate the incredible stress experienced by our members. People have felt isolated and overwhelmed, highlighting the need for the types of personal reflections and supportive interpersonal connections that can be formed through Narrative Medicine. So I reached out to Drs. Thoele and Getz and, as part of the ACH Narrative Medicine Program, we created the Facebook Group – The Weekly Breather: Telling Our Stories, to allow more people to share their reflections. Now that this Facebook group is fully launched, we are inviting all ICAAP members and anyone else, patient or provider, interested in Narrative Medicine to join.

The Weekly Breather is a closed group for anyone who would like to explore and participate in Narrative Medicine in a way that is both personal and interactive. It is a place to feature writing and to reflect on shared experiences.

At least one writing prompt and one meditation are posted each week, and members are encouraged to share their responses in the comments section. The goal is to promote open communication. However the act of writing a reflection alone has great value, and some people choose to keep their writing private. Our responses reflect our roles in the medical community (provider, patient, etc.); allow us to learn from each other’s experiences; and make us better communicators.

We invite you to learn more about Narrative Medicine by attending a Zoom meeting (8:00-9:00 am CST on the first and third Tuesdays of each month) or by joining The Weekly Breather Facebook group. To join the meetings, send an email to david.thoele@aaah.org and ask to be added to the narrative medicine email list. We’ll send you the Zoom link. To join the Weekly Breather Facebook group, follow the link, click the Join button, and answer a few simple questions that give insight into your interest in Narrative Medicine (there are no right or wrong answers). Once this is received by an administrator, you will have access to both past and future posts. You can also follow the International Narrative Medicine Institute Facebook page @INMIGroup to learn more about work being done in Narrative Medicine, including research by the members of the ACH Narrative Medicine program.

It is our hope that you will join, reflect, share and experience the power of Narrative Medicine with us. For more information, please contact Dr. Mariana Glusman.

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“A scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering. Along with scientific ability, physicians need the ability to listen to the narratives of the patient, grasp and honor their meanings, and be moved to act on the patient’s behalf.”

– Rita Charon, MD, PhD
Families Fighting Flu: Stressing the Importance of Annual Flu Vaccination

BY SERESE MAROTTA, FAMILIES FIGHTING FLU, CHIEF OPERATING OFFICER

As a parent and scientist, I know the importance of routine immunizations, including annual flu vaccinations. My experience with flu began eleven years ago when I lost my healthy five-year-old son, Joseph, to flu. Although Joseph had received a seasonal flu vaccine in September 2009, the seasonal vaccine did not protect against the pandemic strain of H1N1, which ultimately led to his death. Prior to Joseph’s loss, I didn’t realize the tremendous burden that influenza has on our public healthcare system or how dangerous flu can be, especially for young children.

The loss of my son brought me to Families Fighting Flu (FFF), a national non-profit organization that was formed in 2004 by families like mine that had lost children to flu. Since 2004, our organization has focused on raising awareness about the seriousness of flu and the importance of annual flu vaccination for everyone six months and older, consistent with the recommendation from the Centers for Disease Control and Prevention (CDC).

Sadly, there are many families just like mine who have lost loved ones to flu. Here at FFF, we share these family stories as part of our education and advocacy efforts, as well as evidence-based information around flu prevention, diagnosis, and treatment. Our efforts are focused at the national level through educational campaigns such as Stay in the Game™, down to the community level through our Flu Champions program where we work with local advocates to increase flu awareness.

Although studies have shown the benefits of flu vaccination in children, pediatric vaccination rates are still less than ideal (e.g., only 64% of children ages six months through seventeen years received a flu vaccine during the 2019-2020 season). The CDC reported that 195 children died from flu last season and the majority of them were not vaccinated. So how do we increase annual flu vaccination rates? By empowering parents with information, improving access to vaccines, and having trusted healthcare providers make strong vaccine choices.

The CDC reported that 195 children died from flu last season and the majority of them were not vaccinated.
As part of our library, we also offer a Flu Education Resource for Healthcare Professionals that focuses on pediatric populations and was created in collaboration with the National Association of Pediatric Nurse Practitioners (NAPNAP) and HealthyWomen. This resource includes family stories, infographics, and talking points for conversations with vaccine-hesitant parents. We encourage providers to use these educational resources in their practices.

Beyond just flu-related facts and statistics, we know it’s important to use narrative communication, i.e., storytelling, to convey the importance of vaccination. Data and numbers – while important to inform our approaches to fight illness – do not motivate behavior change, but personal stories do. What makes FFF unique is our personal stories and how we use storytelling to teach, influence, and inspire others. We are real families who have been touched by flu and we empathically share our stories of loss and survivorship in an effort to raise awareness and stress the importance of annual flu vaccination. Our personal stories create an emotional connection and help people understand that they can take action to help protect their families against influenza.

Especially during the COVID-19 pandemic, I’m asking healthcare providers to make every patient visit a “vaccine visit.” Have those difficult conversations with parents, provide them with educational resources, and create a culture of immunization in your practices. My son Joseph was only one of close to 2,000 children that have died from influenza since 2004. As healthcare providers, your recommendation for annual flu vaccination is a critical part of making sure other families don’t have to go through what mine did.

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recommendations. We know that parents have questions and concerns about flu and flu vaccination. Is my child really at risk from influenza? Is vaccination safe and effective? These are legitimate questions that we need to answer in an effort to raise pediatric vaccination rates.

At FFF, our goal is to provide flu-related information to the general public through various communication channels (e.g., social and digital media) in an effort to empower them to make informed decisions about flu vaccination for themselves and their families. One way we do that is by providing numerous educational resources in various formats that can be used by healthcare providers, stakeholders, partners, and advocates. These educational resources range from posters, fact sheets, and infographics to digital social media graphics, family video testimonials, and public service announcements. We have compiled these resources on the FFF website (www.familiesfightingflu.org) and made them available in both hard copy and digital formats. To address diversity and inclusivity, we’ve also translated some of these educational materials into Spanish.
Diabetes Apps for Patients and Families

BY ERIKA MCLEAN, MD, PEDIATRIC HOSPITALIST AT CARLE HOSPITAL, URBANA, IL

In my work as a community pediatrician as well as a pediatric hospitalist, I have noticed an increase in the number of patients with new-onset diabetes in my area. I can pontificate about the calorie rich/nutrient poor food that has become the norm in modern society, but I would like to focus instead at this moment on one modern convenience that may help manage this overwhelming diagnosis: phone apps. I am motivated to somehow make the task of calculating insulin dosage easier on my patients and their families, because my heart goes out to them as I watch them trying to calculate their child’s insulin dose for the first time. These are not mathematicians, yet they are expected to calculate the number of carbohydrates in their food, divide by a correction factor (for example 1 unit for every 15g of carbs) to come up with the first component of the insulin dose; then add the insulin required for the blood glucose correction (frequently 1 unit for every 50 points over 150, for example) to arrive at the total required insulin.

Thanks to modern technology, there are multiple phone apps that allow an adolescent patient or a parent of a new diabetic to describe the food, take a picture, or even scan the bar code to come up with the number of carbohydrates per serving. As a pediatric hospitalist I have had the opportunity to directly observe the new-onset diabetes teaching that is conducted on the inpatient pediatric unit, for which I give full credit to the nursing staff and diabetic educators. I am ashamed to admit that I am not so well versed on the carbohydrate content of many foods, nor are my colleagues. However, thanks to modern technology, there are multiple phone apps that allow an adolescent patient or a parent of a new diabetic to describe the food, take a picture, or even scan the bar code to come up with the number of carbohydrates per serving. Thanks to the popularity gained by the ketogenic diet, numerous apps are equipped with the carb counts of any food you can think of. Where I have found my disappointment in many apps I have explored for insulin dependent diabetics is that they do not provide patients directly with the actual insulin dosage they will need at that moment based on their carb and blood glucose corrections. Obviously, this must be done with caution, because an error in data entering could lead to incorrect insulin dosing and an episode of hypoglycemia; but if parameters are entered properly, I
think help with the actual calculation can be very useful. In this vein, I searched the internet and downloaded several apps that claim to help manage diabetes, and I have narrowed down the ones that seem to be most useful.

What the apps all have in common is that patients can manually enter the number of carbs they’ve consumed, what their blood sugar level was, and how much insulin was injected. To me this is not much better than a notebook log unless it encourages kids to do so because the log is always available on their phone, and—let’s face it—so are they. I would like to emphasize that these apps would be the most useful for a patient who has to calculate injections who is not on a continuous pump that automatically adjusts the insulin dose for glucose levels throughout the day. Ironically, patients must prove their compliance with checking and injecting up to four times a day before insurance will pay for the upgrade to the insulin pump. With that in mind, here goes!

By far the most useful app for children with insulin-dependent diabetes is called **BlueLoop™**, which is available on iPhone and Android. It was invented by a mother after her school-aged daughter was diagnosed with diabetes and it was developed in conjunction with the Children’s Hospital of Wisconsin. It appears to be entirely free. The initial step is establishing a free username and password at mycareconnect.com, where the parent’s name, cell phone number and email address is entered followed by the child’s information. This is because BlueLoop™ keeps parents “in the loop” about how much their child is eating and injecting while at school in real time via email and text message, so nothing gets lost or miscounted, even away from home. The school nurse can also log into the account as another source of information and guidance. The app provides carb counting and insulin calculation (after carb and glucose corrections are entered), and up to six family members can share this information amongst each other. This same information can be shared with their endocrinologist in real time as well. This establishes a community of care for each child with diabetes while still allowing for autonomy in older children, but always within the safe environment provided by real time supervision. I would suggest that when a patient is initially diagnosed and hospitalized, or initially starts using the app, the endocrinologist could double check entry of the carb and glucose corrections and go through a few trial calculations to ensure that indeed the correct insulin dose is calculated.

The next most useful app was called **GlucoseBuddy™**. It is geared more towards adults and is offered initially for free, but an upgrade to $14.99/month or $39.99/year is required to stop seeing advertisements while trying to work the app. This cost may be a burden on some families and may prohibit them from upgrading. Like other apps, it helps with carb counting and insulin injection calculation. The app’s advantages are that it calculates the user’s potential A1c and it can theoretically be linked to a step counter, both of which may be motivating. It also offers various graphs and charts like “learn which meals impact your glucose the most.” A disadvantage is that the glucose/insulin logs have to be printed out to share with the healthcare provider (rather than being shared digitally).

The simplest of apps I explored is called **InsulinCalc™**, and that is exactly all that it does. It is free, and once the carb counting ratio and glucose correction factors are entered into the settings, the number of carbs and current glucose can be entered in, and like a calculator it spits out the insulin dose. I don’t see any place to store more information, however many glucometers store glucose readings, so this would be the app for folks who are really struggling with the mathematical component of their dosing. Of course, there is no electronic app that will ensure compliance, motivation, or understanding of insulin-dependent diabetes.

As a physician, it is daunting to review and understand how the numerous apps available could be helpful for now, but I am hopeful that apps like those above could at least make life a bit easier for the newly-diagnosed pediatric patient and their families.

Disclaimer: I have no financial investment in any app.

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The Illinois Chapter, AAP Presents...

Adolescent Health Provider Education Training Series: Part 3

Addressing Health Inequities in Adolescent Care
January 29, 2021, 12-1 PM CT
Registration: https://bit.ly/2Kej3aE

Adolescents and Mental Health
February 26, 2021, 12-1 PM CT
Registration: https://bit.ly/3gBX3ml

The Social Emotional Aspect of Adolescent Health
March 26, 2020, 12-1 PM CT
Registration: https://bit.ly/2JVgHxE

Note: Continuing Education Credit is pending for this webinar series.

About
The Illinois Chapter, American Academy of Pediatrics has developed an adolescent health provider education series. The series is designed for providers and health professionals to learn how to increase adolescent well-care visits and address the needs of adolescents and their families.

Audience
- Physicians
- Nurses
- Care Coordinators
- Counselors
- Social Workers
- Psychologists
- Therapy Providers

Funding provided by the Illinois Department of Public Health, OWHFS, Maternal Child Health MCH Title V Block Grant.
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Melrose Park

School Health
Cynthia Mears, DO, FAAP
Oak Park

Social Determinates of Health
Deanna Behrens, MD, FAAP

Sports Medicine
Holly J. Benjamin, MD, FACSM, FAAP
Chicago

Jeffrey Mjaanes, MD, FAAP
Chicago

AAP LIASIONS AND CHAMPIONS
Asthma
Aaron Donnell, MD, FAAP
Chicago

Ruchi Gupta, MD, MPH, FAAP
Chicago

Breastfeeding
Malika Shah, MD, FAAP
Chicago

CATCH Coordinator
Michelle Barnes, MD, FAAP
Chicago

Carrie Drazba, MD, FAAP
Chicago

Disaster Preparedness Response
Paul Severin, MD, FAAP
Chicago

Early Career Physicians
TBD

Early Childhood Champion
Reshma Shah, MD, FAAP
Chicago

E-Cig Champion
Susan Sirota, MD, FAAP
Highland Park, IL

Early Hearing Detection Champion
Daniel Morra, MD, FAAP
Breese

Immunizations
Anita Chandra-Puri, MD, FAAP
Chicago

Oral Health
Geisel Collazo, MD
Chicago

Osteopathic
Gene Denning, DO, FAAP
Tinley Park

PROS Co-Coordinator
Rebecca Unger, MD, FAAP
Chicago

Emalee J. Flaherty, MD, FAAP
Evanston
ICAAP eLearning
2021 Course Catalog

The Illinois Chapter, American Academy of Pediatrics (ICAAP) is pleased to provide the following web-based Continuing Medical Education (CME) approved educational offerings. Some activities are approved for Maintenance of Certification (MOC) Part 4 credit. To register for ICAAP's eLearning platform visit, https://icaap.remotel-learner.net and create an account. Then visit the Course Catalog where you can access all of the educational offerings.

For more information about course offerings, please contact:
Kathy Sanabria, Associate Executive Director, ksanabria@illinoisaap.com or Erin Moore, Manager, emoore@illinoisaap.com, (312) 733-1026 ext. 204.

CME Training Modules

Child Development and Screening 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 for infants and toddlers. 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 | Expires November 30, 2019
CME Approval Renewed until November 30, 2021

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 highlighting professional expectations as part of the Perinatal Mental Health Disorders Prevention and Treatment Act. Participants will learn about procedures for screening and referral, as well as ways to engage families.

1.25 AMA PRA Category 1 Credits™, Free | Expires November 30, 2019
CME Approval Renewed until November 30, 2021

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 communication and practice strategies, as well as identifying available resources to help children and families.

1.25 AMA PRA Category 1 Credits™, Free | Expires November 30, 2019
CME Approval Renewed until November 30, 2021

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 | Expires November 30, 2019
CME Approval Renewed until November 30, 2021

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

1.25 AMA PRA Category 1 Credits™, Free | Expires November 30, 2019
CME Approval Renewed until November 30, 2021

CME Webinars

Breastfeeding Webinar Series:

Breastfeeding as a Health Prevention Strategy
This webinar is Part I of a three-part series presented by ICAAP. This webinar will help providers understand what they need to know about breastfeeding and how to counsel patients more effectively. The first webinar, Part 1 Breastfeeding as a Health Prevention Strategy, focuses on breastfeeding promotion.

1.00 AMA PRA Category 1 Credits™, Free | Expires January 31, 2020
CME Approval Renewed until February 28, 2023

Breastfeeding the Healthy Term Infant
This webinar is Part 2 of a three-part series presented by ICAAP. This webinar will help providers understand what they need to know about breastfeeding and how to counsel patients more effectively. The second webinar, Part 2: Breastfeeding the Healthy Term Infant will focus on attachment techniques, AAP recommendations and lactation in hospital settings.

1.00 AMA PRA Category 1 Credits™, Free | Expires January 31, 2020
CME Approval Renewed until February 28, 2023

Breastfeeding, Special Considerations
This webinar is Part III of a three-part series presented by ICAAP. This webinar will help providers understand what they need to know about breastfeeding and how to counsel patients more effectively. The third webinar, Part 3: Breastfeeding, Special Considerations, will cover topics such as lactation during separation and neonatal glucose levels.

1.00 AMA PRA Category 1 Credits™, Free | Expires January 31, 2020
CME Approval Renewed until February 28, 2023
Adolescent Health Training Webinar Series:

**Transitioning Youth to Adult Healthcare for Pediatric Providers: Training and Resources**
This webinar is Part 1 of a five-part series presented by ICAAP. This webinar training provides an introduction to transition care for providers to successfully transition youth, especially those with special health care needs. It will also discuss the Transitioning Youth to Adult Health Care for Pediatric Providers online training.

1.00 AMA PRA Category 1 Credits™, Free | Expires December 31, 2022

**The Teen Brain Development: Effects on Health and Behavior**
This webinar is Part 2 of a five-part series presented by ICAAP. This webinar training was designed to educate physicians on the dynamics of adolescent brains and how their development affects their health and decisions.

1.00 AMA PRA Category 1 Credits™, Free | Expires December 31, 2022

**Counseling Teens on Sexual Health and Risky Behaviors**
This webinar is Part 3 of a five-part series presented by ICAAP. This webinar training focuses on assisting providers with becoming comfortable broaching sexual health topics and behaviors with their adolescent patients in order for youth to disclose sensitive information.

1.00 AMA PRA Category 1 Credits™, Free | Expires December 31, 2022

**Bright Futures Guidelines: Implementation for Adolescents (11-21 years old)**
This webinar is Part 4 of a five-part series presented by ICAAP. This webinar training is intended for providers who care for adolescents’ ages 11-21. They will receive information and resources on how to best implement these evidence-based guidelines into their practice to improve their patients’ health outcomes.

1.00 AMA PRA Category 1 Credits™, Free | Expires December 31, 2022

**Marijuana: Medical and Recreational**
Illinois recently became the 11th state to legalize the use of recreational marijuana in the United States. The goal of this training is to provide education and tools for pediatric providers to use to prepare for the increased use of marijuana and mitigate the harmful effects that may arise among patients and families within their practice.

1.00 AMA PRA Category 1 Credits™, Free | Expires December 31, 2022

**Use of Social Media for Outreach**
As social media gains popularity, the use of social media in practices can aid providers in effectively communicating with patients and their families, in addition to providing them with informative health care resources and information. The goal of this training is to provide physicians with practical knowledge of how they can incorporate social media into their current practice and connect patients and families with effective tools and resources.

1.00 AMA PRA Category 1 Credits™, Free | Expires December 31, 2022

Use of Social Media for Patient Outreach
This webinar is Part 5 of a five-part series presented by ICAAP. This webinar training aims to provide physicians with practical knowledge of how they can incorporate social media into their current practice and also connect patients and families with effective tools and resources.

1.00 AMA PRA Category 1 Credits™, Free | Expires December 31, 2022

Preparing Pediatric Providers to Address Health Effects of Climate Change Webinar Series:

**Vector-Borne Diseases, Public Health Implications from Floods, and Mental Health Concerns**
This webinar will help providers understand what they need to know about climate change to help them discuss the implications of climate change on the health of patients. This webinar focuses on climate change’s impact on vector borne illnesses, extreme weather events, and mental health.

1.00 AMA PRA Category 1 Credits™, Free | Expires May 31, 2020
CME Approval Renewed until May 23, 2022

**Heat-Related Illness, Asthma, and Allergies**
This webinar will help providers understand what they need to know about climate change to assist them discuss the implications of climate change on the health of patients. This webinar focuses on air quality, respiratory health, and heat-related illnesses.

1.00 AMA PRA Category 1 Credits™, Free | Expires May 31, 2020
CME Approval Renewed until May 23, 2022

**MOC Part 4 and CME**

**Transitioning Youth to Adult Health Care Pediatric Course Updated (2018-2021)**
The goals of the Transitioning Youth to Adult Health Care Pediatric Course Updated are 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. The course includes completion of chart reviews and inputting data into the LMS every six weeks for 18 weeks for a total of four data collections cycles.

(baseline = cycle 1, plus three cycles)
15.00 AMA PRA Category 1 Credits™ | Expires April 30, 2021
20 MOC Part 4 Points approved by ABP | $275 members; $300 non-members

**Improving HPV and Adolescent Vaccination Rates Quality Improvement Project**
The goal of this course is to improve HPV vaccine rates by improving access for vaccine uptake. This course will provide information, tools, and resources for providers to help patients and families understand the importance of the HPV vaccine in cancer prevention. To receive MOC Part 4 credit, learners must enter baseline data, cycle 1 data, and cycle 2 data over a period of 15 weeks.

3.00 AMA PRA Category 1 Credits™ | Expires March 31, 2022
25 MOC Part 4 Points approved by ABP | $100 members; $150 non-members

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

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

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.

January 2021
The American Academy of Pediatrics Illinois Chapter has partnered with HealthCare Associates Credit Union to bring you:

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