

# Illinois Pediatrician

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The Lingering Long COVID-19

Applied Behavior Analysis Provision in Early Intervention: An Underutilized Service

Time to Revisit the Forgotten Vaping Crisis

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Illinois Chapter

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American Academy of Pediatrics

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American Academy of Pediatrics (family engagement)	Meridian, a WellCare Health Plan, Inc. company (housing)
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Illinois Department of Public Health (adolescent health/immunization)	Pritzker Children's Initiative (early childhood)
Illinois Public Health Institute (breastfeeding)	Robert R. McCormick Foundation (early childhood)

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PRESIDENT'S COLUMN

## “What Now?”

**MARY DOBBINS, MD, FAAP**  
PRESIDENT, ILLINOIS CHAPTER OF THE AMERICAN  
ACADEMY OF PEDIATRICS

Getting to see Grandma. Eating out. Graduations.  
Vacations. Ballgames. Festivals and fairs.....

The list goes on and on as we rediscover the joys of being able to do things that we took for granted prior to the pandemic. We are gradually emerging into the “new normal”.

This is a wonderful, yet precarious time. Wonderful for all of the obvious reasons. Precarious in that it is tempting to slip back into old ways instead of continuing to strive for “the world as it could be”. As pediatricians, we are in a unique position to have a continuing and positive impact on this vision for our future.

First of all, people trust us. It was very disheartening to experience the rejection of science and medical recommendations during the pandemic. Yet pediatricians have always maintained a special altruistic credibility. The AAP is valued as a resource for our current administration as it develops policy and legislation. ICAAP remains a trusted “neutral convener” for discussions regarding statewide initiatives. As individuals, we have credibility on social media and within our communities and institutions. Subsequently, it will be important to maintain visibility and consistent, positive messaging (especially as those with detrimental messaging maintain such a strong public voice). Whether you volunteer in the community,

serve on a board, give an interview, or have an active Twitter account, social presence has become mainstream pediatrics – and our credibility is a powerful tool.

### **As individuals, we have credibility on social media and within our communities and institutions.**

We are also leaders and role models. During the pandemic we have witnessed divisiveness over recommendations for vaccines and measures for containment. In many ways this reflected the deeper rift of “us” versus “them” in our culture. Minority populations were disproportionately affected, not only by illness and lack of access to care, but also by the domino effect of loss of services (such as education and daycare) and dramatic shifts in employment. Protecting privilege in certain groups while continuing to marginalize others systematizes and chronically perpetuates a culture of “toxic stress”. This in turn adversely affects health, education and economic outcomes. Whether you serve on an admissions committee, volunteer as a mentor, oversee staff, insure diversity in office materials and presentation, or explore implicit bias on a personal level, societal health through inclusion and diversity has become mainstream pediatrics – and our leadership provides untapped opportunity.

Most importantly, we have heart. We care about and develop relationships with the children and families that we serve. In fact, out of all of the services we offer, the personal interaction may very well provide the greatest enduring benefit. (“You don’t have to be a therapist to be therapeutic!”)

The need for relationships is built into our very DNA. We feel self-worth when someone shows that we have their attention and regard. We develop trust in that person and listen to their message. We learn to both appreciate the uniqueness of the individual and recognize the commonality between us.

Through these relationships we can blur the distinctions between “us” and “them”. We can decrease

barriers to care for those who are afraid they will be shamed or rejected when coming to see us. We can foster patient engagement. We can help patients and families to feel heard. We can help someone understand they matter enough to live another day.

These relationships also benefit us as we juggle the bureaucracy of practice with the constant barrage of new information and skills to assimilate into our practice. We can continue to be inspired by our patients. We can continue to find joy and meaning in our work. We can help heal ourselves and our culture one encounter at a time. Relationships have always been mainstream pediatrics – and our heart is our superpower.

Last but not least, we have strength in numbers. In the past six months (and in addition to our other ongoing services), ICAAP has helped to pass legislation strengthening telehealth, worked with campaigns to get patients back in the office and to increase vaccination rates, expanded social media efforts, created an Equity Agenda, worked to decrease lead poisoning, developed an EI Toolkit, addressed homelessness/housing, begun a needs assessment for mental health resources, and provided continuing medical education. (We have been especially pleased to be able to offer the Annual Educational Conference free of charge to our membership this year.) Support for each other is part of mainstream pediatrics, and ICAAP continues to be a strong advocate for our members and their patients.

Always remember, “Nobody can do it all, but everyone can do something.” Take care of yourselves and take heart in knowing that you are creating the “world as it could be”.

Best,

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## 4.6 Million children live in homes with guns that are loaded and unsecured.

You talk to your patients about car seat safety, vaccines, developmental milestones and allergies...

**Have you talked to them about safe gun storage?**

Advise your patients to:

**BE**  
**SMART**

<b>Secure</b> all guns in your home and vehicles	<b>Model</b> responsible behavior around guns	<b>Ask</b> about the presence of unsecured guns in other homes	<b>Recognize</b> the role of guns in suicide	<b>Tell</b> your peers to be SMART
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For more information on what you can do to keep kids safe, visit  
[BeSmartForKids.org](http://BeSmartForKids.org)

Email [besmartillinois@gmail.com](mailto:besmartillinois@gmail.com) for information on trainings, materials and ways to have the conversation with your patients.

ICAAP extends special thanks and appreciation to the newsletter editors for their many volunteer hours and service to edit and publish the semi-annual *Illinois Pediatrician*. Views expressed by authors are not necessarily those of ICAAP.

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## **Navigate Your Practice Through Uncharted Waters**

**As we enter the next stage of the pandemic, ISMIE continues to support and encourage healthcare professionals in their fight against COVID-19. With vaccinations more readily available, our Risk Management team has released *COVID-19 vaccines: Guidance for healthcare professionals* to aid medical practices steering through these extraordinary times.**

**Read more at visit [ismie.com/vaccines](https://ismie.com/vaccines).**

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# Highlights from the 2020-2021 ICAAP Flu and COVID-19 Vaccination Campaigns

**KATHY SANABRIA**, MBA, PMP, ICAAP ASSOCIATE EXECUTIVE DIRECTOR AND  
**SUZI MONTASIR**, MPH, CONSULTANT

## Avoiding a Twindemic – ICAAP’s 2020-2021 Flu Immunization Campaign

Last fall, ICAAP, in partnership with the Illinois Department of Public Health (IDPH) and the Chicago Department of Public Health (CDPH) initiated a flu immunization campaign as the country watched and waited to see how the 2020-2021 flu season would play out during the time of COVID-19. Given the potential for a “twindemic” with both viruses circulating at the same time, public health and medical professionals stressed the importance of the flu vaccine this past flu season. An estimated 22,000 people in the U.S. died due to influenza during the 2019-2020 flu season<sup>1</sup> and studies have shown flu vaccination reduced the risk of flu-associated death by over half among children with underlying high-risk medical conditions and by nearly two-thirds (65%) among healthy children.<sup>2</sup> Despite these statistics, during the 2019-2020 flu season, flu vaccine coverage in Illinois was only about 60.5% for children, leaving many still at risk.<sup>3</sup> With the goal of giving Illinois families a better chance of avoiding the flu, ICAAP worked on the following activities to promote the flu vaccine:

- Eliciting and distributing strategies from Illinois providers in terms of how they were planning to increase flu vaccine uptake this year.
- Working with Edelman (public relations firm)



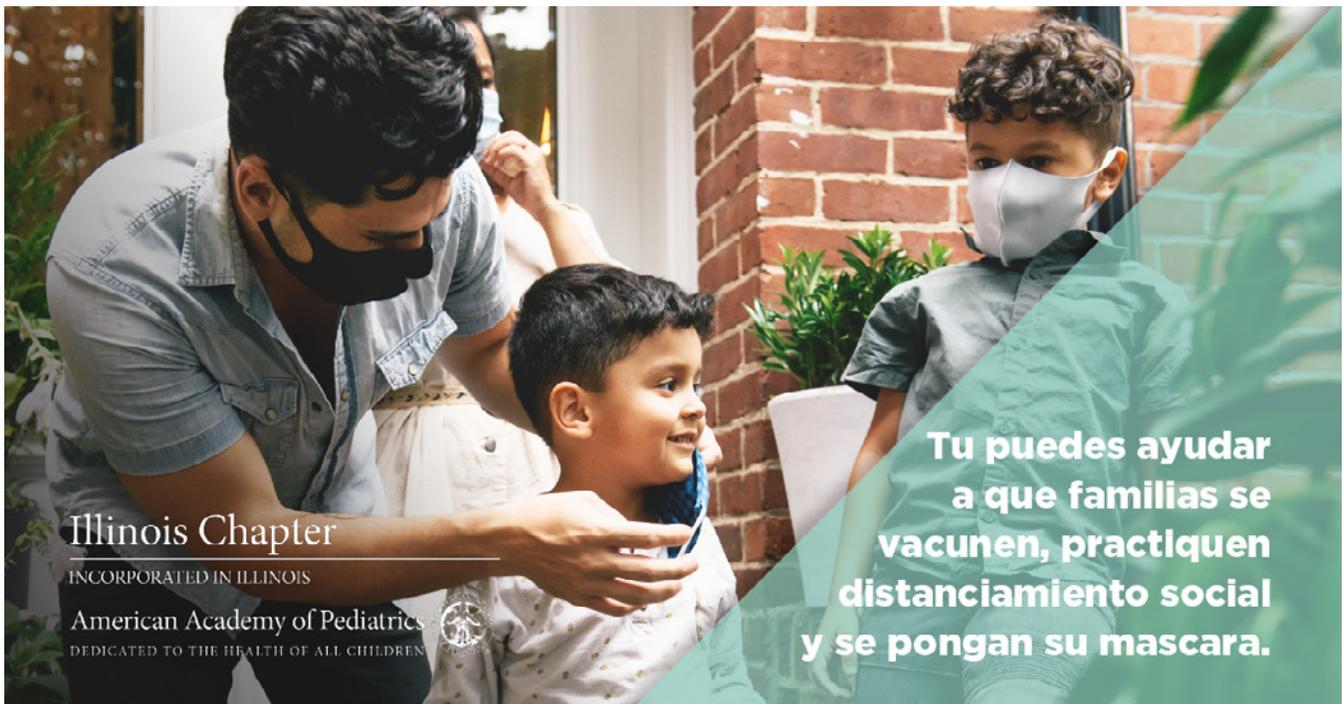
Poster mailed to Illinois providers

to launch livestream flu vaccine promotion messages targeting parents via Spotify.

- Launching the Flu Immunization Campaign page on ICAAP’s website (<https://illinoisAAP.org/flu-immunization-campaign/>), listing resources for both providers and families as well as social media messages and images available for use.
- Launching a LinkedIn campaign targeting pediatric providers in Illinois to access resources on ICAAP’s website to help strengthen the ability of Illinois providers to encourage flu vaccination as well as set up flu vaccination clinics safely during the COVID-19 pandemic.
- Mailing the latest guidance and resources directly to Illinois providers to support the uptake of flu vaccine in their clinics.

## Preparing for what’s Next – ICAAP’s 2021 COVID-19 Immunization Campaign

With the availability of multiple COVID-19 vaccines and clinical trials including children underway, it has



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Tu puedes ayudar  
a que familias se  
vacunen, practiquen  
distanciamiento social  
y se pongan su mascara.

become increasingly important for pediatric providers to stay connected to efforts for promotion of COVID-19 vaccines, so that families can be prepared once vaccines become available to them. In collaboration with IDPH and CDPH, ICAAP also developed a COVID-19 immunization campaign to provide resources and information to Illinois providers and families. As a part of the ICAAP COVID-19 Immunization Campaign, the following efforts were taken:

The ICAAP COVID-19 Immunization Campaign page was launched on ICAAP's website (<https://illinoisap.org/covid19-immunization-campaign/>), listing resources for both providers and families as well as social media messages and downloadable posters for use in practices to promote the COVID-19 vaccine as well as other public health measures to prevent the spread of COVID-19.

Similar to what was done for flu, a LinkedIn campaign, targeting pediatric providers in IL, was created to direct folks to COVID-19 vaccination resources on ICAAP's website.

A mailer was sent directly to Illinois providers including the latest guidance on COVID-19 vaccinations and resources for practices (e.g. ACIP schedules, COVID-19 posters, and stickers).

ICAAP continues to partner with others from around the state that are working hard to prepare the public to accept

one of the COVID-19 vaccines, while remaining vigilant with other public health measures to prevent the further spread of COVID-19 and its variants. ICAAP will continue to update content on our website (<https://illinoisap.org>) as more information becomes available, especially as it relates to COVID-19 vaccines for younger children.

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2. <https://pediatrics.aappublications.org/content/139/5/e20164244>
3. <https://www.cdc.gov/flu/fluview/coverage-1920estimates.htm>

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# Highlights of the AAP 2021 Virtual Advocacy Conference

TAMELA MILAN-ALEXANDER, ICAAP FAMILY  
NETWORK LIAISON



I am the family liaison for ICAAP and had the opportunity to join dedicated pediatricians and others who attended the 2021 AAP Advocacy Conference

to showcase the importance of childhood health issues that impact the work of strengthening families across Illinois. This year the virtual conference took place April 11-13, 2021. As a parent liaison, it is not often that we can collaborate on such ventures, so it was most empowering to add to the dialogue to improve the health of our children. Pediatricians and pediatric trainees from across the country attended advocacy skills-building workshops, heard from distinguished guest speakers, and learned

**Pediatricians and pediatric trainees from across the country attended advocacy skills-building workshops, heard from distinguished guest speakers, and learned about policy priorities impacting children.**

about policy priorities impacting children. On the final day of the conference, participants joined other attendees from their state to attend virtual meetings with their congressional offices to discuss a key child health issue.

While we had limited time during the conference, we didn't feel rushed. And even though I am not a pediatrician, to share how vaccine hesitancy is impacting my particular community on the West Side of Chicago felt like it resonated throughout the presentation because of the disproportionate impact of vaccine access and hesitancy in black and brown communities. I was proud to be given a speaking place to drive home how important it is to serve and connect with those communities, as well as not being a bystander when given the opportunity to share my voice and concerns. I felt like our group was a well-oiled machine in our task to convey the message we had, and to be a part of it was one of the highlights of my promise to give. I also enjoyed Stacy Abrams' presentation and learning that we must educate, advocate, and agitate; so thank you, ICAAP, for letting me do it all.

Sincerely,

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*NOTE: ICAAP extends thanks and appreciation to Ms. Tamela Milan-Alexander for serving as ICAAP's Family Network Liaison and attending the AAP 2021 Virtual Advocacy Conference and ICAAP's Educational Seminars held in June 2021. Tamela's participation at these conferences was supported by a mini-grant from the AAP Family Network initiative.*

## The American Academy of Pediatrics Advocacy Conference – formerly named the Legislative Conference – took place virtually April 11-13, 2021.

### This year's conference learning objectives included:

- Learn what it means to be an effective child health advocate from your home state, especially when these efforts are virtual.
- Hear firsthand from guest speakers and child health policy experts.
- Learn about policy priorities impacting children and pediatricians.
- Build your advocacy skills with workshops based on your interests.
- Meet with your congressional offices and their staff.
- Network with other advocates and AAP leaders from across the country.
- Attend programming created specifically for pediatric medical and surgical subspecialists.

Be sure to check the AAP website early next year to learn about the 2022 conference learning objectives.

Graphics courtesy AAP

### Advocacy Conference by the numbers

More than **720** attendees from all **50** states, Washington, D.C., and Puerto Rico

**290** pediatric subspecialists

**281** trainees

**54** state delegation leaders

More than **360** virtual Capitol Hill visits



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**ADVOCACY**  
CONFERENCE 2021

AMERICAN ACADEMY OF PEDIATRICS  
AAP.ORG/ADCON #AAPADVOCACY2021

APRIL 11-13, 2021

# THIS IS ICAAP

Illinois Chapter, American Academy of Pediatrics  
supports our 2,000+ members....but we also do so much more.



## EARLY CHILDHOOD

Connecting families to early childhood programs and resources



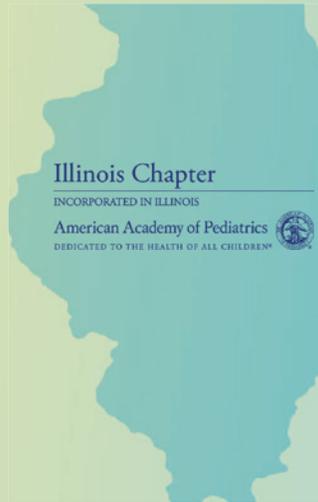
## EDUCATION

Hosting educational conferences, workshops, and networking events



## ADVOCACY

Testifying at countless hearings and lobbying statewide for improvements



## MEDICAID POLICY

Serving as a recognized statewide leader in Medicaid Policy



## IMMIGRANTS

Supporting immigrant children with physician training



## CHILD HOMELESSNESS

Advocating for more improvements to reverse child homelessness



Membership dues only fund 20% of ICAAP's critical work. Make a donation to support ICAAP and make children a priority in Illinois.

[illinoisAAP.com](http://illinoisAAP.com)



# Understanding Quality Improvement from a Payer Perspective

WILLIAM A FRESE, MD, MPH, FAAP

ASSISTANT PROFESSOR, UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE, HOSPITAL, & HEALTH SCIENCES SYSTEM, STRATEGIC MEDICAL DIRECTOR, BLUE CROSS AND BLUE SHIELD OF ILLINOIS

When thinking about Quality Improvement (QI), chances are considering it from a payer lens is not the first thing that comes to mind. However, in this era of shared-risk, accountable care, and value-based contracting, understanding QI from a payer perspective is essential towards practices achieving a successful business model. Understanding what payers may commonly call QI, but may more-simply be considered “performance benchmarking”, is important for its impact upon payment, publicly-reported performance, potential

patient referrals, corrective action, or even removal from a payer’s network if performance is persistently concerning. This article aims to provide a high-level understanding of QI from a payer perspective, plus offer practical considerations for improvement.

## Why Payers Engage Providers in QI

Like any consumer-driven business sector, payers must compete among each other to sell their various

private, public, and exchange health insurance products. Consumers have come to expect healthcare payers not only to process and pay claims efficiently, but also to be more accountable in assuring their provider networks meet certain clinical quality and customer satisfaction standards. While beyond this article's scope to fully detail, depending on the insurance product, payers must meet certain QI and consumer satisfaction accreditation and/or public reporting requirements before an insurance product can be sold to consumers, plus as a way for consumers to compare health plan performance. The care provided by

a payer's provider network is a key component to health plans' ability to maintain a "market edge", which partly is why payers enfold various payment and risk incentives around these measures into provider contracting.

### Common QI Metrics

The Consumer Assessment of Health Plan Survey (CAHPS®) and Healthcare Effectiveness Data and Information Set (HEDIS®) are perhaps two more-utilized data sets available that payers enfold select measures into provider contracting to drive performance. Both generally provide

Commonly Reported Pediatric and Adolescent HEDIS® Measures*	
Measure Name (Abbreviation)	Measure Description
Well-Child Visits in the First 30 Months of Life (W30) <sup>1,3</sup>	The percentage of children who turned fifteen months old and had six or more well-child visits, or who turned 30 months old and had two or more well-child visits during the past fifteen months.
Child and Adolescent Well-Care Visits (WCV) <sup>1,4</sup>	The percentage of children and adults ages 3–21 years who had at least one comprehensive well-care visit.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (WCC) <sup>2,5</sup>	The percentage of children age 3–17 years who had an outpatient visit and evidence of BMI percentile documentation, counseling for nutrition, and/or counseling for physical activity.
Lead Screening in Children (LSC) <sup>2</sup>	The percentage of children who had one or more tests for lead poisoning by two years of age.
Chlamydia Screening in Women (CHL) <sup>1,5</sup>	The percentage of females age 16–24 years who were identified as sexually active and who had at least one chlamydia screen.
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) <sup>1,6</sup>	The percentage of females age 16–20 years who were screened unnecessarily for cervical cancer.
Childhood Immunization Status; Combination 10 (CIS) <sup>2,5</sup>	The percentage of children who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by age two years.
Immunizations for Adolescents; Combination 2 (IMA) <sup>2,5</sup>	The percentage of adolescents who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap), and completed the human papillomavirus (HPV) vaccine series by age thirteen years.
Appropriate Testing for Pharyngitis (CWP) <sup>1,5</sup>	The percentage of episodes for children three or more years old who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test.
Appropriate Treatment for Upper Respiratory Infection (URI) <sup>1,5,7</sup>	The percentage of children three or more months with a diagnosis of upper respiratory infection that did not result in an antibiotic-dispensing event.

a common standard to compare health plans and provider networks. CAHPS® generally focuses on enrollees' consumer experiences with health plans, measuring items such as patient satisfaction with providers, access to care, and other customer service-related items.<sup>1</sup> HEDIS® is a set of 90 quality indicators that focuses more on clinical care and service performance.<sup>2</sup> These and other databases have both unique and overlapping measures, and so it's important to understand similar-sounding measures between measure-sets may be calculated differently.

Accessing and understanding datasets' technical specifications, which are available for free or purchase, is therefore key to mastering the many nuances regarding measures' specific eligible populations, measurement time-frames, exclusions, administrative versus hybrid specifications, criteria for supporting medical record documentation, and other requirements.<sup>3</sup> For example, administrative measures use only claims in their performance calculations, and so accurate billing of ICDs and CPTs is as important as clinical performance. Additionally, a common source of confusion for clinicians

Commonly Reported Pediatric and Adolescent HEDIS® Measures*	
Measure Name (Abbreviation)	Measure Description
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) <sup>1,5,7</sup>	The percentage of episodes for children three or more months with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic-dispensing event.
Asthma Medication Ratio (AMR) <sup>1,5</sup>	The percentage of children and adults age 5–64 years who were identified as having persistent asthma and had a ratio of controller to total asthma medications of 0.50 or greater.
Follow-Up Care for Children Prescribed ADHD Medication (ADD) <sup>1,5</sup>	The percentage of children age 6-12 years with a prescription for ADHD medication and one follow-up visit 30 days after the prescription, with two additional visits during the next nine months.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) <sup>1,5</sup>	The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization, telehealth or medication treatment within fourteen days of the diagnosis, and remained engaged in ongoing AOD treatment within 34 days of the initiation visit.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) <sup>1,5</sup>	The percentage of children and adolescents age 1–17 years who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) <sup>1,5</sup>	The percentage of children and adolescents age 1–17 years who had two or more antipsychotic prescriptions and had one blood glucose and one cholesterol test.
<p>*Refer to HEDIS® Technical Specifications for a full, more complete description of measures.<sup>3</sup></p> <ol style="list-style-type: none"> <li>Administrative-only measure.</li> <li>Can be calculated as an administrative or hybrid measure.</li> <li>This measure was updated in 2021 to include different sub-measures that assess visits in the first &lt;15 and 15-30 months of life.</li> <li>This measure was updated in 2021 to combine previous adolescent and well-child care ages 3-6 years measures, plus include 7-11 year age groups.</li> <li>Includes sub-measures that focus on specific performance and/or age-groups.</li> <li>Contrary to most other indicators, rates closer to zero are desirable.</li> <li>This measure is reported as an inverted rate in (i.e. indicator reports on absence of antibiotic prescribing).</li> </ol>	

leveraging these datasets is to keep in mind that some measures may be subtly different from clinical care guidelines (i.e. childhood vaccine requirements related to HEDIS® are slightly different than ACIP's vaccine recommendations for the same age).

The following table lists common HEDIS measures that variably appear in provider contracting. Additional measures for tonsillectomy, cholecystectomy, bariatric, and other procedures are also available.

## Recommendations for Improving Performance:

**Understand Payer Contracts.** Become familiar with contracted performance and risk-based measures; payers include different measures, benchmarks, and payment they wish to push in a given contract cycle that may change. Also consider creating a practice-specific dashboard of all payer measures, distilling related/common measures into common-denominator performance goals.

**Be a Bench-marker too.** In addition to any individual and/or medical group-specific public performance reporting offered by payers, regularly access Quality Rating System (QRS) and National Committee on Quality Assurance (NCQA) reporting for contracted payers and products as these resources offer not only helpful feedback of one's own performance, but also a gauge of what payers and credentialing entities consider important, and where future contracting pushes may occur.<sup>4,5</sup> Additionally, Quality Compass® offers performance percentile rates for HEDIS® measures by select products (i.e. HMO, PPO, and etc.), region, state, and nationally that is helpful for both internal practice, broader network, and payer performance comparisons.<sup>6</sup>

**Work your List.** Some payers provide lists of empaneled and attributed patients. Review these lists for accuracy, ensuring patients are actively part of the practice. Work with payers to update lists as necessary. Additionally, depending on the product and payer, some payers will provide regular patient gap reporting. Proactively review these lists, cross-checking with patients' medical records, outreaching patients with confirmed gaps, and reconciling lists with payers for any closed/incorrect ones.

**Divide and Conquer.** It's unlikely any practice can put full, equal energy into all contracted/dashboard measures. Prioritize contracting payment, risk, and other considerations to strategically focus on measures that may offer more payment and/or are easier to close margins. Additionally, leverage and focus on above lists for patient outreach campaigns.

**Educate Providers.** Make a point to not only teach about contracted measure specifications, but especially for claims-based HEDIS® administrative measures sometimes performance issues are more about "billing and coding" issues than clinical performance; doing audits can help figure out root causes. In addition to technical specification, many payers offer provider QI educational tools and resources.

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# The Lingering Long COVID-19

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Since the pandemic started, our focus was on the acute, inpatient setting of COVID-19 illness.

Healthcare providers all started with the same level of awareness and knowledge; the world was hit hard. Initially, we were not seeing children affected by the virus. Now, data has evolved, and Multisystem Inflammatory Syndrome in Children (MIS-C) due to COVID-19 disease can be managed with good outcomes.<sup>1</sup>

On another note, even months after vaccination roll-out, we are seeing COVID-19 positive mothers suffering from COVID-19 pneumonia and being put on extracorporeal

membrane oxygenation (ECMO), leading to premature deliveries.<sup>2</sup> We have seen teenagers being ventilated longer than expected. Children with full blown MIS-C are being seen for repeat visits in the emergency departments. We have made recent strides and now children 12-15 years of age are being vaccinated.<sup>1</sup> But, even with “light at the end of the tunnel,” and as the nation begins to reopen completely, the devastation is still very much present.

Now, we are seeing patients who are not returning to their usual state of health following acute COVID-19 illness. Patients, including young people who were previously healthy before SARS-CoV-2 infection, are reporting

symptoms lasting several months after acute illness. In a study of university students, 51% of participants who contracted COVID-19 infection experienced symptoms for  $\geq 28$  days. Symptoms included exercise intolerance, dyspnea, chest pain, chemosensory impairment, lymphadenopathy, rhinitis, and appetite loss.<sup>3</sup>

The interim terminology for this symptomatology is deemed “Post-Acute Covid-19 Syndrome (PACS)” also known as, Long COVID-19.<sup>1</sup> There is no clearly delineated consensus definition.<sup>1,4</sup> For the purpose of this writing, we will refer to this group of patients as having Long COVID-19, of which we know very little about their management in the outpatient setting. These symptoms may help differentiate Long COVID-19 from other general symptoms people have experienced during the pandemic.

Although we have certainly made significant progress in understanding acute COVID-19 infection and its complications in children, we continue to find new aspects of its clinical picture. Lately, long COVID-19 is becoming more relevant. It is estimated that 80% of COVID-19 infections are associated with a mild or asymptomatic course, 15% are severe, and 5% are critical infections. In those with mild disease, symptoms usually resolve within two weeks.<sup>5</sup> The National Institute for Health and Care Excellence (NICE) guideline on Long COVID-19 states that Long COVID-19 is thought to

**Recent data demonstrated a prolonged cognitive dysfunction, even in patients with a mild COVID-19 course that did not require hospitalization.<sup>12</sup> This could potentially be of significant concern in the pediatric population, where the majority of patients are asymptomatic or experience mild symptoms.<sup>12</sup>**

## Reported symptoms of long COVID-19

- FATIGUE
- HEADACHES
- LOW GRADE FEVERS
- COUGH
- SHORTNESS OF BREATH
- CHEST PAIN
- PALPITATIONS
- MOOD SWINGS
- DEPRESSION
- TINGLING SENSATIONS
- ANOSMIA
- RASHES AND THROMBOEMBOLIC EVENTS
- BRAIN FOG



occur in about 10% of infected people, and defines the condition as “signs and symptoms that develop during or following an infection consistent with COVID-19 and which continue for more than four weeks and are not explained by an alternative diagnosis.”<sup>6</sup> Additionally, some authors suggest that a positive COVID test should not be required for diagnosis, as testing availability was initially limited, and false negative tests are possible.<sup>7</sup>

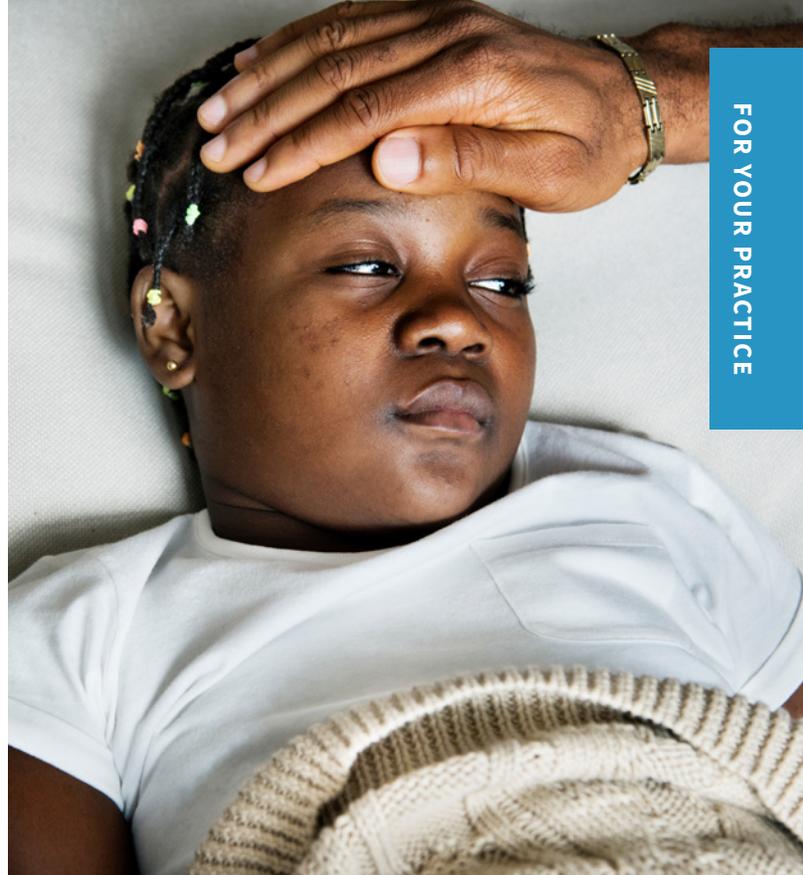
Available reports describe a variety of symptoms ranging from more persistent ones, such as fatigue, to intermittent headaches, low grade fevers, cough, shortness of breath, chest pain, palpitations, mood swings, depression, tingling sensations, anosmia, rashes and thromboembolic events.<sup>6-9</sup> A persistent cognitive impairment, sometimes referred to as “brain fog”, has also been frequently reported.<sup>10,11</sup> It has been previously described that hospitalizations requiring mechanical ventilation for a variety of causes are associated with a persistent cognitive impairment.<sup>10,11</sup> However, recent data demonstrated a prolonged cognitive dysfunction, even in patients with a mild COVID-19 course that did not require hospitalization.<sup>12</sup> This could potentially be of significant concern in the

**The patients had a median age of twelve years,<sup>13-16</sup> and were experiencing persistent symptoms over two months following their COVID-19 clinical diagnosis by their primary care physician.**

pediatric population, where the majority of patients are asymptomatic or experience mild symptoms.<sup>12</sup>

The data on Long COVID-19 in children are very limited. One of the first reports by Ludvigsson described prolonged symptoms following COVID-19 infection in five Swedish children with a systematic literature review.<sup>13</sup> The patients had a median age of twelve years,<sup>13-16</sup> and were experiencing persistent symptoms over two months following their COVID-19 clinical diagnosis by their primary care physician. The two most common symptoms reported two months following the initial diagnosis were fatigue and dyspnea, followed by headaches, dizziness, muscle weakness, and problems with concentration.<sup>13</sup> The patients also reported abdominal pain, memory problems, depression, and rashes. This broad clinical picture is consistent with the one described in adults. Additionally, the author points out that the affected children had not been able to return to school full time six to eight months following acute infection. This raises concern about how Long COVID-19 could potentially impact education, especially in a time when many countries continue to encourage remote learning. In our personal clinical experiences, virtual learning has been a struggle even for children without the burden of pre-existing health conditions.

A more recent study by Buonsenso and colleagues analyzed symptoms in a much larger group of Italian children (n=129) with a mean age of 11 +/- 4.4 years who had microbiologically confirmed SARS-CoV-2 infection.<sup>14</sup> After an average of 162.5 days, 41.8% of children fully recovered, and 58.2% had at least one persistent symptom, with 22.5% reporting three or more



symptoms. The most commonly reported symptoms included anosmia, respiratory symptoms, congestion, fatigue, muscle pain, and difficulties with concentration. An important finding of this study is that even children with asymptomatic or mild COVID-19 infection, which constituted the majority of the cohort, developed symptoms persisting >60 days following initial infection.<sup>14</sup>

More data are still needed to identify the most frequent symptoms and management strategies for long COVID in children. The available literature focusing on adult patients suggests system-based management, with a strong emphasis on formulating individualized treatment plans and providing validation to individual patient symptoms and experiences.<sup>7,17</sup> Patients with

**Even children with asymptomatic or mild COVID-19 infection, which constituted the majority of the cohort, developed symptoms persisting >60 days following initial infection.<sup>14</sup>**

chronic cough and shortness of breath could benefit from breathing exercises, and should be referred to pulmonary specialists when symptoms become debilitating.<sup>5,15</sup> The NICE guideline also recommend that a chest radiograph should be obtained in patients with respiratory symptoms if still present twelve weeks after acute infection.<sup>6</sup> Pain and persistent fevers can be managed with analgesics and clinical reassessment.<sup>7</sup> Chronic anosmia could potentially be improved with “olfactory training,” which involves repeated sniffing of a set of odorants for at least three months.<sup>15</sup> For chronic fatigue, authors suggest low intensity exercise and stress management, with involvement of mental health professionals if necessary.<sup>7,17</sup> Cognitive behavioral therapy, memory training, and occupational therapy have also been listed as potentially useful interventions.<sup>16,17</sup>

With the clinical information we currently have, Long COVID should be on the differential diagnosis for similar presentations. The nation is starting to establish Post-Acute COVID-19 care clinics at medical centers to bring together multidisciplinary teams to provide comprehensive and coordinated treatment for COVID-19 aftercare. Multi-year studies will be warranted for post COVID-19 conditions in all age groups.<sup>18</sup> The National Institutes of Health (NIH) will invest \$1 billion to study Long COVID in all age groups as well.<sup>19</sup> We will revisit the topic as more data are gathered and published. Stay tuned for an update.

## NICE Guidelines for Long COVID-19

SYMPTOMS	TREATMENT
chronic cough and shortness of breath	breathing exercises, refer to pulmonary specialists when symptoms become debilitating <sup>5,15</sup>
pain and persistent fevers	analgesics and clinical reassessment <sup>7</sup>
chronic anosmia	olfactory training
chronic fatigue	low intensity exercise and stress management; if necessary, cognitive behavioral therapy, memory training, and occupational therapy <sup>16,17</sup>

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## VISIT THE AAP COVID-19 PAGE FOR THE LATEST INFORMATION

Visit the COVID-19 vaccine for children page on [AAP.org](https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/covid-19-vaccine-for-children) to find guidance on vaccine implementation, coding information, educational resources for clinicians and families, an FAQ, and more.

<https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/covid-19-vaccine-for-children>

For questions or comments related to the pandemic, email [COVID-19@aap.org](mailto:COVID-19@aap.org).





# Pediatric Travel During the COVID-19 Pandemic: How to Manage Traveling Safely with Unvaccinated Children?

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*Note: Article written June 18, 2021. Some CDC guidance may have changed since this article was submitted for publication. Please check the CDC website for the latest travel information.*  
<https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>

With the school year finished and COVID-19 vaccine availability is expanding to individuals twelve years of age and older, there is light at the end of the tunnel. In the U.S., COVID-19 infections are decreasing as more individuals are receiving COVID-19 vaccines. The Centers for Disease Control and Prevention (CDC) has announced that individuals who are fully immunized can resume domestic travel. These individuals don't need to get tested before or after travel or self-quarantine when they get to their destination. For individuals who

are not immunized, the CDC recommends delaying travel until you are able to get fully vaccinated. If you are not fully immunized, individuals need to keep taking all precautions until you are fully vaccinated.

If your child is unvaccinated, he or she should:

- Wear a mask over their nose and mouth in public.
- Avoid crowds and stay at least 6 feet/2 meters (about two arm lengths) from anyone who is not traveling with you.
- Wash hands often or use hand sanitizer with at least 60% alcohol.

As a parent and a pediatric provider, I am looking forward to taking a break and leaving my house to have a vacation. My husband and I are fully vaccinated, but we have a three-year-old and five-year-old that are not vaccinated and will not be until a COVID-19 vaccine is approved later this year. I am looking forward to having a small break and need it for my mental health. As pediatric providers, we need to acknowledge that families may decide to travel this summer. We need to be prepared to educate parents on how to reduce risk, prevent illness, and maintain safety while traveling. When I see patients and parents, I am using the visit to assess if they will be traveling. If they are, I use the opportunity

**Because there is not a COVID-19 vaccine [approved for children under the age of 12], masks are the only way to protect them from COVID-19 infection.**

to discuss their plans to reduce COVID-19 transmission and make sure they are up to date with routine vaccines such as the Hepatitis A and Influenza vaccines.

At the visit, I am educating my unvaccinated patients that currently there is not an approved COVID-19 vaccine for children under the age of twelve. Because there is not a COVID-19 vaccine, masks are the only way to protect them from COVID-19 infection. It is important to recognize that children may find these rules unfair and we need to acknowledge their feelings and answer any questions. I use this time to educate them that as soon as the pediatric COVID-19 vaccine has been reviewed and approved it will be their turn and they need to be ready to get the shot.

**Figure 1: Coronavirus Disease 2019 (COVID-19)**

Domestic Travel RECOMMENDATIONS AND REQUIREMENTS	Not Vaccinated		Fully Vaccinated	
Get tested 1-3 days before travel	✓			
Get tested 3-5 days after travel and self-quarantine for 7 days. Self-quarantine for 10 days if you don't get tested.	✓			
Self-monitor for symptoms	✓		✓	
Wear a mask and take other precautions during travel	✓		✓	

**During travel, vaccinated and unvaccinated individuals still need to wear a mask over their nose and mouth while on planes, buses, trains, and other forms of public transportation traveling into, within, or out of the United States and in U.S. transportation hubs such as airports and stations—whether you are vaccinated or not.**

If families are traveling, I encourage parents to have a plan on how their family will handle masking with parents being vaccinated while children less than twelve are not. I inform my patients that even though I am vaccinated that

I will be wearing my mask out in public to model mask wearing behavior to support my unvaccinated children.

If parents do decide to travel they need to be aware of CDC recommendations for domestic and international travel. Parents need to know if they are traveling internationally that there are more requirements around testing before, during, and after returning home. Parents need to be prepared if any of their family members would test positive for COVID-19 prior or during travel as this may significantly disrupt travel plans. If a family member were to be found to be COVID-19 positive while abroad, they would need to quarantine and would be unable to return home for seven to ten days or until symptoms are resolved. Parents need to be prepared to have back up plans, additional funds, and potentially the ability to work remotely while abroad. I would encourage families who are traveling internationally to consider getting traveler's insurance and make sure these disruptions would be covered. Parents should check if their employer would allow for work to occur while abroad.

During travel, vaccinated and unvaccinated individuals still need to wear a mask over their nose and mouth while on planes, buses, trains, and other forms of public

**Figure 2: Coronavirus Disease 2019 (COVID-19)**

International Travel RECOMMENDATIONS AND REQUIREMENTS	Not Vaccinated	Fully Vaccinated
Get tested 1-3 days before traveling out of the US	✓	
Mandatory test required before flying to US	✓	✓
Get tested 3-5 days after travel	✓	✓
Self-quarantine after travel for 7 days with a negative test or 10 days without a test	✓	
Self-monitor for symptoms	✓	✓
Wear a mask and take other precautions during travel	✓	✓

transportation traveling into, within, or out of the United States and in U.S. transportation hubs such as airports and stations—whether you are vaccinated or not.

### Listed below are the CDC travel recommendations for unvaccinated travelers:

#### Visiting Individuals

- Try to only have contact with just members of your household.
- Try to have contact with only fully vaccinated people.
- When taking short road trips try to limit stops along the way to decrease exposure to unvaccinated individuals.
- If families must fly, try to take direct flights or flights with the fewest stops or layovers.
- When families are traveling try to avoid crowds.

#### Accommodations

- Stay in a house or cabin (for example a vacation rental) with people from your household or fully vaccinated people.
- Try to use contactless check-in.
- Only visit a fully vaccinated family member's or friend's home.

#### Restaurants/Food

- Bring your own food and drinks.
- Get takeout.
- Use drive-thru, delivery, and curbside pick-up options and wear a mask when interacting with restaurant employees.
- If you must eat at a restaurant try to eat outside.
- If families are traveling internationally they need to make sure that they know COVID-19 requirements for entry, testing, and quarantining for their destination. Figures 1 and 2 are CDC guidelines regarding COVID-19 testing and quarantine for both domestic and international travel.

In addition to being aware of COVID concerns while traveling, parents should not neglect the routine precautions that summer and travel require like safety, wearing helmets, and always using a seat



belt. We need to remember as we are outside spending more time in the sun, it is important that we all wear sunscreen and stay hydrated.

If there is anything that I have learned in the last 18 months is that anything can change and we need to try to be as prepared as possible. COVID-19 vaccines are coming to our pediatric population soon. As providers we need to talk to parents and recommend that all eligible children and adults get vaccinated so we can return to life before masks.

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# Finally! I Can Do Something About This Pandemic

**RUBEN J. RUCOBA, MD, FAAP, DIRECTOR, MEDICAL SERVICES, PEDIATRUST**

One of the best days of the pandemic, and truly one of the most gratifying days of my professional life, was the day we started giving the COVID vaccine in my practice. After more than a year of watching patients, family members, friends, neighbors, and millions more around the globe suffer from and, in many cases, succumb to COVID-19, I finally felt like I was doing something about this infernal virus.

The appreciation of the recipients, many of whom are not patients at our practice and some of whom are adults, was overwhelming. The sense of empowerment that my coworkers and I felt was palpable. The only time in the preceding thirteen months to rival that was

the day I got my first vaccine in December. On both days, there was a sense of relief, joy, gratitude, and a communal sense of celebration. It truly was a glorious feeling of victory, of being able to finally fight back.

I know that sounds hyperbolic, but it's true. For those of you who've given the shots, either at a mass vaccination site or in your office, you know I'm not exaggerating. For those who have yet to experience it, you probably will soon, as IDPH plans to enroll more primary care sites in the vaccination rollout, especially with younger age groups being included.

But I will admit, it wasn't easy getting to that day. For months, I kept looking for ways to get the vaccine

so we could distribute it to our patients. It's the perfect case of, "be careful what you wish for," the vaccine comes with a lot of complicating factors.

I'm in somewhat of a different situation than most of you: as the medical director of PediaTrust— a large, twelve-practice "supergroup" with offices in the northern, northwestern, and western suburbs of Chicago, I had to deal with five different county health departments. When the rollout of vaccine to primary care sites started in the spring, the distribution was handled by the Illinois Department of Public Health (IDPH) through the county health departments, each one with their own rules and quirks.

One county required their allotment to be given only to residents of that county, while another said it could be given to anyone as long as they were Illinois residents, and a third had no such restrictions at all. If you had a pulse, you could get the shot. Under the rules of one county, we could give the vaccine at any site we wanted, while another county demanded that the vaccine be stored overnight only in the site it was given to, which severely restricted where we could transport it and administer it in a given day.

One county, Cook, even required armed security to transport the vaccine, and they would provide this if we couldn't. I'm not sure if there was any real danger that the COVID vaccine would be hijacked (how would the vaccine thieves even know what's in the cooler in my car?) or merely leftover precautions from the days of Dillinger and Capone, but it seemed extreme. Fortunately, I never had to resort to that, but with a sheriff's deputy packing heat in the car behind me, I bet I could have made the run from the Cook County Department of Public Health to my office in record time, for sure.

It quickly became apparent that ordering, obtaining, transporting, storing, and giving the COVID vaccine is complicated and unlike any other vaccine we deal with; which makes it difficult to routinely administer in our offices when compared to, for example, the MMR vaccine. For us, mass vaccination clinics were the way to go, so that's what we did. As summer wears on, I expect we can give it in our offices in batches, but the mass vaccination clinics seem to work for us for now. As time goes on, we

will need to be more accessible and more convenient for the vaccine holdouts, and that's OK. The goal is always to get shots in arms, however we achieve that.

As part of our deal with IDPH, we had to agree to give the vaccine to community members who are not our patients. We all viewed this as a positive, as it allowed us to showcase our vaccine expertise to a much larger audience in our community, and gave us an opportunity to be part of something "bigger" and more meaningful.

But the older patients also are more likely to have serious reactions than the younger ones. Sure enough, the only real allergic reactions we saw were in adults, which presented us with some minor medical challenges. Fortunately, we never needed to call an ambulance, but we were glad we had cots, medicines, and an EMT on site when these issues arose.

I will admit, I have not been a big fan of the previous administration's efforts overall concerning this pandemic, but this is something they did right. They quickly funded the vaccine efforts, they ensured it was done safely, and they began the rollout. The current administration has continued and quickened the pace of the rollout. To both administrations, I'm very grateful. The process does work, and it gives me faith in our often criticized health system. Furthermore, this renewed public awareness of vaccines makes me proud to be a pediatrician, a member of a profession long-committed to vaccines. Now, if I can just convince those holdouts to get a vaccine. Vaccine lotto tickets, anyone?

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# Applied Behavior Analysis Provision in Early Intervention: An Underutilized Service

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Behavior analysts, the therapists who are board-certified in behavior analysis (BCBAs), are an underutilized resource in the Illinois Early Intervention (EI) system. BCBAs have received extensive didactic and practicum training on the provision of applied behavior analysis (ABA), an intervention that is frequently sought by parents of children with Autism Spectrum Disorder (ASD) because extensive research has demonstrated improved outcomes. Yet parents and health care providers — and even some early intervention service coordinators — are often unaware that ABA services can be obtained through early intervention for children with

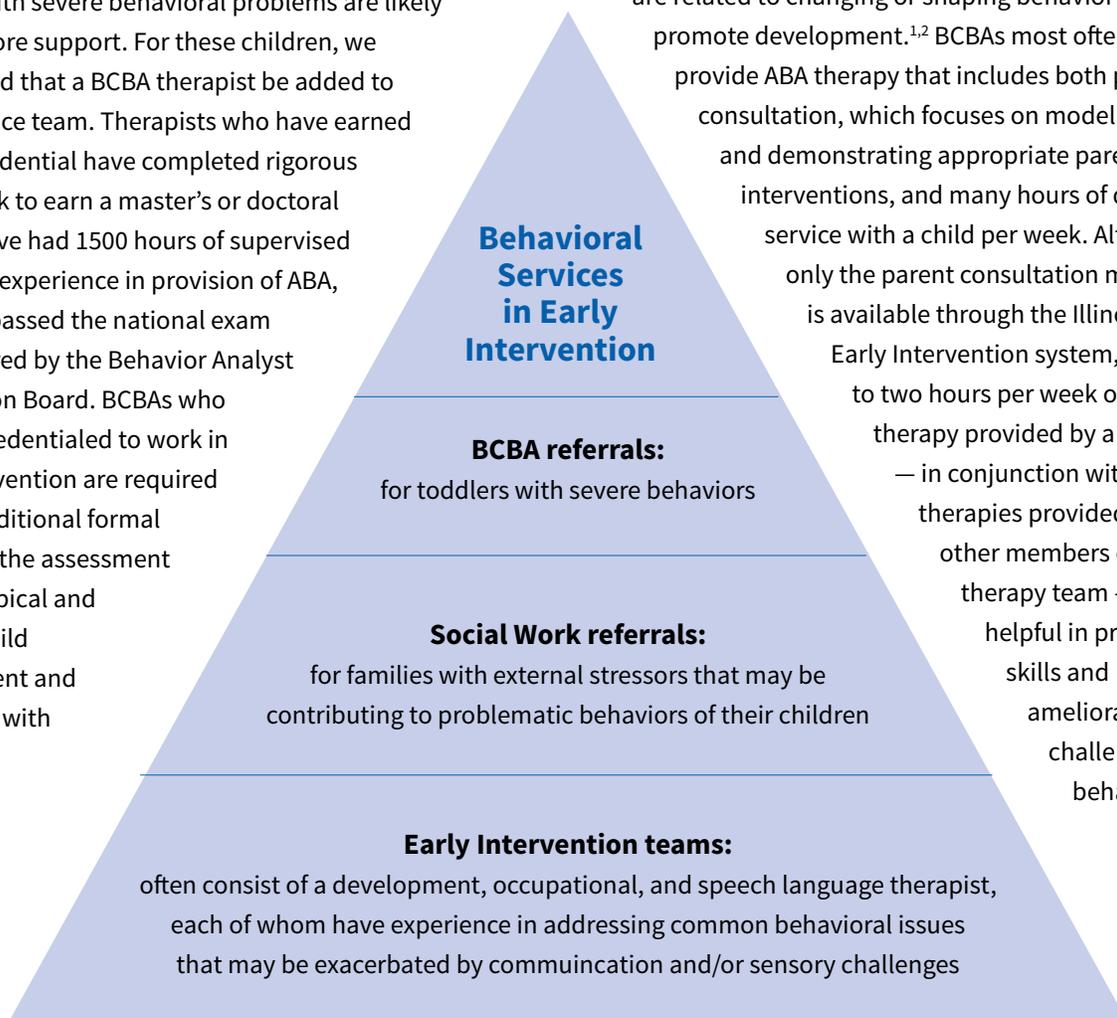
challenging behavioral concerns. And, like all therapies provided in early intervention, a medical diagnosis and/or insurance coverage is not required to receive behavior intervention services. Primary health care providers can help families of young children with challenging behaviors and developmental delays by requesting evaluation and treatment by a BCBA. Because there are still relatively few credentialed therapists within the Illinois Early Intervention system, we suggest that the recommendation for a BCBA to provide therapy be reserved for children with more challenging behaviors, such as frequent aggression, self-injurious behavior,

severe pica, elopement, and other disruptive behaviors that negatively affect global development or impede the family from participating in the community.

Pediatricians are well aware of the fact that behavioral concerns are common among young children. For children with delays and disabilities many problematic behaviors can be resolved or ameliorated by addressing developmental challenges, such as communication delays and sensory issues. The therapists most commonly utilized in early intervention — developmental, occupational, and speech-language therapists — can (and do) address many behavioral issues. Social workers are often consulted when children have behavioral concerns that are not responding to the therapies mentioned above. Social workers can be especially helpful with families who have external stressors (such as family discord), since their training in mental health and support systems can provide families with services that need to be in place as challenging behaviors are addressed. But children with severe behavioral problems are likely to need more support. For these children, we recommend that a BCBA therapist be added to the EI service team. Therapists who have earned a BCBA credential have completed rigorous coursework to earn a master's or doctoral degree, have had 1500 hours of supervised practicum experience in provision of ABA, and have passed the national exam administered by the Behavior Analyst Certification Board. CBAs who are also credentialed to work in early intervention are required to have additional formal training in the assessment of neurotypical and atypical child development and in working with families.

## What is ABA?

Applied behavior analysis (ABA), a set of principles that form the basis for many behavioral interventions, is based on the science of learning and behavior. Applied behavior analysis can help the parents and EI team understand a child's behavior, recognize how physical and social environments impact behavior, and learn what can be done to teach new skills and change behaviors. ABA principles can be used to enhance language and communication skills of a young child, decrease challenging behaviors by teaching a behavior that could replace the challenging behavior, and improve social skills, adaptive skills, and learning. ABA principles have been used for many years and have been found to be helpful for children both with and without disabilities. It is a common misconception that ABA principles and interventions are appropriate only for children with autism; in reality, these principles can be helpful for any child in EI whose functional outcomes are related to changing or shaping behavior to promote development.<sup>1,2</sup> CBAs most often provide ABA therapy that includes both parent consultation, which focuses on modeling and demonstrating appropriate parental interventions, and many hours of direct service with a child per week. Although only the parent consultation model is available through the Illinois Early Intervention system, one to two hours per week of this therapy provided by a BCBA — in conjunction with the therapies provided by other members of the EI therapy team — can be helpful in promoting skills and ameliorating challenging behaviors.



## Key takeaways:

- ABA services to help with severe challenging behavior are available in EI.
- Within the EI system, ABA is provided in a parent consultation model of one to two hours per week.
- ABA services can be obtained by requesting a behavioral evaluation by a BCBA-credentialed therapist.

Health care providers can help families obtain ABA when needed by letting parents know they can ask their EI service coordinator for a behavioral evaluation by a BCBA-credentialed therapist.

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## Worried About Your Toddler's Behavior?

Speech delays and/or sensory challenges can increase the severity of "terrible twos" behaviors such as tantruming, striking out, or running away. In these cases, an evaluation and treatment through Early Intervention can be helpful.

For children with very challenging and persistent behavior concerns, evaluation by a board-certified behavior analyst (BCBA) is advised. BCBA-credentialed therapists can provide parent consultation through early intervention.

# What Can Pediatricians Do to Help Children Get the Early Intervention Services They Need?

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Due to pandemic-related issues, Early Intervention (EI) referral and active Individual Family Service Plan (IFSP) numbers have declined (22% and 23% respectively, SFY21 vs. SFY19 averages).<sup>1</sup> What can pediatricians do to help children get the services they need?

## 1. Provide developmental screening to all young children you see.

Many children have missed previously routine opportunities for developmental screening due to COVID-19-related factors, which makes it critical for pediatricians to conduct developmental screening at every recommended visit.

- Make sure to ask about changes to children's skills during the pandemic, e.g. regression of previously acquired skills, social-emotional or behavioral concerns
- Familiarize yourself with reasons to refer & learn about the diagnoses that make children automatically eligible for Early Intervention. Get the list of eligible diagnoses by visiting ICAAP's website and accessing the ICAAP Early Intervention Toolkit [illinoisicaap.org/early-intervention/](https://illinoisicaap.org/early-intervention/). Or, you can find this information by visiting the Illinois Department of Human Services Early Intervention website here: <https://www.dhs.state.il.us/page.aspx?item=96962>

## Milestone Checklists

How a child plays, learns, speaks, acts, and moves offers important clues about his or her development. Families can use these checklists to track and celebrate their child's development and learn what to do if they ever have concerns. To learn more, visit [https://www.cdc.gov/ncbddd/actearly/pdf/checklists/Checklists-with-Tips\\_Reader\\_508.pdf](https://www.cdc.gov/ncbddd/actearly/pdf/checklists/Checklists-with-Tips_Reader_508.pdf)

## 2. Who should be referred to Early Intervention?

- Children ages 0-3 with diagnoses that make them automatically eligible for EI.
- Children ages 0-3 with NICU stays.
- Children ages 0-3 with parents who have a mental health concern or a developmental disability.
- Children ages 0-3 found to have high levels of lead.
- Children 0-3 years of age with a delay in any of these five domains:
  - Physical (including auditory, vision, and motor)
  - Cognitive
  - Communication
  - Social and emotional
  - Adaptive

Note: A child does not need to have a diagnosis to be evaluated by EI.

### 3. Talk to families about the importance of monitoring development and the impact of early interventions to promote their child's best health and well-being.

- Provide the CDC's "Learn the Signs. Act Early." educational materials starting at birth to help parents understand their child's development and identify concerns (see side box for more info).
- Stress the importance of intervening before age three to take advantage of the brain's early neuroplasticity and not to wait once a delay is identified.
- Consider helping family prioritize needed therapies and address barriers to engaging services.

#### Did You Know?

- Early Intervention providers are qualified/credentialed professionals with specialized training to work with children ages birth to three with special needs.
- Early Intervention service delivery is based on a family-led, parent-coaching model.
- Services provided are determined by evaluation, family goals, and Early Intervention team recommendations and are offered in the home or by Live Video Visit, depending on determined needs.
- Live Video Visits can be effective in delivering needed therapies as well as providing parent coaching to help families gain helpful strategies for everyday living and to effectively promote

#### Conversation Starting Points for Talking to Families about Possible Delays

It's important to share your concerns with the family as clearly as possible. Focusing on strengths and family concerns/goals may help open up conversation to potential concerns. Using "I wonder" statements can also help bring up ideas about potential needs for evaluation and therapies.

Helpful phrases to start the conversation:

What are your child's strengths? Are there skills you are particularly working on?

Describe strengths, and then express concern about possible delays: "While your son has great motor skills, I am concerned that ...."

When you go to the park, how do you notice your child interacts with other children?

Are there any classes/experiences/family routines that you would like to do with your child that have been harder than expected?

Is there anything about your child's development that you'd like to talk about?

Do you have any concerns about your child's development or behavior? Do any family members or friends have concerns or questions about your child's development or behavior?

If the parent is struggling with certain daily living activities, discuss how EI may potentially partner with them to build strategies and skillsets to help daily routines and work on the family's goals, for instance:

"I really see that you want your child to enjoy mealtime together. I'm wondering about getting some input from people who have some experience in feeding and sensory processing to help your family enjoy this time together?"

"I am hearing your concerns about these tantrums, I wonder if your child is experiencing frustration about their inability to effectively communicate wants and needs and may benefit from some support with this." Or "I wonder if we can do something to help their communication abilities?"

### Early Intervention Services Provided

- Assistive technology
- Audiology/aural rehabilitation
- Developmental therapy/special instruction
- Family training and support
- Health consultation
- Medical services (only for diagnostic or evaluation purposes)
- Nursing
- Nutrition
- Occupational therapy
- Physical therapy
- Psychological/counseling services
- Service coordination
- Sign language or cued language
- Social work
- Speech language pathology
- Transportation
- Vision
- Translation/interpretation to other languages

their child's development at home.

- Behavior therapists, including BCBAAs, work in Early Intervention to support daily living activities and address challenging behaviors in the home if that is a determined need of the family.

### Making a Quality Early Intervention Referral – Use the Illinois Early Intervention Referral Form and Explain Concerns

1. Start by clearly reviewing your concerns with the family and give specific examples of delay(s) that cause concern (see conversation starters).
2. Complete the Illinois EI Referral & Release of Information (ROI) Fax Back Form (available at [illinoisap.org/early-intervention/](https://www.illinoisap.org/early-intervention/))
3. Describe your concerns as specifically as possible on the referral form. Clearer descriptions will help the child get appropriate interventions faster. For example:
  - State whether you are concerned about a specific diagnosis.

- Describe symptoms or concerning behaviors if you are uncertain about a diagnosis (e.g., delayed speech, poor core strength, abnormal gait, or challenging tantrums).
- If you do not feel you have sufficient evidence to warrant a diagnostic concern requiring immediate discussion with the family, consider describing the core symptoms or behaviors regarding your concern. For instance, for a concern for autism you could describe: social communication delay, repetitive behaviors, language delay, self-directed interest/lack of reciprocal social engagement, difficulty with transitions, or other behavior concerns.

4. Ask parent to sign the EI consent to release of information (ROI) portion before they leave. The consent allows your office to follow up on referrals.
5. Fax the Form to the local Early Intervention office, called “Child & Family Connections” (CFC) Offices: <https://www.dhs.state.il.us/page.aspx?module=12&OfficeType=4&County=> (The CFC office is based on the family's home address) – Get the list of CFC offices above or at [illinoisap.org/early-intervention/](https://illinoisap.org/early-intervention/).

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### Access the ICAAP Early Intervention Toolkit on ICAAP's website at [illinoisap.org/early-intervention/](https://illinoisap.org/early-intervention/):

- Access the Illinois Early Intervention Referral & Release of Information (ROI) Fax Back Form
- Find Your local Child & Family Connections (Early Intervention) Offices
- List of Diagnoses that make children automatically eligible for Early Intervention services
- Info about the CDC Learn the Signs. Act Early. to give your patient families
- More conversation starters and tips to help discuss delay concerns with families

And more!



## Learn the Signs. Act Early. (LTSAE) Digital Toolkit

### Learn the Signs. Act Early. Family Materials, Co-Created by CDC and AAP

**Offer the CDC's Learn the Signs. Act Early. tools to patient families to promote family understanding of expected development because family surveillance + physician screening identifies more children with needs.**

The CDC and AAP co-created free materials for you to share with your patient families to promote family engaged developmental monitoring and help make office visit conversations easier regarding child development. Barger et al. (2018) found that when parents are educated about and involved in developmental monitoring, twice as many children are referred to EI than with just standard screening practices alone.<sup>2,3</sup>

Check out the new CDC Learn the Signs. Act Early. (LTSAE) available here: <https://www.aucd.org/docs/actearly/LTSAE%20Digital%20Toolkit.pdf>

Free Learn the Signs. Act Early. tools to share with families include:

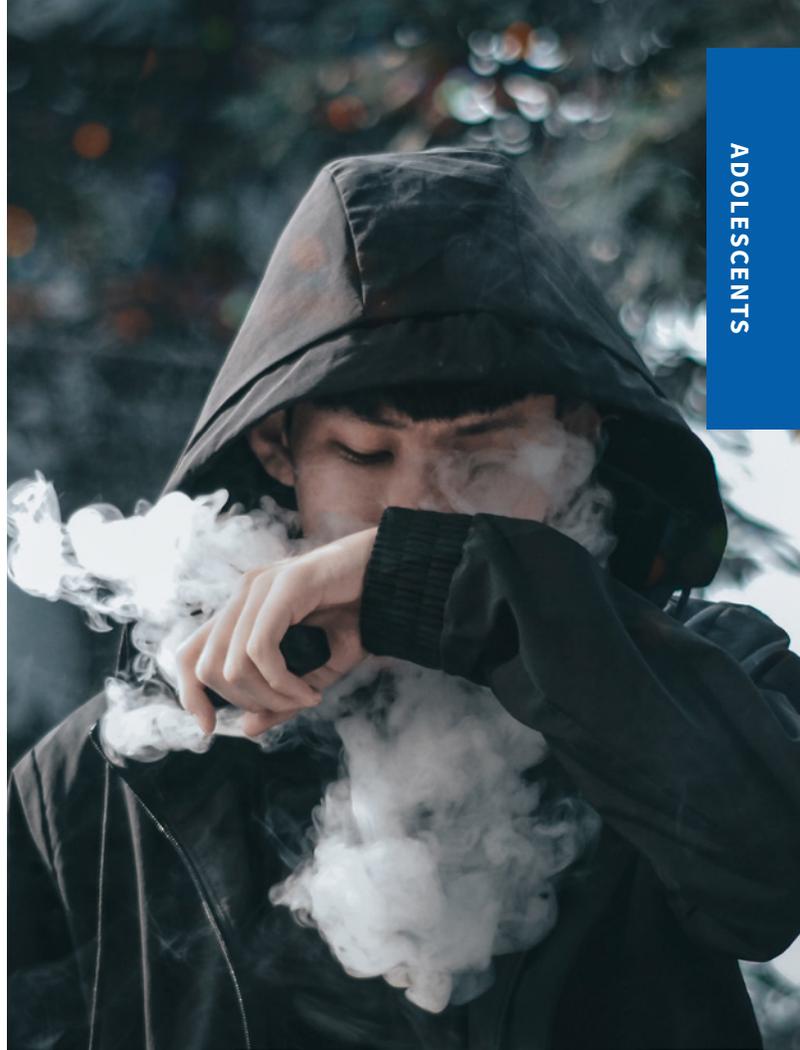
- [The Milestone Tracker App \(available in Spanish and English\)](#) helps parents track their child's development and reminds them to make their well-child visits.
- Online and printable Milestone Checklists that review expected milestones at each well child visit age.
- Online videos and in-app videos to clearly demonstrate milestone moments to parents.
- Growth charts to use at home with developmental info.
- Books for one, two, and three-year-olds promoting parent interaction and child development.
- Multiple languages are available.
- All available to order or download free at [www.cdc.gov/ActEarly](https://www.cdc.gov/ActEarly).

# Time to Revisit the Forgotten Vaping Crisis

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With more than a year of the SARS-CoV-2 pandemic behind us and the prospect of teens returning to school in person this fall, it's time to re-focus on the teen vaping public health crisis. Even during this past year, this crisis didn't go away. If we screened for e-cigarette in our patients, we would be bound to find it. We saw the teen who was more ill from COVID-19 despite not having a history of predisposing conditions or asthma. We saw the college kids who came home for remote learning and came in the office to see if we could help them quit vaping. COVID-19 didn't give pause for vaping; rather, the pandemic as well as the ensuing teen mental health crisis together accelerated the need for us to address the teen vaping public health crisis.

Let's look at some numbers. When we headed into the pandemic in 2020, data from the 2019 National Youth Tobacco Survey revealed 27.5% of high school students reported past month use of e-cigarettes. This number reflects data that more than doubled between 2017 to 2019. In addition to high rates of use among high school students, the report found that 10.5% of middle school students reported e-cigarette use as well.<sup>1</sup> More troubling was additional information from the same survey indicating that 34.2% of high school e-cigarette users and 18% of middle school users were vaping twenty or more days per month.<sup>1</sup> Lured by sleek, easy to conceal devices like JUUL with mint, fruit, and dessert flavors to disguise the harsh taste of salt-based high concentrations of nicotine, teens were rapidly becoming addicted. Teens were choosing e-cigarettes for the flavor, unaware of the harms from nicotine; according to the 2020 Monitoring The Future Survey, nearly 30% of high schoolers surveyed thought they were vaping just flavoring.<sup>2</sup>



Unfortunately, although the anecdotal data hints at the usage of vaping during the pandemic, there is a dearth of the annual information typically published. National and State data collection was cut short with the arrival of SARS-CoV-2 in 2020 as teens headed home for remote learning and sheltered in place. What we saw after a doubling of rates of vaping from 2017 to 2019 were rates holding steady in 2020 at these high levels with past year use for twelfth graders at 34.5%.<sup>2</sup> However, as flavors came under FDA regulation, there was a decrease in use of JUUL brand products and a shift to disposable devices that, exempt from flavor bans, offered teens more flavor options. In Illinois, the school shutdown in March of 2020 resulted in insufficient data collected preventing a statewide report and a City of Chicago report from being produced. E-cigarette use in the Illinois suburban population was 20% by the end of high school as compared to 36% reported in the Illinois rural population.<sup>3</sup>

Time will tell what the impact of the COVID-19 Pandemic will be on teen e-cigarette use rates. Evidence has already shown that COVID-19 diagnosis is five times more likely

among ever-users of e-cigarettes.<sup>4</sup> It is not clear what was happening with vaping use patterns while teens were remote learning. There is some suggestion that rates might have diminished with less access to devices, less time with peers, more day to day exposure to parents in the home, and fear of health outcomes from COVID-19 infection.<sup>5</sup>

With 2020 use rates continuing to sound the alarm, you might wonder what is happening with Illinois policy. In July of 2019, Tobacco 21 passed prohibiting the sale of tobacco products, including e-cigarettes, to anyone under the age of 21. In July of 2020 the Smoke Free Illinois Act was amended to include the use of alternative nicotine products and e-cigarettes in the definition of smoke or smoking. What about flavor bans in our state? In February of this year SB2282 the Flavored Electronic Cigarette Ban Act was introduced prohibiting the sale of any flavored e-cigarette or related flavor product, including prohibition of ordering, purchasing, or shipping products to a person in the state.

Despite the flavor ban, nicotine products are still making their way to our patients. Learning about these products makes you better able to take a meaningful tobacco history from your patients. Some products to keep your eye on include heat-not-burn products like the IQOS or ZYN nicotine pouches (promoted as tobacco free) and various brands of disposable e-cigarettes, which are cheaper and considered more convenient than JUUL. Similar to cartridge devices, disposables contain salt-based nicotine that delivers much higher doses of nicotine, increasing the risk of addiction.

As pediatricians, we know it is not enough to consume information about health harms affecting our teen patients — we must act in order to improve the health of our patients. With this focus on action in mind, the American Academy of Pediatrics (AAP) has developed a new E-cigarette and Vaping Curriculum that is free to access.<sup>6</sup> This comprehensive tool can serve as a guide as you take action in your own practice. Begin with acknowledging the crisis and develop a plan for routine in-office screening of all teen patients, not just older teens and young adults. For those patients who have developed nicotine dependence, learn how to provide the cessation treatment they need. Consider taking time to educate your community about the risks of youth vaping.

And finally, we can all advocate for flavor bans, higher tobacco taxes which make purchases more difficult for teens, and policies that ban the pervasive e-cigarette marketing to youth. Both the Illinois Chapter of the AAP and the AAP provide advocacy training opportunities.

As we slowly emerge from the pandemic, we are reminded of the vulnerability of our teen patients and the significant mental health burden they have borne for so many months. So let's turn our attention back to an almost forgotten but lingering teen vaping crisis so that we can maintain focus on a healthier, tobacco-free future for our patients.

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# Addressing Adolescent Health Needs Through Education, Guided Survey Results, and Toolkit

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## Overview

The Illinois Chapter of the American Academy of Pediatrics makes it a priority to address the needs of children and families through advocacy and education. When it comes to addressing health issues, behavior change and successful health outcomes, focusing specifically on adolescent health needs is a must. The transition from childhood to adulthood is one of the most dynamic but best times for engagement in human development. The rate to which physical, emotional and intellectual changes occur during adolescence is the second greatest period preceded only by infancy. As their brains and bodies shift through extensive remodeling, adolescents are making important social transitions as well. It is essential to their future health and well-being that their independence is built upon a very strong foundation that inspires them to invest in and view their future as healthy adults.

## Adolescent Health Mini-Conference Highlights

With the challenges brought on by the COVID-19 pandemic, along with the evolving needs of adolescent patients and their families, ICAAP hosted its first virtual Adolescent Health Mini-Conference on May 20, 2021. The conference



was specifically designed to provide educational tools and resources to providers and health professionals.

### Highlights from the conference included:

- **Understanding how health inequities play a role in adolescent care and how to combat them.** As presented by Dr. Felicia Scott-Wellington, health inequities that exist within the areas of Race/Ethnicity, Socioeconomic Status, Location, Gender and/or Sexual Orientation, and Age are root causes for the health disparities that exist among adolescents in the U.S. To mitigate and reduce health inequities in adolescent care, Dr. Scott-Wellington emphasized the importance of using adolescent well-child visits as an opportunity for providers to influence health and development through screening and counseling.
- **Mental health concerns among adolescents are at an all-time high due to the COVID-19 pandemic.** Dr. Elie Saltzman, licensed clinical psychologist with a specialty in children and adolescents, noted during his presentation that adolescence is a crucial developmental stage, with many neurological

changes taking place all at once. With added external pressures such as socioeconomic status, peer relationships, social media (cyberbullying etc.), adolescents can become burdened by illnesses such as anxiety, depression, and mood disorders, among others. As a care option for treatment of mental illnesses in adolescents, Dr. Saltzman provided an overview of Neurofeedback Therapy, emphasizing its natural benefits and low rates of side effects. It also shows promise for prevention of mental illness.

- **Who knew that techniques from “improv” could be used in caring for adolescent patients?** Dr. Bernice Man presented an excellent presentation on the usefulness of how improvisational theater is beneficial in the healthcare setting. Improv is a form of theater that does not use written dialogue or predetermined information. Much like during a well-visit, providers do not know all of the concerns of adolescents or their families and by being open to listening, accepting the information, and then responding, providers utilize improv techniques to provide care to patients and families.
- This conference also featured a well component for attendees to share in by way of Yoga. Experienced yoga instructor, Pierce Doerr led the audience through a series of movements and breathing exercises that promote stress reduction and clarity. This portion of the conference was intentional to stress the importance of self-care while caring for adolescents and families.

For more on the conference such as the recording and presentations, visit [www.illinoisAAP.org/adolescent-health](http://www.illinoisAAP.org/adolescent-health).

## Adolescent Health Needs Assessment and Educational Curriculum (Toolkit)

In addition to the conference, to continue supporting providers and healthcare professionals in addressing the needs of adolescents, ICAAP is developing an Adolescent Health Education Curriculum. This curriculum will be a two-part toolkit comprised of a component for pediatrics providers and another component for parents/caregivers of youth and youth themselves. The pediatric provider curriculum will feature topics that focus on the concrete needs of adolescents such as

behavioral health, substance use, nutrition and pandemic challenges and best practices for how to serve them. It will provide both general and specific resources for providers that they can choose from based on the needs of their population. The parents/caregivers and youth curriculum will focus on utilizing effective tools to improve adolescent engagement in their healthcare needs. This will include guidance on how to identify credible sources for health information, importance of confidentiality, and education on other health-related issues.

It is important that this two-part toolkit have a quality improvement approach. This includes guidance and review from experienced, well-versed physicians, as well as from conducting a needs assessment through surveying Illinois physicians and healthcare professionals. Staff and consultants have been researching the most updated and evidence-based resources to include for optimal health outcomes during the adolescent well-visit. Once the toolkit is complete later in 2021, ICAAP can assist in fostering safer, healthier and more responsible adolescents and communities.

## Conclusion

Adolescence is a time of many changes. It is important for providers and health professionals to be well-equipped to respond to these changes effectively, promoting positive health outcomes and quality of life for adolescent patients and families. Through ICAAP's adolescent health program activities, we are resolved to continuing to support providers and health professionals to serve their adolescent populations through up-to-date information and resources. For more information on ICAAP's Adolescent Health Program, visit [www.illinoisAAP.org/adolescent-health](http://www.illinoisAAP.org/adolescent-health) or contact Olyvia Phillips at [ophillips@illinoisAAP.com](mailto:ophillips@illinoisAAP.com).

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# ICAAP eLearning 2021 Course Catalog

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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.remote-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:

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## 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*<sup>™</sup>, 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*<sup>™</sup>, 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*<sup>™</sup>, 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*<sup>™</sup>, 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*<sup>™</sup>, 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*<sup>™</sup>, 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*<sup>™</sup>, 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*<sup>™</sup>, 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*<sup>™</sup>, Free | Expires May 31, 2020  
CME Approval Renewed until May 23, 2022

**MOC Part 4 and CME**

**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*<sup>™</sup> | 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*<sup>™</sup> listed above. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



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