The Newsletter of the New Hampshire Chapter of the American Academy of Pediatrics!

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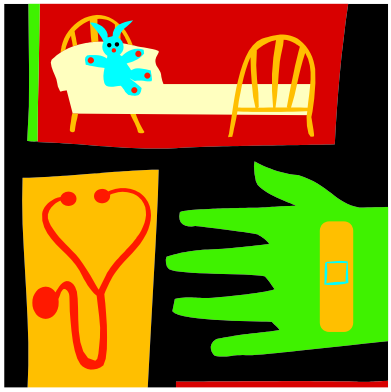
Pediatric Psychiatric Boarders

On any given week the inpatient pediatric ward at Children's Hospital at Dartmouth hosts about 1-3 "psych boarders:" children who qualify for inpatient psychiatric admission but for whom a bed at a state psychiatric facility is not available. These children range from suicidal teenagers to children with oppositional defiant disorder who have become too violent for their caregivers to handle. This system is costly, inefficient, and deprives children who need intensive psychiatric management of adequate care.



The boarding of pediatric psychiatric patients on the inpatient pediatric ward denies this particularly vulnerable population the treatment that they need. Children are seen on weekday mornings by a pediatric psychiatrist whose schedule is also filled with outpatient appointments. They receive adjustments to their medications, but do not receive counseling or behavioral therapy. Sometimes, they get additional "as needed" sedative medications to compensate for the lack of behavioral supports available.

Additionally, while precautions such as individual sitters and removal of bed sheets are taken to keep children safe, the inpatient ward is not the safest place for children with psychiatric disturbances. Our nursing staff, while trained to handle the spectrum of normal child behavior, is not equipped with the strategies and skills to manage psychiatric patients. Patient rooms have shelves, refrigerators, and basic medical equipment that I have seen thrown or pulled off the walls by an agitated child.

Finally, the cost of boarding on an inpatient pediatric floor is substantial. When a patient spends several days waiting for treatment on the inpatient unit, several thousand dollars of healthcare funds are spent for what amounts to a hotel room.

This problem is also not unique to NH. A recent study by Caludius et al (2014) in the Journal Hospital Pediatrics found that 50% of involuntary pediatric psychiatric admissions from one children's hospital ED had to board on the pediatric floor due to lack of space. The study found that "patients admitted to affiliated psychiatric institutions were far more likely to receive counseling and medications." Patients on the inpatient pediatrics ward often waited for a week or more without treatment.

So what is the solution? Increasing the availability of inpatient psychiatric treatment facilities in the state of NH, while costly as well, is a far more efficient way to help these

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children to manage their illnesses. Early intervention may help prevent future hospitalizations and inpatient treatment when these children become adults. Expanding the number of intensive outpatient psychiatric therapy programs is an excellent option to help reduce the cost of hospitalization.

The lack of resources for inpatient or comprehensive outpatient pediatric psychiatric care in New Hampshire is a growing problem for some of our state's most high risk children. While New Hampshire is not alone in this problem, we should strive to stand out by restructuring this unproductive "model" of care. More financial resources must be allocated to expand pediatric psychiatric care in the state of NH. Doing so would improve quality of care, quality of life for children and their families and would ultimately reduce healthcare costs.

-Christine Arsnow MD

SUMMERTIME IS POOL TIME

From 2000-2009, 116 children under age 15 in New Hampshire were admitted to hospital emergency departments and pediatric units.21 died. Many more suffered permanent brain damage.

Finding a child face down and motionless in a pool is a terrible event. It's also preventable. Here's how:

Number 1: Always have adult supervision when children are near water. This means that when children are in a pool the responsible adult should be with them, not watching from the yard or the house. And the supervising adult should be paying attention to what the children are doing. Distractions like conversation, reading, electronic devices or tasks that have to get done should be put on "hold". When the children are infants or toddlers, the adult should be in the water, no further away than arm's length, even if the child is in a secure floatation device or in a "kiddie" pool with just a few inches of water. The adult should know how to swim, how to keep all children in control and how to perform CPR. The national Safe Kids Organization makes a Water Watcher card that reminds the adult holding it that their attention is vital. Passing off that responsibility should only happen when another adult agrees to hold the card. The card is available (along with other good safety tips) at www.usa.safekids.org/water.

Number 2: There must be a fence on all 4 sides of any pool. The fence is especially important for the side of the pool that faces the house. Doors and windows make any house inadequate as a protection for the children inside. A common way for children to drown is for them to open a slider or other door, leave the house and fall into the pool without anyone realizing where they are. Any pool in New Hampshire, whether in-ground or above-ground, must have a fence that is at least 4 feet high. Any gates must be self-closing and self-latching. These regulations are part of the New Hampshire state building code. You can find them at the NH Building Official's Association website: www.nhboa.net. Warning: these regulations are not consistently enforced by town governments. Pool owners should be responsible but sometimes they aren't. Parents should beware any time their child visits at a house where there is a pool. They should make sure that these pool safety rules are followed. It's not worth risking a child's life if they're not. People without children or those whose children have grown up may especially need reminders of how to keep youngsters safe around a pool.

Number 3: An excellent resource is the Consumer Product Safety Commission's web site: www.poolsafely.gov. There you can find safety guidelines, interactive videos for young children that teach pool safety and public safety announcements, among other features. And check out the website of the National Drowning Prevention Alliance at ndpa.org and the activities and tip sheets for parents, educators and children of all ages at SeattleChildrens.org.

This message was brought to you by the New Hampshire Child Fatality Review Committee. This group reviews all child deaths in the state with the goal of preventing future ones.

- submitted by Wendy Gladstone MD

Dental Caries Prevention

New recommendations have just been published about prevention of dental caries in children from birth to age 5 by the United States Preventive Services Task Force (USPSTF). http://pediatrics.aappublications.org/content/early/2014/04/29/peds.2014-0483

Grade B recommendations include:
Prescribing oral fluoride supplements starting at age 6 months for children whose water supply is deficient in fluoride
Applying fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption

These recommendations are significantly different in both the higher B level of the recommendations and the inclusion of all children, not just those screening positive for high risk for dental caries. Arguments to extend the supplements and varnish to all children include universal high sugar exposure, inappropriate bottle feeding, developmental defects of the enamel, and maternal and family risk factors.

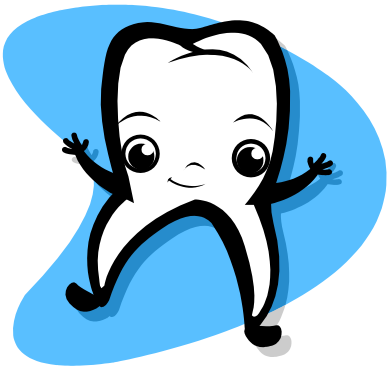
Generally recommendations made by the USPSTF are required to be included and covered by insurers and under the Affordable Care Act (Obamacare) this would include all preventive interventions with strong supportive evidence such as this one.

Currently New Hampshire remains one of only 5 states that have not yet paid any reimbursement to providers for applying fluoride varnish in spite of legislation mandating PCP reimbursement for this service that was passed several years ago. It is also unclear at this time what oral health preventive recommendations, if any, will be included in the well child visit expectations for providers when the reimbursement will come from the 3 HMOs who were successful in winning the contracts for Medicaid in New Hampshire. There is uncertainty whether fluoride varnish application will be reimbursed as an additional service or bundled into the payment for the well child visit. Of additional interest is whether non Medicaid insurers will be required to allow PCP coding and reimbursement for varnish application as an additional service since the new evidence based recommendations apply to all children.

Stay tuned for more clarification about preventive oral health services in New Hampshire's children, and if an opportunity arises for training in oral health screening, varnish application and provision of fluoride supplements consider becoming knowledgeable in these areas. You might want to refer to the link below to access the Smiles for Life Curriculum offering free web based training in oral health. Modules 2 and 6 are specific to children and provide the information needed to adequately address the oral health issues of the children in your practice setting.

www.smilesfor lifeoralhealth.org

- Suzanne Boulter, MD



Communication Delays: Common Misconceptions

Popular misconceptions regarding communication delays in boys, bilingual children, and younger siblings may prevent these groups from getting the help they need. All children who show early warning signs of a delay should immediately be referred for a developmental screening by a speech-language pathologist. Developmental screenings are typically free and last approximately 15 minutes. Early detection and treatment give children with communication delays a greater chance of improving with speech therapy.

Misconception #1: It is normal for boys to show delays in speech and language. While boys tend to acquire communication skills at a slower rate than girls, they should still fall within the typical age range for major milestones1, 2. Any signs of a communication delay in both boys and girls should be addressed in a timely manner.

Misconception #2: Bilingual children talk later than monolingual children. Bilingual children will reach communication milestones at the same pace as their monolingual peers, with first words appearing around 11 to 14 months3, 4. Total vocabulary growth is the same between typically developing bilingual and monolingual children when every language is taken into account.

Misconception #3: Younger siblings talk later because their older siblings talk for them. All children are motivated to communicate their own needs and wants as soon as they can. Studies have shown that there are no differences in general communication development between first-born children and later-born children5, 6.

Communication delays, ranging from hearing and oral-motor issues to difficulties with language comprehension and production, can be detected within the first year. If an infant does not seem to respond to sounds or faces, or is not producing age-appropriate coos, babbles, or words, refer him or her for a screening. Pediatric therapy clinics typically offer free developmental screenings to help all children reach their fullest potential. For additional information on early communication development, please visit Pathways.org.

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Pathways.org is a national not-for-profit organization dedicated to providing free resources and information for health professionals and families on children's motor, sensory, and communication development. The Pathways.org Baby Growth and Development Chart has been recognized and endorsed by the American Academy of Pediatrics, and additional educational materials are available online to download, copy, and share freely. For more information, please visit Pathways.org, email friends@pathways.org, or call our toll-free parent-answered hotline at 1-800-955-CHILD (2445).

[1] Özçalskan, S, Goldin-Meadow, S. Sex differences in language first appear in gesture. Developmental Science. 2010; 13(5): 752-760.

[2] Huttenlocher J, Haight W, Bryk A, Seltzer M, Lyons T. Early vocabulary growth: relation to language input and gender. Developmental Psychology. 1991; 27(20): 236-248.

[3] Petitto, LA., Holowka, S. Evaluating attributions of delay and confusion in young bilinguals: special insights from infants acquiring a signed and spoken language. Sign Language Studies. 2002; 3(1): 4-33.

[4] Werker, JF, Byers-Heinlein, K. Bilingualism in infancy: first steps in perception and comprehension. Trends Cogn Sci. 2008; 12(4): 144-151.

[5] Oshima-Takane Y, Goodz E, Derevensky J. Birth order effects on early language development: do second born children learn from overheard speech? Child Development. 1996; 67(2): 621-634.

[6] Tomblin, JB. The effect of birth order on the occurrence of developmental language impairment. Br J Disord Commun. 1990; 25(1): 77-84.

- Virginia Li, Pathways.org

Please Take Notice!

The New Hampshire Pediatric Society wants to improve immediate communication with and among our members. If your email address is not on our master list (or if you're not sure) please add your preferred address to the list by contacting Gil Fuld.

Our plan is to periodically send out the updated address list to everybody on it. If you haven't recently received a copy, we don't have your address.

-Gil Fuld
Communications and
Public Relations Chair
f uldandfuld@ne.rr.com

It's official!

We are now accepting nominations for the 2014 New Hampshire Pediatric Society Annual Awards.

Something new!

The NHPS Executive Committee is exploring a new method of awarding the recipients. Instead of asking awardees and their significant others to trek to Concord—either to an NHPS quarterly meeting or to a CME event—NHPS will come to them, no matter where they work in the state!

Once the awardees have been determined by a vote of the membership, NHPS representatives will work with the nominator and colleagues of each winning candidate to organize an appropriate acknowledgement, at a time and place convenient to each one.
We believe this will make the event more memorable (and certainly more convenient) for the individuals to whom we wish to show our gratitude.

Like it? Don't like it? Feel free to write and let me know.

Everything else stays the same. We will be granting awards in the early all. Nominations will be accepted until midnight, June 23. Voting (via Survey Monkey) will be open during the month of July.

Nominations are sought for the following individual honors to be bestowed in early Fall 2014:

- New Hampshire Pediatrician of the Year
- New Hampshire Public Citizen of the Year
- The Franklin Norwood Rogers Award (Retired New Hampshire Pediatrician of the Year)
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If you need to see the guidelines for a more detailed description of each category, drop me a note.
A list showing the winners in previous years follows.
Please send your suggestions for nominee(s) together with a brief biographical sketch and a paragraph or two explaining your reasons for nominating the individual(s) to me, Jenny Lipfert, NHPS Secretary, at jenny.lipfert@gmail.com.
Remember, a thoughtful nominating paragraph specifically delineating how your nominee has made unique contributions to improving care for children and families is essential. Your nomination shall remain confidential.
Any questions? Drop me a note.
Best wishes,
Jenny Lipfert, NHPS Secretary
jenny.lipfert@gmail.com

New Hampshire Pediatric Society Annual Awards Guidelines

Three awards are granted annually. Solicitation for nominees begins in mid-December. Nominations must include a biographical sketch of the nominee and paragraph describing the reasons she/he is being nominated. The slate of nominees is announced and voting begins in mid-March and ends in mid-April. Winners are announced and recognized at the Spring CME meeting of the Pediatric Society.

The identity of nominating individuals should not be shared with voters or nominees. Nominating individuals must be members in good standing of the New Hampshire Pediatric Society.
Nominees may not previously have won an award in that particular category.

New Hampshire Pediatrician of the Year:
The New Hampshire Pediatrician of the Year Award is given to an outstanding pediatrician who has contributed to the improvement of child health care in our state or nationally. It can be given for either a special project or for years of service on behalf of children. In order to be eligible for the Pediatrician of the Year Award, a chapter member must be a member in good standing of the NHPS.

Nominations may be based on the following criteria:
1. Active involvement in local chapter initiatives
2. Work in the area of advocacy for children
3. Involvement in community public awareness campaigns on behalf of children
4. Excellence in clinical areas

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5. Active involvement on state-level or national-level committee(s)
6. Active involvement in the passage of state legislation benefiting children
7. Involvement in projects or programs that serve the needs of children
8. Well respected in medical and public communities
9. Longevity, with a notable number of years devoted to the community and chapter on behalf of children
10. Involvement in other special projects or activities that contribute to the improvement of child health care

New Hampshire Public Citizen Award:
This award recognizes the individual who has performed extraordinary work in the effort to promote the health and welfare of New Hampshire's children and families. The award is presented to a resident (nonphysician or physician) of New Hampshire who has contributed outstanding work as an advocate for children and children's healthcare.
Nominations may be based on the following criteria:
1. Demonstrated service to a project or cause on behalf of children
2. Established community involvement to effect change in systems affecting children's issues
3. Proven commitment to children's issues
4. Local, state, or national champion of causes affecting children

Franklin Norwood Rogers Award (Retired New Hampshire Pediatrician of the Year):
The Franklin Norwood Rogers Award is given to an outstanding retired pediatrician who has
contributed to the improvement of child health care in our state or nationally. It can be given for
either a special project or for years of service on behalf of children. In order to be eligible for the
Retired Pediatrician of the Year Award, a chapter member must be (or have been, prior to
retirement) a member in good standing of the NHPS.
The selection criteria are identical to those for Pediatrician of the Year with the additional stipulation that the pediatrician is retired from active practice.

New Hampshire Pediatric Society Annual Award Recipients (to 2013)

NH Pediatrician of the Year
2013—William H. Edwards, MD
2012—John Moeschler, MD
2011—Torunn Rhodes, MD
2010—Ardis Olson, MD
2009—Greg Prazar, MD
2008—Leonard "Skip" Small, MD
2007—Skip DeVito, MD
2006—George Little, MD
2005—Gene LaRiviere, MD
2004—Chuck Cappetta, MD
2003—William Boyle, MD
2002—Sol Rockenmacher, MD
2001—Carl Cooley, MD
2000—Gilbert Fuld, MD
1999—Suzanne Boulter, MD
1998—Wendy Gladstone, MD
1997—Patricia Andrews, MD
1996—Judith Frank, MD
1995—Charles McMurphy, MD
1994—Steve Kairys, MD
1993—Selma Deitch, MD

Franklin Norwood Rogers Award (Retired NH Pediatrician of the Year)
2013—William Boyle, MD
2012—Suzanne Boulter, MD
2011—n/a
2010—Arthur Simington, MD
2009—Eugene Lariviere, MD
2008—Al Rozycki, MD
2007—Sol Rockenmacher, MD
2006—Spencer Brody, MD
2005—Sam Dugan, MD
2004—John Brooks, MD
2003—Jim Pilliod, MD
2002—Gilbert Fuld, MD
2001—Pat Adams, MD
2000—Robert Klein, MD
1999—Robert Chamberlin, MD
1998—Richard Waters, MD (posthumously)
1997—Robert Wilson, MD

NH Public Citizen of the Year
2013—Audrey Knight, MSN, RN (MCH)
2012—NH Partners in Health Coordinators
2011—Shawn LaFrance
2010—José Montero, MD
2009—Don Shumway
2008—Terry Ohlson--Martin, Sylvia Pelletier
2007—Elaine Frank
2006—Susan Lynch, MD
2005—Gina Balkus
2004—Kathy Scambati, Sandi Van Scoyoc
2003—Rep. Barbara French
2002—Joan Ascheim (MCH), Bill Boyle, MD
2001—Jim Squires, MD
2000—Katie Dunn, Tricia Brooks
1999—Jane Hybsch (DHHS)
1998—Martha--Jean Madison (DHHS--SMS)
1997—James Pilliod, MD
1996—Rep. Katherine Wells Wheeler, Sen C. Jeanne Shaheen
1995—Rep. Mary Jane Wallner,Rep. Sharon Nordgren
1994—Rep. Douglas Hall, Rep. Susan McLane