



# The SOOp Box

## Section on Ophthalmology

Newsletter

[www2.aap.org/sections/ophthalmology/](http://www2.aap.org/sections/ophthalmology/)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



SPRING 2016

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### Letter from the Chairperson

Sharon S. Lehman, MD, FAAP



Sharon Lehman

The AAP Section on Ophthalmology has been very busy over the past 6 months advocating for pediatric ophthalmologists, pediatricians and most importantly, our patients!

A new joint AAP/AAPOS/AAO/AACO policy statement on “Visual System Assessment in Infants, Children, and Young Adults by Pediatricians” and a supporting clinical report, “Procedures for the Evaluation of the Visual System by Pediatricians,” were released online on December 7, 2015, and appeared in the January 2016 print edition of *Pediatrics*. These are landmark works defining the process and setting the standards for vision screening for children in the medical home. We are indebted to lead author, Sean Donahue, and co-authors, Geoff Bradford and James Ruben for these contributions. For more information, see page 5.

In February 2016, the AAP sent a letter to the largest national and regional carriers informing them of new AAP published recommendations for vision screening. The letter urges payers to provide benefits coverage and appropriate payment for vision screening, particularly instrument based screening, based on the newly published recommendations. For more information on this, please see pages 5-8.

The Section submitted formal comments on behalf of SOOp, AAPOS, and AAO on a draft of the 4th Edition of *Bright Futures* during a review comment period in August 2015. Section members participated in revising the *Bright Futures* Periodicity Schedule in order to make it consistent with the joint AAP/AAO/AAPOS/AACO policy statement and clinical report on vision system assessment by pediatricians.

The National Quality Forum recently endorsed a quality measure related to vision screening in children for trial use. The measure encourages early screening for visual impairment in preschool age children and appropriate referral of those who do not pass screening. The quality metric’s journey started when it was introduced by Jim Ruben in 2011 when he was Chair of the Section. It was almost derailed when an opposing group appealed the NQF decision. A joint effort by the AAP, AAO, AAPOS, and AACO, including testimony by AAO and AAP representatives on an NQF call, saved the measure; it is now slated for adoption for trial use by CMS...a metric that will truly have meaningful use! We celebrate this collaboration with our sister organizations. The AAP Section remains an important link between ophthalmology and pediatrics.

*(Continued on page 2)*

### From the Editor’s Desk – Geoff Bradford, MD, FAAP

We hope you enjoy reading this edition of the newsletter. Please share it with colleagues, patients and friends and let them know you are a member of the Section. Much of this newsletter is devoted to communicating the activities of the AAP and of our Section to you, as well as providing updates on clinical and advocacy topics. Our newsletter can be an important avenue of communication for our Section and for those who share our passion of providing the best care possible in our field for children.



Geoff Bradford



## AAP Section on Ophthalmology – Sponsored Events and Awards at the 2016 AAPOS Annual Meeting

April 6-10, 2016 – Vancouver, BC

The AAP Section on Ophthalmology takes great pleasure in having the opportunity to partner with the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) each year in offering a few events affiliated with their annual meeting.

**AAPOS Workshop – Myopia – Pathogenesis, Control and Treatment – A Practical Update for the Clinician**  
Friday, April 8  
10:30-11:45am

**Workshop Participants:**

- Sharon Lehman, MD, FAAP
- Ken K. Nischal, MD, FRCOphth, FAAP
- Evelyn Paysse, MD, FAAP
- Seo Wei Leo, MD
- Audrey C. Mok, MD
- David B. Granet, MD, FAAP



Sharon Lehman



Ken Nischal



Evelyn Paysse



Seo Wei Leo



Audrey Mok



David Granet

**AAP Section on Ophthalmology Social Reception**  
Friday, April 8  
12:30 – 1:15 pm  
Vancouver Convention Center

For more details, see page 3

**AAP Update and Presentation of Section Service Award**  
Saturday, April 9  
11:28 am

The 2016 Award for Outstanding Service to the AAP Section on Ophthalmology will be presented to Dr. Sean Donahue for his remarkable work as lead author on the new joint AAP/AAPOS/AAO/AACO policy statement “Visual System Assessment in Infants, Children, and Young Adults by Pediatricians” and its supporting clinical report, “Procedures for the Evaluation of the Visual System by Pediatricians”. Congratulations to Dr. Donahue, and many thanks for all your efforts!



Sean Donahue

### Chair’s Letter

*(Continued from page 1)*

The AAP communicated in a letter to CMS opposing significant cuts in the 2016 RBRVS Medicare physician fee schedule that affected nasolacrimal duct procedures frequently performed on children. The AAP expressed that the cuts would negatively affect children by further limiting providers who would be willing to provide this type of care in light of decreasing reimbursement.

At the center of all of these activities is safeguarding the best care possible for our patients. The Section provides many opportunities for those interested to work on policy, educate and advocate for our profession and our patients.

I thank you for your continued membership in the AAP Section on Ophthalmology. Please encourage your colleagues who are not yet members to join. We will be hosting a Section Social Reception at the AAPOS meeting in Vancouver. Please join us for ice cream during the second half of the lunch break on Friday, April 8, 12:30-1:15pm. All are welcome, AAP members and non-members alike. For more details, see page 3.

The Section has opportunities for your engagement. Please look for emails on the AAP Ophthalmology listserv where we will be soliciting your help. Please contact Jennifer Riefe, our Section Manager, at [jriefe@aap.org](mailto:jriefe@aap.org), or me at [slhman@nemours.org](mailto:slhman@nemours.org) with any ideas you have for initiatives and projects for the Section.

## Welcome New Members

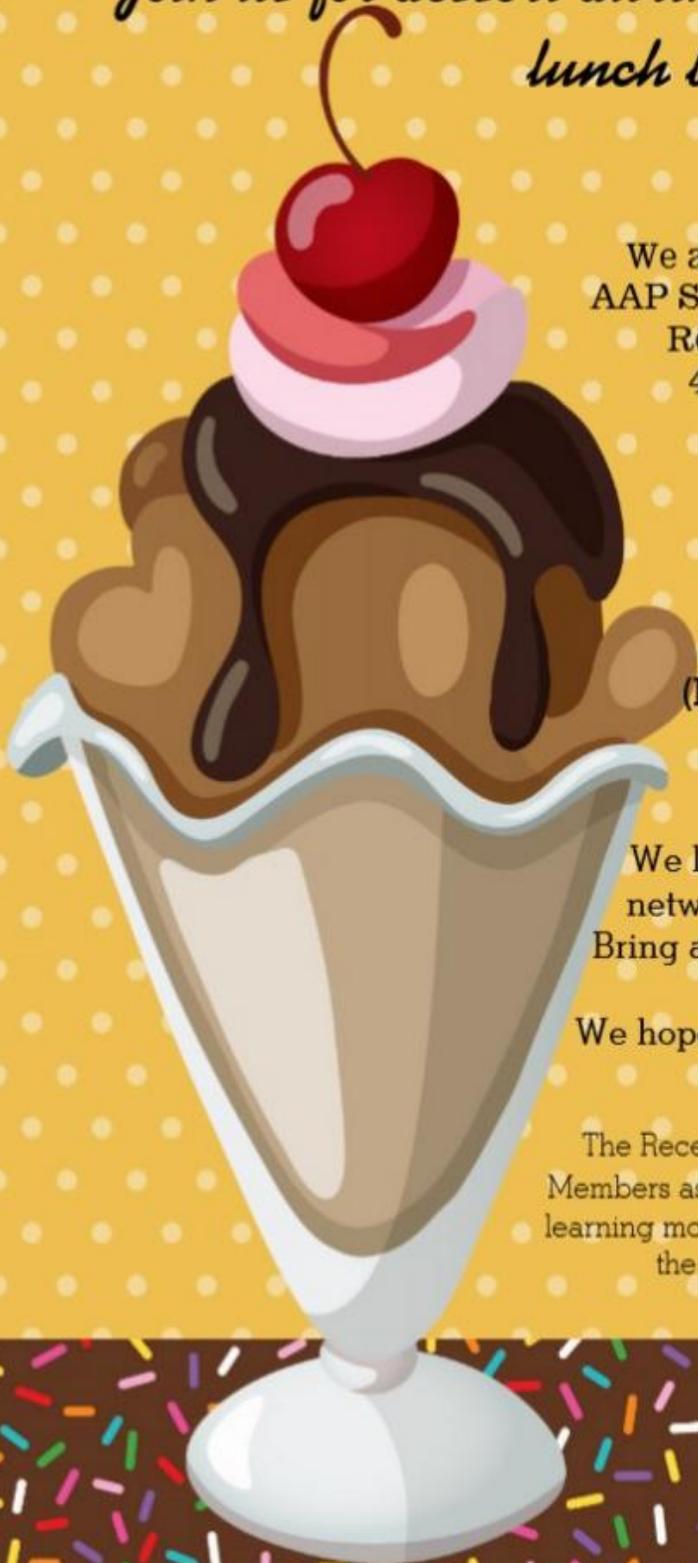
Raymond Areaux, Jr.  
Casey Beal  
Nisha Krishan Dave

Meghan Flemmons  
Daniel Greninger  
Kyle Miller

Anthony Panarelli  
Rajesh Rao  
Erin Salcone



*Join us for dessert during the last half of your lunch break!*



We are pleased to invite you to the AAP Section on Ophthalmology Social Reception during the AAPOS 42nd Annual Meeting 2016!

**Friday, April 8, 2016  
12:30-1:15pm  
Vancouver Convention Center  
East Building – Foyer S  
(Foyer adjacent to AAPOS Friday Workshops)**

We look forward to catching up and networking over ice cream sundaes! Bring a friend!! Dues are 50% off for new members.

We hope to see you and your guests at our Social Reception.

The Reception is open to all current AAP Section Members as well as to any non-members interested in learning more about the importance of membership in the AAP for support of our profession.

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Section on Ophthalmology

## Section on Ophthalmology 2016 Election Results

Thanks to all of you who voted in the Section election in March.

**We are pleased to announce that Dr. John Roarty will be joining the AAP Section Executive Committee as of November 1, 2016.**

### John Roarty, MD, FAAP

A close working relationship between Pediatrics and Pediatric Ophthalmology is crucial to our long term goals. As a committee member and chair serving AAPOS, the AAO and MiSEPS committees, I have been an effective team player. I hope that experience and having boards in Pediatrics and Ophthalmology will bring a useful perspective to the AAP Ophthalmology Section.



John Roarty

#### Qualifications:

- Boards in Pediatrics and Ophthalmology
- Chief, Ophthalmology, Children's Hospital of Michigan
- Past Chair, Bylaws, AAPOS + other committees
- Past Regional Director, AAO Secretariat State Affairs
- Committee member, OPHTHPAC
- Past President, MiSEPS

**We are pleased to announce that Dr. Geoffrey Bradford will be taking on the role of Section Chairperson-Elect as of November 1, 2016, after completing two three-year terms as a member of the Section Executive Committee.**

### Geoffrey Bradford, MD, FAAP

After earning his advanced degrees from Penn State University, Dr Bradford completed his residency in Ophthalmology at Summa Health Care System and Akron Children's Medical Center in Akron, OH. His fellowship in Pediatric Ophthalmology was done with Zane Pollard, MD in Atlanta, GA.



Geoff Bradford

Initially in private practice five years, Dr Bradford joined the Departments of Ophthalmology and Pediatrics at West Virginia University in 1998. He is also the Residency Program Director and has

served as Vice President of the West Virginia Academy of Ophthalmology. He has been an AAP SOOp member for seventeen years and has served on its Executive Committee for nearly six years, working in part as the editor for its biannual newsletter. At present he also serves as Vice Chair of the AAPOS Vision Screening Committee and as a member of the Legislative Affairs Committee. Recently he also joined the Expert Advisory Committee of the National Center for Children's Vision and Eye Health.

Dr Bradford has presented nationally and published in the areas of early childhood vision screening and legislative affairs. His most recent work includes contributions to the recently updated AAP Vision screening recommendations. For ten years he served as Director of the WVU Vision Initiative for Children Program, which developed and taught improved vision screening practices amongst lay and professional pediatric care providers throughout West Virginia.

Dr Bradford sincerely appreciates the opportunity to serve as the Chairperson of the SOOp Executive Committee and plans to work to continue its current initiatives and to develop new goals advocating for improved ophthalmic care for all children.

Dr Bradford and his wife Kathy, a pediatric infectious disease specialist at WVU, have two teenage boys, two dogs, and enjoy the cultural and outdoor opportunities that WVU and West Virginia offer.

**We are also pleased to announce that Dr. Steven Rubin will serve a second three year term as member of the Section Executive Committee beginning November 1, 2016.**

### Steven Rubin, MD, FAAP

Dr. Rubin completed his Ophthalmology residency at the University of Pennsylvania-Scheie Eye Institute (which included two tours through the Children's Hospital of Philadelphia), and after a Fellowship year at the Wills Eye Hospital, returned to the Scheie Eye Institute to be the Assistant Chief-of-Service. He was then recruited to be Physician-in-Charge (and later



Steven Rubin

Chief) of Pediatric Ophthalmology at the Schneider Children's Hospital (now the Cohen Children's Medical Center) of the Long Island Jewish Medical Center. Since 1991, Dr Rubin has been Chief of Pediatric Ophthalmology at North Shore University Hospital and is currently also Vice Chair. He is the immediate past Residency Program Director of that Department.

He has authored and co-authored several dozen peer-reviewed articles and book chapters on various topics in Pediatric Ophthalmology. Dr Rubin is a Past President and Secretary/Treasurer of the American Association for Pediatric Ophthalmology & Strabismus. He is also an Assistant Dean at the Hofstra Northwell School of Medicine. He has been a Section member for more than twenty years.

## Executive Committee 2016

### Sharon S Lehman, MD FAAP

*Chairperson*  
Wilmington, DE

### Daniel J Karr, MD FAAP

*Chairperson-Elect*  
Portland, OR

### Geoffrey E Bradford, MD FAAP

*Newsletter Editor*  
Morgantown, WV

### Kanwal (Ken) Nischal, MD FAAP

Pittsburgh, PA

### Steven E Rubin, MD FAAP

Great Neck, NY

### Donny Won Suh, MD FAAP

Omaha, NE

### David B Granet, MD FAAP

*Immediate Past Chair*  
San Diego, CA

## Liaisons

### Pamela Erskine Williams, MD FAAP

*American Academy of Ophthalmology (AAO)*

### Gregory T Lueder, MD FAAP

*American Academy of Ophthalmology Council (AAOC)*

### Christie L Morse, MD FAAP

*American Association for Pediatric Ophthalmology and Strabismus (AAPOS)*

### Shelley Klein, CO COMT

*American Association of Certified Orthoptists (AACO)*

## Staff

### Jennifer Riefe, MEd

*Section Manager*  
[jriefe@aap.org](mailto:jriefe@aap.org)



## DEPARTMENT OF FEDERAL AFFAIRS

A new Academic and Subspecialty Advocacy Report is available from the AAP Department of Federal Affairs. To read the full March 2016 report, visit: [https://www.aap.org/en-us/my-aap/Documents/subpeds\\_report\\_academic\\_subspecialty.pdf](https://www.aap.org/en-us/my-aap/Documents/subpeds_report_academic_subspecialty.pdf).

The Report contains updates on the following topics:

- Access to Care
- Children's Health Insurance Program
- ACE Kids Act
- Academic and Subspecialty Workforce
- Support for Pediatric Subspecialists
- Children's Hospital GME Funding and Reauthorization
- Title VII Training Grant Appropriations
- International Physician Legislation Physician Payment Medicaid Payment Equity
- Pediatric Drugs and Devices 21st Century Cures Initiative/ Innovations for Healthier Americans
- Pediatric Drug Laws
- Pediatric Device Consortia Program Appropriations
- OxyContin Approval in Children
- Drug Shortages Pediatric Research
- National Institutes of Health Appropriations
- Precision Medicine Initiative
- National Children's Study
- Inclusion of Children in NIH-Funded Research
- Proposed Updates to Common Rule
- NIH-Wide Five-Year Strategic Plan
- Budget and Appropriations
- President's FY 2017 Budget
- Administration Proposes New Emergency Funding Measures
- FY 2016 Appropriations
- Emergency Medical Services for Children
- Federal Aviation Administration Emergency Medical Kits
- Grassroots Advocacy: AAP Key Contact Program
- How to Become a Key Contact
- FederalAdvocacy.aap.org: Dept. of Federal Affairs Online Resource Center
- Engage with AAP on Social Media
- AAP 7 Great Achievements Campaign
- Advocacy Training Opportunities in Washington, DC

## New Policy Statement and Clinical Report on Visual System Assessment by Pediatricians Released in Print in January 2016

A new joint AAP/AAPOS/AAO/AACO policy statement on "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" and a supporting clinical report, "Procedures for the Evaluation of the Visual System by Pediatricians," were released online on December 7, 2015; They later appeared in print in the January 2016 edition of *Pediatrics*. The new statements supplant the following AAP policies: *Eye Examination in Infants, Children and Young Adults by Pediatricians* (2003); *Red Reflex Examination in Neonates, Infants and Children* (2008); and *Instrument-Based Pediatric Vision Screening* (2012).

The new policy statement and clinical report offer updated guidance for eye examination and vision assessment, including frequency of procedures as well as detailing validated methods pediatricians can use for examining the eyes and visual system of patients from newborns to adolescents. Thanks to lead author and Section member, Sean Donahue, and co-authors, Geoff Bradford and James Ruben, for their work on these very important documents. To access full pdf copies, visit:

For Policy Statement: <http://pediatrics.aappublications.org/content/pediatrics/137/1/1.51.full.pdf>

For Clinical Report: <http://pediatrics.aappublications.org/content/pediatrics/137/1/1.52.full.pdf>

The AAP also published its updated schedule of its Recommendations for Preventive Pediatric Health Care, also known as the periodicity schedule, in the January 2016 issue of *Pediatrics*. Outlining evidence-based screenings and assessments that should be addressed at well-child visits, the revised schedule reflects new and revised recommendations published by the AAP over the past year, including the new policy statement on visual system assessment. The changes to the schedule were approved by the AAP Committee on Practice and Ambulatory Medicine, Bright Futures Periodicity Schedule Workgroup in March 2014, May 2015 and October 2015. You can access the revised recommendations at: <http://pediatrics.aappublications.org/content/137/1/1.64>.

## AAP Takes ACTION - Advocates for Third Party Payment for Vision Screening Per the New January 2016 Policy Statement on Visual System Assessment

In February 2016, the AAP sent a letter to the largest national and regional carriers informing them of new AAP published recommendations for vision screening. The letter urges payers to provide benefits coverage and appropriate payment for vision screening, particularly instrument based screening, based on the newly published recommendations. AAP Chapters, pediatric councils and members can also use this letter in their discussions with payers. A copy of the letter can also be accessed by AAP members along with other AAP letters to carriers on the AAP Member Center, private payer advocacy page at: [https://www.aap.org/en-us/Documents/payeradvocacy\\_policy\\_vision\\_screen.pdf](https://www.aap.org/en-us/Documents/payeradvocacy_policy_vision_screen.pdf). The letter also appears on pages 6-8 of this newsletter.

# AAP Takes ACTION - Advocates for Third Party Payment for Vision Screening Per the New January 2016 Policy Statement on Visual System Assessment (Background on bottom of page 5)

American Academy of Pediatrics

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February 16, 2016

Dear Medical Director:

The American Academy of Pediatrics (AAP) is a professional medical society of over 64,000 pediatricians, pediatric medical sub-specialists and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents and young adults. The AAP is advocating for coverage and payment for vision screening, particularly instrument based screening, based on newly published recommendations.

The AAP has published a new clinical report and policy statement on updated guidance for eye examination and vision assessment, including frequency of procedures as well as detailing validated methods pediatricians can use for examining the eyes and visual system of patients from newborns to adolescents.

The policy statement *Visual System Assessment in Infants, Children and Young Adults by Pediatricians* is available at [www.pediatrics.org/cgi/doi/10.1542/peds.2015-3596](http://www.pediatrics.org/cgi/doi/10.1542/peds.2015-3596), and the clinical report *Procedures for the Evaluation of the Visual System by Pediatricians* is at [www.pediatrics.org/cgi/doi/10.1542/peds.2015-3597](http://www.pediatrics.org/cgi/doi/10.1542/peds.2015-3597). Both are published in the January 2016 issue of *Pediatrics*. The policy statement articulates the screening criteria and screening methods, and the clinical report explains the various evaluation procedures that are available for use by the pediatrician or primary care physician.

The guidance is included in the 2016 Bright Futures/AAP *Recommendations for Preventive Pediatric Health Care*, or Periodicity Schedule and supplants the following AAP policies: *Eye Examination in Infants, Children and Young Adults by Pediatricians* (2003); *Red Reflex Examination in Neonates, Infants and Children* (2008); and *Instrument-Based Pediatric Vision Screening* (2012). The 2016 Bright Futures-AAP *Recommendations for Preventive Pediatric Health Care*, or Periodicity Schedule, reflects the new guidance on vision screening and may be accessed at:

<http://pediatrics.aappublications.org/content/pediatrics/137/1/1.64.full.pdf>

The AAP encourages payers to revise their policies to provide coverage and payment for vision screening and assessment as per these recommendations. We seek your feedback regarding how your standard certificate of coverage and payment policies will be updated to reflect these updated guidelines:

#### Executive Committee

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Benard P. Dreyer, MD, FAAP

##### President-Elect

Fernando Stein, MD, FAAP

##### Immediate Past President

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##### Executive Director/CEO

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Fayetteville, GA

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- Instrument based screening, if available, can be used at any age and can be attempted beginning at age 12 months,<sup>1</sup> and a previous study has demonstrated better eventual outcomes for children undergoing their first photoscreening before 2 years of age.<sup>2</sup>  
Instrument based screening at any age is suggested if unable to test visual acuity monocularly with age-appropriate ototypes.
- Instrument-based screening can be repeated at each annual preventive medicine encounter through 5 years of age or until visual acuity can be assessed reliably using optotypes. Using these techniques in children younger than 6 years can enhance detection of conditions that may lead to amblyopia and/or strabismus compared with traditional methods of assessment.<sup>3</sup>
- Instrument-based screening may be a helpful alternative in screening developmentally delayed children of any age.<sup>4</sup>

As noted in the AAP clinical report, instrument-based screening can be relatively quick and requires less attention from the child compared with traditional visual acuity screening. Further, as stated in the AAP documents, instrument based screening is an approved technology that is endorsed by the United States Preventative Services Task Force (USPSTF).

Payers are also urged to pay for the visual acuity screening (CPT code 99173) and instrument based ocular screening (CPT codes 99174 and 99177). For the former, payers may utilize 2016

Medicare RBRVS values to pay for visual acuity screening as a separately reported service. However, the ocular screening codes do not yet have values published on RBRVS. The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has submitted valuation recommendations to CMS for CPT codes 99174 and 99177 but CMS has failed to publish them in the current iteration of RBRVS. Therefore, in the interim, public and private payers are urged to provide coverage benefits and to pay appropriately for instrument based ocular screening as a separately reported service, apart from the reported office visit and other preventive care services.

We look forward to your response on coverage and payment for visual screening as this is a critical preventive service with substantial health and cost implications.

If you have questions or need additional information, please contact Lou Terranova, Senior Health Policy Analyst at [lterranova@aap.org](mailto:lterranova@aap.org) or 847-434-7633.

Sincerely,

/s/

Benard P. Dreyer, MD, FAAP  
President

BPD/lt

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## References

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3. Salcido AA, Bradley J, Donahue SP. Predictive value of photoscreening and traditional screening of preschool children. *J AAPOS*. 2005;9(2):114–120pmid:15838437
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## The National Center for Children's Vision and Eye Health at Prevent Blindness Issues New Report to Improve Children's Vision Health

### "Children's Vision and Eye Health: A Snapshot of Current National Issues" Report Includes Detailed Statistics, Information and Strategies to Improve Children's Vision in the United States

To help address the need for effective programs and strategies for children's vision, The National Center for Children's Vision and Eye Health at Prevent Blindness (NCCVEH) has released a comprehensive new report titled "Children's Vision and Eye Health: A Snapshot of Current National Issues" (available on the newly designed website from Prevent Blindness at: <http://www.preventblindness.org/content/childrens-vision-and-eye-health>).

Vision impairments are common conditions among young children. If not detected and treated early, they could affect all aspects of life, negatively impacting a child's ability to learn, athletic performance, and self-esteem.

Data from the report includes:

- The economic costs of children's vision disorders are significant, amounting to \$10 billion yearly in the United States.
- More than one in five preschool-age children enrolled in Head Start have a vision disorder.
- Visual functioning is a strong predictor of academic performance in school-age children.
- Amblyopia (sometimes called "lazy eye"), is the most common cause of vision loss in children.
- Uncorrected refractive errors (including significant near-sightedness, far-sightedness, and astigmatism) in infants and preschool-age children are

associated with developmental delay, as well as with clinically identified deficits in cognitive and visual-motor functions that may, in turn, have a negative impact on school readiness.

- Among children with diagnosed eye conditions, African American children have lower overall health care expenditures than Caucasian children, but twice the expenditures for eye/vision-related emergency services, possibly indicating less access to a regular source of office-based health care.
- More than a third of Hispanic/Latino and non-Hispanic black adolescents have inadequately corrected refractive error.

The *Children's Vision and Eye Health: A Snapshot of Current National Issues* report begins with an outline of the current landscape for children's health issues including national prevalence rates for vision conditions (amblyopia, strabismus, astigmatism, myopia, hyperopia, etc.), including breakdowns by age and ethnic groups.

Also in the report are details on the impact of access to care issues, a summary of school vision screening rates and requirements by state, examples of effective state program approaches, and a state-by-state breakdown of regulations related to school-age and preschool-age vision screening.

The goal of the report is to provide information and examples that may translate into effective community-level health promotion strategies that lead to improved vision systems for children.

In 2009, Prevent Blindness was awarded a grant from the Maternal and Child Health Bureau at the Health Resources and Services Administration of the U.S. Department of Health and Human Services to establish the NCCVEH. The mission of the NCCVEH is to develop a coordinated public health infrastructure to promote and ensure a comprehensive, multi-tiered continuum of vision care for young children. In addition, the NCCVEH has established a national expert advisory committee from the fields of ophthalmology, optometry, pediatrics, research, and public health along with family representation. The panel assisted in the completion of the report.

"When we established the NCCVEH, we set out to identify and address the vision health needs of our children, as well as put together effective strategies and programs," said Hugh Parry, president and CEO of Prevent Blindness. "Our new report was created to provide an easy-to-use, evidence-based guide that helps us demonstrate the need for essential vision care for our kids and sound approaches to achieve a lifetime of healthy vision."

## News from the AAP Surgical Advisory Panel

**Constance S. Houck, MD**

Chairperson, AAP Surgical Advisory Panel

### A Little History....

As an organization dedicated to the health of children, the American Academy of Pediatrics has always recognized the importance of being inclusive of **all** physicians who care for children. Many of the adult specialty organizations were not initially supportive of pediatric specialization so the AAP became a "home" for pediatric surgical specialists. In 1948, just 17 years after the AAP was initially formed, 3 groups of pediatric specialists formed "Sections" within the Academy to provide a continuing education experience for their members. The Section on Surgery was one of these 3 original Sections and was the first physician organization focused solely on surgery in infants and children. By 1987, there were 12 medical and surgical Sections in the Academy. As the number of pediatric subspecialists increased in the 1980's so did the number of AAP Sections. Currently there are 52 Sections (see list at: [http://downloads.aap.org/DOSP/Section Forum Action Groups.pdf](http://downloads.aap.org/DOSP/Section_Forum_Action_Groups.pdf)), which include not only medical and surgical subspecialty groups but also multidisciplinary groups of pediatric providers with an interest in a particular aspect of children's health. The Sections now provide the majority of the educational content at the AAP's annual National Conference and Exhibition and are important contributors to the development of AAP Policy.



Constance Houck

### What is the Surgical Advisory Panel?

The Surgical Advisory (SAP) is a collaboration between the Chairs of the 10 AAP surgical specialty sections: Anesthesiology and Pain Medicine, Neurological Surgery, Ophthalmology, Oral Health, Orthopaedics, Otolaryngology and Head & Neck Surgery, Plastic Surgery, Radiology, Surgery and Urology. SAP meets twice a year - in March at the Annual Leadership Forum and at the AAP National Conference and Exhibition in the fall. The Chair of the Surgical Advisory Panel serves on the Section Forum Management Committee and represents the pediatric surgical specialists at the AAP Board meetings in January, May and October.

### Current Collaborative Perioperative Initiatives

- **Optimal Timing Task Force** – A task force is being formed within SAP to evaluate the evidence and make recommendations regarding the optimal timing of surgical procedures. The task force will be specifically looking at the timing at which function is optimized and perioperative complications are minimized.
- **Surgical Specialist involvement on Committees and Councils** – SAP has launched an effort to increase the number of surgical specialists on important AAP Committees and Councils. This effort has already led to a significant increase in the number of surgical specialists on several key committees over the last 2 years.
- **Specialty Fellow membership** – Medical subspecialists have recently formed the Medical Subspecialty Advisory Panel (MSAP), and they have joined our efforts to advocate for specialty membership options that include more streamlined benefits and reduced dues. We also have a surgical specialist on the Membership committee so we will continue these efforts in earnest.
- **Surgical Plenary Session at NCE** – Each year since 2012, the Surgical Advisory Panel has presented a Surgical Plenary session and reception at the NCE meeting. The Panel topic is designed to have broad appeal for all surgical specialists. This year's Panel will be on co-management of surgical patients by pediatric hospitalists.

There are many perioperative concerns that we share with our colleagues in the AAP Surgical Advisory Panel. Please email me: [constance.houck@childrens.harvard.edu](mailto:constance.houck@childrens.harvard.edu) if there are other multidisciplinary issues and/or advocacy concerns that you think would benefit from a strong, collaborative effort with our surgical colleagues.

## Section Sponsors Advocacy Ambassador to Attend the AAO's 2016 Mid-Year Forum

The AAP Section sponsors a pediatric ophthalmology fellow or ophthalmology resident to attend the AAO's Mid-Year Forum as its Advocacy Ambassador on an annual basis. This



Smith Ann Chisholm

program allows Fellows training in pediatric ophthalmology and strabismus fellowship programs and/or ophthalmology residents intending to pursue pediatric ophthalmology and strabismus fellowship training to attend the AAO's Mid-Year Forum in Washington, DC, for advocacy training. This year's SOOp Advocacy Ambassador is Dr. Smith Ann Chisholm from University of Michigan. If you are attending the Mid-Year Forum in Washington, DC, April 13-16, 2016, please take a moment to introduce yourself to Dr. Chisholm.

## Seen in *Pediatrics* – April 2016

**Neurodevelopmental Outcomes Following Bevacizumab Injections for Retinopathy of Prematurity**

<http://pediatrics.aappublications.org/content/early/2016/03/16/peds.2015-3218>

**Concerns for Development After Bevacizumab Treatment of Retinopathy of Prematurity**

<http://pediatrics.aappublications.org/content/early/2016/03/16/peds.2016-0057>

## New AAP Recommendations on the Perioperative Anesthesia Environment and on Prevention and Management of Pain in the Neonate

### Critical Elements for the Pediatric Perioperative Anesthesia Environment

The American Academy of Pediatrics has published updated recommendations for hospitals and other surgery settings to keep infants and children undergoing anesthesia as safe as possible.

The policy statement, "[Critical Elements for the Pediatric Perioperative Anesthesia Environment](http://pediatrics.aappublications.org/content/136/6/1200)" (<http://pediatrics.aappublications.org/content/136/6/1200>), was published in the December 2015 issue of *Pediatrics* (published online Nov. 30).

Infants between 1 month and 1 year of age have roughly four times higher risk of anesthesia-related cardiac arrest than patients between age 1 and 18 years, and newborns younger than 1 month old have six times the risk faced by other infants. Children undergoing complex procedures or who have co-existing medical conditions also have an increased risk of complications.

The AAP urges hospitals to look at the entire team and setting where children receive anesthesia to provide the best possible care. This includes recommendations that surgical facilities set a minimum number of pediatric

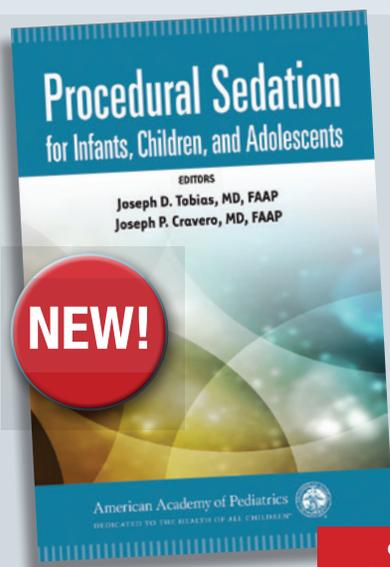
anesthesia procedures conducted annually to maintain peak performance. The report states that high-risk pediatric patients need anesthesiologists with subspecialty certification in pediatric anesthesiology who dedicate at least 30 percent of their clinical practice to neonates and children with complicated medical conditions. Other recommendations include having a separate, family-centered preoperative area for pediatric patients and their families.

"Anesthesiologists and the institutions in which they practice need to have a structured assessment of all the resources at hand—personnel, equipment, facilities, laboratories and ancillary services—to make sure all the pieces are in place to provide the safest possible pediatric anesthesia care," said lead author David M. Polaner, MD, FAAP. "The AAP policy statement advises institutions on how they should tailor the depth of these resources to the complexity and ages of pediatric patients they serve."

The policy statement is aligned with the AAP-endorsed American College of Surgeons Children's Surgery Verification and Quality Improvement program standards.

### Prevention and Management of Procedural Pain in the Neonate: An Update

Pain that newborns experience from routine medical procedures can be significant, especially in premature infants with more intensive health needs. Research suggests that repeated exposure to pain early in life can create changes in brain development and the body's stress response systems that can last into childhood. Because of this, a new American Academy of Pediatrics policy statement recommends every health facility caring for newborns should use strategies to minimize the number of painful procedures performed, and routinely monitor and treat pain with greater emphasis on proven non-drug interventions. The policy statement, "[Prevention and Management of Procedural Pain in the Neonate: An Update](http://pediatrics.aappublications.org/content/137/2/1.61)" (<http://pediatrics.aappublications.org/content/137/2/1.61>), appeared in the February 2016 issue of *Pediatrics* (published online Jan. 25). Authors of the statement said that routinely giving newborns sucrose and glucose to reduce pain during procedures is effective, but there are concerns that excessive use can affect neurological development. At the same time, the authors said, safe and effective interventions such as skin-to-skin contact and breastfeeding remain underutilized.



## Ensure safe and effective procedural sedation for your patients.

Authored by experts in a variety of specialties, *Procedural Sedation for Infants, Children, and Adolescents* is a comprehensive guide to help educate pediatric health care professionals on medications used for sedation, associated adverse events that may occur, and treatment of these events.

#### Contents include

- Pre-sedation evaluation
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- Monitoring for procedural sedation
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- Non-pharmacologic interventions
- Topical and local anesthetic agents
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## Should all babies born at 22 weeks of gestation be resuscitated?

by John D Lantos, MD, FAAP, Children's Mercy Bioethics Center

A recent New England Journal of Medicine has a paper on the differences in rates of active treatment of babies by their assigned gestational age at birth. (Rysavy MA, et al. Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants. The New England journal of medicine. 2015;372(19):1801-11.) The study was done in hospitals that are part of the NICHD Neonatal Research Network, so they are all tertiary care centers. Among these elite, high-tech hospitals, there was pretty dramatic variation in the approach to babies born at 22 weeks of gestation. In four hospitals, no babies born at 22 weeks were resuscitated or admitted to the NICU. In six hospitals, all of the babies born at 22 weeks were resuscitated and admitted to the NICU. The other hospitals resuscitated some but not others. Overall, 22% of babies born at 22 weeks were resuscitated. Among the babies born at 22 weeks, 5.1% survived and 3.4% survived without severe impairment. Of the 22 week babies who received active treatment, 23.1% survived and 15.4% of those did not have severe impairment. (To frame this another way, two thirds (3.4/5.1) of the babies who survived were not severely impaired.)

The study has some interesting implications. First, it shows tremendous practice variation. At some centers, the variation seems to result from individualized decision making. That is, some babies are resuscitated and some are not. But much of the variation results from institutional policies. At those centers, it is all or none. The decisions are not, apparently, left up to doctors or parents (except in the sense that it is probably the doctors who make the policies.)

Another interesting implication is that many babies who might have survived are allowed to die. There were 357 babies born at 22 weeks. Of those, 278 did not get active treatment. Had they been treated, and had their survival rate been the same as that of the babies who were treated, then another 45 babies would have survived, 30 of them without severe impairment.

A third important finding is that the prevalence of severe impairment among survivors is better at each gestational age. But not remarkably better. For babies born at 23 weeks, 33% of the babies who received active treatment survived, and 25% (or 75%) did not have severe impairment. For those born at 24 weeks, 81% of survivors were relatively unscathed. Because more 24 weekers were resuscitated, however, there were more survivors with severe impairments in that group (217) than in the babies born at 22 (118) or 23 (217) weeks.

The official policy of the American Academy of Pediatrics, based on recommendations made by the President's Commission on Bioethics nearly 4 decades ago, is to encourage shared decision making for babies whose outcomes are considered to be "ambiguous or uncertain." The data suggest that there is disagreement in the professional community about whether or not outcomes should be considered ambiguous at 22 or 23 weeks of gestation. Overall, the trend has clearly been toward active treatment of smaller and smaller babies with improved outcomes at every gestational age. Based on these data, it seems likely that this trend will continue. Twenty-two weeks seems to be the clear threshold of viability.

### Online Pediatric Bioethics Certificate Program: Engaging Pediatric Health Professionals

Bioethical decision-making in pediatrics diverges from similar decision in other medical domains because the young child is not an autonomous decision-maker. Thus the balance between autonomy and beneficence is fundamentally different in pediatrics than in adult medicine. Deciding what might constitute "harm" and where to draw the line between appropriate and inappropriate deference to a child's preferences and/or parental authority are the fundamental dilemmas of pediatric bioethics.

While ethical dilemmas that reflect these fundamental issues are common, many pediatric health care training programs do not delve into the issues or offer specific training on resolving these dilemmas. To meet this need, the Children's Mercy Bioethics Center (CMBC) in Kansas City, Missouri, created an online certificate program specifically dedicated to serving practicing, experienced pediatric health professionals.

The CMBC Certificate Program in Pediatric Bioethics is a single, intensive, and blended learning program lasting nine months.

The Fall 2015 AAP Section on Bioethics Newsletter featured a nice article on the Certificate Program. If you're interested in learning more, you can read the full article at:

<http://downloads.aap.org/DOSP/BioethicsCertProgram.pdf>

## Electronic Health Care: Logging on to Your Children

### Jeffery Weness, MBA

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*(This was also printed in "Minnesota Physician Magazine" – Reprinted with Mr. Weness' permission)*

If you walk down the health technology aisle of a major retailer you'll observe a tremendous variety of activity tracking devices—Fitbit, Jawbone, Garmin, Misfit, and others. But look closer and you'll see the emergence of the next generation of devices that address more specialized areas: Kinsa, a smart thermometer; Mimo, a smart onesie; Sproutling, a "Fitbit" for babies; and the iHealth suite of products including blood pressure cuffs, scales, and glucometers. Online you'll find products like AliveCor, a smartphone connected ECG or CellScope, a smartphone connected otoscope. All of these products can be alluring for the tech-savvy parent. But all of the data from these devices can be overwhelming to a health care provider.

Until recently the data from these sensors had little use in a clinical setting. The data lived in a proprietary app and cloud with little connectivity to any clinical setting. Advances in secure integration are turning that disconnected data into actionable information when coupled with proper clinical oversight.

### Pediatrics and Health Technology

As these emerging health management tools gain greater traction, they will impact clinical interactions across the patient spectrum—none more so than for pediatrics. As parents adopt these technologies with their children, particularly those with chronic conditions such as diabetes and asthma, clinicians will need to become adept at using these new sources of information. Through this persistent connectivity, we can improve health outcomes and lower costs for many patients.

Three years ago, fitness trackers were primarily for "early adopters." Now fitness trackers are everywhere, including the type you wear on your wrist to those built directly into other devices, such as your smartphone, watch, and even your car. Consumer-grade pediatric health devices will likely follow a similar path. As we think of innovation in health devices, who better than kids and young parents to lead the charge? Kids love technology, as do many young parents. Neither group has a fear of technology, in fact,

they embrace technology more than any other generation. Plus, they give honest feedback. Mobile technology is firmly entrenched in their everyday lives.

It's entirely possible that a baby born today could have every heartbeat in their lifetime monitored and digitized. From a baby's smart onesie to wearable heart rate monitors to integrated sensors in mattresses, automobiles, and other everyday items, every aspect of their life might be quantified, and available to their health care team at the touch of a button.

### The Challenges

Creating meaningful action from this onslaught of data is a tremendous challenge. Text alerts for sports scores, online posts, and weather are ubiquitous, but you are a passive recipient of that type of information. Parents, kids, and providers will need to become engaged and responsive users of health care data. Systems to alert the parent of a chronically ill child of a meaningful health event are not readily available. The parents of a diabetic children until just recently had to "hack" into their children's glucose monitor to access the information in real time. Providing this relevant health information (glucose levels, pollen count, etc.) at the right time and in a format that achieves the greatest engagement for parents and health care providers is a top priority for many digital health companies today, however this is not without challenges. Four primary challenges exist in the pediatric health monitoring space: regulation; market size; data security; and connectivity to the care team.

### Regulation

Most connected health devices are making only general wellness claims, thus avoiding FDA regulation. This results in marketing the devices that track a baby's respiration, heart rate, O2 saturations, and sleep position as "smart baby monitors." Just as a medication can be used off label, devices are also used off label. There are stories of parents removing the motion sensors from the smart onesie and sewing them into larger pajamas as a means of notification that their nine or 10 year old is having a seizure during the night. Parents have

learned how to "hack" a product or system and create something that better fits their needs. Nightscout is a widely used data sharing cloud-based system that came out of parents "hacking" an FDA approved continuous glucose monitor (CGM). Parents are clamoring for ways to better manage their kids with chronic conditions.

### Market size

The pediatric market for health management tools is small in comparison to the adult market. Since kids are not simply small adults, tightening the strap on an adult Fitbit doesn't make it work for kids. Dedicated design of a health devices for infants and children is crucial for accuracy and ease of use. Given that the market is small (and the regulations more complex), major manufacturers have made the pediatric market a lower priority but we now starting to see products come to market.

### Data security

Physicians must address and prioritize the privacy of patient data from remote sources. Having secure transfer and integration methods into the medical record are important factors when choosing the health management partners Validic, and companies like it, make secure integration of data in the patient record possible. As we consider remote monitoring in pediatrics, many complex issues must be addressed: security on the monitoring device; security in the transmission of data to the cloud; rights and controls in accessing the data in the clinic and by parents/guardians. Parents and caregivers can't act on data if it isn't available or communicated.

### Connectivity to a Care Team

Diseases that require daily management; diabetes, asthma, heart disease; eating disorders – all lend themselves to daily remote monitoring and care team connectivity. In most existing care models, intervention happens between clinic visits only. With emerging connected technology, healthcare providers can access to data between scheduled clinic visits. In the case of a type 1 diabetic child, connected glucose monitors (intermittent and

*Continued on page 14*

## Electronic Health Care

(Continued from page 13)

continuous) allow real-time transmission of blood glucose data to both parents and the clinic. When paired with a connected insulin pump or “smart insulin pen,” caregivers can start to see a more complete picture. Through smartphones and secure cloud-based portals, real-time management of our patients will become a viable reality in the coming years.

When connected devices can securely transmit data to a connected care team, the model of care starts to shift dramatically. Interesting emerging models include Glooko and Marucci.

Glooko is a connected diabetes management system allowing for near real-time remote management of patients with diabetes. When a patient performs a glucose test using their standard glucose meter, they connect and sync through the Glooko device and transmit their results to a secure patient-management platform. In addition to glucose data fitness, activity data also syncs to the management tool. A clinician (or parent) can log in and review the glucose and activity data. Parents can now inquire about a test or practice instead of opening every conversation with “what were your numbers?” And clinicians can manage patients between scheduled quarterly visits. Glooko is adding CGM and insulin pump data in future versions of their software, which will enhance the functionality and usefulness of the service. Research is underway to start creating data sets that may eventually enable more advanced machine-based, real-time disease management.

Marucci is a sporting goods manufacturer. Their BodiTrak system integrates in-helmet concussion sensing, locker room baseline testing and virtual clinical care. Many helmets are now incorporating impact detection, but the true innovation at Marucci comes after the player is pulled from the field of play. Once a hit of significant force is detected, and the player is removed from the game, a diagnostic assessment via a tablet can take place in the locker room. An immediate, virtual connection, with impact and baseline data, will be made to a concussion specialist through the MDLive care platform. By the time the child leaves the locker room, they’ve been evaluated by a concussion specialist, have a care plan in place, and an appropriate follow-up scheduled.

### Conclusion

Technology is moving forward at an increasingly rapid rate. Dramatic changes to care models will emerge as these advances in health monitoring become more engrained in pediatrics. As hardware and software merge with smart systems, physicians will have access to information not previously available. For children with chronic conditions, these tools could be game-changers. Smart connected systems could alert the patient, the parent and the provider to potentially harmful health events such as an abnormally low glucose reading. For otherwise healthy kids, connected technology could quantify an impact to the head that needs ongoing treatment and allow that child to recover and return to school more quickly. The technology, in all cases, can be seen simply as another tool to keep children healthy and safe.

Reprinted from the Fall 2015 edition of the AAP Section on Advances in Therapeutics and Technology Newsletter

## Special Supplement to Pediatrics Spotlights Care and Treatment of Children and Adolescents with Autism

The February 1, 2016 Issue of *Pediatrics* includes a special supplement featuring federally supported, collaborative research on the health care and medical treatment of children and adolescents with autism spectrum disorder (ASD) and other neurodevelopmental disorders. Released by the Autism Intervention Research Network on Physical Health (AIR-P) and Autism Speaks Autism Treatment Network (ATN), the supplement includes analyses of a database of more than 7,000 children and youth with ASD.

The supplement, “[Health Care for Children and Youth with Autism and other Neurodevelopmental Disorders](http://pediatrics.aappublications.org/content/137/Supplement_2)” ([http://pediatrics.aappublications.org/content/137/Supplement\\_2](http://pediatrics.aappublications.org/content/137/Supplement_2)) reports on a broad array of findings by network investigators, as well as other research supported by the U.S. Maternal and Child Health Bureau through its coordinated programs to improve care for children with autism and related conditions. The compendium also includes practice guidelines addressing anxiety treatment and studies on access to diagnosis of ASD, creating autism-specific care plans in hospitals, evaluation of emergency department care for children with ASD, transition services for youth with ASD and co-occurring symptoms such as depression, sleep, irritability and behavior problems.

## AAP Statement on U.S. Preventive Services Task Force Final Recommendation Statement on Autism Screening

by: Benard Dreyer, MD, FAAP, President, American Academy of Pediatrics

The American Academy of Pediatrics (AAP) agrees with the call from the U.S. Preventive Services Task Force (USPSTF) for more research on the impact of screening and interventions for children who have autism spectrum disorder (ASD), especially those in early childhood. This critically important research must be funded so we can learn how to better identify children with ASD early in life, and how to design the most effective interventions and treatments.

However, strong evidence already exists on the benefit of formal screening using standardized tools. This type of screening can identify children with significant developmental and behavioral challenges early, when they may benefit most from intervention, as well as those with other developmental difficulties. For screening to be effective, by design it must be applied to all children – not only those who exhibit overt symptoms, or those an individual clinician judges would benefit.

The AAP stands behind its [recommendation](http://pediatrics.aappublications.org/content/120/5/1183.full.pdf+html) (at <http://pediatrics.aappublications.org/content/120/5/1183.full.pdf+html>) that all children be screened for ASD at ages 18 and 24 months, along with regular developmental surveillance. This recommendation is encapsulated in the [Bright Futures Guidelines](#) for Health Supervision of Infants, Children, and Adolescents, which serves as the blueprint for well-child visits and coverage under the Affordable Care Act. Health insurance coverage of ASD screening should not be impacted by the USPSTF statement.

Research shows that early intervention can considerably improve children’s long-term development and social behaviors. The AAP remains committed to providing its 64,000 member pediatricians with the tools and training they need to appropriately identify children with autism spectrum disorder and refer them to the treatment and services they need.

## CDC Outlines Ways to Prevent, Diagnose and Treat Children with Zika Virus Disease

Noting the rapid spread of the Zika virus, an article to be published in the May 2016 edition of *Pediatrics* was released early on March 23, 2016. It offers health care providers guidance on how to recognize, test and treat children who show signs of infection. Diagnosis can be challenging, based on limited data that shows that most infants and children with Zika virus display mild symptoms that resemble common childhood illnesses, according to the report, “Zika Virus Disease: A CDC Update for Pediatric Health Care Providers,” (<http://tinyurl.com/gtggnuuy>) by the U.S. Centers for Disease Control and Prevention. Zika virus has been identified in 37 countries and territories as of March 9, 2016. No vaccine is available to prevent infection with the virus, which is typically spread by mosquitoes and has also been reported to occur through sexual transmission from male partners. The Zika virus has been associated with birth defects, including microcephaly, with warnings issued for pregnant women to postpone travel to areas where local Zika virus transmission has been reported. Children and adults who contract the virus may show symptoms of fever, rash, joint pain or conjunctivitis. Health care providers should suspect mosquito-borne transmission of Zika virus infection in children who have traveled to or resided in an affected area within the past two weeks and exhibit at least two symptoms. Treatment consists of supportive care, including rest and fluids.

### AAP Resources on Zika Virus

The AAP is closely monitoring the spread of the Zika virus and is working closely with CDC leaders to determine how best to evaluate infants who may have been exposed. Pediatric health care providers are advised to report suspected cases to state health departments so diagnostic testing can be performed.

The AAP has collated guidance, articles and announcements, and resources on a site dedicated to Zika Virus and geared toward the pediatric health professional. The site is updated on an ongoing basis, as the situation with Zika virus is evolving. Please visit <http://tinyurl.com/AAPzika> for more information.

### Sign Up For CDC Updates!

The CDC uses a Health Alert Network (HAN) to share cleared information about urgent public health incidents. Sign up for HAN e-mail updates at <http://emergency.cdc.gov/han/updates.asp>. To receive additional e-mail updates from the CDC regarding Zika virus, visit the Keep Informed Web page at <http://www.cdc.gov/other/emailupdates/index.html>.

## Shortage of Pediatric Specialists, Rising Number of Chronically Ill Kids Prompts AAP Call to Revamp Training Funds

A shortage of pediatric specialists combined with growing numbers of children with chronic health problems and special medical needs prompted the nation’s largest group of pediatricians to call for revamping the way graduate medical education (GME) is funded.

A newly updated American Academy of Pediatrics (AAP) policy statement in the April 2016 issue of *Pediatrics*, “Financing Graduate Medical Education to Meet the Needs of Children and the Future Pediatrician Workforce” (<http://tinyurl.com/jggso6x>), notes that although U.S. medical schools have increased their enrollment to address physician workforce shortages, there hasn’t been an equal number of federally funded training positions added for new medical graduates. In addition, only three years of residency training are fully funded, while additional years of subspecialty fellowship training and other programs that train more specialized caregivers are funded at 50 percent.

Pediatric training programs face additional challenges because while most teaching hospitals receive the bulk of their GME funds through Medicare, pediatric residency programs based in children’s hospitals rely on less secure funding from the Health Resources and Services Administration (HRSA) that must be re-allocated each year.

Among the recommendations in the updated policy statement, the AAP urges that GME training for all pediatricians, including pediatric medical subspecialists and pediatric surgical specialists, be fully funded. It also recommends increasing pediatric GME positions, stabilizing funding for children’s hospital residencies and expanding the sources of GME funding to include all those who benefit from a well-trained pediatrician workforce. Government, hospitals, healthcare systems, health maintenance organizations, the pharmaceutical industry, private and public insurers, medical device and equipment companies, health information technology companies and others, it says, should contribute funding to GME training without being able to influence the curriculum or training requirements.

Authors of the report said GME training is a “public good” that is essential to having pediatricians who practice the highest quality, patient-centered care that’s accessible to all children.

“The need to fix our nation’s graduate medical education funding system has reached a critical point,” said William B. Moskowitz, MD, FAAP, chair of the AAP Committee on Pediatric Workforce and one of the policy statement’s authors. “It has to be structured so that it can produce a physician workforce that meets the evolving health needs of the country, and especially its children.”