

Fall 2010

MD INSIGHTS



Features

Management of Infants with Chronic Lung Disease

Coordinating Care of Respiratory Technology Dependent Children

Introducing Pediatric Endocrinologist Anita Swamy, MD
New Medical Director of Chicago Children's Diabetes Center at La Rabida



LA RABIDA
CHILDREN'S HOSPITAL

Perspectives in Care for Children with Special Healthcare Needs

MDINSIGHTS
Fall, 2010

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About La Rabida

La Rabida is a pediatric acute care specialty hospital. The only hospital of its kind in Chicago, it treats children with chronic illness and disabilities. Its 49-bed inpatient unit is staffed and equipped to treat and manage:

- Medical technology dependency
- Recovery and rehabilitation following surgery, a NICU or PICU stay
- Acute exacerbations of a chronic illness
- Conditioning in preparation for medical procedures

La Rabida extends its interdisciplinary team approach to all outpatient care, offering a wide range of primary care programs and specialty clinics on site. In addition, the hospital provides psychosocial care for children who have experienced abuse, neglect and/or trauma. La Rabida strives to be the hospital of choice and a trusted partner in the medical management of the children it serves and their families.

Medical Home Programs

- Adolescent
- Bronchopulmonary dysplasia
- Chronic disease
- Failure to thrive
- Premier Kids (birth to age 5)
- Sickle Cell
- Nephrology*
- Neurology*
- NICU follow-up
- Orthopedics*
- Pediatric incontinence
- Physical medicine /rehabilitation
- Podiatry
- Psychiatry*
- Rheumatology
- Spasticity multispecialty management
- Traumatic brain injury
- Technology Dependency

Specialty Clinics

- Adolescent
- Asthma, allergy
- Diabetes
- Down syndrome
- G-tube*

*For La Rabida patients only; unable to accept referrals.

Spotlight

Developmental and rehabilitative therapies

La Rabida is equipped with state-of-the art rehabilitation facilities, specifically equipped for children with special healthcare needs. Its staff of infant development specialists, physical therapists, occupational therapists and speech language pathologists provides intensive and goal oriented therapy on an inpatient and outpatient basis.

The overall goal is to help children accomplish the work of daily living: playing, exploring, communicating and completing tasks independently.



MD to MD

In this debut issue of MDINSIGHTS, La Rabida pediatric medical providers present their point of view on care for the infant with chronic lung disease and how the roles of a pediatric nurse case manager and a social worker contribute to the execution of a comprehensive care plan for children with medically complex conditions. As providers of care for children with special healthcare needs (CSHN), the clinicians of La Rabida Children's Hospital are applying years of experience across a wide range of disciplines to maximize the potential of children with chronic illness and developmental disabilities.

The aim of sharing this expertise is to build a strong network of support in the pediatric medical community for the CSHN population. MDINSIGHTS is being sent to 9,000 thousand pediatric physicians and subspecialists in northern Illinois three times annually.

In October, La Rabida is launching its 2010 – 2011 CME series *Primary Care for Children with Special Healthcare Needs*. The first is entitled *Approach to the Infant with Chronic Lung Disease in a Busy Pediatric Office*. It will expand upon the content found in this issue.

I'm a pediatrician who has devoted her practice to the treatment of children with medically complex conditions. I know well that it takes a community of pediatric professionals across a variety of disciplines to provide the wide range of services these children need.

Through publications and educational programs, La Rabida aims to share protocols and interventions that have been found to make a difference in the lives of children who have lifelong conditions.

We invite you to help shape future issues of MDINSIGHTS. Email your editorial suggestions to info@larabida.org.

It's my pleasure to introduce you to the clinicians and services that help distinguish La Rabida as a trusted medical resource and partner.

Dilek Bishku, MD
Vice President, Medical Affairs
La Rabida Children's Hospital
and MDINSIGHTS
Editor-In-Chief

Dilek Bishku, MD, MPH is an attending physician who cares for children with complex health care needs during their acute hospitalizations. She joined La Rabida Children's Hospital in 1998 as Director of the Failure to Thrive Program and since 2007, she has been Vice President of Medical Affairs. Dr. Bishku is an Assistant Professor of Pediatrics at the University of Chicago Pediatrics Department, Section of Chronic Disease.

INSIDEINSIGHTS

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Introducing

The 2010-2011 CME Series by La Rabida Children's Hospital
Primary Care for Children with Special Health Care Needs

Register NOW

La Rabida Children's Hospital In Conjunction
with The Chicago Medical Society

Presents

Approach to the Infant with Chronic Lung Disease in a Busy Pediatric Office

Rajinder Arora, M.D.

Director of Pulmonary Medicine, La Rabida Children's Hospital
Assistant Professor of Pediatrics, Pritzker School of Medicine, The University of Chicago

Raoul Wolf, M.D.

Chief, Section of Asthma, Allergy and Immunology, La Rabida Children's Hospital
Professor of Pediatrics, Pritzker School of Medicine, The University of Chicago

Nancy Richer, MSN, RN

Program Manager, Homeward Bound; Case Manager for Vent/BPD, La Rabida Children's Hospital

The above faculty members have no significant financial relationship to disclose.*

Tuesday, October 19, 2010

12:00 – 1:30 p.m.

La Rabida Children's Hospital
East 65th Street at Lake Michigan
Lunch will be provided

Target Audience and Scope of Professional Practice: Pediatricians, Family Practitioners,
Pediatric Nurse Practitioners.

Desired Learning Outcomes: At the completion of this learning activity, participants should be able to:

- Recognize components critical to the management of infants with Chronic Lung Disease by the community-based Primary Care Provider
- Establish a Plan of Care for complex pediatric respiratory patients in the home, including knowledge of one new resource required for successful support of families.
- Discuss newer modalities to assist in diagnosis and management of PHTN and complex airway issues.

This activity has been planned and implemented in accordance with the Essential Areas and policies of an Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the Chicago Medical Society and La Rabida Children's Hospital. The Chicago Medical Society is accredited by the ACCME to provide continuing medical education for physicians.



The Chicago Medical Society designates this educational activity for a maximum of **1.5 AMA PRA Category 1 Credits™**. Physicians should only claim credit commensurate with the extent of their participation in the activity.

*Planning members disclosures will be provided on the meeting agenda.

Register online at www.larabidacme1.eventbrite.com
or call 773.753.9605



Essential Management of Chronic Lung Disease of Infants in the Pediatric Office

Raoul L. Wolf, MD and Rajinder Arora, MD

Introduction

Over the past several years, there have been steady advances in care of the fragile infant who is born into extreme prematurity. As a consequence, there has been an increase in the number of children with complex chronic lung disease (CLD) who are in need of primary care. CLD is truly a multisystem disorder and has far reaching consequences extending into childhood and beyond. It most often presents as bronchopulmonary dysplasia (BPD) as a result of extreme prematurity. Other causes include pneumonia, sepsis, meconium aspiration, pulmonary hypoplasia, pulmonary hypertension, TE fistula, congenital diaphragmatic hernia and congenital heart disease.

The purpose of this feature article is to present an approach to the management of these children in a primary care office.

Description of the Patient

LM is a female who is the first of twins born at 32 weeks of gestation. She developed respiratory distress syndrome and required prolonged assisted ventilation and high oxygen leading to BPD and long term ventilator dependency. In addition, she had stenosis of the foramen magnum which required surgical decompression. Both infants have achondroplasia.

This patient illustrates the complexity of chronic lung disease in infants, most especially the presence of ventilator and oxygen dependence.

Causes of CLD

Premature birth is the most frequent and often severe cause of CLD. Premature infants under the age of 32 weeks of gestation lack pulmonary surfactant. The resultant high surface tension between the walls of the alveoli forces the infant to generate very high negative intrathoracic pressures with each breath. Alveolar collapse and a ventilation perfusion mismatch occur, where collapsed areas have good blood flow, but no oxygen while overinflated areas have oxygen but no blood flow. The result is rapid exhaustion and the need for ventilator support, usually at high pressures, which results in lung damage. Because the infant lacks in vitamins A and C, there is poor healing of damaged lungs. The result is the development of bronchopulmonary

dysplasia, which is characterized by metaplasia of ciliated columnar epithelium to squamous epithelium, scarring and overdistention and areas of pulmonary collapse, and an asthma like picture of airway reactivity. BPD is often a cause of ventilator dependency. Despite the use of high levels of O₂, the infants often experience hypoxemia. The consequences of hypoxemia are eye damage in the form of retrolental fibroplasia (dependent on blood oxygen levels), and lung damage (dependent on inhaled oxygen levels) which is aggravated by the lack of antioxidants in the premature lung.

While the use of synthetic and semisynthetic surfactants, such as Survanta™, has generally reduced the frequency of respiratory distress, extremely premature infants now survive because of the use of surfactants and develop severe lung disease.

Aspiration of **meconium** can also lead to long term respiratory difficulty, in proportion to the severity of the initial pulmonary insult. Meconium is intensely irritating in the airways, resulting in activation of macrophages and the potential for ongoing chronic peribronchial inflammation, similar to that seen in asthma. An infant with post severe meconium aspiration may remain ventilator dependent.

Cardiac diseases that result in increased blood flow through the pulmonary vascular bed can produce a reduction in compliance which produces restrictive lung disease. Examples include patent ductus arteriosus and ventricular septal defect. These infants may also require prolonged ventilator support.

Congenital abnormalities of lungs can cause compression of the airways and obstructive lung disease. In premature infants, the most common form that this obstruction takes is bronchomalacia. Compression of the airways can occur from masses, such as cysts or tumors within the lumen or in the wall of the airway. The airway can also be compressed from the outside by vascular rings or slings or masses such as a bronchogenic cyst. Both flexible bronchoscopy and rigid bronchoscopy can be used to evaluate the trachea and other intrathoracic airways.

Essentials of management

Ventilator management

An infant or child in chronic respiratory failure can be well maintained on artificial ventilation at home. This approach removes the immediate risk of respiratory arrest, and allows an infant at high risk to be cared for at home. Where possible, the simplest settings will be used. In general, changes in these settings should be made under observation by the pulmonologist, and only minor alterations are made in the home or office setting.

Tracheostomy management

The most vexing area of airway management is the question of infection and when tracheal cultures are significant. All infants with tracheostomies need to breathe humidified air, and all have waterborne organisms such as pseudomonas and acinetobacter that live as commensals. A guide to when they become invasive and the infant needs therapy is the presence of fever, tracheal culture that shows a single organism with the presence of white cells, CBC with a left shift, and pulmonary invasion such as pneumonia. Note, however, there is a risk of organisms developing resistance with frequent use of antibiotics.

Oxygen

While oxygen is a major pathophysiological agent in the development of BPD and retinitis of prematurity, it is essential to provide adequate oxygenation in managing these infants. The patient should receive supplemental O₂ to keep O₂ saturation above 95%. This approach improves growth, and with it the development of new, healthy, lung tissue. The use of O₂ does not increase risk of injury in infants and children once past the immediate premature newborn stage. A particularly insidious complication caused by low arterial O₂ is cor pulmonale. In addition to the cardiovascular complications of cor pulmonale, alveolar development is impaired, with a reduced number of alveoli forming during somatic growth. Generally, patients with cardiac complications of BPD require follow-up by a pediatric pulmonologist and/or cardiologist. Pulmonary vasodilator therapy may be required which needs close monitoring.

Nutrition

Infants with CLD have difficulty maintaining expected growth rate, weight gain, and development. The causes of growth failure and malnutrition in affected infants include dysfunction of multiple organ systems, decreased nutritional intake, hypoxemia and increased work of breathing. Fluid retention may significantly limit or restrict pulmonary function in infants with BPD and makes it difficult to prescribe an adequate diet. These components need to be

addressed individually. Many patients with BPD require caloric intake as high as 130 Kcals/kg and they should be on adequate oxygen to meet more than baseline demands. Diuretics help to control excess fluid, especially pulmonary fluid, but should be titrated to the least dose needed for control. Hypercalcaemia and hypercalcemia often occur in infants on chronic diuretic therapy and the patients should be monitored for these complications.

Home monitoring

An increased risk of mortality has been documented in infants with CLD. Werthammer and coworkers reported histologic evidence of resolving CLD at autopsy in all SIDS infants with CLD. The diagnosis of SIDS was based on the absence of any other causes of death at autopsy. Gray and Rogers demonstrated reduced risk for SIDS in infants with CLD with appropriate management including close attention to oxygenation. These risks emphasize the need for home monitoring. In addition to the intrinsic pressure alarms on a ventilator, oxygen saturation and apnea monitors are recommended.

Conclusion

Infants with CLD present a complex management challenge, especially in a general pediatric office. In addition to high pulmonary demands, these children often have multiple neurological and growth problems that demand attention. To cope with these demands, the patients need frequent visits to the office so that attention can be given to the key areas of oxygenation and respiratory stability and growth and nutrition. If necessary, additional visits can be used for routine pediatric care and other problems that do not carry the risk of being immediately life threatening.

See additional readings on page 10.



Rajinder Arora, MD is Director of Pulmonary Medicine at La Rabida Children's Hospital and Assistant Professor of Pediatrics at the Pritzker School of Medicine at the University of Chicago.



Raoul Wolf, MD is Chief, Section of Asthma, Allergy and Immunology at La Rabida Children's Hospital and medical editor for this issue of MDINSIGHTS. He is Professor of Pediatrics, Pritzker School of Medicine at the University of Chicago.

Practice Insights

Helpful Hints for the Busy PCP Caring for the Infant with Chronic Lung Disease

Dilek Bishku, MD

Introduction

For most of us general pediatricians, a NICU calling to ask if we can follow a baby discharged home with a trach, or a PICU referring a vent dependent child to our office is both fascinating and anxiety provoking. Nowadays more and more children with chronic lung disease (CLD) are discharged home on artificial ventilation, and as primary care pediatricians we are excited to be a part of patient care at this new frontier. At the same time, we feel uncertain. Is it really possible to manage a vent dependent child in a busy pediatric office? If so, how do we do that? What kind of skills and resources do we need to acquire? Can our staff handle the needs of the family? Are we equipped to deal with the level of complexity presented by a ventilator dependent baby?

Drs. Arora and Wolf as pediatric specialists and Dr. Jaudes as a primary care pediatrician (PCP) are among the physicians who have been providing comprehensive outpatient multidisciplinary care to children with complex health care needs at La Rabida Children's Hospital for many years. In the following pieces they outline the issues concerning the management of infants with CLD and provide helpful suggestions to get the primary care pediatrician started on this new and exciting path.

"A child who is chronically dependent on a ventilator can be managed in your office, live at home and go to school. Interdisciplinary support will be crucial."

Helpful Hints for the Primary Care Pediatrician

- It may look intimidating at first, but a child in chronic respiratory failure does not necessarily belong in a PICU or a hospital floor. A vent dependent child can live at home, go to school and be managed in your office. Of course, you will need help.
- Ventilator management at home is different than ventilator management in PICU. Home vent settings do not need to be changed as often. As long as you keep an active dialog going and update each other regularly, a pediatric pulmonologist can manage the ventilator settings without you having to make complex decisions.
- Children with trach tubes can get colds and nonspecific URIs just like all children. It is not necessary to

prescribe antibiotics just because the child has a trach. Let the clinical picture and judiciously sent cultures guide your decisions rather than anxiety.

- Growth and the new alveolar tissue generated by growth is the only "cure" for CLD of the preemie. Carefully monitor the growth and maintain O₂ saturations above 95% at all times. Proper nutrition is necessary to ensure adequate growth.
- A child with BPD may require caloric intake as high as 130 Kcals/kg and adequate oxygen to meet more than baseline demands and grow. Use the lowest dose of diuretics you can possibly use but do not cut down on the calories to avoid diuretic use.
- Use home monitors for the child with CLD and teach the caretakers how to respond to monitor alarms.

- Organize. Create and work with specific care plans and establish goals. Share the plans and goals with the family and treat them as members of the medical team.
- Learn the reimbursement rules and use appropriate coding and billing practices so that you can afford to provide the attention your patients with CLD need. Children with complex health care needs require more frequent office visits and more time so that all aspects of their care can be adequately addressed.
- CLD is best managed with a interdisciplinary team and in a medical home setting. Collaborate and communicate with all the professionals involved in the patient's care and optimize your use of information technology.
- Remember that case managers and social workers are the back bone of your patient care team and crucial to success.

Coordinating the Care of Respiratory Technology Dependent/Medically Complex Children

By Paula Jaudes, MD, Nancy Richer, MSN, RN, and Rosalva Torres, MSN, RN, CCM

Coordination is paramount when providing primary healthcare for a child who is respiratory technology dependent. Only by working with a team of interdisciplinary health providers can the primary care provider provide the day-to-day and long range requirements for that child and the family. The Medical Home Model, first coined by the American Academy of Pediatrics, is the gold standard for providing primary care for children with special healthcare needs.

While the pediatrician and pediatric pulmonologist deal with most of the complex medical needs of the child, the other members of the team help provide the supportive services and safety net for a family to keep their child who is medically complex at home. Two important team members, the Pediatric Nurse Case Manager (NCM) and Pediatric Social Worker ensure continuous and coordinated care for these children and their families.

Role of the Nurse Case Manager

The NCM serves as a central contact person for the patient, family, caretakers, interdisciplinary team members, and all other providers involved. The complexity of coordinating the care of respiratory technology dependent, medically complex children requires the contributions of multiple agencies and professionals in order to provide optimal care and supportive services (see Table I and Table II). The NCM has the expertise required to collaborate within and across the interdisciplinary team and multi-agencies. No single discipline holds the key for optimal delivery of care. The collaboration and coordination of care is crucial. Caring for these children and meeting their needs is the driving force of the interdisciplinary team and multi-agencies involved (Harrigan et al., 2002).

In the inpatient setting, the coordination of the discharge process is multifaceted. It includes the coordination of the education and training required by families and caretakers to enable competent, safe, and effective care in the home (see Table III).

Assessing family and caretaker needs as well as identifying potential barriers -- such as reading ability, sight, hearing, and language barriers -- is essential to the design and implementation of an educational training program that successfully accommodates learning style preferences and meets the needs of the child and the adult learners.

The transition to home is stressful and overwhelming even after optimal competence is achieved by families and caretakers. Their home environment will be severely disrupted in order to accommodate the multiple needs and services required from multiple providers. Early identification of their needs allows for timely implementation of individualized, family

centered care and training. The coordination and implementation of supportive services provides access to comprehensive hospital, home, and community services (Noyes, 2002).

In the outpatient setting, the NCM continues to serve as the central contact person and coordinates and monitors the appropriateness of the care

and services provided by all the agencies and personnel involved in the child's care (see Table IV). The NCM serves as the liaison between re-hospitalizations and re-integration of services and support systems once the child is ready to return home.

The Role of the Social Worker

If the NCM serves as the anchor for the team, it is the social worker who functions as the safety net for families who may otherwise flounder. While the NCM addresses the family's concrete needs, the social worker focuses on the less tangible aspects of the patient-family system, often providing a measure of otherwise absent psychosocial support. This is accomplished through the formation of relationships with family members utilizing the non-threatening framing of questions that families often do not wish to hear and nurses do not wish to ask. These include queries related to mental health or substance abuse issues, community agency involvement, and other personal information regarding individuals residing in the home.

Some major areas of concern tackled by the social worker may also include assisting families of technology-dependent children in the reconciliation of the dual role of parent/caregiver (Kirk, Glendinning & Vallery, 2005), the execution of Advance Directives (Provine, 1994) or in the identification of parental depression which has been found to significantly impact the family functional status and, thereby, the child's care (Boebel-Toly, 2009). Although the NCM can be trained to gather this type of information and generate appropriate community referrals, it can be difficult to toggle casually from one role to another and has the potential for disruption of the nurse-family relationship.

Since most community-based practitioners do not routinely employ social workers, it may be necessary to secure a potential referral source prior to agreeing to serve technology-dependent children and their families. This will help to assure a safe home environment for the family and allow practitioners to provide the best possible care. In addition, this practice concurs with American Thoracic Society recommendations for technology-dependent patients, "A multidisciplinary health care team is needed to address the patient's holistic needs." (ATS, 2005)



Paula K. Jaudes, MD is president and CEO of La Rabida Children's Hospital, where she has treated and advocated for pediatric patients for more than 30 years. Jaudes is a board-certified pediatrician who also is a Professor of Pediatrics at the University of Chicago. She has received numerous honors for her leadership and now is President Elect of the Illinois Chapter of the American Academy of Pediatrics.



Nancy Richer, MSN, RN is a respiratory case manager at La Rabida Children's Hospital, where she has worked for 15 years. Richer serves as a liaison between home and hospital for chronic ventilator-dependent children, coordinating ventilator clinics and training home healthcare nurses. Richer received the 2010 Champion for Children's Award from the University of Illinois at Chicago, Division of Specialized Care for Children.



Rosalva Torres, MSN, RN, CCM is a nurse case manager for the inpatient ventilator dependent patients at La Rabida Children's Hospital, where she has worked for 21 years. Torres works with the Illinois Division of Specialized Care for Children and oversees the transition of vent dependent patients from hospital to home. Fluent in Spanish, Torres serves as case manager for inpatient Spanish speaking families and provides weekly training on gastrostomy and tracheotomy tube care and CPR for parents and caregivers.

Table I. Sample list of interdisciplinary team members

- Physician
- Resident
- Psychologist
- Nurse
- Nurse Case Manager
- Social Worker
- Nutritionist
- Respiratory Therapist
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Infant Development Specialist

Table II. Sample list of providers involved in the care of medically complex/technology dependent children provided by the Division of Specialized Care for Children (DSCC)

- Home Care Nursing Agency
- Equipment Company
- Early Intervention
- Schools
- Primary Care Provider
- Specialty Care Providers
- Social Service Agencies
- Transportation Services

Table III. Education and training needs

- Gastrostomy Tube Care/Nutrition Management
- Tracheostomy Tube Care/Airway Management
- Ventilator Care
- CPR/Airway Obstruction Training
- Medication Administration
- Home Therapy Early Intervention Program
- Emergency Care

Table IV. Sample list of services provided by nurse case manager

- Education and training
- Appointment follow-up and coordination
- Revision of home care nursing plan of treatment
- Home nursing care coordination
- Durable medical equipment and supply coordination
- Safe patient home care management coordination
- Readmission coordination of services
- Re-establishment and coordination of home care services

Introducing
Anita Swamy, MD
 New Medical Director Diabetes Program

Anita Swamy, MD and two other pediatric endocrinologists from Children's Memorial Hospital, joined the Chicago Children's Diabetes Center (CCDC) at La Rabida Children's Hospital in September.

Dr. Swamy brings proven experience and impressive credentials to her position as Medical Director and Program Co-Director, a position she shares with Co-Director Rose Briars, ND, PNP-BC, CDE.

Previously, the Director for the Pediatric Diabetes Program at Hope Children's Hospital, Dr. Swamy built a comprehensive program that now serves children with Type I and Type II diabetes.

She recently sat down with La Rabida's Media Relations Specialist Zion Banks to discuss the future of diabetes care, her personal experience with the disease, and her inspirational patients.

ZB: Why did you choose to come to the Chicago Children's Diabetes Center (CCDC) at La Rabida?

AS: I came to Chicago in 2008 to start a diabetes program at another institution. I wanted to know which institution at the time exemplified "best practices" in diabetes management. My search led me here and I visited for a tour and overview of the CCDC. The minute you walk in, you can sense the passion. There is a dedicated team for children with diabetes, and great teaching initiatives. Also, it's a personal challenge having started and grown a program elsewhere, to further develop the existing program with the help of the other physicians and excellent staff.

ZB: What do you want other pediatric providers to know about the CCDC at La Rabida?

AS: Diabetes is chronic care, so you have to consistently reeducate and update. We're giving parents tools to manage their child's care at home in anticipation of problems so they may be avoided.

The CCDC at La Rabida also has support programs for parents, kids and school-based caregivers. I don't think there's another pediatric diabetes program in the city that addresses all those audiences.

Another important aspect is the number of clinics at the CCDC. It's so easy for patients to get in and see providers. Also we accept Medicaid, and at a time when the bottom line is everyone's concern, it's nice to know that we can treat all patients regardless of their ability to pay.

ZB: How do you communicate with referring pediatricians?

AS: After the patient visit, I send a letter to the physician outlining my plans, concerns and goals. I also plan to host physician education programs -- to explain the evaluation and treatment of diabetes, and what we can offer through the Chicago Children's Diabetes Center at La Rabida to help them. They can have their questions answered and network with other providers who may see patients with similar issues or challenges.

ZB: What are the challenges of managing pediatric diabetes in a primary care setting?

AS: Diabetes care is very challenging for any provider to manage. There are so many things that I did not know, even as the daughter of a diabetic, that I learned only after years of training in my specialty and continued clinical experience.

And, we're continuing to learn. Our program focuses on the diabetic patient and with all the things that are out there to benefit them -- new medicine, new methods of delivery, new technology. Diabetes care is daily. Families need to have a way to reach a clinical expert at a moment's notice.



Rose Briars, ND, PNP-BC, CDE ; Anita Swamy, MD; Jennifer Miller, MD; Courtney Finlayson, MD

ZB: So is providing education the most satisfying part of your work?

AS: Yes, seeing a child who is not doing well at all and teaching them to take care of themselves and then witnessing their improvement is so satisfying. We've kept so many kids out of the hospital and helped improve their lives.

If you spend time with them in the beginning and tell them how important this is from day one, they will respond. I have quite a few patients who want to be pediatric endocrinologists in the future and that's a very good feeling to know that I not only helped treat their diabetes, but that I could actually be a role model.



Anita Swamy, MD, a Children's Memorial Hospital board certified pediatric endocrinologist is the medical director of the Chicago Children's Diabetes Center at La Rabida.

Chicago Children's Diabetes Center

AT LA RABIDA CHILDREN'S HOSPITAL

Anita Swamy, MD and Rose Briars ND, CPNP, CDE Co-Directors

- An ADA - recognized program
- An interdisciplinary team who provides pediatric speciality care to nearly 1,000 children
- Offices located in Chicago, Hinsdale, New Lenox and coming soon to Northwest Indiana
- Public and private insurance accepted

How to Make a Referral

La Rabida welcomes referrals from hospitals and physicians across metropolitan Chicago and Northwest Indiana. It accepts public and private insurance.

Inpatient referrals: Call 312.498.4408, 24/7

Outpatient referrals: Call 773.753.8627, weekdays during business hours

La Rabida Literature

together

Scope of Services Brochure

This 20-page brochure highlights the inpatient and outpatient services La



Rabida provides to children with special healthcare needs.

It describes the hospital's interdisciplinary and family-centered approach

to patient care and explains La Rabida's:

- Care team staffing
- Typical types of inpatient admissions
- Medical home model for primary care
- Developmental and rehabilitative therapy services
- Psychosocial support services.

To receive a copy of the brochure email tbrim@larabida.org or call 773.753.8649. To view the brochure online, visit www.larabida.org/physicianresources.

Additional Readings

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