CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

Project ECHO®

ADVANCING INTEGRATED HEALTHCARE

# Pediatric Sleep ECHO®

## Session 3:
## Focus on Young children (ages 1-3)

Date: July 25, 2024

*PLEASE NOTE: Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a project ECHO setting*

*Care Transformation Collaborative of RI*

# Welcome

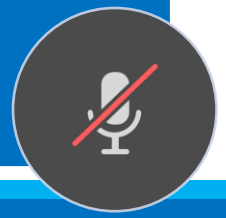
- This session will be recorded for educational and quality improvement purposes
- Please do not provide any protected health information (PHI) during any ECHO session

**Introduce Yourself**

- Please turn on your video
- Please enter your name and organization in the chat box

**Microphones**

- Please mute your microphone when not speaking



# Agenda

| Time | Topic | Presenter |
|---|---|---|
| 7:30 – 7:35 AM | Welcome | Liz Cantor, PhD |
| 7:35 – 8:00 AM | Didactic Session:<br>Focus on Young children (ages 1-3) | Julie Boergers, PhD |
| 8:00– 8:25 AM | Case Study and Discussion | Colette Vieau, MD<br>Partners in Pediatrics |
| 8:25-8:30 AM | Wrap Up | All |

# Case Presentation Schedule

- Continue Practice Facilitation meetings with Liz Cantor
- Practices discuss case presentations to prepare for the upcoming sessions

| Session # | Date | (Tentative) Content to be Covered | Practice presenting case study |
|---|---|---|---|
| 1 | 5/23/24 | Sleep 101 | |
| 2 | 6/27/24 | Focus on Infants | Anchor |
| 3 | 7/25/24 | Focus on Young children (ages 1-3) | Partners in Pediatrics |
| 4 | 8/22/24 | Focus on Preschool aged children (ages 3-5) – 1 | Group Discussion |
| 5 | 9/26/24 | Focus on Preschool aged children (ages 3-5) – 2 | Blackstone Valley |
| 6 | 10/24/24 | Autism and sleep | Atlantic |
| 7 | **11/21/24*** | Focus on Elementary school aged children (ages 6-10) | PRIMA |
| 8 | **12/19/24*** | Focus on Middle School aged children (ages 11-13) | Waterman |
| 9 | 1/23/25 | Focus on High school aged children (ages 14-18) – 1 | |
| 10 | 2/27/25 | Focus on High school aged children (ages 14-18) – 2 | |
| 11 & 12 | 3/27/25<br>4/24/25 | Practices present success stories | |

# ECHO Series: Optimizing a Behavioral Health Approach to Children's Sleep in Pediatrics

# Sleep in Toddlers


## Julie Boergers, PhD


## July 25, 2024

BROWN
Alpert Medical School

Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
*A Lifespan Partner*

# Objectives

- Describe sleep-wake patterns in toddlers
- Discuss strategies to collaborate with families to improve readiness for sleep
- Discuss strategies to collaborate with families to reduce night wakings

# Sleep in Toddlers

- 11-13 hrs/day including naps
- Development of nighttime fears, nightmares
- Struggles for control; end of day disorganization
- Sleep problems (20-40%) and nighttime wakings (up to 60%) common
- Bedtime routines, transitional objects become more important

# General Sleep Tips for Toddlers

- Reassurance during periods of normative regression (e.g. changes in caregiving, toilet training, birth of sibling, etc)
- Anticipate that transition from crib to toddler bed can create issues
  - Temporarily sitting silently by door (inside or outside room)
  - Baby gate pros/cons
  - Baby monitors

# More Sleep Tips for Toddlers

- Dealing with the “ninja” who climbs into parents’ bed undetected (bell on door – return every time)
- How to encourage transitional objects, once allowed
  - Have parent carry it around and/or sleep with it, model comfort behavior
- Don’t assume there is a consistent routine; collaborate on one
- Explore family values – cosleeping as a choice? Vs. reactive, part-night co-sleeping to get more rest – harder to break

# Night Wakings

- Is bedtime appropriate? (excessive time in bed for age can lead to sleep fragmentation)
- Check if expectations are appropriate (some wakings are normal)
- Consider manipulating nap (earlier? shorter?)
- Snoring? Restless sleeper?
  - Screen for low iron stores, especially if a picky eater and/or excessive milk intake. Target ferritin level is >50 in children with sleep disturbance (though lab will not flag unless v low)

# Night Wakings

- Are they falling asleep elsewhere and being transferred to own bed? (can confuse/unnerve them)
- Any condition present at bedtime should also be present during the night (e.g. white noise)
- ***Even if parent tells you the child has no trouble falling asleep, always ask about HOW they fall asleep and check for sleep onset associations (e.g. parental presence, rubbing back, bottle/cup, pacifier, TV)

# AASM Practice Parameters for Behavioral Treatment of Bedtime Problems and Night Wakings in Young Children

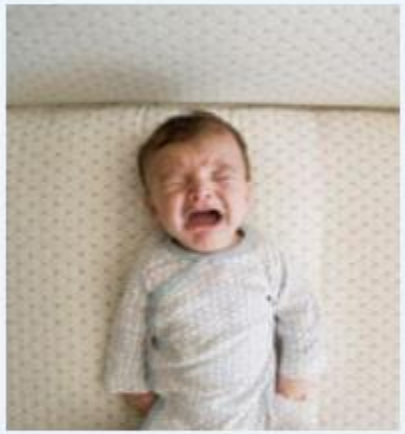
- Behavioral treatment produces clinically significant, reliable, and durable changes
- Produced positive effects on secondary outcome variables
  - Child-related, such as daytime behavior
  - Parent-related, such as parental well-being
- Adverse effects of behavioral treatments were not identified in any studies
- Insufficient evidence to recommend any single “sleep training” technique over another.

*(Mindell et al., 2006)*

# Countering Misinformation

SATURDAY, JANUARY 23, 2010

## Crying It Out Causes Brain Damage



Research suggests that allowing a baby to "cry it out" causes brain damage.

by Dr. Stephen Juan

Psychology Today

Find a Therapist | Get Help | Magazine | Today

Ph.D.

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CAREGIVING

## Dangers of "Crying It Out"

The practice comes from comes from a misunderstanding of child development.

Updated May 17, 2024 | Reviewed by Matt Huston

KEY POINTS

- Mothers and babies are designed to be a responsive dyad. Babies express their needs through crying.
- Letting babies "cry it out" is a form of need-neglect that leads to many long-term effects.
- The "cry it out" method releases stress hormones, impairs self-regulation, and undermines trust.

# In defense of behavioral interventions…

- Self-soothing is an important step in the development of self-regulation
- Improvement in bedtime problems and night wakings leads to improved well-being for both caregiver and child
- Unaddressed sleep problems may become chronic
- Negative consequences have not been identified (other than short-term distress)

# Countering Misinformation

- A small study suggesting an association between cry it out and insecure attachment (Ainsworth et al, 1978, n=26) has never been replicated
  - Strong evidence from studies with larger/more diverse samples that there is **no** significant association between cry it out and attachment (Van IJzendoorn & Hubbard, 2000, n=50; Bilgin & Wolke, 2020, n=178; Giesbrecht et al., 2020, n=137).
- No significant increase in cortisol levels of infants before and after sleep training (Middlemiss et al.2012)
- 5-year followup (n=225) of a nurse-delivered sleep training intervention showed *no long-term effect* (+ or -) of tx on emotional/behavioral probs, diurnal cortisol, attachment, parent mental health, or sleep habits/problems (Price et al., 2012)

# Popular Sleep Training Methods

- **Cry it Out** - Place child in crib, leave the room, return in the morning
- **Ferber Method/Controlled Crying** - Leave the room, come back for *quick* checks for reassurance *without picking child up*. Gradually increase time between checks.
- **Excuse Me Drills** - Sit in room until child is calm/sleepy, then make up an excuse to leave, “be right back”. (Gradually increase time you’re out of the room).
- **Chair Method/Camping Out** - Stay in room until child is asleep. Sit in chair next to bed, and over time move chair closer and closer to door.
- **Pick Up/Put Down** - If child cries, pick them up/soothe them, put back in crib when calm but still awake, leave the room; repeat as often as necessary

# How to Develop a Treatment Plan

- Recognize there are multiple possible etiologies and many ways to sleep train
- Evaluation guides intervention – “nitty gritty” specifics about conditions under which the child falls asleep (esp where is the caregiver?), caregiver response
- Help family choose among different approaches *(how quickly does it need to happen? How well can they, and the child, tolerate distress? What are their parenting values/goals? Are there other family members/neighbors who would be disturbed by excessive crying?)*
- Work on extinguishing one sleep “prop” at a time (e.g. bottle, rocking)
- Fussing/displeasure vs. crying
- Consistency the key to any approach

# Example: Extinction *with* Parental Presence (aka camping out, chair method, etc)

- Parent remains in room until child falls asleep, but provides progressively less reinforcement each night
- Parental presence is gradually shaped such that child learns to self-soothe. E.g. start by laying in bed with no physical contact, then sit on side of bed, then sit in chair at bedside, etc.  Progress to next step after child able to fall asleep in 20-30 min. for >=3 days.
- If child can't tolerate a step, break down further (e.g. hold hand > hold finger
- Parent **must** ignore child – no talking or otherwise interacting.  If necessary, return child to bed with "poker face," minimal interaction ("Time for bed").
- Repeat same procedure for all night wakings (or just start with bedtime/naptime at first)


In hall
By door
In room
By bed
Rub back

# Avoiding Pitfalls

- Avoid doing “cry it out” unless can really commit to it
- With training methods that involve checking, avoid increasing reinforcement
- Avoid allowing child to extend sleep via later wakeup time or longer nap if they took longer to fall asleep due to sleep training process
- Easier to accomplish before child transitions to bed
- Temporary slightly later bedtime (a.k.a. “bedtime fading”) can be very helpful to ensure sleepiness
- Ensure parents understand rationale, and warn about Extinction Burst!

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# Pediatric Sleep ECHO®
# Case Presentation

Presenter(s): Colette Vieau, MD

Date: July 25, 2024

Contact Info: (401) 437-6777

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# Basic Patient Information

Do Not Include PHI

| | |
|---|---|
| **Age/Grade in school (if relevant)** | 3 yo |
| **Gender Identity** | Male |
| **Race/Ethnicity** | Caucasian |
| **How long has this individual been in your care?** | Since birth |
| **Who does the patient live with/family constellation?** | Mom and dad |
| **Insurance type (Commercial, Medicaid, Uninsured, Other)** | Commercial |

# Reasons for Selecting this Case

Do Not Include PHI

| | |
|---|---|
| **Presenting problem** | • 3-year-old male presents for well check; mom has list of Qs, biggest concern being about **bedtime and sleep**<br>• **transitioned to toddler bed** already<br>• **good bedtime routine** consisting of bath, book, song<br>• **strong attachment to mom**, he always wants mom to put him to bed<br>• but it **ends in a struggle** for her to leave the room; she often finds herself lunging for the door before he can get out of bed to grab her; he will start **hitting and screaming,** pulling hair...it is very **traumatic** for both of them<br>• **much better when dad does bedtime** - he cries but then goes to sleep |
| **What questions do you have for the group?** | What guidance would you give?<br>Melatonin?<br>Refer? |

# Relevant Background

Do Not Include PHI

| | |
|---|---|
| **Relevant medical and/or behavioral comorbidities** | Generally healthy.<br>Still having trouble with drop off at school - tears |
| **Relevant medications, lab results** | none |
| **Relevant SDOH Screening results** | none |
| **Other relevant background** | Child is often aggressive with mom, not just at bedtime; control issues |
| **Any previous interventions for sleep?** | Previously discussed sleep training and consistent bedtime routine; discussed how to handle when he gets physical and how to utilize positive reinforcement techniques |

# Relevant Social History

Do Not Include PHI

| | |
|---|---|
| **Family history of sleep disorders?** | none |
| **School related concerns?** | Does great at school |
| **Other social history concerns?** | none |

# Patient /Family Successes and Strengths?

Do Not Include PHI

- Very invested parents
- Willingness to listen and learn
- Both parents are "on the same page"
- Have successfully implemented sleep training strategies previously

# Summary & Clarifying Questions

# Reasons for Selecting this Case

Do Not Include PHI

| | |
|---|---|
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# CME Credits

## (Pending credit for MDs, PAs, Rx, RNs, NPs, PsyD, PhD)

- CME Credits – Please request session credits when filling out the evaluation at the end of the meeting.

- Evaluation/Credit Request Form:
  https://www.surveymonkey.com/r/echosleep

*The AAFP has reviewed 'Advancing Community-Oriented Comprehensive Primary Care Through Improved Care Delivery Design and Community Health,' and AAFP credit is pending. Term of approval is from 04/19/2024 – 04/19/2025. Physicians should claim only the credit commensurate with the extent of their participation in the activity.*
*NPs and RNs can also receive credit through AAFP's partnership with the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification Board (AANPCB).*

# Thank you!

## Next Meeting:

Thursday August 22nd, 2024 - 7:30 – 8:30 AM

Focus on Preschool aged children (ages 3-5)

Evaluation/Credit Request Form: https://www.surveymonkey.com/r/echosleep