CME Article

Failure to Thrive, Kairys, 6

Case Reports

Autoimmune Hemolytic Anemia in a Child with Ulcerative Colitis, Monteiro, et al, 16

Short Report

Raynaud Phenomenon, Moorthy, Boneparth, 10
Screening for Sleep Disorders in Children with Adverse Childhood Experiences, Gallo, 12
Intrathecal Baclofen Therapy in Pediatrics: A Pediatrician's Perspective, Mazzola, et al, 18

Resident Voice

Paving the Way to the Future: Reflections of a Pediatric Chief Resident, Mohla, 22

Legal

Out of Network Challenges to Providers, Schoppmann, 14

Legislative

Access to Care/CSOC/Mental Health/Vaccine Mandate, Simonetta, DeSarno, 15

Resources

Strengthening Families' Health with WIC Services and Breastfeeding Support, Gateway WIC 20

Winter Safety Tips, AAP, 26

Family Voice

Families and Pediatricians Working Together for Children Who “Fail to Thrive,” Agoratus, 32
6 CME Activity  
Failure To Thrive  
By Steven Kairys MD, MPH, FAAP

10 Raynaud Phenomenon  
By L. Nandini Moorhy, MD, MS, FAAP  
Alexis Boneparth, MD

12 Screening for Sleep Disorders in Children with Adverse Childhood Experiences and Other Special Needs  
By Ralph Gallo, MD

16 Case Study: Autoimmune Anemia in a Child with Ulcerative Colitis  
By Iona Monteiro, MD  
Jaclyn Tamaroff

18 Intrathecal Baclofen in Pediatrics: A Pediatrician’s Perspective  
By Catherine Anne Mazzola, MD  
Brianna Nicole Carr  
Kara R. Bradley  
Melissa Ann Eppinger, BA  
Michael DiGaetano

22 Resident Voice: Paving the Way to the Future: Reflections of a Chief Resident  
By Rachika Mohla, MD, MS

28 Pediatricians and Pediatric Neurosurgeons on the Same Side  
By Catherine A. Mazzola, MD

30 Pediatrics in Bhutan  
By Lisa M. Nalven, MD, MA, FAAP

32 Family Voices: How Pediatricians and Families can Work Together for Children  
By Lauren Agoratus, MA

32 ARTICLES & COLUMNS

3 President’s Column
4 Executive Director’s Column
5 Medical Director’s Column
6 CME Activity
9 CME Quiz
11 MOC Part 2 and Part 4 Opportunities
13 Collaborative Mental Health Care Pilot Program
14 Legal Update
15 Legislative Update
19 C.A.T.C.H.
20 Strengthening Families’ Health with WIC Services and Breast-feeding Support
23 Twenty Babies Saved: CCHD Screening with Pulse Oximetry
24 School Health Conference
26 AAP Holiday Safety Tips for Parents and Caregivers
29 Save the Dates
31 Pre-K Our Way
33 Healthy Eating Strategies
34 Human Trafficking Red Flags
Disaster Planning for Dummies: Three Steps for Preparing Your Office and Patients

While National Preparedness Month was spotlighted in September, natural disasters and the need to be prepared for them should be on your radar year round. Throughout the month, we were reminded that ten years have passed since Hurricane Katrina, four since Hurricane Irene and three since the most recent disaster, Super Storm Sandy. In the aftermath of Sandy, many of you may still be recovering, or continue aiding your patients and their families cope. In an effort to simplify your work in this regard, I have gathered together some of the tools that were developed in the wake of these past disasters and present them now in a few simple steps to prepare ourselves, our offices and our patients for events that would interrupt power and/or communications for an extended period of time and disrupt any sense of normal functioning. The resources mentioned throughout this article (plus additional ones) can be found on the www.AAPNJ.org home page by clicking on the Disaster Toolkit link. Each of the numbered links in this column corresponds with the similarly numbered link in the ToolKit. Additionally, there are many resources available through both AAP - (www.aap.org/disasters) and the CDC (beta.ready.gov) dealing with disaster preparedness that we should familiarize ourselves with. Many of the most important of these resources have also been included in the Disaster Toolkit for your convenience.

Ideally you have already reviewed this information and are 100% prepared for the next disaster. But, chances are you, like most of us, are aware of the need, but do not know where to start. To tackle this seemingly daunting task, I offer the following three steps that will help you get started.

STEP ONE: Prepare a Vaccine Action Plan for your office(s)

If you already have a standby backup generator, you may not need to do this. Start with (LINK#1) for information on safe vaccine storage and transport. Next, open (LINK#2) and fill out the worksheets, designating who is responsible and what their tasks are for securing and transporting vaccines. Make sure you have arranged a safe place to which they can be moved. Potential safe sites may include a partner’s residence, who has a standby or portable generator or perhaps your local hospital pharmacist, or a local EMS squad. Review these arrangements annually to ensure contacts are still in place. Not to overstate the obvious, but all these plans should be printed out in hardcopy and be readily available in multiple locations on and off site.

STEP TWO: Help your patients fill out a Special Needs Disaster Action Plan.

Certainly among the most vulnerable patients during a disaster will be those who rely on power and communication for nebulizers, ventilators, regular medications, etc. The AAP has provided guidelines for managing Emergency Preparedness for Children With Special Health Care Needs. Access the information and forms through (LINK#3). Both the patient and the practice should retain a copy of these forms and they should be updated regularly. Take time to complete the Emergency Information Form for Children with Special Health Care Needs at (LINK#4a,b). In addition, familiarize yourself and your special needs families with the NJ Department of Health Medical Needs Shelters. This information is available through (LINK#5)

THIRD STEP: Educate your patient’s families about the importance of their own preparation.

The CDC has an excellent campaign, that in addition to other valuable information, provides toolkits for families to help them prepare for the unexpected. You can get them started by giving them these 3 checklists handouts from FEMA: (LINK#6), (LINK#7) and (LINK#8).

So, even though thoroughly preparing your office and patients for disasters may seem like an overwhelming task, these three steps will move you and your patient’s families a little closer. Updating these plans on a regular basis, perhaps every September during National Preparedness Month, should become a regular part of your patients’ anticipatory guidance as well as ongoing quality improvement for your office.

Elliot Rubin, MD, FAAP
President, NJAAP
Executive Director’s Column

Fran Gallagher, MEd  
Executive Director, NJAAP

We made a difference in 2015!

NJAAP is an active and vibrant Chapter, focused on optimal health for all children in New Jersey, through family-centered health care in pediatric medical homes. Our Chapter offers a strong voice for all children and support for their families by focusing on assistance and support for you – the pediatricians caring for children. We’re growing. We welcomed 190 new members in 2015, and 44 members who had lapsed for 3+ years have rejoined. Welcome! Please let us know what you find most valuable from the Chapter and what you would like us to incorporate into our work in 2016. We’re always interested in what’s important to you and we are open to your thoughts on how we can enhance membership value.

It’s hard to believe that 2015 is coming to a close. Before that happens, I’d like to share a few highlights…

• Our Government Affairs Committee works on advocating on important pediatric and pediatrician related issues, see page 15 for the Legislative Update review.

• Over 2,700 pediatricians and health care providers participated in various NJAAP continuing education opportunities through, conferences and grant quality-improvement initiatives.

• New Jersey Pediatrics published 3 Special Editions and 3 regular editions throughout the year. All totaled, our publications provided members with 8 CME activities. Check out the back cover of this issue to learn how you can easily access and share them with your colleagues.

• NJ Immunization Network (NJIN) reached over 900 health care providers via educational outreach. The Network partnered with the American College of Physicians and the NJ Department of Health to hold the Adult Immunization Summit, for which an 84-page Adult Immunization Sourcebook was created. NJIN secured funding and partnered with the Horizon Foundation, to provide 70 pediatric and medical residents and faculty with quality improvement training related to Health Literacy.

• Our partnership with the NJ Department of Children & Families continues to expand our child abuse and neglect prevention efforts. Follow-up data from our MOC, Part 4 project, Strengthening Pediatric Partners, revealed 796 families received interventions from practices participating in this unique project. Suspected Child Abuse & Neglect prevention education programs continued expansion throughout the entire Medical Home Neighborhood to encompass EMTs, Emergency Departments, WIC staff and more! Next up, we are exploring how we can work to link pediatric medical homes to the state’s 54 (and growing) Family Success Centers. See the Family Success Center insert to locate your closest Center.

• We’ve built technical assistance capacity to offer support to Medical Homes seeking NCQA recognition – webinars, a warm line, and we now have a certified NCQA coach on staff. Need help figuring out where to begin? Already started and could use samples of documents that satisfy NCQA documentation? Call the NJAAP warm line: (609) 842-0014.

• Preventative Oral Health efforts have also expanded. Close collaboration with the NJ Dental Association Oral Health Coalition has led to the development of a Pediatric Health Home Subcommittee. We are working to promote Medical / Dental Collaboration, strategies for financing preventative oral health and best practices for reaching out to the Community. Stay tuned, as so much is happening, including the new oral health website, which goes live in January. Visit healthyteethnj.com in the New Year.

continued on next page
Medical Director’s Column

Steven Kairys, MD, MPH, FAAP
Chairman, Department of Pediatrics
Jersey Shore University Medical Center.
Medical Director, K. Hovnanian Children’s Hospital

New Jersey Pediatrics is undergoing a metamorphosis.

Since its inception in 2009, New Jersey Pediatrics has focused on providing information and medical reports pertinent to the practice of pediatric medicine in New Jersey. The journal is edited by Indira Amato, MD, Assistant Professor of Pediatrics at Robert Wood Johnson Medical School and NJAAP Director of Communications, Michael Weinstein.

The Journal publishes articles covering a range of topics and formats. There are case reports, short reports, commentaries, comprehensive reviews that often have CME questions, letters to the editor, calendar of events, and resident and family voices sections.

This array of formats will continue. The journal has also published original research. There has been some peer-reviewed process for the research, but there has not been a standardized format for authors to follow, nor a standardized approach for reviewers to use.

State partners, Foundations, and myriad community partners are working to improve oral health – many resources will be made available via this website.

• Five practices are working through our Project Launch to implement the Survey of Wellbeing of Young Children (SWYC – free screening instrument) and Ages and Stages (ASQ3). With support from NJ DCF, each practice received a $2500 mini-grant. The grant enabled practices to subscribe to CHADIS, plan and hold office health fairs and purchase materials and resources that reflect the culture of the of the families served by their practice.

• Working in partnership with NJ Department of Health, through our Critical Congenital Heart Disease (CCHD) Screening Program (Pulse Ox), 20 babies with previously unknown CCHD have been saved (NJ Birth Defects Registry data through October 2015 – see page 23)! Regina Grazel, MSN RN BC APN-C, NJAAP Program Director is co-investigator in the largest evaluation of CCHD screening in NICU to date with data on over 4500 infants.

• The Mental Health Collaborative Program, which links mental and behavioral health to pediatric primary care through a subcontract with the lead grantee, Meridian Health, offers an ABP-approved MOC Part 4 Mental Health Program. The pilot includes 34 pediatricians from 20 practices working to improve access and quality of pediatric mental health services.

Pediatricians involved learn about resources in their communities. These events traditionally strive to link pediatricians and their health care teams with available resources to support their patients. If you have not yet experienced an NJAAP event, I encourage you to take advantage of one or more in 2016. The events feature expert local, national and international presenters. Our events are planned by a group of New Jersey pediatricians supported by a knowledgeable staff. See page 29 for some important Save the Date information.

In closing, heartfelt thanks go to our Officers and Executive Council members, our growing number of MD Champions who work on QI programs, you our membership, and our talented and dedicated staff. Call on them to learn more about the opportunities through our Chapter’s QI work, becoming a trainer, editorial board member, participate in committee work (e.g. practice management). We look forward to hearing from you in the New Year!

Happy Chanukah! Merry Christmas! Happy Kwanza!

A Healthy and Joyous 2016 to all!

Warm Regards,

Warm Regards,
Failure to Thrive (FTT) refers to poor weight gain or weight loss. It is often misused as a term for children who are not gaining height normally.

Three distinct criteria are used in order to diagnose failure to thrive:

1. A child younger than 2 years of age whose weight is less that the 3rd percentile for age, as measured on more than one occasion.
2. A child less than 2 years of age with weight less than 80% of ideal weight for age measured on more than one occasion.
3. A child less than 2 years whose weight crosses two major percentiles on a standard weight curve below a previously established growth rate.

Failure to thrive is a common pediatric finding. Five to ten percent of infants and toddlers meet the criteria detailed above.

Important exceptions to these criteria

Exceptions are children born small for gestational age, and thus, below the 3rd percentile for weight from birth, or infants and toddlers whose height and weight cross major percentiles due to inherited genetics, causing a large infant to move down the percentiles to meet genetically determined parameters by 12 to 15 months of life. These children then track at that level from this point onward.

The concern for FTT must be based on more than one weight measurement. A combination of anthropometric measures provides the most reliable information. Tracking of weight over time, weight for length and weight velocities are useful. World Health Organization-recommended measures used in many parts of the world are here: www.who.int/childgrowth/standards/en/)

Most infants double their birth weight by 4 to 5 months of life. Infants 1 to 3 months of life usually gain 25 to 30 grams a day. During 3 to 6 months of life, the gain is 20 grams a day; and from 6 months to 1 year the gain is 12 grams a day. Infants to age two years require approximately 100Kcal/kg/day to grow normally; older children reduce their need to 90kcal/kg/day for 4 to 6 years of life, and 70Kcal/kg/day for 7 to 10 year olds. This requirement can be higher if the infant is very active as compared to a more sedentary infant.

Failure to thrive, at its root cause, always means a lack of adequate caloric intake for the needs of the child.

The three categories primarily responsible for lack of adequate calories include:

1. Poor caloric intake
2. Inadequate caloric absorption or malabsorption
3. The need for excessive caloric intake over a normal calorie intake

In the past there were thought to be two major global factors for failure to thrive: either the child had an organic condition causing the poor weight gain, or the parents were abusing or neglecting the child. Twenty years ago, all failure to thrive infants were hospitalized and if they gained weight in the hospital and no organic illness was found, they were reported as being neglected or abused. Failure to thrive can still be classified as organic and non-organic, but abuse and neglect comprises only a small portion of the children with non-organic failure to thrive.

Of the three mechanisms for a lack of adequate caloric intake, poor absorption and excessive need are almost always organic in etiology. Poor absorption has many causes including: malabsorption from infection, liver or pancreas disorders, food allergy, celiac disease, inflammatory bowel disease, or inborn errors of metabolism. The list is long, but not the primary focus of this review. However, a detailed history, and screening labs – blood, stool, and urine, will most often point toward an organic etiology. Red flags for an organic etiology include: dysmorphic features, failure to gain despite documented adequate calories, organomegaly, history of recurrent infections, recurrent emesis and diarrhea, etc.

Excessive need for calories, beyond the normal requirements, occurs in thyroid disease, some chronic infections, cardiac disease or vascular malformations, chronic pulmonary or neurologic disease or cancer. These children are unable to take in the calories needed to maintain proper weight gain.

The major mechanism, however, is poor caloric intake; it is the cause of over 80% of the children with failure to thrive. The issue of poor caloric intake as the major cause of FTT, will be the focus of the balance of this review.

Even in the United States, inadequate intake as a result of poverty, is the major cause of FTT. Most of the poverty-related cases occur in children (22 percent) as a result of their diets, which are often of poor quality. Despite food stamps and WIC, there are still many families unable to provide their children with adequate calories. Asking a family the simple question, “Do you have trouble making ends meet at the end of each month?” can be a very effective screen for families in need of additional supports.

Failure to thrive can be accidental, often the family is unaware that the child is lacking adequate calories.

continued on next page
Breast feeding can appear to be going well, but the infant is not ingesting enough during each feeding, or the breast is not producing enough milk, or the milk is not of the right quality. Some infants sleep excessively and fail to be awakened by hunger or to cry for feedings. Mothers, not aware of the poor caloric value of reduced-fat milk can inadvertently cause long periods of poor caloric intake. Some mothers switch prematurely to solid foods that are filling, but provide less caloric value than formula or other milk products. These children can be active and gain weight but at a lower than expected weight velocity. Children on excessive juice intake rather than milk can present with poor weight gain.

There are a small percentage of children who are FTT due to neglect or willful starvation. Mothers with serious mental health issues, serious substance abuse behaviors, mothers who neglect their children because of distorted relationships or domestic violence are all potential sources of FTT in their young children. In children who do present with neglect and lack of supervision and safety, failure to thrive may be the best tangible finding of abuse and neglect and open the door for intervention by Child Protection Services.

The last category, which is both the major cause of environmental FTT in this country - and the most difficult to understand and treat - includes a matrix of infant feeding difficulties including: infant oral-motor dysfunction, food aversion, attachment issues between mother and child, and poor maternal child interactions, especially related to feeding communication.

Numerous studies have documented child characteristics associated with non-organic FTT. Drotar in 1992 and Stewart in 2001 describe more difficult behaviors with deficits in behavioral organization, ego control and ego resiliency. Wright found the infants to have demanding behavior, low appetite, and poor feeding skills, poor oral motor coordination. Ramsey similarly found that early feeding history showed long duration of feeding time, poor appetite, delayed tolerance to food textures, and deviant feeding behaviors. Bithoney documented high reactivity to visual and auditory stimuli and disordered feeding interactions with the mother.

Many parental factors have also been detailed in the literature. Black found parents to be less nurturant. Steward described mothers less likely to be involved in play with their infants. Hutcheson found that mothers of infants with non-organic FTT were more hostile and intrusive and less flexible, less likely to respond to infant hunger cues. Bithoney found that many of the families were socially isolated and had few extended family members to help.

Thus for a number of infants with non-organic failure to thrive, the issues are multifactorial with some abnormal or delayed infant feeding patterns coupled with mothers with their own issues, who do not properly read or respond to the often complicated cues from the infant.

These issues are not environmental neglect and abuse and weight gain for most of these infants improves by 24 months of life.

Evaluation

As always in Pediatrics, history is the major evaluation tool. It includes an accurate and detailed history of the child’s eating behaviors as well as intake and awareness of the parent-child interactions. Asking breastfeeding mothers to pump or to weigh the infant before and after feeding helps catalog breastfeeding adequacy. Watching a feeding and noticing feeding behaviors and interactions is also very instructive. A three-day food diary can be extremely helpful in sorting out the issue of caloric intake.

The physical examination is important, especially if organic failure to thrive is still in the differential. Laboratory testing for the most part is not useful, unless there is high concern for an organic etiology.

Referral to a nutritionist or feeding specialist can also help inform the pediatrician about the subtleties of intake and feeding concerns. And for children with severe FTT, a period of hospitalization can be vital to defining the issues and initiating interventions.

A basic evaluation plan

1. Ask for 24 hour calorie counts or food diaries
2. Try to understand social issues, poverty, family dynamics
   - Arrange a home visit by home nursing
3. See the children every month to track weight
4. Do simple screening for organic disease- a history and physical,
   - complete blood count, basic metabolic panel
5. Ask a nutritionist to observe and assess feedings
6. Only involve Child Protection Services, if there are major concerns about neglect

Treatment

The preferred outcome, of course, is to increase caloric intake. For some parents this can be done with education and pediatric office support and follow up. For many parents, especially those with infants with feeding issues or parents with poor parent-child interactions, referral to a multi-disciplinary feeding team can be invaluable. This can be augmented by home visits and home nursing services. This is an important issue for the medical home. These families need a care plan and an organized care management process. The office team should have the skills to be able to monitor caloric intake, assess feeding techniques and provide family education.

Catch up growth demands 20% more calories per day then maintenance calories. Home nursing visits, support groups and feeding team management can all be very productive. Child
Protection Services can be an option, if there are clear concerns of environmental deprivation or signs the family is not willing or able to adhere to an agreed upon management plan.

There are many helpful community resources. Certainly, WIC and food stamps can help provide families with greater access to more adequate food for their children. The Family Success Centers, which are located in every county in New Jersey, offer families a wide variety of local support services and support groups. A complete list of these centers is included in this publication.

**Prognosis**

Most infants and children with FTT do well over time. For many, it is a slow process with the family needing a great deal of structure, guidance, support and care management along the way. FTT is just as significant a chronic problem as any major organic illness.

The primary care pediatrician needs to be able to track these children and develop a care management and coordination process that includes the parent as a core and key member of the team. There are often cultural feeding issues that need to be recognized and included in the care plan.

Parents need to feel respected and supported, and pediatricians must convey the message that the issue is a complicated one and one not caused solely by the parent.

**References**


**New Jersey Pediatrics**

The process for submitting content for publication consideration in *New Jersey Pediatrics* has changed. New guidelines and criteria for submitting have been adopted in order to support Chapter efforts to elevate the publication to peer-reviewed status.

Submissions for consideration are now being accepted on an ongoing basis, rather than the former issue-to-issue, call for articles. This enhanced approach will provide the Editorial Board and reviewers with adequate time to thoroughly review, consider and respond to accepted submission.

**The peer-review policy**

*New Jersey Pediatrics* is supported by an authoritative Editorial Board augmented by pediatric specialists and sub-specialists. Contributors to *New Jersey Pediatrics* benefit from fast and professional peer-review process. Following an initial screening and approval for general suitability, Editors, Indira Amato, MD, FAAP and Michael Weinstein, will assign submissions for external peer review. The journal will operate on a blind peer-review policy, and will aim to reach a first decision by two reviewers within six weeks of submission.

For additional content submission information, please visit: www.aapnj.org/showcontent.aspx?MenuID=2132

Interested in serving as a reviewer for *New Jersey Pediatrics*? Please contact Michael Weinstein at mweinstein@aapnj.org.
1. Which criteria must be used for diagnosing Failure to Thrive
   a. A child <2 years of age whose weight is less than the 3rd percentile for age, as measured on more than one occasion
   b. A child <2 years of age with weight less than 80% of ideal weight for age, measured on more than one occasion
   c. A child <2 years of age whose weight crosses two major percentiles on a standard weight curve below a previous established growth rate
   d. All the above

2. Which of the following IS NOT one of the three categories primarily responsible for lack of adequate calories?
   a. Poor caloric intake
   b. Need for excessive caloric intake over a normal caloric intake
   c. Children born small for gestational age
   d. Inadequate caloric absorption or malabsorption

3. Attachment is a critical factor that helps a child develop a conscience and become a functional part of a family and society
   a. True
   b. False

4. In the past, not gaining height normally and child abuse and neglect were thought to be the two major global factors for Failure to Thrive
   a. True
   b. False

5. Poor caloric intake is the major mechanism in 80% of the cases of children with Failure to Thrive
   a. True
   b. False

6. Contributing factors to accidental Failure to Thrive include:
   a. Infant not ingesting enough milk during each feeding
   b. Poor quality breast milk
   c. Premature switch to solid foods offering less caloric value
   d. All the above

7. A small number of children are Failure to Thrive due to:
   a. Domestic violence
   b. Substance abuse
   c. Both a and b
   d. None of the above

8. Parental factors attributed to Failure to Thrive include:
   a. Mothers less likely to be involved in play
   b. High tolerance to food textures
   c. Socially active
   d. All the above

9. A physical examination is important, especially if organic Failure to Thrive is still in the differential
   a. True
   b. False

10. Referral to a multi-disciplinary feeding team can be invaluable for:
    a. Parents of infants with feeding issues
    b. Parents with poor parent-child interactions
    c. Parents who would benefit from a care plan and organized care management process
    d. All the above

CME Instructions
Read the CME-designated article and answer the Summer issue, quiz questions above. Print your name and phone number and mail or fax this form within six months from the date of issue to: NJAAP CME Quiz, 3836 Quakerbridge Road, Suite 106, Hamilton, NJ 08619 • Fax: 609.842.0015

NAME __________________________ PHONE __________________________

EMAIL ____________________________________________

Submitter must answer 8 of the 10 questions correctly to qualify for CME credit

Accreditation Statement:
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Medical Society of New Jersey through the joint providership of Atlantic Health System and the American Academy of Pediatrics, New Jersey Chapter. Atlantic Health System is accredited by the Medical Society of New Jersey to provide continuing medical education for physicians. Atlantic Health System designates this live activity for a maximum of 1.0 MA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Raynaud Phenomenon

Episodic color change of the fingers and toes, often triggered by cold exposure, is known as Raynaud phenomenon. In 1862, Maurice Raynaud first described a three-stage series of color changes of the fingers and toes, occurring in response to environmental cold and emotional stress. Although not all persons with Raynaud phenomenon have all three color changes; the classic sequence is one of blanching or whitening followed by a dusky blue-purple phase and in some individuals, a third phase of exaggerated redness as blood flow returns to the fingers. Associated symptoms can include pain, numbness, tingling and burning.

Raynaud phenomenon is relatively common, with prevalence among teenage patients estimated to be 12-18%.\(^1\) Cold is the most common trigger for episodes of Raynaud phenomenon, but stress and physical exertion may also act as triggers. Episodes may also occur spontaneously without an identifiable trigger. Although environmental cold exposure is a common trigger in the winter months, exposure to air-conditioning, reaching into a refrigerator, or a decrease in central body temperature can also trigger episodes.

Under normal circumstances, environmental cold exposure leads to contraction of vascular smooth muscle and reduction of blood flow to the extremities. This physiologic mechanism is thought to play a role in regulation of core body temperature. Patients with Raynaud phenomenon often have an exaggerated vasomotor response to cold, which leads to excessive arterial constriction and decreased digital blood flow. Most patients with Raynaud phenomenon do not have any other underlying vascular pathology; this is referred to as primary Raynaud phenomenon. In contrast, Raynaud phenomenon may be related to underlying inflammation, injury and/or fibrosis of the vascular endothelium, causing vascular obstruction; this is called secondary Raynaud phenomenon. Typical causes of secondary Raynaud phenomenon include; lupus, scleroderma, and mixed connective tissue disease. Raynaud phenomenon may be the presenting symptom of these disorders. Severe Raynaud phenomenon may be associated with tissue necrosis secondary to prolonged ischemia or reperfusion injury.

Digital ulcerations, soft tissue loss, and bone resorption of the distal phalanges can occur and are typically associated with underlying connective tissue disease.

In a recent case series of 123 pediatric patients with Raynaud phenomenon, 28% were reported to have secondary Raynaud phenomenon.\(^2\) In the above case series, positive antinuclear antibody (ANA) was significantly associated with the presence of an underlying connective tissue disease - although 25% of patients with primary Raynaud phenomenon were ANA positive - reflecting the common background prevalence of ANA positivity in the general population. Abnormal appearance of the nailfold capillaries was also associated with secondary Raynaud phenomenon. (Capillaries at the edge of the nailfold can be visualized under magnification, and the presence of hemorrhage, tortuosity, or irregularity of these vessels can be a sign of underlying endothelial pathology.) Antiphospholipid antibody positivity was common in both primary and secondary Raynaud phenomenon, being present in approximately one third of the patients in each group.

Exposure to stimulant medications (e.g. attention deficit hyperactivity disorder treatments) and other vasoactive drugs has been associated with Raynaud phenomenon and may exacerbate symptoms. Malnutrition has also been associated with Raynaud phenomenon, and cases have been reported in association with anorexia nervosa.\(^1\) In considering how to clinically address Raynaud phenomenon, it is important to assess for the presence of these potential contributing factors. For many patients, especially those with primary Raynaud phenomenon, avoiding cold exposure and rewarming during an episode are sufficient measures to minimize symptoms. Keeping the central body warm with layered clothing and wearing hats to minimize heat loss through the scalp may be helpful recommendations.

For those patients who have tissue damage, or who experience bothersome symptoms despite non-pharmacologic treatment, there are a number of pharmacologic options. Calcium channel blockers are the most commonly used medications for treatment of Raynaud phenomenon. Angiotensin blocking agents, selective serotonin reuptake inhibitors, phosphodiesterase inhibitors, and endothelin receptor antagonists - among others - can also be useful as second-line therapy or adjunctive therapy. For patients who experience a severe refractory episode with potential for tissue necrosis, inpatient treatment with intravenous prostanoids may be required.

Realistic goals for pharmacologic therapy may not include resolution of symptoms. For some patients, a relative reduction in attack frequency and symptom severity may be the measure of successful treatment. Patients may choose to make their treatment seasonal, only requiring medication during the colder seasons.
Raynaud Phenomenon continued

REFERENCES


Screening for Sleep Disorders in Children with Adverse Childhood Experiences and Other Special Needs

It is well known that adverse childhood experiences (ACEs) lead to a proportional increase in future health problems as children grow into adults, and sleep disorders are also often identified as contributors. Thus, making it generally important to screen for sleep problems in childhood, but especially in children with ACEs and other special needs, such as Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder.

The earlier these conditions are recognized the better the chance for recovery and a healthier lifestyle. Additionally, early recognition of sleep disorders in this population leads to improved outcomes. An approach for the early identification of sleep disorders includes the following the “Eight-Step” Program.

THE EIGHT-STEP PROGRAM: LOOKING FOR SLEEP DISORDERS

A. Remember to ask!
B. Provide clinical advice and counseling
C. Refer to a pediatric sleep specialist if clinically indicated

Step #1. The amount of sleep
Stress and special needs can decrease the opportunity for sufficient sleep due to biological, medical, behavioral, environmental, and/or family issues. Insufficient sleep is a health risk with increased morbidity even in the absence of a sleep disorder.

ASK: Is the amount of sleep obtained age-appropriate for the child?

Step #2. Insomnia
Stress and maladaptive behavior can lead to an inability to initiate or maintain sleep. The root cause could be anxiety, fear of sleep, separation problems, difficulty transitioning and adapting from wakefulness to sleep.

ASK: Does the child have difficulty falling asleep and/or waking during the night? Does this impact daytime functioning?

Step #3. Hypersomnia/Chronic fatigue
Sleep deprivation or the presence of a sleep disorder, such as insomnia or apnea, can lead to daytime sleepiness, tiredness, lack of interest and motivation, attentional impairment, and behavioral and mood disorders. These consequences are particularly worrisome in children already at risk.

ASK: Does the child have appropriate daytime functioning alertness, focus, refreshed from sleep, even temperament and mood, appropriate school function?

Step #4. Parasomnias
Parasomnias (sleep walking, sleep terrors, nightmares, enuresis etc.) are often an expected event of childhood, but can present a problem if intense, frequent, or dangerous. Sleep deprivation subsequently results in increased deep sleep. Stress and anxiety result in brain wave arousals during sleep. Parasomnias are the result of arousals during deep sleep. The result is that not enough sleep in children under stress can exacerbate parasomnias in predisposed individuals.

ASK: Are there noticeable behaviors of concern during sleep?

Step #5. Circadian Disorders
These are disorders of the biological clock (driven by the “superchiasmatic nucleus” and hormonal [melatonin] rhythms). In this condition, day/night are out of synch with wake/sleep cycles. Although stress and adverse events are not a direct cause of circadian disorders, they can interfere with daytime function in an already precarious situation.

ASK: Is there normal alignment of day/night with wake/sleep cycles?

Step #6. Sleep-related breathing disorders
Obstructive sleep apnea (OSA) is based on physical obstruction of the airway and not as a result of stress and adverse events. Obesity is a common cause of OSA, and correlated to ACEs. The increasing prevalence of childhood and adult obesity has precipitated a higher incidence of OSA and its associated serious medical consequences.

ASK: Does the child snore at least 50% of the time during sleep? Is it loud? Is breathing shallow or irregular? Is there known tonsillar hypertrophy? Sleepiness? ADHD?

Step #7. Sleep-related movement disorders
Restless legs and nocturnal limb movements are often associated with iron deficiency. Thus, iron deficiency should always be a consideration in high-risk populations. Motor stereotypes, such as head banging and body rocking, are usually benign and often manifest in children with neurodevelopmental disabilities; however, motor stereotypes can disrupt sleep.

ASK: Is sleep calm or are there disruptive movements?

Step #8. Seizures
Epilepsy can often be associated with nocturnal seizures, and such seizures can disrupt sleep. In children with ACE and/or special needs who display sleep disruption, nocturnal seizures warrant consideration.

ASK: Are there clinical phenomena suggestive of seizures in sleep?

continued on next page
In conditions as significant as Adverse Childhood Events and major neurodevelopmental problems, it is well worth taking some extra time to ask questions about sleep patterns and issues.

It is important to recognize pediatric sleep problems early so that early interventions are implemented, and adverse health effects as adults are avoided. Although not all children with special needs manifest sleep disorders, many do have treatable sleep issues.

The most common sleep disturbances in this population that can persist into adulthood are insomnia and daytime fatigue and dysfunction, which are major roadblocks to productive lives and for maintaining good health. Remember, ask about sleep!
A provider’s billing process is critical to its financial stability and overall success. For out-of-network providers, it is important to understand the potential challenges to reimbursement and the legal issues involved.

With out-of-network status, may come the loss of referrals from insurers, more scrutiny from insurance carriers and more denied claims. Insurers may be more likely to scrutinize claims for services based on charges significantly in excess of in-network rates. In most plans that provide out-of-network benefits, insurers typically cover what they deem to be the “usual, customary, and reasonable” (UCR) charge for the services rendered except for the insured’s applicable co-payment, co-insurance, or deductible, if any. This ordinarily results in a larger out-of-pocket cost to the patient. When the patient cannot afford to pay or refuses to pay the balance, the provider is left unpaid.

Out-of-network providers may question whether they can lawfully waive patients’ co-payments, co-insurance and deductibles to encourage patients to seek treatment without the fear of large balance bills. The U.S. Department of Health and Human Services has taken the position that a provider’s routine waiver of such payments in the Medicare and Medicaid context may violate the Anti-Kickback Act or the Medicare False Claims Act. Several states, including New York, prohibit the practice with respect to commercial insurers. However, while there have been recent efforts in the New Jersey legislature to outlaw the practice, there is currently no law that prohibits such waivers. Commercial insurers in New Jersey strongly oppose this practice and have instituted lawsuits alleging that such waivers constitute the submission of fraudulent claims.

To encourage in-network participation, many insurance carriers have included anti-assignment clauses in their health benefit plan contracts which provide that the plan reserves the right not to recognize any assignment of benefits. When an out-of-network provider is involved in the care of the member, the insurance carrier makes the entire payment to the patient, who then must either endorse the reimbursement check to the provider or deposit the reimbursement check and write a separate check to the provider. Many patients fail to make these payments to the provider.

However, some states have laws that require health plans to accept assignment of benefits directing the health insurance carrier to make a payment directly to the provider for the insurance covered portion of the services.

This ensures that out-of-network providers receive more timely reimbursements when providing services to patients. New Jersey law requires health insurance carriers offering fully insured managed care health plans that include out-of-network benefits to reimburse claims submitted by out-of-network providers based on a valid assignment of benefits. According to the law, the carrier may either reimburse the health care provider directly in the form of a check payable to the health care provider, or as an alternative, a check payable to the health care provider and the covered person as joint payees, with a signature line for each payee. Any payment remitted to the patient rather than the out-of-network provider under these circumstances would be considered unpaid under the New Jersey Prompt Payment Law and subjects insurers to the penalties of the Prompt Payment Law.

Lawmakers in many states are moving to protect consumers from unexpected medical bills received from out-of-network providers. For example, the New York State Legislature recently enacted the “Emergency Medical Services and Surprise Bills” law to provide protection for consumers against medical bills from non-participating providers. The law requires that patients in emergency medical situations pay no more to out-of-network providers than they would have to pay to those participating in their insurance network. The law also imposes new disclosure obligations for health care professionals and plans. Healthcare providers, including licensed professionals and their group practices, diagnostic and treatment centers and health centers, must disclose to patients and prospective patients, in writing or through their website, their plan and hospital affiliations prior to the provision of non-emergency services and verbally at the time the appointment is scheduled. An out of network provider must inform the patient, prior to providing non-emergency services, that (i) the actual or estimated amount for the service is available upon request, and (ii) if requested, will be disclosed in writing with a warning that costs could go up if unanticipated complications occur. In addition to the foregoing, a physician must provide a patient and the inpatient or outpatient hospital in which the patient is scheduled for admission with the name, practice name, mailing address and phone number of any other physician scheduled to treat the patient and information as to how to determine the health plan(s) in which the provider(s) participates. The law also sets up an independent dispute resolution entity (IDRE) for resolving billing disputes between insurers and providers.
Budget issues among the Executive and Legislative branches consumed much of the second quarter of 2015. In terms of pediatric issues, the budget contained funds to address the expiration of the federally funded Medicaid Parity program. The enhanced payments to primary care physicians, including pediatricians, provided under the Affordable Care Act, expired at the end of 2014. With their expiration, there is a concern that the problems of access, particularly to the pediatric subspecialties will be exacerbated. The budget signed by the Governor includes $45 million to increase payments for certain participating Medicaid physicians beginning January 1, 2016. The budget does not specify how the funds are to be allocated. NJAAP is pushing for a sizeable percentage to be allocated to pediatricians and pediatric subspecialists.

The budget also provides funds for the Children’s System of Care which addresses the holistic needs and concerns of families with children with multiple needs, including behavioral health, substance abuse and intellectual and developmental disabilities. The fiscal 2016 budget includes a total of $522.9 million in State and federal funds for the operations and services provided by this Division, an increase of $13.9 million over last year.

And the budget contains $2.4 million to continue work on the Mental Health Collaborative Pilot program. This pilot program was first funded in last year’s budget at half the amount.

On the issue of mental health, Assembly Women and Children’s Committee Chairwoman Pam Lampitt introduced A4498 on June 4th. This legislation requires insurance coverage for expenses incurred in screening patients who are under 18 years of age for depression, including, but not limited to, a depression screening performed by a pediatrician using a nationally-recognized screening tool.

The measles outbreak in parts of the country brought the issue of vaccines to the forefront. The Senate Health Committee released S1147 and the Assembly Health Committee released A1931, legislation that provides statutory clarification for the State policy governing exemptions from immunizations of students that are mandated by the Commissioner of Health by regulation or otherwise required by law. Essentially this legislation permits an exemption from immunizations if a parent or guardian provides either a written statement to the school by a licensed physician with the reason why the vaccine is medically unnecessary or a statement by explaining that a vaccine conflicts with their religious practices.

**Oral Health in the South Asian Community**
A Program to Integrate Oral Health into Primary Care
St. Peter’s Medical Center, October 27, 2015

Preventing Early Childhood Caries (ECC) - Medicaid reimbursement for fluoride varnish application - Connecting to Dental Home Providers
Case Study: Autoimmune Hemolytic Anemia in a Child with Ulcerative Colitis

INTRODUCTION:
Autoimmune hemolytic anemia (AIHA) develops in 1.7% of patients with Ulcerative Colitis (UC) at an average age of 50.5 years and onset between colitis and AIHA diagnosis is typically 17 months. This is compared to a general incidence of AIHA of 1 to 3 cases per 100,000 per year. Most reports of AIHA note that it typically occurs during a flare of UC, though in the reviewed pediatric case, AIHA occurred while the patient was in remission though still having some intestinal bleeding. Upon review of the literature, only one previous case in the pediatric population was reported with both of these diseases. We present this case of a child with a recent diagnosis of UC who presented with AIHA and exacerbation of UC.

CASE REPORT:
11-year-old male with no significant past history was diagnosed with UC 4 months earlier and responded to mesalamine. At presentation his hemoglobin (Hb) was 9.2 and mean corpuscular volume (MCV) 77 (fig.1). Five days prior to initial admission he presented to an outside hospital with fever, headache, vomiting, and pallor and was discharged from ER on acetaminophen. He then stopped taking mesalamine and developed bloody stools, weight loss, anorexia, and jaundice. Physical exam was significant for delayed capillary refill, icterus and pallor. Pertinent labs: Hb 7.6, reticulocyte (retic) 16.5, MCV 92.5, total bilirubin (T bili) 6.3, direct 0.3, LDH 1127, haptoglobin<10, ESR/CRP 135/6, WBC 18.5. Direct coombs: positive with warm autoantibody. Hepatitis panel, ANA, dsDNA, G6PD and sickle cell were all negative. Folate, B12, anticardiolipin, immunoglobulins, and C3/C4 were also within normal limits. Imaging showed gallbladder sludge and top normal sized spleen of 10.9cm. During admission patient was restarted on mesalamine and bloody stools resolved. Hb trended from 7.6 to a nadir of 6.9 with retic count of 35.6. He was started on prednisone and Hb increased to 8.6 and the jaundice and pallor improved. Hb normalized at 2 weeks post discharge.

After four months on continued mesalamine and tapered prednisone, he presented to the ER again with right upper quadrant pain, nausea, hematochezia, anorexia and weight loss. His labwork at this time revealed Hb 10.3, retic 23.8, MCV 107.5, T bili 23.6, direct 3.8, LDH 419, AST/ALT 68/405 (Figure 1).

The ultrasound again showed gallbladder sludge. He was started on mercaptopurine and prednisone dose was increased. His clinical status as well as his hemoglobin and total bilirubin improved and the patient was discharged. At follow-up the patient has continued to improve and the prednisone was tapered very gradually.

Eight months following discharge, on continued mesalamine, mercaptopurine, and tapered prednisone, patient continued to improve. He began gaining weight and denied hematochezia. His jaundice improved and Hb continued to increase to peak of 14.8 (fig.1). T bili did not normalize completely but has remained below 4 since hospitalization, while AST/ALT have normalized. Prednisone continued to be tapered gradually and was discontinued one year following initial presentation. The patient is currently taking mesalamine and mercaptopurine and is no longer taking prednisone; he is doing well with no additional flares of his UC or AIHA.

DISCUSSION:
This case suggests that AIHA can be associated with UC in pediatric patients. A patient with UC presenting with anemia is often assumed to have iron-deficient anemia from blood loss, anemia of chronic disease, or a vitamin-deficient anemia from anorexia and malnutrition. If this is not the case, or if the patient is noted to have jaundice and hyperbilirubinemia, a full workup for hemolytic anemia should be undertaken. Reported cases in adults required the use of cyclosporine or infliximab for UC associated AIHA.
Steroids, immunosuppression, and biological treatments have all been used to avoid splenectomy or colectomy in patients with these diseases.³

In the reviewed pediatric case, IVIG, steroids, azathioprine, and ultimately cyclosporine were all used to induce remission of both the UC and AIHA.⁵ In this case as well, prednisone was not adequate despite initial response and additional immunosuppression with mercaptopurine was necessary.

As noted, since AIHA typically appears during a UC flare, control of UC might be critical in controlling AIHA.⁴

**CONCLUSION:**

AIHA is reported in adults with UC and has been shown to be resistant to steroids alone. This case illustrates that it can also occur in children with UC and has a similar resistance to steroid therapy alone. Further study to determine the best treatment options for pediatric AIHA associated with UC is needed to better understand how to treat these children.

**References:**

4) Molnár, T; Farkas, K; Szepes, Z et al. Autoimmune hemolytic anemia associated with ulcerative colitis: the most important step is to induce complete remission. Am J Gastroenterol. 2010;105:1203–1204
5) Pozzi, E; Micheli, A; Bronzini, F et al. Coombs-positive Autoimmune Haemolytic Anemia in Ulcerative Colitis: Spectrum of Same Disease? J Pediatr Gastroenterol Nutr. 2006;43:s49
spasticity and knowledge on therapeutic interventions, in addition to their referral to a specialist are critical during a child’s young life. This study attempts to investigate pediatricians’ perspectives to identify as well as manage patients with muscle movement disorders. In addition, this study will access a pediatrician’s familiarity with ITB therapy and its clinical indications.

Methods
A retrospective analysis of the General Electric Centricity database was performed. We conducted a search of all pediatric patients who received an intrathecal baclofen pump between the years of 2005-2014. We were able to contact 16 pediatricians to compete a response survey. Out of the pediatricians surveyed, 14 pediatricians described patients with infantile or acquired cerebral palsy, and two pediatricians reported patients with anoxic brain damage. Information was gathered concerning the quantity of patients followed, onset of spasticity, pump referral, ITB therapy awareness, and caregiver satisfaction.

Results
Average age of onset pediatricians noted patients’ spasticity, dystonia or hypertonia was between 9 and 10 months old. The quantity of patients with mixed movement disorders followed by these pediatricians varied from 1 to 50 patients. Pediatricians initially referred patients with muscle movement disorders to a pediatric neurologist (81% or 13/16), physiatrist (13% or 2/16) or rehabilitation specialist (6% or 1/16). Only 2 of 16 pediatricians surveyed would consider prescribing oral medications for spasticity in children themselves. There was a general awareness of other treatment options such as intramuscular botulinum toxin injections and alcohol nerve blocks, however, not all pediatricians (81% or 13/16) reported prior knowledge of ITB therapy before their patient received a baclofen pump.

Pediatricians reported ITB therapy to be associated with all (50% or 8/16), some (37.5% or 6/16) or without (12.5% or 2/16) caregiver satisfaction with tone reduction. A general consensus amongst pediatricians was reported to refer another patient with spasticity for ITB therapy. However, two pediatricians cautioned their recommendation to a pediatric neurologist first to try oral anti-spasticity medications initially, but if a patient maxed out on these medications or became dystonic, they would recommend an evaluation by a pediatric neurosurgeon for ITB therapy.

Conclusion
Overall, pediatricians were concerned about recognizing/identifying pediatric patients at risk for developing muscle and joint contractures. An earlier referral made by pediatricians to a pediatric neurosurgeon may reduce hypertonia-related complications from raising in these patients. Pediatricians should stress the importance of early intervention with these muscle movement disorders. In our clinical experience, hypertonia-related complications appear to not only interfere with a child’s development, but also with the child’s ability to ambulate. Patients can still develop contractures despite various tendon lengthening procedures, physical therapy, and anti-spastic medications including oral baclofen, botulinum toxin injections and alcohol blocks. Therefore, an increased understanding of ITB therapy in pediatricians to make an earlier referral in their patients’ young lives may continue to improve patients’ and caregivers’ quality and ease of life. Although the pediatrician’s role is not to surgically implant the baclofen pumps, their role does involve guiding patients’ families to manage their child’s spasticity. We recommend an earlier initiation of ITB therapy to intervene the progress of neuromuscular problems before complications arise. A pediatricians’ recommendation, referral and increased knowledge of ITB therapy is critical for patients with spasticity, dystonia and hypertonia.
New Jersey law requires that when a patient is either admitted to an in-network facility by an out-of-network provider, or receives services from an out-of-network provider in an in-network facility and was admitted by an in-network provider, the facility is paid by the carrier at the carrier’s full contracted rate without any penalty for the patient’s selection of an out-of-network provider. A covered person’s liability when admitted to an in-network facility by either an in-network or out-of-network provider, is the copayment, deductible and/or coinsurance applicable to network facilities. However, New Jersey lawmakers have introduced Bill A-4444 in the Senate proposing to codify the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (the “Act”). The Act’s goal is to increase transparency in pricing for health care services and contain rising costs, as out-of-network coverage charges have been steadily exposing consumers to additional costs. The Act will impose additional responsibilities on health care professionals, requiring disclosure of, among other things, financial responsibility, procedure costs and description, in-network/out-of-network provider information, and out-of-pocket expenses to patients prior to their scheduled procedure date. Most importantly, the Act would establish a Healthcare Price Index that would establish a range of between 75% and 250% of in-network reimbursement rates for certain services determined to be “inadvertent out-of-network services” and certain emergency services rendered by out-of-network providers.

We recommend that all out-of-network physicians take the time to consider how developing trends and new legislation will affect their practices. Physicians who provide out-of-network services or refer patients to out-of-network providers or facilities should review their current policies and procedures regarding billing, assignment of benefits, and patient disclosures to assure compliance with the applicable laws and regulations referenced above, and, in the case of in-network providers referring to out-of-network facilities or services, the terms of their provider agreements.

References

1. Department of Health and Human Services (HHS), Office of Inspector General (OIG), “It is unlawful to routinely waive co-payments, deductibles, coinsurances or other patient responsibility payments.” (67 Fed. Reg. 72,896 (Dec. 9, 2002)).

2 Opinions of General Counsel Nos. 04-02-25, 03-04-09 and 01-02-20.

3 In 2010, a bill was introduced in the New Jersey Senate and Assembly that would have prohibited the waiver of patient responsibility and established the practice as a form of insurance fraud in violation of the New Jersey Insurance Fraud Prevention Act. S-1753, 214th Legis., § 4 (introduced Mar. 11, 2010); A-2511, 214th Legis., § 4 (introduced Mar. 16, 2010). The legislature has taken no action on this bill since its introduction

4 N.J.S.A. 26:2S-6.1(c)

5 The Emergency Medical Services and Surprise Bill amends the New York Insurance Law, Public Health Law, and Financial Services Law

6 New York Insurance Law Section 3241(c)

7 Financial Services Law Article 6

8 N.J.S.A. 26:2S-6.1a(1)

9 N.J.S.A. 26:2S-6.1a(2)

Congratulations to David Garcia, MD, Teenu Cherian, DO and Vidya Naganathan, MD from Jersey Shore University Medical Center in Neptune, New Jersey.

Of the 67 applications submitted, their application: Improving Access to Pediatric Vision Care, was one of 15 proposals awarded a 2016 CATCH Resident (cycle 1) grant.

The CATCH Call for Proposals is now open at www.aap.org/catch/funding.htm

Submissions are due at 2:00 pm CDT, January 29, 2016 and as a reminder, pediatrician grants are $10,000 and resident grants are $2,000.

These are great grants for residents. The AAP Section on Obesity has also partnered with CATCH in the funding of Resident Grants whose primary topic is obesity, nutrition, or physical activity.

These grants are part of the general call for proposals and must follow the same application and reporting procedures and meet the same eligibility and selection criteria. If you have any questions, contact me at PSchwartzberg@meridianhealth.com.
For the past 41 years, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) has been instrumental in improving the health, growth and development of at-risk women and children (NWA, 2015). The WIC Program provides nutrition education, nutritious foods, breastfeeding support, and healthcare referrals for income-eligible women who are pregnant or post-partum, infants, and children up to age five. In 2014, WIC served approximately 8 million mothers and young children monthly through 10,000 clinics nationwide (NWA, 2015).

### Work Cited

Table 1 “How WIC Impacts the People of New Jersey” by National WIC Association. February 2015

**What is WIC?**

The Special Supplemental Nutrition Program for Women, Infants and Children is a short-term public health intervention program designed to influence lifetime nutrition and health behaviors in a targeted, high-risk population. In addition, hemoglobin and hematocrit testing is conducted during the certification process to screen for iron deficiency anemia and when necessary, appropriate nutrition education and referrals are provided.

**Why WIC matters.**

Costs for preterm births in the United States exceed $26 billion a year (NWA). Poor nutrition during early childhood increases the chance of anemia, limits a child’s ability to learn, and adds to health care costs. The WIC program contributes to better birth outcomes, increased breastfeeding rates and key nutrients in the diet as well as ensuring adequate growth and development. Healthy behaviors are emphasized during pregnancy to reduce risk for gestational diabetes and obesity which can lead to difficulties in delayed lactogenesis and reduced lactation (Feldman-Winter, 2013).

Breastfed infants have a reduced risk of infections, asthma, obesity, and SIDS compared with formula fed infants. Mothers who breastfeed have a reduced risk of breast cancer, ovarian cancer, and postpartum depression compared to those who do not breastfeed. It is estimated that $13 billion would be saved per year if 90% of U.S. infants were breastfed exclusively for six months (NWA). New Jersey’s WIC participation breastfeeding rate of 64% is slightly less than the national average of 67%, while states like California, New York, and Oregon boast much higher rates of 78%, 79% and 89% respectively (New Jersey, 2015).

The WIC program provides access to nourishing foods which include fruit, vegetables, low-fat dairy and whole grains. All healthy foods aimed at reducing food insecurity, obesity and type 2 diabetes. In 2013, 18.5% of children in New Jersey experienced lack of access to food or nutritionally adequate food (Association). Additionally, the obesity rate of low-income children, ages 2-4 years old, in 2011 was 16.6%; the second highest in the country (The State of Obesity in New Jersey, 2015).

### How does WIC promote breastfeeding?

WIC promotes breastfeeding as the optimal infant feeding choice and supports moms along the way. The WIC staff educate and support pregnant women on the benefits of breastfeeding. Moms can also benefit from hearing first-hand accounts, personal experiences and advice from trained breastfeeding peer counselors, which has shown to improve breastfeeding initiation and maintenance (Feldman-Winter, 2013, p. 174). Lactation consultants, professional breastfeeding specialists, provide an additional layer of support by teaching mothers how to help their baby latch and provide assistance for those experiencing painful nursing and low milk production. For others, being able to call a 24-hour help hotline adds another layer of emotional security. WIC clients can obtain additional encouragement through classes, support groups and education materials.

The American Academy of Pediatrics (AAP) encourages collaborative engagement between physicians and the WIC Program (reference below). A partnership between healthcare providers and WIC breastfeeding coordinators can reinforce clinical linkages and aid in reducing chronic disease risk associated with malnutrition and obesity. Physicians are encouraged to utilize WIC as experts in providing breastfeeding assistance and support to pre- and postpartum mothers. When you think of nutrition and breastfeeding support services like these, does the WIC Program come to mind?

---

**Gateway CAP WIC Programs**

<table>
<thead>
<tr>
<th>Atlantic County</th>
<th>Camden County</th>
<th>Cumberland County</th>
</tr>
</thead>
</table>

Made possible with funding from the National WIC Association (NWA)

---

**Works Cited**

continued on next page


AMERICAN ACADEMY OF PEDIATRICS: WIC Program
Provisional Section on Breastfeeding
Pediatrics 2001; 108:5 1216-1217; doi:10.1542/peds.108.5.1216

Table 1- NJ WIC Participation
People often ask me why I chose to take a job as a chief resident. I expected this question from my non-medical colleagues but am always surprised to hear it being asked from fellow physicians-in-training. I thought every resident had a desire to serve as a chief resident. Posed with this question on several occasions, I was encouraged to reflect on the meaning of this year for myself, and likely for many of the other individuals in my position. Why did I choose to do this?

The decision to take the role of a chief resident is a rather personal one. It is not a good match for every personality type and is often a position that a particular type of person desires to have. The job description is rather broad and puts you in this strange location between resident and attending physician, liaison and supervisor, child and parent. You no longer perform the tasks required of you as a resident such as completing admission histories and physicals or presenting cases during morning report, yet you are also not a full-fledged attending physician. It is like you were finally asked to join the cool kids’ group in high school but then miss your nerdy science club friends. For me this transition was especially interesting since I took the job at a program different from the one at which I completed my own residency training.

While the transition is uncomfortable and difficult at first, you find yourself paving your way almost immediately. Guided by your inherent skills and driven by your aspiration to be a good teacher, mentor, and physician, you realize that just as you once filled those giant internship shoes you thought you would never fit into, you were again growing into a new role that would make you a better version of yourself.

At the start of my year as a chief resident I recall having many doubts about my abilities. I just finished residency myself, what would I be able to teach others? How would I resolve conflicts among peers without making (at least some) residents dislike me?

I remember one of my first morning reports as a chief resident. One of the senior residents was presenting the case of a patient that was recently admitted to our pediatrics floor. I was standing at the whiteboard asking questions and actually teaching on the fly! I think I surprised myself that day! I found myself facilitating case presentations and providing important pearls of knowledge I did not even know I had.

The first time I had to address a non-medical resident professionalism issue I remember e-mailing the resident in question to come to my office when he was available. I did not allude to the topic of the meeting in my e-mail, but simply asked him to stop by. Not even a minute later he walked into my office, quiet and obviously fearful, asking me what I needed to talk to him about. We discussed the matter at hand, he apologized and expressed understanding of the situation, and then for the next fifteen minutes we talked casually about completely non-work related topics. Phew! That went much better than I had expected. Even I had been fearful of this encounter myself. I realize that not every resident meeting about serious issues will go smoothly, but it was a small victory for me personally.

Lastly, coming into my new role as an attending (which I call a “pre-tending” as a chief resident) has probably been the most anxiety-provoking this year. My first week on-service as the junior attending on the general pediatrics floor proved to be both incredibly challenging and rewarding. I started during a busy week with many complex patients. I took my own night-call each evening and was expected to lead family-centered rounds and teach the other physicians-in-training who were rotating on the ward. The week flew by and I found myself running rounds nearly efficiently, creating management plans with the residents, and teaching them as we went along. At the end of the week I was thrilled to receive feedback from the other residents on my teaching skills and the manner in which I ran my rounds. I actually felt like a real attending!

Some of you reading this warm and fuzzy reflection piece might be wondering if I am purposely leaving out some of the more negative aspects of the job. Truth is, yes, I am. Anyone who has been a chief resident, or has witnessed one in action, knows that the role also entails having to deal with difficult personalities, be “on-call” essentially all the time, and perform some not-so-thrilling administrative and committee tasks. As with any job, there are aspects that do not help make it easier to get up in the morning; however, the opportunities for personal and professional growth that are possible during a chief residency year are abundant and will undoubtedly provide me with the skills needed to excel in various aspects of my own career.

As I consider the experiences I have had in just a few short months, it is clear why I chose to spend a year as a chief resident. I wanted to challenge myself and improve my abilities as a teacher, a leader and an attending physician. I wanted to provide mentorship to current residents using the lessons I learned during my own training and I wanted to encourage myself to seek out experiences that would inevitably help me determine my own future in pediatrics.
At the National Association of Neonatal Nurses’ (NANN) annual business meeting, conducted during the October 31st Annual Educational Conference in Dallas, Regina (Jean) Grazel, MSN, RN, BC, APN-C, was elected president for 2015–2016 in a special election to fill the vacancy in the office of president. Jean also will serve as the immediate past president in 2016–2017.

Jean is a certified advanced practice nurse with more than 30 years of neonatal nursing experience. She holds several clinical designations, including board-certified high-risk perinatal nurse, neonatal resuscitation program regional trainer, NANN neonatal developmental care specialist, and certified breastfeeding counselor.

Jean served two terms on the NANN Board of Directors and is a former president of her local chapter, Delaware Valley Association of Neonatal Nurses. She has held varied positions as nurse clinician, educator, project director, and public health nurse. Jean is the project coordinator for the New Jersey Department of Health Critical Congenital Heart Disease Screening Program and is employed by the New Jersey Chapter, American Academy of Pediatrics through a federal Health Resources and Services Administration grant.

Twenty Babies Saved & Counting
Results of CCHD Screening with Pulse Oximetry
August 31, 2011 – October 31, 2015

260 failed screens reported to the NJ Birth Defects Registry.
117 received diagnostic evaluations solely due to screening.

Detected through newborn screening with pulse oximetry

20 infants with CCHD
Coarctation of the aorta (7)
Ebstein anomaly (1)
Tricuspid atresia (1)
d-Transposition of the great arteries (TGA)(2)
Total anomalous pulmonary venous return (8)
TGA + Double outlet right ventricle (1)

14 infants with CHD
Atrial septal aneurysm
Atrial septal defect
Pulmonary artery/ pulmonary artery branch stenosis
Ventricular septal defect

10 infants with serious non-cardiac conditions
Sepsis
Pneumonia
Pulmonary hypertension
Pulmonary bulla
School Health Conference 2015
The Palace at Somerset Park

Elliot Rubin, MD FAAP, Jeffrey Bienstock, MD, FAAP, Margaret Fisher, MD, FAAP

Alan Weller MD, MPH, FAAP, Committee Chair

Robert Murry, MD, FAAP

Fran Gallagher, MEd

Thomas McPartland, MD

Wayne Yankus, MD, FAAP

Margaret Fisher, MD, FAAP, Jordan Greenbaum, MD

Tolga Taneli, MD

Jack Gladstein, MD, FAAP

Christene DeWitt-Parker, MSN, CSN, RN

Susan Sterling, MS, MSW, LCSW
MD Advantage

WE PROVIDE
VALUE BEYOND INSURANCE.

At MD Advantage®, our mission is to be a haven of safety, stability and strength for New Jersey healthcare. We advocate for physicians and actively support the practice of medicine in New Jersey. We have earned a reputation for integrity, responsiveness and decisive management, and stand prepared to assist healthcare providers in facing the challenges associated with today’s changing healthcare environment.

Want to know more?
Visit www.MDAdvantageonline.com
100 Franklin Corner Road, Lawrenceville NJ 08648-2104
888-355-5551
Holiday Safety Tips for Parents and Caregivers from AAP

The holidays are an exciting time of year for kids, and to help ensure they have a safe and happy holiday season, AAP offers these safety and mental health tips for you to share with Parents and other Caregivers.

TOY SAFETY
- Select toys to suit the age, abilities, skills and interest level of the intended child. Toys too advanced may pose safety hazards for younger children.
- Before buying a toy or allowing a child to play with a toy that he has received as a gift, read the instructions carefully.
- To prevent both burns and electrical shocks, do not give young children (under age 10) a toy that must be plugged into an electrical outlet. Instead, buy toys that are battery-operated.
- Young children can choke on small parts contained in toys or games. Government regulations specify that toys for children under age three cannot have parts less than 1 1/4 inches in diameter and 2-1/4 inches long.
- Children can have serious stomach and intestinal problems – including death – after swallowing button batteries or magnets. In addition to toys, button batteries are often found in musical greeting cards, remote controls, hearing aids, and other small electronics. Small, powerful magnets are present in many homes as part of building toy sets. Keep button batteries and magnets away from young children and call your health care provider immediately if your child swallows one.
- Children can choke or suffocate on uninflated or broken balloons; do not allow children under age 8 to play with them.
- Remove tags, strings, and ribbons from toys before giving them to young children.
- Watch for pull toys with strings that are more than 12 inches in length. They could be a strangulation hazard for babies.
- Parents should store toys in a designated location, such as on a shelf or in a toy box, and keep older kids’ toys away from young children. Use a toy box with no lid or a lightweight, non-locking lid and ventilation holes.

FOOD SAFETY
- Bacteria are often present in raw foods. Fully cook meats and poultry, and thoroughly wash raw vegetables and fruits.
- Be sure to keep hot liquids and food away from the edges of counters and tables, where they can be easily knocked over by a young child’s exploring hands. Be sure that young children cannot access microwave ovens.
- Wash your hands frequently, and make sure children do the same.
- Never put a spoon used to taste food back into food without washing it.
- Always keep raw foods and cooked foods separate, and use separate utensils when preparing them.
- Always thaw meat in the refrigerator, never on the counter.
- Foods that require refrigeration should never be left at room temperature for more than two hours.

HAPPY VISITING
- Clean up immediately after a holiday party. A toddler could rise early and choke on leftover food or come in contact with alcohol or tobacco.
- Remember that the homes you visit may not be child proofed. Keep an eye out for danger spots like unlocked cabinets, unattended purses, accessible cleaning or laundry products, stairways, or hot radiators.
- Keep a list with all of the important phone numbers you or a baby sitter are likely to need in case of an emergency. Include the police and fire department, your pediatrician and the national Poison Help Line, 1-800-222-1222. Laminating the list will prevent it from being torn or damaged by accidental spills.
- Always make sure your child rides in an appropriate car safety seat, booster seat, or seat belt. In cold weather, children in car safety seats should wear thin layers with a blanket over the top of the harness straps if needed, not a thick coat or snowsuit. See www.healthychildren.org/carseatguide for more information.
- Adults should buckle up too, and drivers should never be under the influence of alcohol or drugs.
- Traveling, visiting family members, getting presents, shopping, etc., can all increase your child’s stress levels. Trying to stick to your child’s usual routines, including sleep schedules and timing of naps, can help you and your child enjoy the holidays and reduce stress.

Fireplaces
- Before lighting any fire, remove all greens, boughs, papers, and other decorations from fireplace area. Check to see that the flue is open.
- Use care with “fire salts,” which produce colored flames when thrown on wood fires. They contain heavy metals that can cause intense gastrointestinal irritation and vomiting if eaten. Keep them away from children.
- Do not burn gift wrap paper in the fireplace. A flash fire may result as wrappings ignite suddenly and burn intensely.
- If a glass-fronted gas fireplace is used, keep children and others well away from it with a screen or gate. The glass doors can get hot enough to cause serious burns and stay hot long after the fire is out.

HOLIDAY MENTAL HEALTH TIPS
- Take care of yourself both mentally and physically. Children and adolescents are affected by the emotional well-being of their parent or caregivers.
- Coping with stress successfully can help children learn how to handle stress better, too.
• Make a plan to focus on one thing at a time. Try a few ideas from “mindfulness” as a strategy to balance the hustle and bustle of things like shopping, cooking, and family get-togethers during the holidays. Stop and pay attention to what is happening at the moment, focus your attention on one thing about it, and notice how you are feeling at the time. Withhold immediate judgment, and instead be curious about the experience.

• Give to others by making it an annual holiday tradition to share your time and talents with people who have less than you do. For example, if your child is old enough, encourage him or her to join you in volunteering to serve a holiday meal at your local food bank or shelter or sing at a local nursing home. Help your child write a letter to members of the armed forces stationed abroad who can’t be home with their own family during the holidays.

• Remember that many children and adults experience a sense of loss, sadness or isolation during the holidays.

It is important to be sensitive to these feelings and ask for help for you, your children, family members or friends if needed.

• Try to keep household routines the same. Stick to your child’s usual sleep and mealtime schedules when you can, which may reduce stress and help your family enjoy the holidays.

• Kids still need to brush their teeth twice a day!

• Don’t feel pressured to “over-spend on gifts.” Consider making one or two gifts. Help your child make a gift for his or her other parent, grandparents, or other important adults and friends. Chances are, those gifts will be the most treasured ones and will teach your child many important lessons.

• Most important of all, enjoy the holidays for what they are –- time to enjoy with your family. So, be a family, do things together like sledding or playing board games, and spend time visiting with relatives, neighbors and friends.

Reprinted with Permission, 2015 - American Academy of Pediatrics
Dr. Wood spoke about the management of complex pediatric patients as they age and how we, as their pediatric neurosurgeons, should carefully direct and manage our patients’ transition from pediatric to adult neurosurgical care. He recommended that we commence the process for our patients at age fourteen. His interest in children with developmental disabilities and neurological disorders is similar to that of many pediatric neurosurgeons. As surgeons for children with hydrocephalus, cerebral palsy (CP) and spina bifida, we experience and understand the stress and the challenges that our patients and their families face every day. As physicians, and as caring adults, we often attempt to alleviate this stress by guarding our pediatric patients as much as possible. We provide child-friendly environments for these children. We develop age-applicable educational materials for our patients and their families. We spend hours talking to parents about their child’s diagnoses and prognosis. We have our patients’ BEST interest at heart, and we always have.

Dr. Wood discussed the American Academy of Pediatrics’ Policy Statement: “Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs.” I read this policy statement and found it to be very informative and also very concerning. Many of my patients have numerous serious, medical co-morbidities.

There is additional stress related to socioeconomic status and educational level of the family, which makes caring for these medically-fragile children extremely challenging.

Transition of care from pediatric to adult neurosurgery is not an issue for me, since I will care for kids with hydrocephalus, spina bifida and cerebral palsy (CP), who grow up. Here are some strategies I have employed successfully:

- I work with the adult spina bifida patients at Kessler Institute of Rehabilitation, in West Orange, NJ.
- I developed an adult cerebral palsy clinic with Drs. Theodore Feigelman and Michelle Sirak at Morristown Medical Center.
- I have developed a relationship with the Family Medicine Physicians at our hospital, to facilitate the transfer of care and to provide a continuum of care from the clinic, to the emergency room, to the ward.

Despite these efforts, I have seen increasing depression and frustration in my patients and their families as services to these patients are increasingly eliminated. State supported programs in New Jersey have been severely cut and adults with developmental disabilities and neurological problems have been dramatically affected. Some very special doctors still spend hours on the phone advocating for our patients’ wheelchairs, medications and orthotics. Dr. Bruce Gans has become very involved on a national level for advocating for patients with disabilities. Dr. Ted Feigelman, Dr. Michelle Sirak and I are honored and privileged to take care of adults with CP and spina bifida and other developmental challenges. We enjoy caring for our patients and our patients truly appreciate the care that we provide.

It was nice to listen to Dr. Wood’s presentation about the transition of care for complex, pediatric neurosurgery patients. It is clear to me that he really cares about his patients and all patients with developmental disabilities and neurological problems.

continued on next page
But it is a chilling reminder that our young patients, who are safely sheltered in their “pediatric” medical “homes,” will soon be facing a scary and unavoidable predicament when they grow up. Not all pediatric specialists can care for adults. Some can’t and some won’t, and for some patients, the adult world will not be as happy and protected as their childhood “medical homes” were. I really worry about this when I think about my patients who are “growing-up” in America, where their medical future is still unclear.
This past September, I had the opportunity to spend the month at the JDW National Research Hospital in Thimphu, Bhutan through Health Volunteers Overseas (HVOusa.org).

Bhutan is a Buddhist country in the Himalayas with a population of approximately 780,000 people: 95,000 of whom live in the capital city of Thimphu. Forty percent of their population is under 14 years of age and seventy percent of the population continues to live by subsistence farming.

Medical care is free to all citizens and is provided through local Basic Health Units (usually no physician), district hospitals, and 3 regional referral hospitals. The pediatric department at JDW Hospital is staffed by 5 attending pediatricians, 4 pediatric residents, and a handful of rotating interns. The attendings maintain their knowledge and skills over a breadth of pediatric medicine: there are no subspecialists. Rounding on the wards or observing in the out-patient clinic provides for a good board-review experience. Despite the excellent clinicians and selected modern amenities, (everyone has cell phones), resources are exceedingly limited and one must be pragmatic in pursuing diagnostic workups and making recommendations to families. If the test you want to order, assuming it is available, will not change your clinical impression or management, it doesn’t get ordered.

Separately, the pediatric outpatient department sees children 9am to 3pm Monday to Friday: 2 physicians are expected to see approximately 50 patients each during that time. This is a walk-in clinic where everyone takes a number and waits for their turn. Some patients are local, while others have travelled by bus and/or by foot over several days. Patients in this clinic may have a simple rash, new diagnosis of nephrotic syndrome or parental concern for ADHD. The attending’s diagnostic skills even extend into my specialty of developmental pediatrics. Most notable were the attendings’ abilities to identify developmental issues in children admitted to the hospital with an acute illness or who first presented at the out-patient clinic with a rash. These clinicians would diagnose FAS, autism, Hunter’s syndrome, Williams Syndrome and refer to the limited developmental services that are available. As a developmental pediatrician at the country’s primary referral hospital, I was kept busy with daily developmental clinics, inpatient consultations and teaching an enthusiastic group of residents. Additionally, I consulted to a middle school that had a special education program and also visited a school for the deaf (there is also a school for the blind).

Although severely under resourced, the capital city had the most to offer and drew families from around the country, enabling me to see a variety of disorders including: dyskinetic CP from kernicterus, William’s syndrome, Down syndrome, Neurofibromatosis, FAS, autism and many others. Parental concerns over their child’s behavior was ever present. Evaluations and recommendation required being respectful of and sensitive to cultural norms and beliefs (seizures are contagious and they increase when a child is fed butter and meats) and knowledgeable about the availability of local resources.

Challenges to practicing medicine in Bhutan are numerous, but progress is being made. I found the staff, residents and families to be appreciative of our collective efforts. Outside of the hospital, the Bhutanese people are kind and interested in the “chilops” (foreigners). The country’s desire to maintain its traditions, culture, and preservation of the environment stand in contrast to its march toward modernization. The vistas are spectacular and hiking locally and throughout the surrounding districts is a must. The temple, monasteries and other surrounding vistas are well worth the climb!
Preschool does more than prepare children for school; it prepares them to lead healthy and productive lives. Research shows that early learning and socialization have strong effects on later achievement, lifestyles and health. Unfortunately, too many of New Jersey’s children go without access to critical early learning. The families into which they are born and the zip codes in which they live often unnecessarily determine their future lives. Pre-K Our Way is a nonprofit, nonpartisan and community-based effort to make sure more 3- and 4-year-olds have access to quality preschool that prepares them for success in school, health and life.

New Jersey has one of the best preschool programs in the nation. Frequent evaluations find that children who experience one or two years of New Jersey’s high-quality preschool demonstrate greater proficiencies in language arts and math in the 5th grade than those who didn’t attend an early education program. In fact, children who attend New Jersey’s pre-k programs achieve at a higher rate, with a 20-40% increase in elementary school test scores. They struggle less in school—they are 40% less likely to repeat a grade—and they overcome barriers to learning to the point where schools see a 31% drop in the need for expensive special education services.

This is good news for promoting healthier lives for all children. Nobel economist James Heckman’s investigation of North Carolina’s Abecedarian preschool school program has found that quality early childhood education that develops both cognitive and social skills drives healthier lifestyles, better health, greater productivity, higher education and higher wages. Early education and socialization provide the skills for self-diagnosis, motivation to seek treatment and the ability to follow medical advice as adults.

Given this evidence, it’s tragic that New Jersey’s proven preschool program reaches too few children across our state. Fewer than 40 communities have the program; a law enacted in 2008 to bring New Jersey’s high-quality pre-k to approximately 90 more communities was never implemented. Pre-K Our Way is working to change that.

Established in early 2015, Pre-K Our Way works to expand New Jersey’s existing high-quality pre-k to 3- and 4-year-olds in more communities. We have a rapidly growing group of individuals and organizations working together to build public support for pre-k expansion. We are pleased to have former Governors Tom Kean and Jim Florio on our leadership group; they are joined by statewide leaders in business, education, child advocacy and health. They’ve been supported by dozens of New Jersey’s foundations, child advocacy and community groups, including the United Ways of New Jersey and the New Jersey YMCA State Alliance – all working to bring high-quality pre-k to more of our state’s communities. Get more info about Pre-K Our Way at www.prekourway.org. Like us on Facebook. Follow us on Twitter. Watch for action on this issue in 2016.

Together, we can make sure each child is prepared for school and life—and build a healthier future for all of New Jersey.
Family Voices: How Pediatricians and Families can Work Together for Children Who “Fail to Thrive”

Lauren Agoratus, MA

According to AAP and the American Academy of Family Physicians, failure to thrive is seen in primary care settings in up to 10% or more of patients. Children with “failure to thrive” (due to lack of adequate caloric intake for the needs of the child) can be especially challenging for pediatricians and families alike. Here are some strategies for parents and professionals to work together to improve outcomes for these children.

Explaining Failure to Thrive to Families

Parents must understand that they may not be doing anything wrong, but that some children may have failure to thrive due to a multitude of reasons. Perhaps the child has a condition such as renal failure which affects their growth. Other children may have structural differences such as cleft palate which would be more obvious. Some children may have food intolerances, serious allergies (such as to formula), or metabolic disorders. Still others could have gastrointestinal reflux. Pediatricians must assure families that they aren’t necessarily being blamed for their child’s condition.

Referrals for Families

There are several options for pediatricians to refer families. Other than recommendations for specialists if there is not yet a diagnosis, pediatricians can offer the following suggestions:

- Breastfeed if possible, as this is easier for infants to digest and boosts the immune system. Hospitals will also allow mothers to store breastmilk for the times they aren’t there around the clock.
- Early intervention for children from birth to 3 would offer comprehensive services if the failure to thrive is caused by, or results in, a disability or developmental delay
- Speech therapists who may have knowledge of feeding problems
- Nutritionists who can work on menus with families and how to add calories to what the child is already eating without increasing the actual amount of food
- Physical or occupational therapists who can work on positioning to address reflux
- Clinics that specialize in feeding/swallowing/choking issues

Practical Tips for Parents

Families may be very frustrated trying to get their child to eat more, or spend literally hours per meal and then the child doesn’t keep the food down. There are other helpful ideas that pediatricians can suggest for parents to try at home.

- Feed the child smaller but more frequent meals
- Try nutritional supplements like Thick-It for swallowing problems and Polycose to add calories
- For reflux, keep the child upright after meals, and elevate the pad of the changing table and crib mattress. NOTE: Make sure families know to raise the surface by putting a rolled towel under the pad or mattress, not on top of it
- Adapted highchair inserts help with choking and reflux

Pediatricians can offer practical solutions as well as recommend other specialists to work with families as they struggle with their child’s failure to thrive. Families need to know that growth and progress happen slowly. (My own daughter weighed 11 lbs. at 1 year of age but was finally on the height and weight charts by age 2 ½.) Parents and professionals working on the same goals will result in better health outcomes for the child.

Resources

Failure to Thrive-KidsHealth information for parents
http://bit.ly/1h7P53B

Lauren Agoratus MA is the parent of a youth with multiple disabilities and is the NJ Coordinator of Family Voices, the national network that “works to keep families at the center of children’s health care.” She also serves as the Central/Southern Coordinator for the NJ Family-to-Family Health Information Center (F2FHIC). In NJ, Family Voices and F2FHIC are housed at the Statewide Parent Advocacy Network (SPAN), www.spanadvocacy.org.
Healthy Eating Strategies Fuel Newark Students

To be healthy, students need access to proper nutrition. Children who regularly eat a healthy breakfast are less likely to be obese and, subsequently, they are less likely to suffer from diabetes, hypertension and other consequences of being overweight. They also perform better academically and have fewer behavioral difficulties in school than those who do not eat breakfast.

New Jersey schools are feeding breakfast to about 211,000 children of low-income families each day, giving them the morning meal that children need to concentrate and learn. But, according to Advocates for Children of New Jersey, an alarming 300,000 children are still missing out on that all-important morning meal at school. To help turn around those numbers, a $247,000 grant from American Association of School Administrators is being used to expand school breakfast service throughout Newark Public Schools with Breakfast After the Bell programs, like Grab n’ Go breakfast kiosks and Breakfast in the Classroom. Switching to serving “breakfast after the bell,” rather than before school, significantly boosts participation, fueling students for their day.

To entice more students to spend time eating breakfast, Arts High School in Newark, New Jersey, on September 30, 2015, unveiled the high school’s newly restyled cafeteria. The invigorating new space now feels more like a café setting. The cafeteria makeover, funded by a grant from American Dairy Association and New York Jets’ Fuel Up to Play 60 school wellness program, included a new color scheme, new furniture and new signage promoting healthy menu choices.

Traditionally, New Jersey schools have served breakfast before school – when children have not yet arrived. To overcome this barrier and increase school breakfast participation, more schools are implementing Breakfast After the Bell. This new approach changes the way breakfast is served – making it available to all children during the first few minutes of the school day. And the strategy appears to be working. The latest Annual New Jersey School Breakfast Report shows a 55% rise in school breakfast participation.

To find out more about Breakfast After the Bell Programs, visit the American Dairy Association and Dairy Council website at www.adadc.com/school-nutrition.html.

A ribbon cutting ceremony on September 30 unveiled Newark’s Arts High School’s newly restyled cafeteria, funded by a grant from American Dairy Association and New York Jets’ Fuel Up to Play 60 school wellness program. Pictured from the left is Ricardo Pedro, School Principal; Brad Haggerty, Assistant Superintendent; Chris Cerf, Newark Superintendent; Tonya Riggins, School Nutrition Director; and, Tony Richardson, former New York Jets player.
Human Trafficking Exists in New Jersey
Do You Know the Signs?

What to Look for During a Medical Exam/Consultation

The following is a list of potential red flags and indicators that can be useful in recognizing a potential victim of human trafficking. It is important to note that this is not an exhaustive list. Each indicator taken individually may not imply a trafficking situation and not all victims of human trafficking will exhibit these signs. However, recognition of several indicators may point toward the need for further investigation.

General Indicators that Can Apply to All Victims of Human Trafficking

- Individual does not have any type of legal documentation – i.e., license or state issued identification for US Citizens; passport, Green Card, or other identification for foreign nationals
- Individual claims to be “just visiting” an area but is unable to articulate where he/she is staying or cannot remember addresses; the individual does not know the city or state of his/her current location
- Individual has numerous inconsistencies in his/her story
- Someone is claiming to speak for, or on behalf of a victim – i.e., an interpreter, often of the same ethnic group, male or female; victim is not allowed to speak for him/herself
- Individual exhibits behaviors including “hyper-vigilance” or paranoia, fear, anxiety, depression, submission, tension and/or nervousness
- Individual exhibits a loss of sense of time or space
- Individual avoids eye contact
- Individual uses false identification papers – may not be victim’s real name
- Individual is not in control of his/her own money

Specific Health Indicators

The following indicators may present in the context of a physical exam or similar health assessment or treatment

- Malnourishment or generally poor health
- Signs of physical abuse – in particular, unexplained injuries or signs of prolonged abuse
  - Bruises
  - Black eyes
  - Burns
  - Cuts
  - Broken bones
  - Broken teeth
  - Multiple scars (including from electric prods)
- Evidence of a prolonged infection that could easily be treated through a routine physical/checkup
- Addiction to drugs and/or alcohol
- Individual has no idea when his/her last medical exam was
- Lack of healthcare insurance – i.e., paying with cash

Specific Indicators that Apply to Sex Trafficking Victims

Victims of sex trafficking may exhibit a unique set of risk factors and warning signs, including the following:

SOURCE: Girls Education and Mentoring Services (GEMS)

- The age of a individual has been verified to be under 18
- The individual is involved in the sex industry
- The age of the individual has been verified to be under 18 and the individual has a record of prior arrest(s) for prostitution

NJ Office of the Attorney General
Division of Criminal Justice
NJ Human Trafficking Task Force

855.363.6548
Hotline: 855.END.NJ.HT
www.NJHumanTrafficking.gov
Discrepancies in behavior and reported age – i.e. cues in behavior or appearance that suggest that the individual is underage, but he/she lies about his/her age

Evidence of sexual trauma

Multiple or frequent sexually transmitted infections (STIs), especially evidence of a lack of treatment for STIs

Multiple or frequent pregnancies

Individual reports an excessively large number of sexual partners, especially when it is not age appropriate (i.e. 15 year old girl reporting dozens of sexual partners)

Individuals who are under the age of 18 who express interest in, or may already be in, relationships with adults or older men

Use of lingo or slang relating to the individual's involvement in prostitution – i.e. referring to a boyfriend as "Daddy" or talking about "the life"

Evidence of controlling or dominating relationships – i.e. repeated phone calls from a "boyfriend" and/or excessive concern about displeaseing a partner

Individual is dressed in inappropriate clothing (i.e., lingerie or other attire associated with the sex industry)

Presence of unexplained or unusual scar tissue – potentially from forced abortions

Tattoos on the neck and/or lower back that the individual is reluctant to explain – i.e. a man's name or initials (most often encountered with US citizen victims of sex trafficking)

Other types of branding – i.e. cutting or burning

Evidence that the victim has had to have sexual intercourse while on her monthly cycle – i.e. use of cotton balls or other products which leave residual fibers

Family dysfunction – i.e. abuse in the home (emotional, sexual, physical), neglect, absence of a caregiver, or substance abuse – these are major risk factors for sex trafficking and can be important warning signs that the individual might be a victim

Individual may either be in crisis, or may downplay existing health problems or risks

Individual may resist your help or demonstrate fear that the information he/she gives you will lead to arrest, placement in social services, return to family, or retribution from trafficker

**Victim Identification**

**How do I conduct an assessment or exam with a potential victim of human trafficking?**

- Utilize existing assessment and examination protocols for victims of abuse/sexual abuse
- Utilize existing culturally sensitive protocols
- Use age-appropriate language if working with minors
- If you ask about sexual history, be sure to distinguish between consensual experiences and non-consensual experiences
- If possible, choose a comfortable space which is conducive to confidentiality
- If appropriate, separate the individual from his/her belongings and escort/interpreter
  - The victim may be wearing/carrying some sort of tracking/communication device such as a GPS transmitter, cell phone or other small device – you can separate the victim from these devices by getting him/her into a gown and into an x-ray room

**What do I do if I think I have identified a victim of human trafficking?**

- Be sensitive, every incident of human trafficking is different
- Make sure you are not putting yourself or the individual in danger (i.e., take care to notice who is around when you are asking questions or providing resources)
- If you suspect that the victim is in immediate danger, notify the police by dialing 9-1-1
- Try to record as much information about the situation as possible – being careful not to put yourself or the individual in any danger
- Call the New Jersey Human Trafficking Hotline to report the incident 855.END.NJ.HT (855.363.6548)

As a health practitioner, you are in a unique position to recognize, identify, and reach out to victims. This list is intended to be a guideline only and should be adapted to fit existing organizational protocols for interacting with potential victims of child abuse, violence, sexual assault and other related crimes. Health practitioners should familiarize themselves with social service providers in their area working on the issue of human trafficking and work with these agencies to create a protocol for responding to victims of trafficking.

*Information provided by Pelicans Project*
Are You Taking Full \textbf{APP}vantage of New Jersey Pediatrics?

CME ACTIVITY in Every New Issue

Easily Locate CME Articles from Past Issues

Don’t Miss a Single Issue...

Download the free App from iTunes or Amazon Today
Share with Colleagues Tomorrow