When You Have An Impaired Parent in Your Office

One of the situations that most troubles us as pediatricians is to have a parent in the office who appears impaired by alcohol or drugs. Even just smelling alcohol when you enter the exam room, regardless of how normal the parent appears, requires a response. A parent who has been drinking (or using a drug) at the time of a medical visit for a child is waving a big red flag. We can’t pretend we didn’t notice.

The first thing to do is make sure the child is safe. Is the parent agitated and acting in a threatening manner toward the child? Is the parent nodding off and at risk for dropping the child? You might need to take the child and put him or her somewhere safe until the situation is resolved. Maybe you can place an infant on the scale again to recheck the weight and use that as the start of keeping the baby out of harm’s way. An older child might be better off sitting up on the exam table. An adolescent can be asked to go with the nurse to obtain a urine specimen in the hall bathroom.

You also need to make sure the other people in the office are safe. If the parent’s behavior is escalating in the waiting area, ask them to please sit down with you in another room so you can discuss things privately. See if responding in a calm manner helps defuse the situation. If you don’t feel that you are making progress, get some help. Do you have a social worker who can meet with the parent? Is one of the nurses in your office good at handling a scenario like this? Calling security or the police should be a last resort but in an extreme situation, might be a necessary thing to do.

Even parents who are upset or angry will most often respond appropriately when treated with respect and kindness. They may be unused to much of either in daily life. Your interest in addressing whatever is going on by helping as best you can will go a long way to getting them to connect with you in a positive way. For example, you might start with “I smell alcohol. It seems to me that you’ve been drinking. Can we talk about that?” Or, “I’m worried about the way you seem so sleepy and the baby almost got dropped just now.” If the parent says they’re on medication, ask what it is and offer to call the prescribing office to let them know what you’re observing. If a mother has just delivered, her medication may need to be adjusted radically to avoid an overdose. Your input can be invaluable.

A parent who is unable to curtail drinking or drug use when arriving for a medical visit has a significant problem that is negatively affecting the child. This much substance use requires treatment that you will not be able to provide yourself. Explain that you are so concerned about them that you are going to ask for assistance from someone who specializes in family safety. In New Hampshire, that means asking the Division for Children, Youth and Families to help out. DCYF staff members help parents keep their children safe and get help with drug and alcohol use. During your call, a plan will be made for the child’s immediate safety.

(Continued on page 2)
(Continued from page 1)

Certainly an impaired parent should not be sent out of the office until they have someone to help them. If DCYF feels the parent can safely leave, your office staff can call a parent’s friend or relative to come and pick them up and once home, stay with them until they’re able to care for the child again. It’s important to be firm about this point. If an impaired parent refuses help, you need to tell them that you’re responsible for anyone leaving your office and that you must insist that they only leave with someone to help them get home safely and remain as long as needed. If they still announce that they’re leaving, you will need to have someone call the police. Then someone should follow the parent out to get a description of their car and note which way it’s headed.

Things will rarely get this far. Usually you can handle these situations without such a confrontation., especially because you likely have a positive relationship already with the parents you serve. They are very likely to let you help them with what is a serious problem. And you will be seen as someone who cares about them and their children. Which you certainly do.

- Wendy Gladstone MD

I am a member of the board of Media Power Youth, a Manchester-based non-profit initiative dedicated to educating elementary school children about the risks of excessive and uncritical media exposure. To that end, classroom curricula have been designed which have been subjected to peer review and strongly validated, particularly at Boston Children’s Center on Media and Child Health and its chairperson, Dr. Michael Rich. Governor Maggie Hassan and the NH State Attorney General have demonstrated strong support, and limited capital investment in MPY is close to state budget approval. A Connecticut-based nonprofit experienced in disseminating professional material to teachers is very interested in assisting MPY launch its curricula in all schools in that state and, quite possibly, nationwide.

The state’s pediatricians are lucky to witness the birth and development of this worthy counter to the strong influence of broadcast, computer, and social media in our midst. Inquiries and donations to help advance MPY’s efforts are welcome on-line at www.mediapoweryouth.org.

Thanks,

Tom Bisett, M.D.

From Our President...

In followup to my past article on Poverty, trying to call to action all pediatricians to determine ways you might address poverty in your practice, I thought I’d point you all toward some excellent resources provided by our younger colleagues in the AAP Section on Medical Students, Residents, and Fellowship Trainees (SOMFSRT).

See their amazing work and fantastic resources, yet another way the AAP adds value to our membership, at http://www2.aap.org/sections/ypn/r/advocacy/FACEPoverty.html

-Bill Storo MD

For those who might be inclined not check out the website, see below the materials available, with lots of links to useful resources:

Welcome to the AAP Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT) 2014-2015 Advocacy Campaign Webpage

Poverty is a significant determinant of child health, affecting not only physical health and development, but also educational achievement, emotional well-being and health into adulthood. The profound effects of childhood poverty have prompted the AAP Section on Medical Students, Residents and Fellowship Trainees (SOMSRFT) to focus on the issue with its annual advocacy campaign.

Called FACE Poverty, the campaign will empower pediatricians-in-training to address many facets of poverty at the community, state and federal levels.

Poverty is defined as an income of $23,850 per year or less for a family of four, regardless of geographic differences or cost of living. Children living in poverty are at high risk for poor academic achievement, high school dropout, teen pregnancy, drug and alcohol abuse, criminal behavior and exposure to “toxic stress” with subsequent negative physiologic and developmental effects.

In addition, children living in poverty have decreased access to quality health care and worse health outcomes. Families living in poverty experience higher infant mortality, and children are at greater risk for developmental delays, asthma, ear infections, obesity, poor nutrition, abuse and neglect.

Pediatricians have an incredible and unique opportunity to make a huge impact on how poverty impacts children. The FACE poverty campaign will focus on four areas crucial to addressing poverty and its consequences on children:

(Continued on page 3)
Food security: Adequate nutrition is vital to the growth and development of all children. In 2013, 14.3% of households were food-insecure, with 5.6% with very low food security. About 45% of low-income families are food insecure. http://www.foodrecoverynetwork.org

Access to health care: Pediatricians-in-training will work to increase children’s access to a patient-centered medical home, which can lead to improved health and well-being. In addition, ongoing advocacy is needed to maintain and strengthen Medicaid and the Children’s Health Insurance Program, which have led to significant improvement in overall access to health care.

Community: Between 1996-2006, most Americans in the bottom 20% never moved up the income ladder. Twenty percent of U.S. children younger than 18 years live in poverty and are likely to remain in poverty as adults. Lack of resources for those in poverty as well as the effects of poverty on child development result in these intergenerational cycles of poverty. The goal of this branch of the campaign is to focus on building family resilience and advocating for positive schooling and neighborhood development.

Education: Early and continued education are strongly associated with income, future employment and overall quality of life. Although early childhood education has improved since 1994, there is still work to be done. In addition, more than 1.2 million U.S. students drop out of high school every year. The campaign will focus on advocating for early childhood education and reducing the high school dropout rate. The FACE Poverty campaign urges trainees to get involved in addressing childhood poverty at the clinic, community and legislative levels. Please browse through the resources below and join trainees across the country as we FACE Poverty!

Background information:
FACE Poverty Powerpoint
Program Delegate Letter
FACE Poverty Poster (coming soon)
AAP Agenda for Children Strategic Plan - Poverty and Child Health
FACE Poverty Advocacy Updates: Sent out on the 22nd of each month to remind us that 22% of US children live in poverty!

October - Access
November - Access
December - Access
January - Community
February - Community
March - Community
April - Food Security
May - Food Security
June - Food Security
July - Education
August - Education
September - Education

Helpful Resources
National Center for Children in Poverty
Children’s Defense Fund
Spotlight on Poverty - Data on your community
Annie E. Casey Foundation

Where you can get involved: Clinic, Community, State and Federal levels!

Food Security/Nutrition
The Hunger Vital Sign
AAP Poverty and Hunger
SOMSRFT Team Healthy Website
Host a SNAP challenge
Access to Healthcare
Medicaid and CHIP Nation and State Reports
CHIP Talking Points
Legislative Letter
Legislative one page information sheet
Community
Toxic Stress and its effects on EBCD
PowerPoint presentations
Center on the Developing Child - Tackling Toxic Stress
Fostering Resilience in Children (more resources below in Advocacy at the Community Level section)
Tips to Promote Social-Emotional Health Among Young Children
Motivational Interviewing
Fostering Resilience
Family and Caregiver Resources
Poverty Simulator
Help keep communities safe by continuing efforts to protect kids from firearm injury - PAVE Website
AAP Symposium on Child Health, Resilience and Toxic Stress Education
Resources for early childhood literacy - Read Lead Succeed Website
For presentations on early childhood education and other great resources
For information on quality early childhood education
Head Start Locator
DOCs for TOT's 'EARLY QUALITY LEARNING' Provider checklist
Find out your local Child Care Resource & Referral Agency call 800-424-2246 or visit Child Care Aware (put in your zip to get your local CCR&R information)
Print out this poster to advocate in clinic
Provide handout of child care and quality regulation resources
Advocacy at the Clinic Level:
IHELLP Pocket Card - After discussing poverty at your program, consider printing and distributing this card to all trainees. This validated tool to screen for social determinant of health can help you identify patients that need to be plugged into community resources.
Poverty infographic poster for the clinic, school, or doctor's lounge. Use it to spread awareness of the issue within your program.
Advocacy at the Community Level:
Consider writing an op-ed or letter to the editor for your local paper.
Christian Pulcini, MD - CHIP must remain strong for children and their families
Organize a clothing or food drive to benefit children living in poverty in your community.
Advocate for increase in minimum wage
Implement a noon conference at your institution that teaches trainees how to foster resilience in their patients.
Center on the Developing Child - Enhancing and Practicing Executive Function Skills with Children from Infancy to Adolescence

(Continued on page 4)
Managing My Meds

My name’s Zach. I’ve been in charge of managing my own medication for about 11 years now, starting when I was a freshman in high school. I take iron pills, a blood thinner that keeps me from getting blood clots and a pill that keeps my thyroid in check. For those who take pills, you need to know what your pills do, even if that means having a cheat sheet of your med names, doses and effects. Medication can be tricky and the prescriptions you are given are tailored specifically to your needs.

Management is one of the most important parts of a person’s daily, weekly and monthly routine. THE most important part of med management, in my opinion, is checking at the start of every month to make sure that you have enough of your pills to last you the upcoming month. If you’re low or out of any of your meds, you or someone else representing you will need to call your local pharmacy to make sure that your meds are refilled.

On a daily basis, a person needs to do one thing: take his or her meds on time. Personally, I keep a pill planner. It has slots for every day of the week so it doesn’t need to be refilled every night. It’s separated into morning, noon, afternoon and night in order to keep track of what I need to take and when I need to take it. It’s filled on a weekly basis. I find it helpful to set multiple alarms in my phone to remind me to take these pills. Sometimes, this alarm goes off while I’ve had to turn my phone off or I forget to bring my pills with me while I’m out so it’s not a perfect plan but it does work 99% of the time. I also have a couple of friends who have memorized my pill schedule for me, just in case something goes wrong with my alarm. It’s always a good idea to have a back up.

Nobody’s perfect. When I miss these pills, I sometimes end up having physical side effects the next day that range anywhere from being completely unpleasant to the people around me to putting myself in the hospital. I notice it the next day, make a mental note of it, start taking my pills regularly again and then I’ve fixed my mistake. Now, I’m not trying to scare whoever is reading this. Missing a single pill isn’t necessarily going to send you to the hospital. In fact, it should be rather simple to put together a plan of action just in case a medication is missed. I’m simply hoping to educate you on the fact that the pills that you take on a regular basis are, in fact, there to help you—instead of just take time out of your day for no reason (like I used to think).

Like I said before, it’s very likely that you’ll miss a pill here and there if you’re an average human being. Thankfully, with the help of alarms and a support system of friends and professionals, it’s easy enough to keep your messups to a minimum and keep med management going smoothly. All you really have to do is make sure that you know what you take, when you take it and where you keep it, whether that be through memory or via a cheat sheet. If you keep tabs on your pills, take them regularly and know who to turn to should issues arise, you’ll be able to look towards the future with a clean bill of health.

Print out the checklist on next page for all the “Zachs” in your practice.

Submitted by Wendy Gladstone MD
A CHECKLIST FOR MY MEDICATION

1. I know what the name of my medical condition is.
2. I know the name of my medication.
3. I know the dose of my medication.
4. I know what the medication does.
5. I know how to tell if it’s working (or not).
6. I know what side effects to watch out for.
7. I know what would be an “emergency” for me.
8. I know what to do if I have an emergency.
9. I know how to call my medical provider’s office with any questions.
10. I know if there are any other medications I shouldn’t take.
11. I know how to order more medication.
12. I know when to order more so I don’t run out.
13. I know what to watch for if I run out of medication.
14. I know how to restart the medication if I run out.
15. I know how long before the medication starts working again.
16. I know what to do if something happens before then.
Webinar Series Announcement:
"It’s All About Teamwork: Incorporating Genetics and Family History into the work of the Patient Centered Medical Home (PCMH)"
http://www.mainequalitycounts.org/page/2-1222/new-england-genetic-collaborative

About the NEGC:
The New England Genetics Collaborative is one of 7 regional organizations across the US dedicated to narrowing the gap between what is and what can be, for individuals with genetic disorders. Funded by HRSA, the NEGC coordinates collaboration among public health, metabolic and genetic clinics, medical homes, academia, and parent groups to support innovation in genetics and improve access to genetic services.

The NEGC is leading a tristate webinar series with the child health improvement partnerships in ME, NH and VT to highlight how a team-approach to caring for children with genetic and complex conditions will improve collaboration, coordination, and satisfaction for families and providers.

Genetics in Primary Care Institute (GPCI) resource are utilized.

Why this is unique:

- Experts in the field determined which activities would be meaningful, doable, & sustainable for the tristate area.
- The series offers practical approaches to advance your practice, emphasis on starting small.
- Jeanne McAllister, Medical Home pioneer, is a presenter.
- Pediatric mental health issues will be incorporated.
- Burn-out is addressed.
- Ideas on billing for care coordination are offered.
- CMEs are available through Maine Quality Counts.

Save these dates, from noon to 1 pm (EDT):

- **May 28, 2015** - "Why Medical Home and Care Coordination are Important for Children"; Jill Rinehart, MD; Jeanne McAllister, BSN, MS, MHA
- **June 4, 2015** - "How to Achieve a Shared Plan of Care for Kids with Primary Care Providers, Families, and Specialists"; Jill Rinehart; Jeanne McAllister
- **July 16, 2015** - "Obtaining and Documenting a Pediatric Family History - Understanding Why it is Important, Identifying Red Flags, and Capturing the Information in the Electronic Medical Record"; Leah Burke, MD; Craig Donnelly, MD (child psychiatrist)
- **September 17, 2015** - "Sustaining the Momentum: Incorporating Genetics in the Management of Children in the Primary Care Office"; Rosemarie Smith, MD; Wendy Smith, MD

Who should attend: Pediatric and family physicians, clinical teams, families interested in best practice
NEWS FROM CHILDREN’S HOSPITAL AT DARTMOUTH (CHaD)  
MAY 2015  
CHaD PROGRAMMATIC NOTES

CHaD Matters is changing to e-CHaD Matters. The publication has served its purpose very well for nearly 18 years, but the connected digital age allows us to bring you up-to-date CHaD news and happenings more efficiently. We have just distributed the last semi-annual issue of the paper version of CHaD Matters. It will be replaced by one annual print edition and a quarterly electronic newsletter. We hope you will take a moment to ensure that we have your email address by visiting www.chadkids.org/signup.

CHaD – Pediatric Specialties Department Consolidating Services

In order to provide each patient with the best care, in the right place, at the right time, every time, we are happy to announce that we will be consolidating our pediatric specialty services into one convenient location:

Children’s Hospital at Dartmouth-Hitchcock (CHaD)  
Dartmouth-Hitchcock Manchester  
100 Hitchcock Way, Manchester, NH

If your patient has an appointment on or after June 15, 2015 with any of the following services, that appointment will take place at the CHaD offices of Dartmouth-Hitchcock Manchester.

CHaD, East Wing, 1st floor
- Medical Genetics
- Pediatric Cardiology
- Pediatric General Surgery
- Pediatric Nephrology
- Pediatric Osteoporosis Clinic
- Pediatric Urology

CHaD, West Wing, 2nd floor
- Pediatric and Adult Cystic Fibrosis Clinic
- Pediatric Endocrinology (603) 695-2790
- Pediatric Gastroenterology (moving from 1st floor to 2nd floor)
- Pediatric Infectious Disease (HIV Clinic)
- Pediatric Lipid & Weight Management Center
- Pediatric Pulmonology
- Neonatology
- Nutrition/Diabetes Education

Phone: (603) 695-2745 • Fax: (603) 629-1869
For more information, visit CHaDKids.org