*The Newsletter of the New Hampshire Chapter of the American Academy of Pediatrics!*

# The Granite State Pediatrician

September-October, 2014 Volume 26, Number 5



## Prescription Drug Addiction: Role of the Pediatrician

As I start my service to the infants, children, adolescents, and pediatricians of New Hampshire, I thought it would be helpful to try to keep you connected to some of the information and issues presented at the variety of meetings we attend as AAP leaders. The meetings attended include the Annual Leadership Forum (ALF), combined District Meetings, the Annual Legislative Conference, as well as the AAP National Conference and Exhibition (NCE). These meetings are excellent opportunities to network with other AAP Fellows from around the country, and learn about regional and national initiatives, priorities, and concerns of import to our practices.

At this year's district meeting, we viewed a film called "The Hungry Heart" (see: thehungryheartmovie.org). The film "provides an intimate look at the often hidden world of prescription drug addiction through the world of Vermont pediatrician Fred Holmes who works with patients struggling with this disease." While his relationship with these patients is established for the provision of suboxone therapy, it is more centered around his intimate connection with his patients which has the power to lead to recovery, healing, and change,

The view of such addiction is startling and stark. Opiate addiction is a public health crisis that we are often not aware of or adequately identifying in our own practices. There has been a dramatic increase in opiate deaths over the past decade or so. In the 130 or so addicts in Dr. Holmes' practice, millions of dollars are taken from the community to support their drug habits. A single patient typically might take 2 Percocets per day at a cost of $100 per Percocet, at an expense of $73,000 per year. Some of his patients were spending as much as $200,000 per year on their habit. And the fact that Dr. Holmes has 130 patients in his practice in rural Vermont is somewhat staggering. I would venture a guess that most of our practices know of only a few patients with such addiction, thus most are likely flying under our radar screen, hiding their addiction from not only us, but likely their parents and possibly even their friends. Addict often do not disclose their addiction and use for fear of shame, as well as an even greater fear of taking their drugs away. They can't imagine how they could survive without their drugs. They try to justify opiate use based on the legitimization of the medication as a "prescription" from a medical provider concerned about their health. They see that "detox" is horrible, and difficult to endure. But the more difficult task is how to reintegrate into daily life without drugs to help get by.

Risk factors for abuse include some of the ACES (Adverse Child Experiences) that we are already aware of, including poverty, lack of parental involvement and oversight, poor parenting, divorce, death, tragedy, substance abusing parents, abuse (physical, sexual, emotional). They often cite their first use of opiates as a legitimate prescription for treatment of pain. Alternatively, their

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initiation to use and subsequent abuse may come at the hands of other teens already addicted, encouraging them to try a new high.
They will finance addiction though a variety of creative means: stealing drugs, robbing pharmacies (daytime, nighttime), robbing homes that have drugs, theft of mail order deliveries, theft of legal prescriptions to then fill, theft from medicine cabinets at open house/houses for sale, theft and/or replacement with placebo from elderly family members, whose medication dosage is then increased due to lack of pain control while taking placebos unbeknownst to them, providing greater and greater supply of the drugs. They also will engage in ways to raise money through the theft and selling of items stolen, or by selling their own items, or family personal items, sometimes accounting for thousands of dollars in losses for families. They will resort to forging prescriptions, falsifying medical symptoms at multiple sites (ED, urgent care, pain clinics, PCP offices) to use and/or deal (sometimes both) to make money to finance their addiction. They will sometimes exchange, sell, or distribute handguns for payment, and even resort to prostitution/sex for drugs or money. On most college campuses, drugs can often be delivered within 30 minutes to virtually any location.
So how can we as pediatricians help?
First we need to try to better identify those addicted. Often they are struggling teens with risk factors and addictive personalities. It's not just "those kids". Such abuse crosses all socioeconomic lines. We need to assess all teens regarding how they are doing - Do they have friends? What are their struggles? What are their supports? Are they are using opiates? And perhaps following the question with "really?" when confronted with a suspicious denial. And ask are they are willing to provide a urine sample for drug screening?
We need to reduce access. We need to be judicious about prescribing in our offices, urgent care centers, ERs, and post-operatively. We need to encourage parents in our practice to safeguard and lock-up any currently used medications, and dispose of any medication in their homes no longer needed, as this becomes a source for addicts to access these drugs. Many police departments have drop boxes or medication disposal days for this purpose.
We need to insure adequate treatment is available to our patients with addiction. There need to be providers willing prescribe suboxone and establish intimate relationships with these patients to care about them and try to guide them in their road to recovery.
Due to steadily increasing opiate deaths, some states have started initiatives for first responders to carry narcan for use if uncertain of possible opiate overdose. In Massachusetts, police, fire fighters are trained in the use of narcan. One story was told of a call in a middle class neighborhood finding an apneic, pulseless infant, and when the first responders were about to call the code, one decided to give narcan, reviving the infant. It turns out that mom was an opiate abuser, and was nursing the infant.
We need to educate teens and parents about the addictive potential of these powerful drugs and their ability to ruin lives. The AAP will likely be developing an initiative around this epidemic, developing resources for education and treatment. In the meantime, we need to be aware, to identify, arrange treatment, and educate as best we can. The NHPS will keep you informed about any new resources, materials, and recommendations from the AAP as they become available.
Thanks for you continued care, concern, and dedication to the most enduring and yet vulnerable segment of our society, our youth. I am honored, humbled, and privileged as I look forward to serve the pediatricians, children, and parents of our state.

-***Bill Storo, MD, FAAP***
***NHPS President***

***Please Take Notice!***

***The New Hampshire Pediatric Society wants to improve immediate communication with and among our members. If your email address is not on our master list (or if you're not sure) please add your preferred address to the list by contacting Gil Fuld.***

***Our plan is to periodically send out the updated address list to everybody on it. If you haven't recently received a copy, we don't have your address.***

***-Gil Fuld MD***
***Communications and***
***Public Relations Chair***
***fuldandfuld@ne.rr.com***

# Teen Driving: Things to consider-

In NH in 2011, 11% of licensed teens were involved in crashes.
Top 3 causes for all ages: Impairment 41%, Distraction 27%, and Speed 10%.

In novice drivers speed and inexperience are the major contributing factors in crashes.
Distraction is also one of the main causes of teen crashes. Teens are less likely to recognize and understand risk.

Seat belt was worn 31%. Not worn 69% for all crashes.

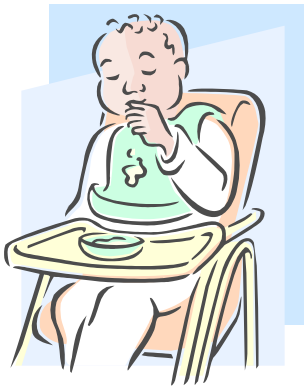
Nationally almost 3000 teens are killed every year in motor vehicle crashes, 300,000 are injured and 55,000 injuries are life changing.
Car crashes are the leading cause of fatal head trauma among teens.
During 2009-2010 16,000 teens suffered acute head injuries.

Because crashes and their outcomes are preventable, let's help create a cultural change. Talk with your teens. Let parents know that parental behavior is one of the most critical factors in promoting safe driving. Even young children are learning driving habits as they watch their parent's behaviors and driving techniques. Teens and parents can be referred to the below helpful resources.

The purpose of the NH Teen Driver Project is to reduce the number of teen driver crashes and establish a safe teen driver culture. Teens will be involved with creating peer focused cultural changes. NH Driving Towards Zero Coalition (NHDTZ.com) is made up of multiple private and government stakeholders.
For other helpful resources contact:
Howard Hedegard, Highway Safety Specialist, Injury Prevention Center at Dartmouth nhtrafficsafety@yahoo.com
Steve Gratton, Coordinator of the Teen Driver Program 603 848-2131 or sgratton@tds.net.

- ***Diana Dorsey, MD, FAAP***
***ddorsey@dhhs.state.nh.us***
***NH Child Fatality Review Committee***
***(The above article was created from a presentation by Howard Hedegard to the NH CFRC)***

# Introducing Solid Food



Parents often rely on their child's healthcare provider for information and support regarding infant feeding practices and nutrition. The American Academy of Pediatrics recommends introducing solid food to an infant's diet around 6 months of age. However, the results of a 2013 survey, which included 1,334 new mothers, indicated that 40 percent of respondents introduced solid foods to their infants much earlier – prior to 4 months of age. Given the short-term and long-term risks associated with early solid food introduction, it is essential for healthcare providers to give clear and accurate feeding recommendations at early well-child visits.

Every infant develops at his or her own pace and parents should be instructed to watch for the following signs of solid food readiness near 6 months of age:

- Able to hold his or her head up when sitting
- Opens mouth when food approaches
- Able to move food from a spoon or fork into throat

Infants can start their transition to solid food with thinly pureed fruits and vegetables, such as bananas, peaches, and squash, as well as single-grain cereals mixed with breast milk or formula. Particular foods should be avoided for the first year, including honey, cow's milk, salt, and artificial sweeteners. Honey contains spores that can cause infant botulism, and infants' digestive systems cannot process the protein present in cow's milk.

Parents may be tempted to start solid foods early if their infant seems particularly fussy or hungry. They may also follow the common misconception that consuming solid foods before bedtime helps an infant sleep through the night; research shows that there is no evidence to support this claim.
Healthcare providers can encourage a healthy transition to solid food by communicating the risks associated with starting too soon. Introducing solid food too early may:

- Cause an infant to choke – in their first few months, infants cannot hold their heads up in a sitting position and have not yet developed the coordination needed to swallow food

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- Result in stomach aches, gas, and constipation– an infant's digestive tract is not prepared to process solid foods until closer to 6 months of age
- Replace breast milk or formula with food that may not meet an infant's nutritional needs – breast milk or formula should remain an integral part of an infant's diet until the first birthday
- Increase the risk of obesity and diabetes

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Founded in 1985, Pathways.org empowers parents and health professionals with free educational resources on the benefit of early detection and early intervention for children's motor, sensory, and communication development. For more information, visit www.pathways.org or email friends@pathways.org. Pathways.org is a 501(c)(3) not-for-profit organization

***-By Virginia Li***
***Pathways.org***

## Resource for grieving children

The Sesame Street folks have helped to produce a "kit" to help children who have had someone close to them die. There is a brochure for adults, a booklet for young children and a DVD with a story featuring Sesame Street characters about a little girl whose mother has died. The materials come in both English and Spanish and include a link to a website where free materials can be downloaded. The kit is really excellent. The New Hampshire Pediatric Society has a limited number of kits available for our members which will be available at the CME conference on August 19 ("Dancing with Many Partners"). We will also distribute them to interested practices after that and hopefully will get more if the interest level is high enough.

You can send requests directly to me at WAGladstone@comcast.net

***- Wendy Gladstone MD***

Dartmouth-Hitchcock CHILDREN'S HOSPITAL AT DARTMOUTH

**News from Children's Hospital at Dartmouth (CHaD)**
**September 2014**

**CHaD welcomes new provider**
Dr. Brian O'Sullivan is an experienced Pediatric Pulmonologist who is joining our practice this September. He will be seeing patients in Pediatric Pulmonology at Dartmouth-Hitchcock Manchester, D-H Lebanon and CHaD Wentworth-Douglas Hospital.

Dr. O'Sullivan received his Doctor of Medicine from Dartmouth Medical School in 1983, and completed his residency in pediatrics as well as a fellowship in Pediatric Pulmonology at St. Christopher's Hospital for Children in 1990. He comes to us from the University of Massachusetts Memorial Health Center where he has practiced for the past 24 years. He has been the Cystic Fibrosis Center Director there since 2002 and is a Professor of Pediatrics and Associate Vice Provost for Research with the University of Massachusetts Medical School. We are excited to have Dr. O'Sullivan join Dartmouth-Hitchcock!

**CHaD Programmatic News**
Increased Access for Autism Clinics
CHaD's Child Psychiatry program in Lebanon has expanded autism clinics. In addition to our diagnostic clinic to determine if a child has an autism spectrum disorder, we have started an evaluation and continuity clinic for children who already have this diagnosis. Children and adolescents will have an evaluation and continued medication treatment with a child psychiatry Fellow or William Daviss, M.D. We have openings for new evaluations, and referrals must come from a physician.

To make a referral by phone, please call Child Psychiatry at 603-650-7075 and specify that the child already has a diagnosis of an autism spectrum disorder.

Jennifer McLaren, M.D.
Assistant Professor of Psychiatry
Geisel School of Medicine at Dartmouth

**Do No Harm: The National Children's Network**
"All teach, all learn" is the model for the National Children's Network (NCN) according to Samuel J. Casella, MD, MSc, Associate Director for Safety and Quality at the Children's Hospital at Dartmouth-Hitchcock (CHaD). "The spirit of the project is that we won't compete around children's safety. If some-

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one has a better way to make a child safe we share and spread it. We're working cooperatively with our peer institutions to improve the safety of children in our hospital and across the nation."

NCN is just one Hospital Engagement Network (HEN) funded by the Centers for Medicare and Medicaid Services (CMS) as part of the largest federal hospital initiative aimed at patient safety and quality of care. Of the 26 contracts CMS originally awarded as part of the Partnership for Patients program, only one—awarded to the Ohio Children's Hospitals' Solutions for Patient Safety (OCHSPS)—focused on pediatric care. All HENs were given the same charge: reduce hospital acquired conditions by 40% and readmissions by 20%.

**The Program**
The Partnership for Patients, which began with only eight children's hospitals in Ohio, phased in additional sites over a two-year period. CHaD joined in the second year of the project. At CHaD, we targeted four areas: surgical site infections, pressure injuries or ulcers, adverse drug reactions, and readmission rates.

OCHSPS enrolled in a third year of the project and about 80 children's hospitals continue to participate, including CHaD. "Now, in the second half of the 2014," notes project manager and Quality and Safety Specialist Diane Andrews, "we still have the same reduction goals of 40/20 by the end of 2014, but we've expanded surgical site infections from just neurosurgery to orthopaedics and our work on pressure injuries has spread from our pediatric intensive care to our pedi-adolescent unit."

In February of 2014, CHaD launched two additional teams focused on Central Line-Associated Bloodstream Infections (CLABSI) and Venous thromboembolism (VTE).

**A Culture of Safety**
In 2013 and 2014, for its work with adverse drug events and CLABSI, CHaD was recognized as a top-performing hospital by OCHSPS. This July, Dr. Casella congratulated the team on nine consecutive months without a single report of a Serious Harm Event. "Of course," he says, "this work is never really 'done.' We will never eliminate medical errors – but we can design systems that make it highly unlikely those errors will ever reach our patients."

The HEN work gets as close to real-time comparison data as possible. We have monthly calls to learn strategies for patient safety from high-reliability organizations, and there are opportunities for formal education, informal conversations, and presentations. Our teams—providers, nurses, a measurement analyst, a nurse facilitator/project manager, and sometimes a pharmacist—each focus on a specific harm. They do a gap-analysis between current practice and recommended best practice for each of these conditions.

Johanna Beliveau, MBA, RN, Administrative Director, Maternal Child Health and Psychiatry, is co-leader of the project with Dr. Casella. She says, "We're continuing to network and collaborate on best practices with our colleagues across the country who specialize in taking care of children." Dr. Casella adds, "Through the network we're able to compare our performance with peer institutions, learn how to improve outcomes, and also share our methods in high performance areas."

"We are unique as an organization in that we are involved in two networks," explains Beliveau. "As an academic medical center we've been involved in the adult network as part of Intermountain Healthcare's HEN since 2012. CMS granted us a special exception to also participate in the NCN because of CHaD."

The Priority
"At CHaD, and across the organization, we're all about prevention; the best plan is one that prevents the situation from ever occurring," says Dr. Casella. "We want to prevent children from being harmed. Patients and parents have a very important role in patient safety as well, and we encourage their active involvement. It's part of our 'culture of caring' and how we view ourselves; these efforts are supported throughout the organization and reflected in our mission and strategic plan."

The ultimate goal is creating a widespread culture of safety, so that patients can walk into any of the participating children's hospitals with the assurance that the hospital knows the best practices. Dr. Casella adds, "The big audacious goal is that every children's hospital in the nation would have this information."

E. Senteio
Communications Specialist
Dartmouth-Hitchcock

***** Save the Date *****

The 25th Dartmouth Pediatric Conference: Contemporary Issues in Office Pediatrics
March 5-8, 2015 - Omni Mount Washington Resort, Bretton Woods, NH

Our Silver Anniversary for this Conference
Join us for an outstanding clinical conference in a spectacular setting! We have confirmed these dy-

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namic and engaging experts:

Dr. Perri Klass - Professor of Journalism and Pediatrics; Director, Arthur L. Carter Journalism Institute, New York University, NY
Dr. Blaise Congeni - Director, Pediatric Infectious Diseases, Akron Children's Hospital, Ohio
Dr. Joseph Congeni - Clinical Co-Director, Center for Orthopedics and Sports Medicine, Akron Children's Hospital, Ohio

Look for more information in the next issue of Granite State Pediatrician.
Target Audience: Pediatricians, Family Physicians, Nurses and Allied Health Practitioners in pediatric practice.

For more information on CHaD conferences, please contact Jacqui Alexander at (603) 653-1770 or Jacqueline.B.Alexander@Hitchcock.org

***-Margaret Rose Minnock, MBA***
***Director, Planning and Regional Services***
***Children's Hospital at Dartmouth***

## Addicted Babies: Helping Our Patients Exposed to Drugs and Alcohol During Fetal Life

It's Friday and you're making morning rounds in the nursery. You go to the next patient's bassinette but he isn't there. At the front desk, one of the nurses is holding him—jiggling him, actually--and he's crying loudly despite her attempts to soothe him. "NAS*" the nurse says over his wails, arching her eyebrows. "And DCYF won't do anything." She is clearly annoyed. So what's the story with protecting the babies of mothers who use drugs (or alcohol) during pregnancy?
The state's child protection agency, the Division for Children, Youth and Families, operates under laws that direct how it should protect children under the age of 18. DCYF sets policies based on those laws and must operate within defined limits on its authority. For example, DCYF cannot get involved if a baby hasn't yet been born. This is why DCYF would not be able to take action on behalf of a fetus whose mother is a serious alcoholic or using illegal drugs or abusing prescription medication. The laws in New Hampshire relative to DCYF also state that in order to require a family to accept interventions, the agency has to prove that something a parent is doing is harming a child or putting them at substantial risk of harm. If a mother is using drugs and says she will limit her use to those times she can leave her baby with someone responsible (like a grandparent) then DCYF cannot intervene. The laws are different in other states and this is why a baby born to an active substance abusing mother in Vermont or Massachusetts is routinely put into foster care but in New Hampshire that doesn't automatically happen.
Federal law requires that the state's child protection agency must be notified when a newborn tests positive for illegal substances (in urine or meconium, for example.) DCYF would hear about such a situation and try to work with the mother to assure that she and her infant get optimal medical care and that she gets help dealing with her drug use.
New Hampshire has a law that when a DCYF worker meets a family for the first time following a report of suspected child maltreatment, the worker must tell the family that they don't have to allow DCYF into their home or, in fact, cooperate at all. The worker offers the family a brochure explaining how DCYF functions and if the parent signs that they have received it, and lets the worker in, then DCYF may begin an assessment and determine what services would help. Sometimes families refuse.
If you have concerns about a newborn's health and safety you should call DCYF and report that to them. If you believe a baby has been harmed by a mother's substance or alcohol use then that is essential information for DCYF. It gives the agency more authority to take action to protect her infant.
Before discharge, it is important to talk with a mother about her drug or alcohol use and why, as advocate for her baby's optimal health and development, you want to help her do everything possible to avoid using again. It's also important to ask parents whether DCYF will have ongoing involvement or not. If so, it helps to know that so you can work cooperatively with DCYF staff to assure optimal protection for your patient. If your office has a care coordinator, that person should meet the mother as soon as possible and at each of the baby's visits after discharge. At those visits, you and the other providers in your office should continue to monitor the infant's well-being. To help, it's a good idea to have a note in the chart reminding everyone if substance use during pregnancy was an issue and, if DCYF is involved, who the worker is. That way it's easier to communicate on behalf of the baby's health and safety.
Remember that after an initial 60 day assessment, many families lose the supports provided by DCYF. That makes keeping a professional eye on how a baby is doing even more important after the 2 month visit. You might want to add a few extra visits in the first year (or even beyond) to support a family coping with having a new baby in the home and the stresses that entails.
You can be a powerful advocate for your newest patients!

***- Wendy Gladstone MD***

## FBI's Child ID APP for Android and iPhones


A child goes missing every 40 seconds in America. Many never return home.

In this era of smart phones and social media, the FBI's Child ID App can be a major life line for parents or guardians. It is free and easy-to-use. Ideal for parents who want immediate access to their children's information should a child become lost. According to the FBI's website, the app allows parents to create profiles for each child in the family and to take or import most recent pictures of each child. This is ideal when a family is traveling or will be in crowded areas such as shopping malls, beaches, sporting events, or amusement parks. In the event that the child disappears, parents will be able to show law enforcement officers exactly how the child looked and what he or she was wearing on that day.

For parents, the app also includes tips on keeping children safe and specific guidance on what to do in those first crucial hours after a child goes missing. The child's information profile is securely stored only on the parent's phone, but it is a resource that parents can access and provide to law enforcement within seconds if necessary. No information about the parent or child will be collected or stored by the FBI or iTunes.

The free app can be downloaded from Google Play (Android version) or iTunes (iPhone version). For more information, to the FBI's blog at http://www.fbi.gov/news/news_blog/the-child-id-app-on-android.

***-Carole Totzkay, MS, CHES***
***DHHS, ESU Public Health Preparedness Planner***

## Philanthropy at AAP

Although AAP dues support the goals of the Academy, many new or urgent child focused problems and initiatives present themselves each year that are vital to the mission of the Academy in supporting children and the pediatricians who serve them and these require additional resources.
Since 2007 the Academy has encouraged its members to consider donations to support these important child health issues. The Friends of Children Fund (FCF) collects and distributes donations annually while the Tomorrow's Children's Endowment (TCE) only distributes the interest from the Endowment funds to make sure that there will be funding into the future.

Here are some ways to contribute to either fund: sustaining memberships with monthly contribution deductions (like contributing to Public Radio) a memorial tribute to a loved one that can be made as a donation or as a brick at the AAP entrance walkway a bequest in your will donation of a life insurance policy or real estate Friends of Children Fund supports many programs each year. The Healthy People 2010 and 2020 grants, for example, have distributed over 1 million dollars in grants to chapters resulting in 14.5 million dollars in leveraged funds. Additional FCF programs in 2014 include resident travel grants, a research conference on children and the media, the Head Start/Medical Home Learning Collaborative to Address Toxic Stress meeting, funds to help pediatricians address electronic cigarette use with patients and families, and the Brush, Book and Bed Pilot study. A site in New Hampshire (Holly Neefe at Elliot Health System) was fortunate to get selected as one of only10 sites for this pilot study since there were over 60 applicants!! The Brush, Book and Bed Pilot is an example of funds coming back to New Hampshire to support pediatricians in promoting healthy child bedtime routines.

Tomorrow's Children's Endowment receives requests for larger funding for new initiatives. Recent funded projects include the Center for Resiliency in Childhood, Childhood Weight and Nutrition Promotion and International Disaster Response Training. Additionally TCE funds are deployed to areas of national or international need after a disaster. Hurricane Katrina, tropical storm Irene and the Newtown, Conn shootings are examples of these funded grants.

Nationally volunteer Academy leaders have increased their donation levels over the past few years from 44% to over 80% and AAP staff donate at an 80% rate. Although New Hampshire is a small state over 50% of our leadership donates to Friends of Children Fund.

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Please consider a donation of any size to Friends of Children Fund. You will be helping children in our state, nationally and internationally who need your support.

***-Suzie Boulter, MD, FAAP***
***District 1 representative to the AAP Committee on Development***

# AND……

### NH Kids Aren't Being Tested For Lead Poisoning

Rates of testing for lead poisoning are down in New Hampshire according to the Department of Health and Human Services. Are you contributing to this worrisome trend? Lead causes irreversible CNS injury

at all detectable blood levels. The schedule put out by Bright Futures calls for testing of all children at age 1 and at age 2. Living in a brand-new house doesn't protect a child from lead exposure: some areas of our state have high lead levels in the soil just beyond a house's walls. Even if the EMR you use isn't reminding you, don't forget to order lead testing at the 12 and 24 month visits. You could help protect your patients' IQ points!

### VOTE

No, not just for your state Senators and Representatives. It's time to vote in the American Academy of Pediatrics election to select the next president. It does matter who represents the AAP nationally. There is background information on the candidates on the AAP website and in AAP news. Choose the best candidate and vote on-line: it's quick and satisfying. Be a part of the future.