American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Iowa Chapter

The Heartland Pediatrician

December 2017

President's Message

Happy Holidays to you all!

2017 has been a year of changes and challenges. As the year draws to a close, Iowa's children are still waiting for Congress to reauthorize CHIP. 84,000 Iowa children are covered by this important program. Please contact your Senators and Representatives once again to let them know how valuable this insurance program is to your patients. Washington needs to hear our stories!

Iowa also face challenges with our Medicaid program and we will need your support at the state legislature this session. Iowa has been selected by National AAP as one of six states to receive a grant to support educational efforts encouraging state legislators to maintain EPSDT standards for our children. We are hopeful that Iowa pediatricians will contact us expressing willingness to meet with legislators representing their hometowns to advocate for EPSDT. Please let us know if you are willing and ready to stand up for kids by **emailing** the chapter!

Our chapter leadership went through a strategic planning process in October guided by National AAP. We decided to focus on three areas over the next few years; **membership**, **access to care**, and **mental health**. We will be reaching out to you over the next few months with opportunities to get involved. Please watch your emails and respond when you see something in which you would like to get involved.

Marguerite H. Oetting, MD, FAAP
President, Iowa AAP

Committee Updates

Obesity

5-2-1-0! These are the numbers you will be seeing more of in the near future. 5-2-1-0 is a Healthy Choices Count campaign announced in October by Governor Kim Reynolds. Now, what do these numbers mean? These numbers are daily recommendations of 5 servings of fruits and vegetables, 2 hours or less of recreational screen time, 1 hour of physical activity, and 0 sugary drinks. Children

with healthy habits learn better, feel better, and have a decreased risk of chronic medical conditions. Click here to learn more about 5-2-1-0 and how Iowa is bringing the message to life!

Legislation

With the coming 2018 legislation session upon us, Iowa AAP will have a daily presence at the Iowa Capitol advocating for the 2018 legislative priorities. We urge Iowa policymakers to act in these five areas to ensure the healthy physical and mental development of children: Children's mental health, Child Health, Child Safety, Childhood Trauma, and Childhood Immunizations to support and improve optimal health of children. Read more about the initiatives and follow its development this year at IA AAP.

PROVIDER BURNOUT & Professional Resiliency CONFERENCE

REGISTER NOW!

February 8, 2018

SAVE THESE DATES!

Annual Legislative Breakfast on the Hill

February 28, 7:00 to 9:00 a.m.

MORE INFORMATION

IA AAP Annual Meeting & Social

Wednesday, April 18, Des Moines

Chapter Champion

Dr. Karin Weber-Gasparoni is an Associate Professor and Head of the University of Iowa Department of Pediatric Dentistry. She received her DDS in 1994 and a certificate in Dentistry for Babies in 1995 from the Universidade Estadual de Londrina, Brazil. She received a Master's Degree in Dental Public Health and a Certificate in Pediatric Dentistry in 1999, as well as her PhD in Oral Science in 2003, from the University of Iowa. She is a diplomate of the American Board of Pediatric Dentistry.

I am a clinical instructor as well as a predoctoral and postdoctoral lecturer. I am the founder and director of the University of Iowa Infant Oral Health Program housed at the Johnson County WIC Clinic where pediatric dentistry residents, senior dental students, and pediatric medicine residents

provide preventive dental care for infants and toddlers. I also see private patients one half-day per week at the Pediatric Dentistry Clinic in the Center for Disabilities and Development. My research specialties include dental care of patients with special health care needs and infants, toddlers, and children of low-income, high risk populations. I am interested in early dental interventions including early childhood caries, psychological theories of motivation, and public health issues affecting the health of pediatric dental patients.

I am extremely honored to serve as the Oral Health Advocate for the Iowa Chapter of the American Academy of Pediatrics. I am very excited to be currently working with Lauren Barone, Iowa AAP's manager of oral health activities, to update the oral health resources available in the Iowa Chapter website. In addition, I hope to soon start a revision of an oral health training program intended for medical and all other professionals involved with young children developed with Dr. Jody Murph, Associate Professor from the Stead Family Department of Pediatrics in 2008. The purpose of this oral health training was to familiarize health professionals with different topics related to the oral health of young children such as caries epidemiology, preventive measures, anticipatory guidance, as well as the incorporation of oral health into the medical home. The oral health training was composed of one introductory presentation and six teaching modules. Each teaching module had a pre- and post-test to assess knowledge improvement and to obtain CME/CEU credit after completing the post-test. Please do not hesitate to contact me if I can be of any assistance to you to improve the oral health of children in Iowa.

*To see a list of IA AAP Chapter Champions, please visit the **IA AAP website**. If you have questions for our champions, please contact the **chapter**.*

Improvements Needed in Childhood Lead Poison Testing

The Iowa Department of Public Health (IDPH) has contacted IA AAP with concerns regarding the need for greater blood lead poison testing in Iowa's children. While the majority of children one to three years of age do receive blood lead testing, IDPH reports a sizable number of children with initial blood lead levels above 10 micrograms per deciliter (µg/dL) who do not receive confirmatory venous blood lead tests in a timely fashion. In addition, only 12% of children in Iowa receive a blood lead test at one year of age. The Centers for Disease Control and Prevention (CDC) and IDPH recommend children be tested as early as 12 months of age when they typically become more active, and are in their prime growth and development years.

Continued Need for Lead-Poisoning Prevention

Data collected in recent years shows that gains have been made in preventing childhood lead poisoning but this data also shows a need for continued improvement. Information on Iowa children, obtained from reports of blood lead tests and data received by the IDPH, indicates both positive trends and areas for improvement.

Positive Trend

- Increased Number of Children Under Three Received a Blood Lead Test
- Approximately 85% of the children born between 2006 and 2013 received a blood lead test prior to age three.

- Decreased Number of Children Under Three With Confirmed Elevated Blood Lead Levels
- Children under age three with a confirmed blood level above 10 µg/dL, has been lowered from 481 to 190.

Positive Trend, But Need for Improvement

- Number of Children Under Three to Receive Confirmatory Test After Initial Elevated Blood Lead Results
- The number of children under age three that did not receive confirmatory blood lead tests after receiving initial results of elevated blood lead levels greater than 10 µg/dL ranged from 455 for children born in 2000 to 106 children born in 2013.

Need for Improvement

Increased Number of Children Under One Received a Blood Lead Test Only 12% Iowa children born between 2006 and 2013 received a blood lead test prior to the of age one.

Reference Blood Lead Levels for Children

In recent years, the CDC has established a new reference blood lead level for children ages 1 to 5. This reference level is 5 µg/dL. At the time this reference level was established by CDC, the blood lead levels of 97.5% of the children between the ages of one and five in the United States were 5 µg/dL and below. The CDC recommends that public health actions be initiated in young children at the blood lead levels above 5 µg/dL. The CDC and IDPH recommend that additional services be provided to children who have blood lead levels greater than or equal to 10 µg/dL.

Physician Guidelines – Childhood Lead Poisoning Prevention

IDPH has prepared a document entitled, Physician Guidelines — Childhood Lead Poisoning Prevention, to assist physicians in caring for children who may be lead poisoned. These guidelines, available on the IDPH **website**, include a recommended schedule for blood lead testing in children. The guidelines also include information on medical follow-up testing, home nursing visits, developmental follow-up, and nutritional follow-up. The protocol in the physician guidelines is to have children receive blood lead tests according to the following schedule:

- At 1 year and 2 years old for children classified as low risk to lead poisoning
- At 1 year, 18 months, 2 years, 3 years, 4 years, and 5 years old for children classified as high risk to lead poisoning

Common Causes of Lead Poisoning

In Iowa, most cases of lead poisoning are caused by lead-based paint. Lead-based paint in a home becomes a lead hazard as it deteriorates and lead-based paint chips end up on the floors and in window wells throughout the home, as well as in the soil around the exterior of a home. The paint chips also crumble and become part of the dust on the floors and window troughs. Most of Iowa's older homes contain lead-based paint. Young children who live in older homes can become lead-poisoned when they put paint chips or exterior soil in their mouths, or when they get house dust and soil on their hands and put their hands in their mouths. Pottery and cultural remedies imported from outside the United States have also caused some cases of lead poisoning in Iowa.

More Information

For more information on the Physician Guidelines or lead poison testing data, please contact Stuart Schmitz, State Toxicologist with the Iowa Department of Public Health at (515) 281-8707, or Kevin Officer, Community Health Consultant with the Iowa Department of Public Health at (515) 242-5902.

Preventing Peanut Allergy

Implementing the Guidelines in a General Pediatric Practice

Javen Wunschel, DO and Diana Bayer, DO – Allergy/Immunology

University of Iowa Hospitals and Clinics

Peanut allergy is the most common cause of food-induced anaphylaxis and reported prevalence has tripled in the last 10 years.[1] Children with moderate to severe atopic dermatitis (AD) have approximately 35% increased risk of IgE-mediated food allergy.[2] In January 2017, an expert panel from the National Institute of Allergy and Infectious Diseases (NIAID) published an addendum for peanut allergy prevention in response to the reduction of peanut allergy in the Learning Early About Peanut Allergy (LEAP) study.[1,3] Below is a flow chart summarizing these guidelines to aid primary care physicians in their implementation.

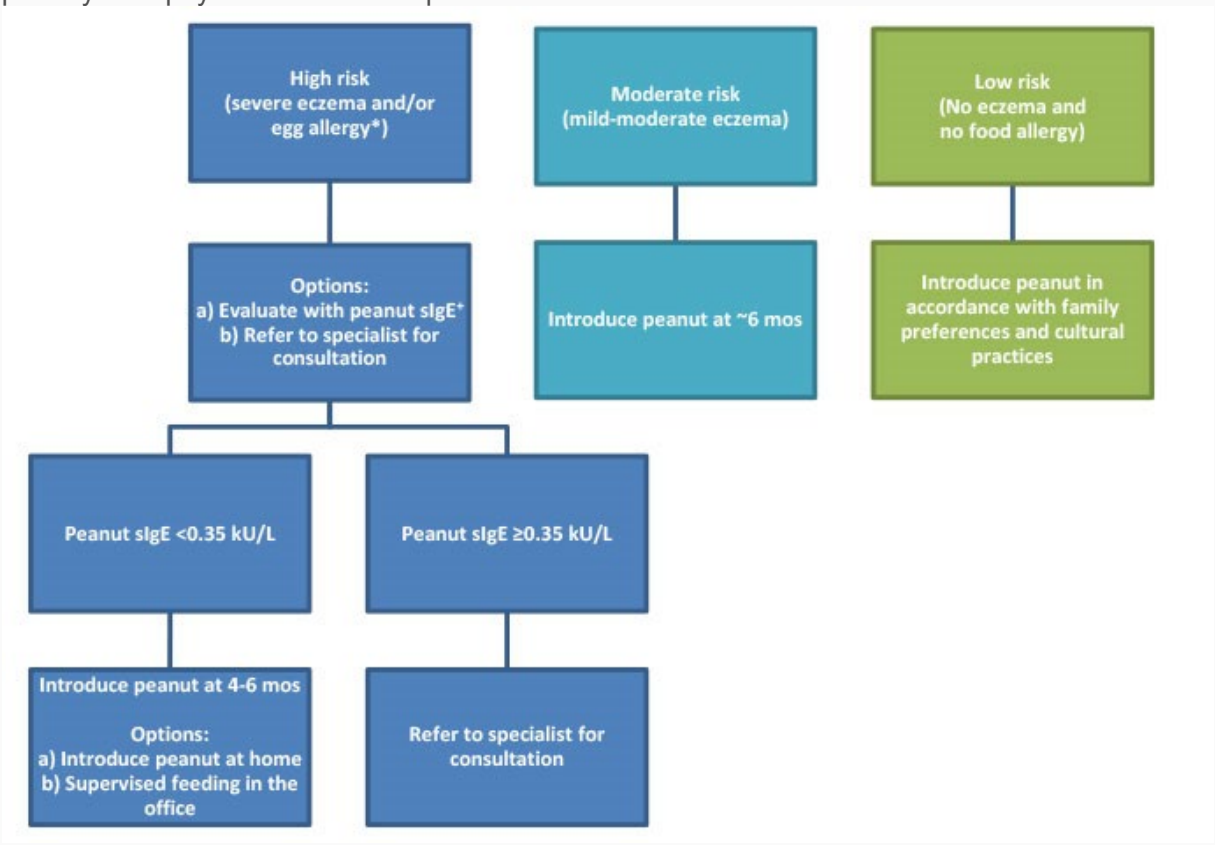

Figure 1. Flow chart summarizing peanut introduction guidelines. sIgE=serum immunoglobulin E.

*Egg allergy defined as history of allergic reaction with or without confirmed diagnostic allergy skin testing or oral challenge.

+ serum peanut specific immunoglobulin E (peanut sIgE)

For providers who evaluate high risk infants via serum peanut specific IgE, it is not recommended to order specific IgE to additional foods other than peanut due to risk for false positive results[3]. An infant may be referred to allergy/immunology at any point based on provider or parent preference. In addition, peanut should be introduced in an age-appropriate form, which may include:

1) Bamba peanut puff
2) thinned smooth peanut butter (with water)
3) smooth peanut butter pureed with fruits or vegetables
4) peanut flour/powder pureed with fruits or vegetables[3].

Implementation of these guidelines may equip providers to safely encourage early dietary introduction of peanut and in turn, potentially reduce the risk of developing one of the most common food allergies.

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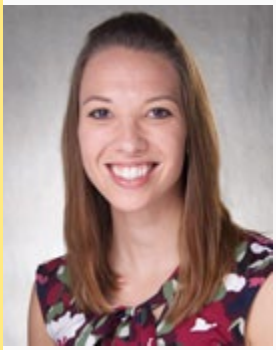
1. Du Toit G et al. *NEJM* 2015.
2. Eigenmann PA et al. *Pediatrics* 1998.
3. Togias A et al. *JACI* 2017.



Javen Wunschel, DO, is a first-year Allergy/Immunology Fellow at the University of Iowa Hospitals and Clinics. She completed medical school at Des Moines University and residency at the University of Nebraska Medical Center. Although still early in her allergy career, she is interested in food allergy, as well as patient and provider education.

Diana Bayer, DO, is clinical assistant professor of allergy/immunology in the University of Iowa Stead Family Department of Pediatrics. She completed medical school at Des Moines University, pediatrics residency at Wayne State University/Children's Hospital of Michigan (Detroit, Michigan), and allergy/immunology fellowship at Baylor College of Medicine/Texas Children's Hospital (Houston, TX).

She is originally from Iowa and enjoys caring for and strives to improve the quality of life for children with atopic disease, including such diagnoses as food allergy, allergic rhinitis, and asthma, as well as evaluation for and management of primary immunodeficiency diseases, in which she has a special clinical interest. She teaches trainees at all levels of training and has engaged in quality improvement for patient and provider education.

Childhood Obesity Free Webinar

Prevention, Assessment, and Treatment

On October 31, Governor Kim Reynolds, announced the launch of **5210 – Healthy Choices Count**. In support of this initiative IMS has added the on-demand webinar *Prevention, Assessment, and Treatment of Childhood Obesity in Iowa* on the **Childhood Obesity** portion of the website.

During this webinar, Jennifer Groos, MD, FAAP, Pediatrician with Blank Children's Hospital and childhood obesity prevention champion will:

- Explore the impact of weight bias on patient experience and how to minimize the impact
- Discuss the staged approach to prevention, assessment, and treatment of obesity in children and identify tools to assist in its implementation
- Explain the benefits of using motivational interviewing and brief action planning during clinic visits
- Explore the importance of multi-setting approach to prevention of obesity and identify ways healthcare providers can advocate for and support this in their community

This is a free webinar, however, participants do need to **register here**. Once the registration is processed, a separate email with the link to the recorded webinar will be sent to the email associated with your IMS account.

1st Five: Post-Partum Depression Screening

An Important Addition to Pediatric Well Child Care

By Shivgami Arora, MD, FAAP

Newborn visits are a special time. A vital relationship is established between parent and pediatrician and it is invested in the health of the growing child. But these visits are not always easy. The unique blend of factors affecting new parents can lead to many challenges. In the fleeting minutes that pediatricians have with parents during initial newborn visits, somewhere between emergency diaper changes, desperate searches for the missing pacifier, and conversations with proud new siblings, the wellbeing of the parent is often ignored. As advocates for the parent-child bond, pediatricians are responsible for identifying one of the most common obstetric complications: post-partum depression.[1]

Post-partum depression (PPD) falls into the larger category of "perinatal depression," with post-partum specific episodes of major depression beginning within four weeks following delivery.[2] Up to 20% of women suffer from perinatal depression,[3,4] and a history of untreated anxiety or depression during pregnancy is the strongest risk factor.[5] "Baby blues," which is a phenomenon distinct from PPD, impacts 50% to 80% of new mothers. Baby blues are characterized by lability of emotions and feelings of anxiety that last up to two weeks following the birth of the infant, but PPD goes so far as to cause impairment in parenting ability and daily function.[3]

Both conditions deserve attention (in some cases, baby blues can escalate into PPD[6]), but they must be distinguished from one another. Post-partum depression is a major depressive disorder, and requires evaluation and specific treatment, whether through psychotherapy, pharmacotherapy, or a combination.[3,4,7,8] The consequences of missing a PPD diagnosis are far-reaching and devastating to the family unit. For the child specifically, brain chemistry and even neuroanatomy are impacted by psychologic stressors, which can lead to pervasive developmental impairments and a cycle of hard-wired familial depression, anxiety, or behavioral disorders.[4,9]

Broaching the subject of a parent's mental health may seem like prying. But as the first medical providers who encounter the parent-infant unit together, pediatricians are in the unique position to screen for PPD using validated tools. The US Preventive Services Task Force (USPSTF), American College of Obstetrics and Gynecology (ACOG), and AAP recommend the use of the Edinburgh Postnatal Depression Scale (EPDS).[3,8,10] The AAP and USPSTF have also endorsed the use of a two-question screen for depression,[3,8] which resembles the Patient Health Questionnaire-2 (PHQ-2).[11]

The EPDS is comprised of ten questions and using simple language, explores how a parent has felt in the past week.[12] The two-question screen for depression covers parental emotions in the prior two weeks.[3] In its similarity to the PHQ-2 (which is a truncated version of the Patient Health Questionnaire-9, used in diagnosis of major

depression[13]), the two-question screen serves as an excellent tool for identifying overwhelmed parents in need of support.

Post-partum depression screening utilizing the EPDS or two-item questionnaire should occur at infant well child visits until six months of age, or longer as dictated by the pediatrician's clinical judgment or suspicion.[3] Positive screens should alert pediatricians to offer extra support, whether in the form of more frequent visits for the child-parent unit, or resources for local psychiatrists, therapists, or support groups.

For pediatricians, nurturing relationships between young patients and their parents is a calling. These strong bonds allow for the growth of healthy children, adolescents, young adults, and eventually, future parents. Identifying PPD is not only within the scope of a pediatrician's practice – it is a fundamental responsibility.

If an infant's development is at risk in association with a mother's depression, a referral can be made to 1st Five. Visit here to learn whether 1st Five is available in your area and to find your local 1st Five Site Coordinator.

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2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-V). Arlington, VA: American Psychiatric Publishing, 2013

3. Earls MF. Clinical Report - Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics*. 2010; 126 (5): 1032-1039. Reaffirmed Dec 2014

4. Center of the Developing Child at Harvard University (2009). Maternal Depression Can Undermine the Development of Young Children: Working Paper No. 8.

5. Wisner KL, et al. Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry*. 2013; 70 (5): 490-498

6. Wisner KL, Parry BL, Piontek CM. Postpartum depression. *N Engl J Med.* 2002; 347 (3): 194-199

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11. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care*. 2003; 41 (11): 1284-1292

12. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *Br J of Psychiatry*. 1987; 150 (6): 782-786

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Grant Updates

Adolescent Wellness

The American Academy of Pediatrics Iowa Chapter was awarded as one of seven chapters to receive the AAP ***Adolescent Vaccinations and Wellness Grant Program*** supported by Merck. The Iowa Chapter, in partnership with the Iowa Cancer Consortium, American Cancer Society, and Iowa Department of Public Health are implementing a multi-component program to educate physicians and clinic staff about HPV vaccinations, including a pilot program. Here are a few updates on their work:

- The UnityPoint clinics recently received the Iowa Cancer Consortium's Iowa Cancer Champion Award for their work through this grant. Feel free to lift whatever you like from **this news release**.

- The UnityPoint clinic team along with Christy Manternach from the American Cancer Society also presented a breakout session at the Iowa Cancer Summit highlighting their project and sharing best practices.
- We will be using grant funds to purchase HPV flash drives loaded with tons of HPV resources for clinicians, clinic managers, QI staff, etc. They are available free of charge to individuals working in the health or public health fields. Contact **Tessa Allred** to make a request.

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