Providing Evidence-Based Medical Care to Immigrant Children

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Objectives

- Review pertinent background regarding care of immigrant children, including changing demographics, the impact of diverse legal statuses on the provision of healthcare, and the current refugee resettlement program.

- Review recommendations regarding comprehensive medical evaluation of newly arriving immigrant children and consider common scenarios regarding history, physical examination, laboratory evaluation, development, mental health, and social determinants of health.

- Identify strategies to integrate care of immigrant children into a family-centered medical home.
Who Are Children in Immigrant Families?

Children in Immigrant Families

Citizens
- Family members are all citizens

Non-citizens
- Lawfully present / lawfully residing immigrants (e.g. refugees, asylees, victims of trafficking, other statuses)
- Undocumented (unauthorized) Immigrants

Mixed citizenship families
Background: Demographics

Children in immigrant families will represent 1/3 of US children over the next 40 years.*

US Arrival of Refugees by State, FY 2006–2015

US Department of State. www.state.gov/r/pa/pl/249076.htm
Unaccompanied Children and Family Units

Figure 1. U.S. Apprehensions of Unaccompanied Minors and Family Units, October 2011-November 2015

Migration Policy Institute. www.migrationpolicy.org
Key Clinical Domains

1. Medical screening
2. Developmental screening
3. Mental health and trauma
4. Social determinants of health

Health literacy:
Families must enter and navigate the system to address these domains.
Case 1

Adera is a 14-year-old girl who is seeing you for a refugee screening exam one month after arriving in the United States. She is from rural Somalia but has lived in Hagadera, a refugee camp in Kenya, for the past 6 years.
Hagadera
Kenya
Rank: 1
Total Refugee Population: **138,102**.
The residents of Hagadera are primarily from **Somalia**.
This camp's population is comparable in size to **Pasadena, California**.

Story Maps. storymaps.esri.com/stories/2013/refugee-camps/?WT.mc_id=EmailCampaignh15201
Case 2

José is a 30-month-old Guatemalan boy who comes to your office with his mother because he has had diarrhea for one week. He looks small for his age, is well-hydrated, and his mother tells you (when asked) that they arrived in the United States 6 months ago. She reveals that her family paid a coyote $6,000 to traffic her and her child to your city.
Case 1
Adera
Visa Medical Examination
- 6 months before departure
- All refugees
- Screening for inadmissible health-related conditions

Pre-Departure Medical Screening
- 3 weeks before departure
- Refugees with Class B1 TB*

Fit to Fly Pre-Embarkation Checks
- 24 to 48 hours before departure
- All refugees
- Screening for lice
- Presumptive treatment of intestinal parasites

* Class B1 TB refers to TB fully treated by directly observed therapy, or abnormal chest x-ray with negative sputum smears and cultures, or extrapulmonary TB.

Panel Physician Overseas Exam

- Tuberculin skin tests (TSTs) or interferon-gamma release assays (IGRAs) 2–14 years
- Chest X-ray only if >15 years
- History of:
  - Syphilis (venereal disease research laboratory [VDRL] test if >15 years)
  - Gonorrhea
  - Chancroid
  - Hansen’s disease
  - Substance use
  - Mental illness
  - HIV testing no longer required and not done
- Past medical history checklist
- Physical exam
- Minimal vaccines given
# Overseas Treatment

<table>
<thead>
<tr>
<th>Medication</th>
<th>Infections Treated</th>
<th>Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Albendazole x 1</strong> (since 1997)</td>
<td>soil-transmitted helminth infections (<em>Ascaris</em>, <em>Trichuris</em>, hookworm).</td>
<td>&lt;1 year, pregnancy, neurocysticercosis, unexplained seizures</td>
</tr>
<tr>
<td><strong>Ivermectin x 2</strong> (since 2005)</td>
<td><em>Strongyloides stercoralis</em></td>
<td>&lt;15 kg, pregnancy, h/o residence in Loa loa endemic area</td>
</tr>
<tr>
<td><strong>Praziquantel x 1</strong> (since 2005)</td>
<td><em>Schistosoma spp</em></td>
<td>&lt;4 years old, neurocysticercosis, unexplained seizures</td>
</tr>
<tr>
<td><strong>Artemether-lumefantrine x 1</strong></td>
<td><em>Plasmodium falciparum</em></td>
<td>&lt;5 kg, pregnancy, breast feeding</td>
</tr>
</tbody>
</table>

*If from Sub-Saharan Africa*
Treat with confidence. Trusted answers from the American Academy of Pediatrics.

**Medical Examination for Immigrant or Refugee Applicant**

- **Name** (Last, First, M.I.):
- **Birth Date** (mm-dd-yyyy):
- **Birthplace** (City/Country):
- **Present Country of Residence**:
- **Prior Country**:
- **U.S. Consul** (City/Country):
- **Passport Number**:
- **Date of Medical Exam**:
- **Date Exam Expires** (3 months if Class A TB, or Class B1 TB, otherwise 6 months):
- **Exam Place** (City/Country):
- **Panel Physician**:
- **Screening Site**:

### Classification

- No apparent defect, disease, or disability (See Worksheets DS-3025, DS-3026 and DS-3030)

#### Class A Conditions

- TB, active, infectious (Class A from Chest X-Ray Worksheet)
- Syphilis, untreated
- Chancroid, untreated
- Granuloma inguinale, untreated
- Lymphogranuloma venereum, untreated
- Hansen's disease, untreated
- Addiction or abuse of specific substance
- Any physical or mental disorder (excluding other substance-related disorder) with harmful behavior or history of such behavior likely to recur
- Amphetamines, cannabis, cocaine, hallucinogens, opioids, phenylecyclamines, sedative-hypnotics, and anxiolytics

#### Class B Conditions

- Sustained, full remission of addiction or abuse of specific substances
- Any physical or mental disorder (excluding addiction or abuse of specific substance) without harmful behavior or history of such behavior unlikely to recur

#### Class B1 TB, Pulmonary

- No treatment
- Completed treatment (Check all that apply and attach all laboratory and DOT documents)
- By panel physician
- By non-panel physician
Case 2
José
<table>
<thead>
<tr>
<th>History (Initial/Interval)</th>
<th>Comprehensive history and physical examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Immigration information (e.g. country of origin, country of transit, refugee camp</td>
<td>- Menarche/LMP for females; pubertal onset for males and females</td>
</tr>
<tr>
<td>history, time residing in the United States)</td>
<td>- Family medical history (e.g. maternal/paternal HIV, Hep B, C, TB)</td>
</tr>
<tr>
<td>- Birth history (e.g. home birth, prenatal lab records)</td>
<td>- Social history (e.g. family structure, status of parents if not in the home, legal guardian/primary care</td>
</tr>
<tr>
<td>- History of overseas blood transfusions, surgeries, female genital cutting, other</td>
<td>taker, other individuals living in the household, social support)</td>
</tr>
<tr>
<td>traditional cutting, tattoos*</td>
<td>- Educational assessment (e.g. last year of school completed, literacy level of patient/parents as applicable,</td>
</tr>
<tr>
<td>- Nutritional history: Foods available overseas/while in-transit, risks for micronutrient</td>
<td>potential learning difficulty and/or need for special education)</td>
</tr>
<tr>
<td>deficiencies</td>
<td>- Substance use—prior and current***</td>
</tr>
<tr>
<td>- Environmental exposure risks (e.g. lead, second-hand smoke)</td>
<td>- Sexual history—consensual/non-consensual</td>
</tr>
<tr>
<td>- Treatment prior to arrival (e.g. pre-departure therapy for parasitic infections for</td>
<td>- History of trauma or abuse</td>
</tr>
<tr>
<td>refugees, overseas medications/home remedies, treatment while in ORR** custody</td>
<td></td>
</tr>
<tr>
<td>for unaccompanied minors)</td>
<td></td>
</tr>
<tr>
<td>- Prior medical records including labs and immunizations</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Developmental Assessment</th>
<th>Psychosocial Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Developmental screening</td>
<td>- Signs/symptoms of PTSD, depression, anxiety</td>
</tr>
<tr>
<td>tools+ with multiple</td>
<td>- Psychosocial screening tools+ such as the PHQ-9²⁰, PSC²¹, RHQ-15²³ (&gt;14 years)</td>
</tr>
<tr>
<td>available languages,</td>
<td></td>
</tr>
<tr>
<td>such as the ASQ³, M-CHAT</td>
<td></td>
</tr>
<tr>
<td>R¹⁶, PEDS¹⁹, and/or</td>
<td></td>
</tr>
<tr>
<td>SVYYC²⁶</td>
<td></td>
</tr>
</tbody>
</table>

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## Comprehensive history and physical examination (continued)

<table>
<thead>
<tr>
<th>Complete Physical Examination/Measurements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Growth evaluation*</td>
<td></td>
</tr>
<tr>
<td>• Screening for female genital cutting (FGC) in at-risk populations: routine external genital examination for all females**</td>
<td></td>
</tr>
<tr>
<td>• Complete skin evaluation (e.g. scarification, tattoos)</td>
<td></td>
</tr>
<tr>
<td>• Pubertal development for males/females</td>
<td></td>
</tr>
<tr>
<td>• Dental evaluation</td>
<td></td>
</tr>
<tr>
<td>• Blood pressure evaluation (&gt; 3 years or risk factors)</td>
<td></td>
</tr>
<tr>
<td>• Vision screen (&gt; 3 years)</td>
<td></td>
</tr>
<tr>
<td>• Hearing screen (Newborn, &gt; 4 years)</td>
<td></td>
</tr>
</tbody>
</table>


Photo credit: Stacene Maroushek

Photo credit: Bill Stauffer, MD
Treat with confidence. Trusted answers from the American Academy of Pediatrics.

This scale includes both mild and severe forms of cutting.
Female Genital Mutilation/Cutting Complications

- Infection, bleeding, sepsis, death—immediate complications
- Recurrent urinary tract infections/pyelonephritis
- Cysts
- Keloids
- Abscesses
- Hematocolpos/dysmenorrhea
- Dysfunctional voiding
- Dyspareunia
- Complications during/post childbirth—increased C-section rate, post-partum hemorrhage, increased infant resuscitation rates
- Infertility
- HIV, hepatitis B, C?

Tiered Approach to Laboratory Screening

Tiered* laboratory screening/parasite treatment options for most immigrant children originating from resource-limited settings or from low socioeconomic circumstances

1. Tuberculosis testing: IGRA (TST if <5 years old)\textsuperscript{b,1,9}
2. Cbc/Diff
3. Lead\textsuperscript{d,e} — Children 6mo–16 years
4. Hep B sAg\textsuperscript{e,10,11}
5. Intestinal Parasite Evaluation (NB: for refugees, may omit if received pre-departure treatment per CDC guidelines)
   - Stool O & P >24 hours apart x 3\textsuperscript{i} OR presumptive treatment with Albenbazole
   - Strongyloides IgG OR presumptive treatment with Ivermectin\textsuperscript{g}
6. HIV\textsuperscript{i}
7. Syphilis EIA, reflex RPR if positive\textsuperscript{j}

Optional laboratory screening/presumptive treatment for children of specific ages, with specific exposures or risk factors

- Urine B HCG
- Urine GC/Chlamydia
- Hep C Ab
- Newborn screen, per state guidelines
- TSH
- Giardia stool antigen

- Hemoglobin electrophoresis
- G6PD activity
- Vitamin deficiency screening based on clinical presentation
- Schistosoma IgG OR Presumptive treatment for schistosomiasis
- Praziquantel

- Malaria thin and thick blood smears x 3 OR Malaria Rapid Diagnostic Test OR Presumptive treatment for P falciparum
- Atovaquone-proguanil OR
- Artemether-lumefantrine

## If No Pre-treatment Exists

<table>
<thead>
<tr>
<th>Screen</th>
<th>Treat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stool Ova &amp; Parasites x 3</td>
<td>Albendazole</td>
</tr>
<tr>
<td>Strongyloides IgG</td>
<td>Ivermectin</td>
</tr>
<tr>
<td>Schistosomiasis IgG</td>
<td>Praziquantel (if from SSA)</td>
</tr>
<tr>
<td>Malaria smears and MRDT vs PCR</td>
<td>Atovoquone-proguanil</td>
</tr>
<tr>
<td></td>
<td>(if from malaria-endemic areas of SSA)</td>
</tr>
</tbody>
</table>
## Opportunities for Practice Change

<table>
<thead>
<tr>
<th>Labs</th>
<th>0 of 4 selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC and Differential</td>
<td></td>
</tr>
<tr>
<td>Quantiferon in-tube (Sendout)</td>
<td></td>
</tr>
<tr>
<td>HIV Antibody</td>
<td></td>
</tr>
<tr>
<td>RPR (Syphilis Serology)</td>
<td></td>
</tr>
<tr>
<td>Lead, State Lab</td>
<td></td>
</tr>
<tr>
<td>Lead, Blood (Sendout)</td>
<td></td>
</tr>
<tr>
<td>Hep-B Surface Ag</td>
<td></td>
</tr>
<tr>
<td>Strongyloides Antibody, IgG (Sendout)</td>
<td></td>
</tr>
<tr>
<td>Schistosoma Antibody (IgG) (Sendout)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C Antibody</td>
<td></td>
</tr>
<tr>
<td>Newborn Screen (State Lab)</td>
<td></td>
</tr>
<tr>
<td>TSH Ultra Sensitive</td>
<td></td>
</tr>
<tr>
<td>Hb Electro Quantitative</td>
<td></td>
</tr>
<tr>
<td>Vitamin D 25 OH, LC Tandem MASS Spectrum</td>
<td></td>
</tr>
<tr>
<td>Malaria Smear</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stool</th>
<th>0 of 2 selected</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Urine</th>
<th>0 of 2 selected</th>
</tr>
</thead>
</table>

Screen shot from the electronic medical record, Wake Forest Baptist Health.
Case 3

- A 4-year-old Burmese boy, born in a Thai refugee camp, arrives in your clinic as a new patient.

- His parents report that others have difficulty understanding what he says, and that he does not speak as well as the other children in the refugee camp.

- What developmental screening evaluation is appropriate for refugee children?
What is Recommended for ALL Children?

Developmental surveillance at all well child care visits with screening at selective intervals or in response to concerns noted with surveillance.

## Sample Screening Tools

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEDS</td>
<td>• 10 questions targeting parental concerns</td>
</tr>
<tr>
<td></td>
<td>• Designed to detect children eligible for developmental services</td>
</tr>
<tr>
<td>ASQ</td>
<td>• Targets age-specific milestones for 5 areas: communication, gross motor, fine motor, problem solving, personal - social</td>
</tr>
<tr>
<td>M-CHAT-R/F</td>
<td>• Identifies children who should receive a more thorough assessment for possible early signs of autism spectrum disorder (ASD) or developmental delay.</td>
</tr>
<tr>
<td>SWYC</td>
<td>• 3-4 components, depending on child’s age:</td>
</tr>
<tr>
<td></td>
<td>• cognitive, language and motor development</td>
</tr>
<tr>
<td></td>
<td>• social-emotional development</td>
</tr>
<tr>
<td></td>
<td>• family risk factors</td>
</tr>
<tr>
<td></td>
<td>• autism</td>
</tr>
</tbody>
</table>

Ages and Stages Questionnaire (ASQ). agesandstages.com
Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F). www.m-chat.org/index.php
Opportunities for Practice Change

- Screen universally—bilingualism does not cause language delay.
- Conduct developmental assessments in the child’s primary language.
- Enlist assistance of interpreters or patient navigators to complete forms.
- Engage developmental specialists for follow-up screening and coordinated referral (integrated services are ideal—Imprints Cares).
- Incorporate literacy promotion into routine care (i.e. Reach Out and Read).
Case 4

- A mother is concerned that her 2-year-old daughter is reluctant to separate from her. The girl and her mother arrived in Winston-Salem 2 months ago after fleeing El Salvador.

- How may you explain this child’s behavior?
## Trauma-Related RED FLAGS

<table>
<thead>
<tr>
<th>Bodily Functions</th>
<th>Behavior</th>
<th>Development and Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping problems</td>
<td>Detachment</td>
<td>Frequent severe tantrums</td>
</tr>
<tr>
<td>Eating Problems</td>
<td>Numbing</td>
<td>Limited working memory</td>
</tr>
<tr>
<td>Toileting Problems</td>
<td>Aggression</td>
<td>Organizational problems</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exaggerated responses</td>
<td></td>
</tr>
</tbody>
</table>

Providers can recognize red flags and help parents to address symptoms.
Case 5

- An 18-year-old refugee girl from Syria presents for her comprehensive medical evaluation. She denies concerns, but review of symptoms reveals difficulty with sleep, appetite, and feeling badly about herself. Upon further questioning, you learn that her family came to the United States as refugees, but her fiancé remained in Syria.

- What mental health screening is warranted for immigrant children?
### Mental Health Risk and Protective Factors

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal exposure to violence</td>
<td>Parental support/family cohesion</td>
</tr>
<tr>
<td>Female (internalizing, emotional)</td>
<td>Support from friends</td>
</tr>
<tr>
<td>Parental exposure to violence</td>
<td>Positive school experience</td>
</tr>
<tr>
<td>Social or language-related isolation</td>
<td>Two-parent families</td>
</tr>
<tr>
<td>Parental mental illness</td>
<td>Bonds with fellow immigrants from the same country of origin on arrival</td>
</tr>
<tr>
<td>Poverty</td>
<td>Safety in schools and neighborhoods</td>
</tr>
<tr>
<td>Housing insecurity</td>
<td>Perceived acceptance in receiving communities</td>
</tr>
<tr>
<td>Perceived discrimination</td>
<td></td>
</tr>
<tr>
<td>Unaccompanied children</td>
<td></td>
</tr>
</tbody>
</table>

“The adverse events that necessitated their flight are often only the beginning of a long period of turbulence and uncertainty.”

Common Mental Health Problems

- Post-traumatic stress disorder
- Depression
- Anxiety
- Conduct disorders
- Somatic complaints

## Sample Mental Health Screening Tools

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
</tr>
</thead>
</table>
| PSC (PSC-Y, PSC-17)         | • Brief questionnaire used to recognize psychosocial problems  
                               • Positive result triggers need for additional evaluation  |
| RHS-15                      | • Developed in a community public health setting  
                               • Detect a range of emotional distress across refugee groups |
| PHQ-9 (PHQ-A)               | • PHQ-9 is specific to depression  
                               • Linguistically comprehensive  |
Treatment and Referral

**Treatment**
- Cognitive-behavioral therapy (CBT)
- Trauma-informed care (including **trauma-focused CBT**)
- Medications if necessary

**Referral**
- Co-located/integrated behavioral health services
- Community-based mental health care
- School-based interventions
  - Trained mental health professionals
  - Supportive, caring environment for prevention and treatment

Let’s return to José.
## Screen for Social Determinants of Health

<table>
<thead>
<tr>
<th>SEEK</th>
<th>Safe Environment for Every Kid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WE CARE</strong></td>
<td>Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education</td>
</tr>
<tr>
<td>IHELLP</td>
<td>Income Supports, Housing and Utilities Education</td>
</tr>
<tr>
<td>ITHELLPS</td>
<td>Income Transportation Housing Education</td>
</tr>
<tr>
<td><strong>SWYC</strong></td>
<td>Survey of Wellbeing of Young Children</td>
</tr>
</tbody>
</table>

Legal Referrals

- No child should ever have to represent himself or herself in immigration court.
  - Many places have LIMITED no cost or low cost legal resources for undocumented immigrants.
    - KIND—Kids in Need of Defense—National network
    - American Immigration Lawyers Association (AILA)
    - Some firms may help...

Medical Care for Uninsured Immigrants

- Federally qualified health centers
- Health departments
- Free clinics
- Public hospitals (charity care)
- School-based health centers
- Foster care
- Title X
- 340b drug pricing: www.hrsa.gov/opa
- Vaccines for Children: www.cdc.gov/vaccines/programs/vfc/index.html
Health Coverage for Immigrant Children | July 2016

Key:
- Green: Medicaid/CHIP for lawfully residing children, regardless of date of entry
- Dark Green: Medical coverage for children, regardless of immigration status
Opportunities for Practice Change

- Create a medical home for immigrant children: Provide comprehensive, coordinated, culturally and linguistically effective care, and continuous health services.
- Offer interpreter services for families with limited English proficiency.
- Develop protocols for screening newly arrived children.
- Offer co-located/integrated services.
- Support school readiness and academic success.
- Maintain a list of current, relevant community resources and incorporate “warm hand-offs” into your system.
- Weave in health literacy initiatives throughout clinical care.
- You may need to redesign your systems—consider quality improvement methodology.
Understanding Their Journey

ENRIQUE’S JOURNEY
The Story of a Boy’s Dangerous Odyssey to Reunite with His Mother
Sonia Nazario
Winner of the Pulitzer Prize
With a new Afterword by the author

CITY OF THORNS
Nine Lives in the World’s Largest Refugee Camp
Ben Rawlence

THE BEAST
Riding the Rails and Dodging Narcos on the Migrant Trail
Óscar Martínez

Supported, in part, by MeadJohnson Nutrition
Conclusions

- When evaluating refugee and other newly arrived immigrant children, put the unique circumstances of each child and family into context.
- Recognize strengths and resilience as assets among immigrant children and families.
- Incorporate tools for screening newly arrived children regarding development, mental health, and social determinants of health.
- Engage available local and national resources to optimize access and services for immigrant families.
- Partner with pediatricians and relevant organizations to advocate on behalf of immigrant children.
Acknowledgements

- American Academy of Pediatrics Council on Community Pediatrics Immigrant Health Special Interest Group—join us!
- Benard Dreyer, MD, FAAP
- Wake Forest Department of Pediatrics
- Denver Health and Hospitals
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8. Center on the Developing Child. Harvard University. Available at developingchild.harvard.edu/science/key-concepts/toxic-stress
16. Kids Count Data Center. Available at datacenter.kidscount.org
18. Migration Policy Institute. Available at www.migrationpolicy.org
22. North Caroline Pediatric Society. Fostering Health NC. Available at www.ncpeds.org/?page= FHNC
28. Survey of Wellbeing of Young Children (SWYC). Floating Hospital for Children at Tufts Medical Center. Available at www.thewyc.org
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