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FALL 2025

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IN-PERSON CONFERENCE 8:00am – 12:00pm Overlook Medical Center 9 Beauvoir Avenue, Summit, NJ 07901		
October 16	Depression – Diagnosis and Treatment <i>Webinar</i>	Sonali Mahajan, MD Katherine Worden, LCSW
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**Katherine Clouser, MD,
FAAP, MBA**
NJAAP Chapter President

As the autumn air settles in, it brings with it a familiar rhythm: the return to school, the changing leaves, and a renewed sense of purpose in our work. This fall, however, feels particularly special for the New Jersey Chapter of the American Academy of Pediatrics.

It is with immense pride and gratitude that I share the news that the NJAAP was honored by the national American Academy of Pediatrics as the 2024 Very Large Outstanding Chapter. We were thrilled to accept this prestigious award in July, and it serves as a powerful affirmation of the collective work we do every day. This honor is not just a plaque on a wall; it is a testament to the tireless dedication of our incredible staff and, most importantly, to you, our members. Your unwavering advocacy on behalf of New Jersey's children and your commitment to our Chapter's innovative program work are what made this recognition possible. Thank you for your passion and your expertise. This award is well-deserved, and it belongs to all of you.

As we carry this celebratory momentum into the fall, we turn our attention to the demanding back-to-school season. We know

this time brings an increase in your workload, from well-child visits and sports physicals to the endless stream of school forms. We also recognize that the challenges facing our patients and their families are more complex than ever. The landscape of pediatric care is constantly evolving, and this season is a stark reminder of our central role in navigating it.

In the face of these demands, we want to ensure you feel supported. We strongly encourage you to lean on the robust resources provided by the national AAP for the latest [vaccine guidance](#) and recommended school exams. Staying aligned with these evidence-based recommendations ensures the highest standard of care for our patients. This work is not done in a silo. We deeply value and encourage your partnership with school physicians to determine the most effective and appropriate requirements for your local districts. Collaboration is key, and we appreciate the strong partnerships that create a unified front for child health in our communities.

To further support this collaborative spirit, please mark your calendars for our upcoming [Annual School Health Conference](#) on Wednesday, October 22, 2025. This event is a vital opportunity for all professionals who work with students—pediatricians, school nurses, school physicians, and administrators—to connect, learn, and share best practices. More details will be shared in the coming weeks.

All of this work—our recent award, our daily clinical care, our advocacy—is built on a remarkable foundation. This year, we continue to celebrate the [75th anniversary](#) of the NJAAP. For three-quarters of a century, our Chapter has been the leading voice for children's health in New Jersey. It is a legacy we are proud to continue.

Did You Know?

NJAAP has the capacity to offer one-time live webinars, live webinar series on a particular theme, recorded webinars and webinar series, half-day or full day sessions or conferences, in-person and virtual group learning sessions and technical assistance, and Project ECHO® (Extension for Community Healthcare Outcomes) programs.

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Felicia K. Taylor, MBA, CAE
Chief Executive Officer
NJAAP

Annual Leadership Conference Recap

The American Academy of Pediatrics Leadership Conference was held July 30th – August 3rd in Itasca, IL. The conference was filled with valuable content covering a wide range of topics, including physician safety and well-being, crisis communication strategies, strategic message framing, advocacy for vulnerable families, and best practices in volunteer team management and member engagement. Among the top 10 resolutions receiving the most votes were initiatives supporting the protection of vulnerable families, advocacy for essential public services and resources for undocumented children, promotion of gender pay equity, and tools to better understand and improve the U.S. healthcare financing system. Stay tuned for updates from the AAP on how these top resolutions will be considered in the coming months.

I would like to echo Dr. Clouser's congratulations to the New Jersey Chapter, American Academy of Pediatrics, recipient of the AAP 2024 Outstanding Chapter Award, Very Large Chapter category. This recognition is truly meaningful, and I am honored to continue serving in a leadership role within such a prestigious organization of dedicated members, staff, and volunteers. During the announcement at the AAP Leadership Conference, several of our chapter accomplishments were highlighted, including the education of over 15,000 individuals through in-person and virtual programming, the implementation of 10 educational programs across the state and the expansion of

training for clinicians, school personnel, and other pediatric health professionals through the Training Institute. Congratulations to the entire NJAAP Executive Council, members, volunteers and staff for their unwavering commitment to advancing the health and well-being of children across New Jersey.

Get Involved, Stay Connected

Are you looking to become more involved in our work? There are many ways for pediatricians to remain engaged, but remaining active with your state chapter will help ensure continued access to quality education and resources and a professional network focused on pediatric development. Especially with shifts in policy at the federal level, remaining connected will not only keep you apprised of changes and opportunities but will empower you to contribute to advocacy when you see fit. Chapter conferences, virtual webinars, and advocacy days foster communications and collegiality that empower you to better care for your patients while simultaneously integrating yourself as an advocate for all children's health needs. If you're looking to become more involved, consider joining a committee or reaching out to chapter leadership at njchapter@njaap.org for any local opportunities for advocacy or mentorship. Your voice and involvement matters, and the more engaged we are, the more engaged we can ensure others will be in listening to the needs of children.

75th Diamond Jubilee Gala

We are excited to announce that registration is now open for the NJAAP 75th Diamond Jubilee Gala! Please mark your calendars and join us in celebrating this historic milestone on Saturday, December 13, 2025, at a stunning new venue, Liberty House in Jersey City, NJ.

To register and learn more, please visit the official 75th Anniversary website at <https://njaap75.info>

We look forward to celebrating the legacy and future of pediatric care in New Jersey with you!



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Steven Kairys, MD, MPH, FAAP

Founding Chair of Pediatrics, Hackensack Meridian School of Medicine

K. Hovnanian Children's Hospital, Jersey Shore University Medical Center, Hackensack-Meridian Health

I would first like to congratulate the New Jersey Chapter for being named the recipient of the 2024 American Academy of Pediatrics Outstanding Chapter Award for Very Large Chapters. It is a great testament to the Chapter for its ongoing commitment to improving the lives of children statewide.

2025 and beyond will see many negative changes in the safety net for children in New Jersey because of the drastic federal cutbacks for Medicaid, Supplemental Nutrition Assistance Program (SNAP), Women Infants Children Program (WIC), and immunizations. The NJAAP will be working to educate pediatricians about these changes and to advocate at the state level.

2025 has also been a year of innovation in New Jersey:

[The Center for Health Equity and Wellbeing](#) launched in 2025. Funded by the Robert Wood Johnson Foundation, it is a nonprofit public health institute with the mission to promote community-driven partnerships to strengthen public health infrastructure. The priorities are supporting evidence-based practices in health care and developing equity zones in high-risk areas of the state. The Center will invest in three high-risk communities: one in northern New Jersey, one in central New Jersey, and one in southern New Jersey.

[NJ Statewide Student Support Services \(NJ4S\)](#)

consists of 15 hubs focused on youth mental health and wellness. The NJ4S support includes workshops and training, small group programming around early identification and brief clinical interventions. Major topics were mental health, social connections, substance abuse prevention, anti-bullying and classroom management. NJ4S started in 2023 but greatly ramped up in 2024 with services to almost 300 schools.

[Connecting NJ](#) is a network of agencies that provide parents with free or affordable access to resources. It uses a county based, single-point-of-entry system that streamlines the referral process for perinatal care. This includes access to community doulas and home visiting programs. An essential program for pediatricians is nurse home visits to parents of newborns. The visit includes assessing the health of the parent and the infant, providing education on feeding and sleeping, child development, infant crying, and also assisting families recovering from the tragedy of stillborn.

[Safe NJ](#) is an initiative from the DOH to provide trauma-informed mental health and safety resources to schools in NJ. Key features include an app that allows anonymous student reporting of bullying, threats or personal struggles and immediate crisis support through the 2ndFloor Youth Helpline.

[The NJ Lead Remediation and Abatement](#) program will remove lead-based paint hazards from homes built before 1978 and for occupants with a gross household income that does not exceed 80% of the state median income.

These programs will be a significant source of support for children in our state. However, the first hint of restrictions due to loss of federal support is the Child Care Assistance funding. Applications are no longer being accepted because the supporting federal dollars have been withdrawn.

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The New Jersey Chapter, American Academy of Pediatrics has been reviewed by Medical Society of New Jersey (MSNJ) and awarded Provisional Accreditation for 2 years as a provider of continuing medical education (CME) for physicians. MSNJ accreditation seeks to assure the medical community and the public that NJAAP delivers education that is relevant to clinicians' needs, evidence-based, evaluated for its effectiveness, and independent of commercial influence.



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**Peer reviewed content*

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Introduction

Autism spectrum disorder (ASD) is a neurodevelopmental condition characterized by challenges in social communication and the presence of restricted, repetitive behaviors. Given the complexity and heterogeneity of presentations, the selection of appropriate interventions is critical to optimizing developmental outcomes. Pediatricians, as the first and often most consistent point of contact for families, are uniquely positioned to influence treatment decisions. In this role, it is essential to be familiar with the core components of evidence-based practices (EBPs) and to help families distinguish these from approaches lacking empirical support. Understanding the scientific evidence behind various treatment options is essential given that the landscape of autism interventions can be complex and at times contradictory, with numerous programs and therapies marketed to families. EBPs for autism have the support of peer-reviewed, high-quality studies that demonstrate the effectiveness of the specific intervention for individuals with autism. In contrast, certain alternative treatments, though widely marketed, have limited or no scientific backing and may actually be harmful or divert time and resources away from effective care [1]. Parents, searching for what will improve quality of life for their child, will naturally be interested in exploring a variety of treatments, and in doing so, may be led to try options that are ineffective. This exploration may cause greater levels of stress and burnout for the parents and a lack of progress or detrimental results for the child [2].

Pediatricians should be prepared to have conversations with families about pursuing effective treatment and help them to secure treatment that is a good fit for both the individual and family. Choosing an intervention approach for a particular child should be influenced by the following factors [3]:

- Demonstrated evidence of effectiveness for individuals with autism
- Clinical judgement
- Values and preferences of the family and autistic individual
- Ability to implement the intervention correctly

As families look for guidance about which potential treatment(s) to pursue, a pediatrician can guide them to ask important questions, such as [2,4]:

- What behaviors should change as a result of the intervention?
- How will these changes be measured?
- What are the risks and benefits of this approach?
- How will success be determined? What data will be collected, and when will we review these data to determine the effectiveness of this treatment for my child?

Because the effectiveness of any intervention will be influenced by fidelity of implementation and treatment intensity, pediatricians can provide valuable support by encouraging regular evaluation of treatment outcomes and progress monitoring. Identifying progress toward the treatment plan, observing the child, and consulting with parents can assist in assessing whether a given approach yields meaningful gains for the individual child.

Evidence-Based Practices

Although research indicates that there is a biological foundation for autism, medical treatments that impact the core characteristics of autism are still lacking. Currently there is no medication that can cure autism, yet there are some that may be used to treat symptoms such as inattention, anxiety, obsessive-compulsive behavior, irritability, or aggression. Oftentimes these medications work best when paired with a therapeutic evidence-based program that teaches the child new skills [2]. Parents may ask you about medical options when trying to determine how best to help their child, and pediatricians should be prepared to talk about the benefits and drawbacks of different treatments and provide referrals to other medical professionals and therapy providers as needed.

A substantial body of research supports early, intensive, and individualized interventions, particularly those based on applied behavior analysis (ABA), as effective in improving cognitive, language, adaptive, and social functioning in children with autism [5] [ABA](#) is an evidence-based intervention supported by decades of research demonstrating its effectiveness for learners with and without special needs. ABA is considered the gold standard for working with individuals with autism. Hundreds of autism-specific studies have proven the effectiveness of ABA for both teaching skills and reducing challenging behavior. Research also indicates that many learners in ABA programs achieve more progress than those in programs involving several different methods [6].

The 2020 report Evidence-Based Practices for Children, Youth, and Adults with Autism by Steimbrenner and colleagues identified 28 intervention practices that met their standard

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of evidence [7]. These interventions are used in focused treatment and also serve as the components of evidence-based comprehensive programs. These interventions include the following:

- Antecedent-based interventions
- Ayres sensory integration (ASI)*
- Augmentative and alternative communication (AAC)
- Behavioral momentum intervention
- Cognitive behavioral instructional strategies
- Differential reinforcement of alternative, incompatible, or other behavior
- Direct instruction
- Discrete trial training
- Exercise and movement
- Extinction
- Functional behavior assessment (FBA)
- Functional communication training
- Modeling
- Music-mediated intervention
- Naturalistic intervention
- Parent-implemented intervention
- Peer-based instruction and intervention
- Prompting
- Reinforcement
- Response interruption/redirection
- Self-management
- Social narratives
- Social skills training
- Task analysis
- Technology-aided instruction and intervention
- Time delay
- Video modeling
- Visual supports

**Note: only three studies were used to substantiate ASI as evidence-based*

This list differed slightly from the National Standards Project, Phase 2 report from 2015 that classified interventions into 3 categories: established, emerging, and unestablished [3]. Those listed as established interventions demonstrated sufficient evidence of effectiveness for individuals with autism; whereas those classified as emerging interventions only had one or more studies demonstrating effectiveness, indicating that more research is needed. This points to the ever-changing landscape of research

in autism interventions and the need to stay abreast of new developments.

Scope of Treatment

The scope of treatment should be aligned with the results of a comprehensive assessment to determine individual strengths and needs.

Evidence-based treatment may be comprised of both focused interventions and comprehensive programs. These differ in the range of skills being targeted, in that focused interventions target a few skills, and comprehensive programs address a variety of core skills across several domains. The treatment should be planned based on the individual's needs, designed at an intensity that is effective in meeting the treatment goals, and not constrained by age. Individualized care may therefore differ in scope, intensity, and duration of treatment. Furthermore, caregiver participation is often encouraged and may vary based on caregiver skills and individual family circumstances [7].

Focused intervention can be used to address a few skills that are essential for health, safety or independence. Examples of these focus areas include self-care, communication, and social skills. Development of these skills may also be part of a behavior intervention plan that is designed to reduce harmful or dangerous behaviors. Some examples of challenging behaviors to be addressed in focused treatment include physical aggression, self-injury, property destruction, pica, and elopement. In these cases, the focused intervention should be provided in a timely manner by qualified professionals to minimize risks for health and safety. A functional behavior assessment (FBA) should be completed to identify the personal and environmental variables that impact the behavior to guide treatment. A behavior plan, based on the results of the FBA, should include both teaching strategies focused on adaptive skill development and strategies for reducing the challenging behaviors.

Comprehensive treatment approaches for autism are intensive, multi-component intervention models that address a wide range of developmental needs over an extended period. Typically, these approaches involve multiple domains such as communication, social skills, behavior, cognitive development, and adaptive functioning. These structured programs often involve coordinated delivery across home, school, and clinical settings and incorporate regular progress monitoring and family involvement. In addition to these comprehensive programs, children may also participate in other therapies to address specific needs, including speech therapy (expressive and receptive language, fluency, social communication, apraxia), occupational therapy (fine motor skills, self-regulation, self-care), and physical therapy (gross motor, core strength, toe walking).

Some examples of evidence-based comprehensive interventions include Early Intensive Behavior Intervention (EIBI) and the Early Start Denver Model (ESDM) [8]. EIBI, based on the

Continued on page 12

principles of ABA and delivered at a high intensity (20-40 hours per week), has demonstrated long-term benefits in language development, adaptive functioning, and intelligence quotient (IQ) when implemented in early childhood [9]. Other well-supported ABA-based models include naturalistic developmental behavioral interventions (NDBIs), such as ESDM, which combine behavioral strategies with child-led, play-based techniques. ESDM has demonstrated an improvement in cognitive and language outcomes in children with ASD.

Comprehensive approaches can promote generalization, functional independence, and long-term outcomes across some or all of the following domains [10]:

- Attending
- Cognitive functioning
- Community participation
- Coping, tolerance, and emotion regulation
- Language and communication
- Play and leisure
- Reduction of challenging behaviors
- Safety skills
- Self-care
- Social skills
- Vocational skills

Intensity and Duration of Treatment

Treatment intensity is an aspect of care that may differ significantly across individuals based on many factors. Oftentimes autism treatment requires many hours, yet individual and family circumstances must be considered when recommending the intensity of services. The Council for Autism Service Providers (CASP) recently released [practice guidelines](#) that suggest hours of treatment be based on what is medically necessary for the child with regard to the complexity and range of treatment goals as well as the significance of the child's needs. The intensity of treatment may also adapt to individual circumstances over time, potentially with greater intensity of services following the diagnosis and at various transitions or different developmental stages. CASP offered the following framework to further clarify how treatment approaches can differ in scope and intensity [10]:

- **High intensity / comprehensive scope:** For example, a child receives 30 hours/week of early intensive behavior intervention. Goals for this program span multiple domains. Parents are involved in some of the sessions, and there is coordination across multiple providers.
- **High intensity / focused scope:** For example, a child's challenging behaviors are both dangerous and interfering with learning. A functional behavior assessment is completed, and a behavior plan is implemented that includes functional

communication training and strategies for emotional regulation. Everyone working with the child is taught proactive strategies and how to manage the behaviors if they occur.

- **Low intensity / comprehensive scope:** For example, a child has previously received 2 years of early intensive behavior intervention and is now in school full-time. Goals for this program span multiple domains and focus on generalization and maintenance of skills.
- **Low intensity / focused scope:** For example, a child has difficulty interacting with siblings and peers at school. The child participates in weekly social skills groups to learn how to communicate and play with others.

The duration of treatment is also highly individualized. Many autistic children benefit from long-term services that adapt over time to address the core symptoms of autism as well as specific skills that need to be addressed at different stages of development. While there is often a focus on communication and pre-academic skills at an early age, there may be an increased emphasis on self-care, social, and vocational skills later.

Measuring Effectiveness

For any intervention implemented to support a child with autism, ongoing data collection and analysis are essential to determine its effectiveness in achieving specific, measurable goals. Even evidence-based interventions can yield variable outcomes depending on factors such as how the intervention is implemented, contextual variables, and individual responsiveness to treatment. Therefore, continuous monitoring is necessary to inform timely adjustments and optimize treatment outcomes. Given that progress may be gradual, maintaining detailed records supports data-driven decision making, facilitates team communication, and ensures that clinical recommendations remain aligned with the child's evolving needs. Home and school programs can provide in-depth data to clearly illustrate the child's progress toward goals as well as any persistent challenges. This may help parents to both understand and communicate with various professionals about their child's needs.

Conclusion

Pediatricians can support families by identifying qualified providers, promoting early intervention, and reinforcing the use of data-based decision making in treatment planning. Additionally, having access to reputable resources can aid physicians in staying informed about emerging evidence and supporting families in navigating complex service systems.

Ultimately, focused or comprehensive evidence-based approaches to autism intervention are most successful when tailored to the individual and supported by a collaborative care team, with the pediatrician serving as a key partner in optimizing developmental outcomes.

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In summary, evidence-based treatment approaches help to ensure that a child with autism will receive care that:

- Provides **effective teaching and safety**
- Considers **efficient use of time and resources**
- Increases the likelihood of **positive outcomes in communication, behavior, academics, and adaptive skills**
- Provides a foundation for **measuring progress and making data-driven decisions**

[Autism New Jersey](#) offers educational materials to assist healthcare providers and families in staying informed about the current state of autism intervention research [11]. Pediatricians can clarify what current research reveals about available methodologies and offers guidance on how to assess and document the effectiveness of a chosen intervention for an individual once it is underway. By promoting the use of validated practices and discouraging the adoption of unproven methods, pediatricians play a pivotal role in advancing care and improving quality of life for children with autism and their families.

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**Peer reviewed content*

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Going in the Wrong Direction

In 2022, I reported that approximately 3,500 infants died in their sleep every year [1]. Now, alarmingly, that number is up to 3,700 per year, and is rising disproportionately for babies in some ethnic minorities [2]. A recent study showed that from 2020-22, the Sudden Unexplained Infant Death (SUID) mortality rate rose over 10% [2]. We have not seen a reduction in SUID since the year 2000. The frustrating part for pediatricians is that we know these deaths are preventable. Indeed, a study done by Rachel Moon et al in 2024 [3] showed that of mothers surveyed, all had knowledge of the ABCs of Safe Sleep (Alone, on the Back, in a Crib). “Mothers recalled learning about safe sleep practices from medical professionals and other sources [4].”

According to the findings of Moon et al., the problem is that despite mothers knowing about safe infant sleep precautions, they often abandon these guidelines and do unsafe things out of sheer exhaustion. These high-risk sleep behaviors can include prone sleeping, bed-sharing, and/or the use of bulky bedding. One study showed that 82% of families who used a prone sleeping position for their infant did so because their babies “didn’t like” being on their back (i.e. cried more) [4]. Another study of parents who utilized the Special Supplemental Program for Women, Infants and Children (WIC) found that 63% of 2,299 mothers reported that their babies were “more comfortable,” (i.e. cried less) when sleeping prone. These mothers were four times more likely to place their babies prone to sleep [5].

Drilling Down on Unsafe Sleep Practices

The Centers for Disease Control and Prevention (CDC) reports that 61% of parents bed-share, at least on occasion [6]. Unfortunately, there is a strong association between bed-sharing and infant fatalities: a study of 8,207 SUID cases from 2004-2012 noted that most fatalities occurred while bed-sharing (69%) [6]. Why does bed-sharing occur so commonly? Breastfeeding advocates sometimes advise bed sharing to improve nursing success. In some families, bedsharing is a cultural norm. Perhaps most common, however, is bedsharing that happens accidentally due to new parent exhaustion. In a study of 4,789 breastfeeding women, 30% brought the baby into their bed at the start of the night, but 60% were bedsharing by morning [7]. In July 2022, the American Academy of Pediatrics (AAP) released new and updated guidance on safe sleep practices, which again cautioned parents

not to bed-share “under any circumstances” [8]. Unfortunately, as society has become more mobile and families are scattered over wide geographical areas, many parents do not have extended family nearby to help them at night.

Soft bedding is another safe sleep issue for infants. In 1999, the Safe to Sleep campaign recommended not using bulky bedding. From 1993-2010, bulky bedding use did decrease from 86% to 55% [9]. Nevertheless, many families still use soft/loose bedding for their baby. In a 2021 CDC report on 4,929 SUID victims (2011-2017), 75% of suffocation victims had airway obstruction from soft bedding [9-11]. Notably, loose and bulky bedding can often be seen in marketing images used to sell cribs and baby products, which is reflective of their popularity and a lack of public awareness of the danger they present.

Where Is the Disconnect?

Existing evidence points to a confluence of three factors that precipitate SUID: a critical age (90% under 6 months), intrinsic vulnerability (genetic factors, prematurity, prenatal smoke exposure) plus an external stressor (e.g. prone position, bed-sharing, bulky bedding, cigarette smoking). This is known as the Triple Risk Model of SUID [2]. Of those factors, external stressors are the easiest to address.

The AAP’s Back To Sleep campaign in the 1990s was successful because it achieved a rapid reduction in one key risk factor: prone sleeping. Unfortunately, after an initial 50% drop, progress in reducing these deaths hit a wall after the year 2000. While back sleeping is clearly safer, the current generation of parents reports difficulty in following the ABC approach [3]. This may be because the supine sleep position can lead to more infant fussing/waking [12]. As Moon et al documented [3], poor infant sleep has led many stressed parents (desperate for sleep themselves) to ignore medical advice and use prone positioning, co-sleeping and other unsafe sleep practices. Given this circumstance, further SUID reduction may depend upon our ability to reduce infant fussing and improve sleep in the supine position during those critical first months.

Achieving Safe Sleep Outcomes

If we want parents to follow the AAP’s advice, we need to hear their pleas for help with infant sleep. The good news is that there are evidence-based practices that boost infant sleep and reduce fussing. Three of the best-known are swaddling, rocking, and sound [13].

Swaddling has been shown to reduce crying and increase sleep [14]. The potential safety benefit of swaddling was reported in studies that showed it significantly reduced prone placement and bed sharing [15]. Of course, swaddling must be done properly

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to avoid overheating, hip restriction, prone position, and loose blankets.

White noise, specifically, helps to elicit a calming response in infants: one study showed that 80% of infants fell asleep within five minutes of white noise stimulation (vs. only 25% without it) [16]. It is important, however, to stay within safe decibel limits when white noise machines are used. Sucking has also been shown to be highly effective in soothing infants after aversive stimuli such as a heel stick or vaccine [17-18]. Furthermore, pacifier use has been shown to decrease SUID risk. Rocking was also an effective tactic to soothe infants after an aversive stimulus [17-18].

Many pediatricians will be familiar with Dr. Harvey Karp’s “5 S’s” strategy to soothe colicky babies, which features the use of several calming strategies simultaneously (as denoted in his book *Happiest Baby on the Block*) [19]. Multiple studies have shown that the use of additive calming measures can quiet upset babies faster [17] and increase infant sleep time [20].

Dr. Moon’s research suggests that we need to make it easier for parents to follow safe sleep guidelines. An innovative way to do this would be to incorporate emerging technology to help babies sleep better in a safe position. For some time now, there have been sleep positioner devices on the market for infants—but unfortunately many have had to be recalled due to safety problems such as suffocation risks. There is now, however, at least one U.S. Food and Drug Administration (FDA) De Novo authorized medical device which is approved for specifically keeping infants safely on their backs until 6 months of age (or whenever the infant demonstrates consistent rolling over skills).

Another promising area of new technology is the “smart bassinet,” which can provide rocking motion and/or white noise. A study done at the University of Amsterdam showed that a responsive bassinet was able to calm fussy babies as quickly as their mothers could [21]. Indeed, the device could often calm infant fussing within two minutes [21]. Yet-unpublished work appears promising for sleep enhancement using data collected from the manufacturer of one such responsive bassinet (Figure 3). Recommendations for parents to use such devices, of course, should be grounded in the device’s proven safety for use during sleep.

It is increasingly clear that frequent infant night waking leads to unsafe sleep practices. In addition, excessive infant crying has been linked to postpartum depression as well as abusive head trauma in infants [23-24]. It stands to reason that sleep technology that can decrease infant crying while keeping the infant in a safe sleep position will be able to improve outcomes for both mothers and infants. In a study of women with a history of depression, participants reported that a responsive bassinet improved their infants’ sleep as well as their own sleep and mood [25]. Users of the responsive bassinet were more likely to swaddle their infants in the supine position for sleep, vs. non-users who reported more unsafe sleep practices [25]. This study illustrates the key connection between maternal sleep, mood, and safe infant sleep practices: this connection may provide a “wedge” we can use to finally move the needle to reduce SUID deaths.

Inpatient nurseries and neonatal intensive care units (NICUs) have long had to manage excessive crying in infants exposed to maternal substance use during pregnancy. Historically, inpatient units have often used swings or bouncers to calm these babies. These devices present a problem, however, if the baby falls asleep during use, as they are not safe for infant sleep. Recently, two devices have been reported to safely lessen infant crying and improve sleep—one of which also was reported to reduce nurse labor 1.9-2.4 hours/shift [26-27].

While we await further technological advances to help babies sleep better and longer, there are several “human touch” approaches that can be used to support new parents in following safe sleep guidelines, including the use of doulas or other health professionals to conduct home visits. These approaches can be especially helpful for parents in higher-risk situations, such as for parents in drug or alcohol abuse treatment programs or parents of premature infants.

Conclusion

If we want fewer infants to die in their sleep, we need to empower their parents to feel comfortable using safe sleep practices. A key component of this is to reduce infant fussing/crying in the safe supine sleep position—and emerging technologies can be effective tools for this purpose. Further research is necessary on infant/caregiver outcomes from new technologies,

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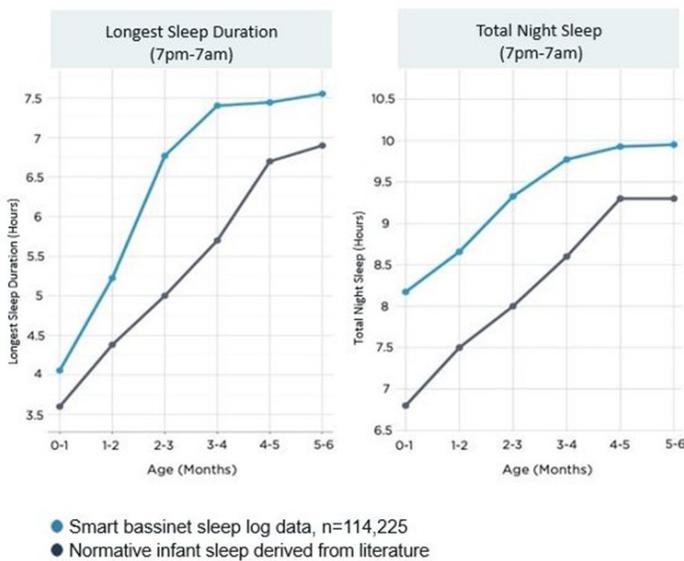


Figure 3. Modified with permission from Karp H. “Evaluation of a Womb-Like Sensory Intervention to Improve Infant Sleep,” Presented at: SLEEP 2022, June 5, 2022. Charlotte, NC [22].

and collaboration between academia, industry, and healthcare payers will be vital for this effort. Third-party payer involvement will also be crucial to allow accessibility to new devices that demonstrate efficacy in improving the safety of infant sleep.

Author Conflict of Interest Statement

Dr. Walsh serves as a Medical Science Liaison Consultant on the Medical Affairs Committee with the Happiest Baby company. She does not hold any financial investment or royalties in any of the company's products.

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The New Jersey Department of Health, Vaccine Preventable Disease Program (VPDP) reminds all providers of the importance of protecting children against respiratory syncytial virus (RSV) this upcoming respiratory virus season. [NJ Vaccines for Children \(VFC\) program](#) has been actively recruiting providers, including birthing hospitals, within the State to gain access, at no cost, to RSV monoclonal antibodies for VFC-eligible children. This effort ensures that newborns can receive timely protection against these serious illnesses.

Providers are encouraged to work within their networks to improve communication with entities such as OB/GYN offices and hospitals to identify children who have not received RSV monoclonal antibodies prior to hospital discharge. New Jersey now collects RSV monoclonal antibody administration in the electronic birth registry. Adding the monoclonal antibody administration to the birth registry enables birthing hospitals to report the dose directly into the infant's New Jersey Immunization Information System (NJiis) record. Children born during the RSV season who do not receive the dose prior to hospital discharge should receive the dose as soon as possible.

The Centers for Disease Control and Prevention recommends one dose of nirsevimab (Beyfortus™) for all infants younger than eight months, born during - or entering – their first RSV season (typically October through March). Provider office administration of nirsevimab may be given at a regularly scheduled two-, four-, or six-month well-baby visit. For a small group of children aged 8 through 19 months who are at increased risk of severe RSV disease, such as children who are severely immunocompromised, a dose is recommended in their second season.

Nirsevimab, which was approved by the United States Food and Drug Administration (FDA) in July 2023, is administered as an injection. Infants born during the seasonal administration window (October 1 – March 31) should get nirsevimab within one week of birth – ideally during the birth hospitalization. Infants with prolonged birth hospitalizations related to prematurity or other causes should receive nirsevimab prior to hospital discharge.

The availability of the maternal RSV vaccine and RSV monoclonal antibodies for children has made a significant impact on the burden of disease. In 2024–2025, the first United States RSV season with widespread availability of maternal RSV vaccine and nirsevimab, analysis of two population-based surveillance networks demonstrated significantly lower RSV-associated hospitalization rates among infants up to seven months who were eligible for RSV prevention products. These studies showed an estimated rate reduction of 28% and 43% compared with

rates during the combined 2018-2020 RSV seasons. The largest estimated rate reductions in hospitalizations occurred among infants up to two months.

Children born to mothers who were not vaccinated against RSV while pregnant are recommended to receive RSV monoclonal antibodies after birth. There are currently two RSV monoclonal antibody products that are approved by the FDA and recommended by the Advisory Committee on Immunization Practices (ACIP), nirsevimab (Beyfortus™) and clesrovimab (ENFLONIA). Nirsevimab has been seasonably available through the VFC program, and we expect that clesrovimab will be added in the future. The VFC Program will notify providers when clesrovimab is available for ordering.

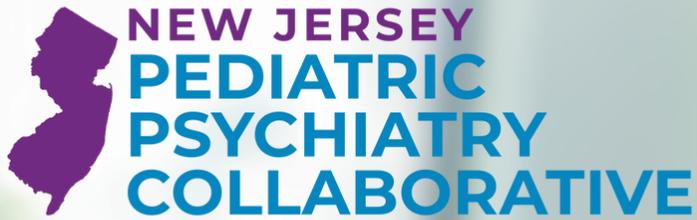
A child is eligible for the VFC program if the child is younger than 19 years of age and is one of the following:

- Medicaid-eligible (FamilyCare A)
- Uninsured
- Underinsured - A child's health insurance does not cover the vaccines or only covers select vaccines
- American Indian or Alaska Native.

The New Jersey VFC program has already partnered with several birthing hospitals and other VFC providers throughout the State to provide access to these life-saving vaccines. If you are interested in enrolling, please contact the NJ VFC program at VFC@doh.nj.gov. Additional information about the program requirements is also available through the [New Jersey Immunization Information System website](#), including the recently updated VFC Provider Manual at njiis.nj.gov/docs/vfc_provider_manual.pdf.

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My Whole Child Pediatrics

There are many unanswered questions about the One Big Beautiful Bill Act that President Trump signed into law. This Bill impacts pediatric physicians, especially those serving rural, immigrant, and low-income populations, due to the significant changes it imposes to Medicaid eligibility and programming. Although the Bill was drafted with the aim of reducing fraud and improving enrollment processes, the overall spending reduction of up to \$1.02 trillion over the next 10 years is anticipated to result in nearly 10 million Medicaid recipients losing coverage. Included below are a few areas of the legislation from the Bill that may impact your practice, patients, and families. Projected for New Jersey, up to 350,000 individuals are at risk of losing coverage due to work requirements and more frequent eligibility checks. An estimated 15,000 to 25,000 individuals may lose coverage due to more restrictive immigration eligibility criteria.

- Beginning 2027, states will be required to redetermine Medicaid enrollment every 6 months for individuals who are enrolled in Medicaid as part of the Medicaid expansion population under the Patient Protection and Affordable Care Act. In addition, individuals who are eligible for Medicaid as part of the Medicaid expansion population will be required to engage in community service, work, or other activities to qualify for Medicaid. One of these will be required, on a monthly basis:

- (1) work at least 80 hours,
- (2) complete at least 80 hours of community service,
- (3) participate in a work program for at least 80 hours,
- (4) be enrolled at least half-time in an educational program,
or
- (5) engage in any combination thereof for a total of at least 80 hours.

Individuals may also qualify if they have a monthly income that is at least as much as the equivalent of minimum wage multiplied by 80 hours.

- Beginning 2029, states will be required to institute cost-sharing requirements for individuals who are eligible for Medicaid as part of the Medicaid expansion population and whose family income exceeds the federal poverty line. Cost sharing may not exceed \$35 for an item or service; total cost sharing for all individuals in a family may not exceed 5% of the family's income. The requirements do not apply to

- (1) services for which cost sharing is already prohibited (e.g., emergency services);

- (2) primary care, mental health, or substance use disorder services; or

- (3) services provided by federally qualified health centers, certified community behavioral health clinics, or rural health clinics.

States may allow providers to condition the provision of services upon the payment of any required cost sharing. States will be required to regularly check federal and state databases to identify and disenroll terminated providers and deceased beneficiaries.

- Section 71115 sets limits on provider taxes. For states that have expanded Medicaid, a provider tax may not exceed the current rate or a specified rate, whichever is lower; the maximum rate gradually decreases from 2028-2032, with a maximum rate of 3.5% beginning in 2032. The section additionally precludes states from imposing a new provider tax if there is not already one in effect.
- Section 71401 provides \$10 billion per fiscal year for 2026 to 2030 for a program that supports the provision of health care in rural areas. Under the program, states may apply for financial allotments to improve the access and quality of care of services in rural areas, such as through enhanced technology, strategic partnerships, and workforce training. States must submit detailed rural health transformation plans and certify that no funds will be used to finance the non-federal share of Medicaid or the Children's Health Insurance Program (CHIP). Centers for Medicare and Medicaid Services (CMS) must approve or deny applications by December 31, 2025; states that receive approval do not need to reapply each year. States are not required to contribute any matching funds with respect to program allotments.
- Beginning 2027, the Bill eliminates the 90-day period during which individuals without verified immigration or citizenship status could receive Medicaid coverage and eliminates premium tax credit eligibility for certain lawful immigrants.

As you can see, there are many pieces of the Bill that raise uncertainty and questions about how the state will adhere to the changes required. Despite the changes in funding, there is a need for large investments in new eligibility systems and resources to support the new requirements. Other impacts include reduced utilization of services, reduced access to care, increased member and provider burden, and increased eligibility workload. NJAAP will continue to advocate for the health and well-being of children and adolescents and support our membership in the process.

Please email Aditi Doshi at adoshi@njaap.org to join the NJAAP Practice Management committee to advocate for pediatric practices across the state during these times.

Every voice matters!

NEW JERSEY'S DEPARTMENT OF HUMAN SERVICES SEEKS APPROVAL FOR INCREASED RATES FOR ADULT AND PEDIATRIC PRIMARY CARE

Guillermo J. Beades, Esq.
Partner, Frier Levitt LLC
General Counsel to NJAAP

On June 30, 2025, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) published a notice that it intends to seek approval from the United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) for an amendment of the New Jersey Medicaid State Plan, in order to implement budget provisions subject to the passage of the New Jersey Fiscal Year (FY) 2026 Appropriations Act.

Impact on Pediatrics

Specifically, DHS announced that it is seeking CMS approval to set primary care rates for adult and pediatric primary care. DHS projects about \$11.2M total in new spending in state FY 2026 (roughly \$3.75M state funds), with a similar amount in state FY 2027. Final fee schedules will be posted on the New Jersey Medicaid Management Information System (NJMMIS) once approved. For practices, that means better reimbursement for core pediatric work, particularly evaluation and management (E/M) and vaccine administration, if (and when) CMS signs off. Those were the same codes used in the 2013 - 2014 federal parity bump and remain the reference set when states implement primary care floor policies. While New Jersey has not published the specific dollar amounts yet, the state's notice points to the NJMMIS website for the updated schedule as soon as it is available.

For pediatricians, higher E/M and vaccine administration fees support longer visits for developmental/behavioral concerns, vaccination-heavy well checks, and care coordination, areas where margins are thin.

Unintended Consequences

While increased rates for frequently used codes are welcomed by providers with large Medicaid patient populations, rate increases often invite greater scrutiny. New Jersey's Medicaid

Managed Care Organizations (MCOs) are contractually required under federal rules to maintain robust fraud, waste, and abuse oversight, including data mining, outlier detection, and focused reviews on specific codes and modifiers. Frequently, when rates and usage increases for any code, MCO Special Investigation Units (SIU) increase oversight through auditing. Providers should expect more pre- and post-payment reviews from MCO SIU, and faster referrals to the state Medicaid Fraud Division (MFD) when coding patterns increase.

Proactive Approach

Understanding your practice's potential exposure is vital to insulate it from overpayment demands, and in the case of MFD audits, a payment suspension that can brutalize a practice's finances. One of the most frequent misconceptions is that the MFD and MCOs only target fraudulent conduct. However, a practice's overuse of high E/M codes (e.g., 99214/5) and certain modifiers (e.g. 25 and 59) will typically issue an audit where insufficient documentation is the single biggest driver of recoupments and payment suspension, not fraud.

In 2024, CMS reported that over 60% of Children's Health Insurance Program (CHIP) improper payments were due to missing or incomplete documentation. That means chart quality, more than intent, often determines whether dollars are at risk in a review. To protect your practice against unfavorable audit findings, you must build a compliance plan that addresses the most frequently used codes and modifiers at the practice, since analytics are bound to identify those services for auditing purposes.

Conclusion

New Jersey is positioning Medicaid primary-care payments, including pediatrics, for a well-deserved meaningful bump. As previously emphasized, this increase in rates will lead to increased scrutiny from MCOs and the MFD. Providers should use this moment to tighten billing and documentation procedures and ensure only credentialed providers are being used to treat Medicaid patients. As you watch NJMMIS's final rate tables, remember to prepare for audits that could be on the horizon.

Tracie DeSarno

On July 4, 2025, President Trump signed HR1, legislation the President dubbed the “One Big Beautiful Bill Act.” HR1 will have a devastating impact on NJ FamilyCare, hospitals throughout the state, and other Medicaid-funded programs. These cuts may also impact school-based, health-related services and possibly behavioral health services provided through our state’s Children’s System of Care.

According to the NJ Department of Human Services, the cumulative effect of these changes to Medicaid will be:

- An estimated 350,000 eligible residents will lose healthcare coverage because of bureaucratic barriers
- \$3.3 billion annual cut in funding to hospitals and public health funding
- \$360 million annual cut to the state budget due to reductions in federal funding and provider assessments

For NJ FamilyCare members the law will:

- Restrict the definition of qualified immigrants (as of Oct. 2026 in the adult population, only lawful residents, Cuban/Haitian entrants, and Compact of Free Association migrants from certain Pacific Island nations will qualify for Medicaid, causing approximately 15,000 to 25,000 individuals in New Jersey will lose Medicaid coverage)
- Impose work requirements for able-bodied adults (as soon as Jan. 2027, and no later than Jan. 2029)
- Require six-month eligibility redetermination for expansion adults (Jan. 2027)
- Limits retroactive coverage to one month prior to application for expansion population and two months prior for traditional enrollees (Jan. 2027)
- Require expansion adults to pay money out of pocket towards the cost of treatment (Oct. 2028)

For Medicaid providers and administrators:

- Prohibit new or increased provider taxes (immediate)
- Cap new state directed payments at 100% of the Medicare rate, any plan enacted prior to May 2025 will be reduced 10% annually until they meet the cap (immediate)
- Limit federal matching funds for emergency Medicaid (Oct. 2026)
- Create stricter budget neutrality standard for 1115 waivers (Jan. 2027)
- Phase down enhanced funding for hospitals and other

providers by lowering the safe harbor limit for provider taxes by 0.5% annually until it reaches 3.5% in 2031 (beginning Oct. 2027)

- Reduce federal match to states for improper payment error rates (Oct. 2029)
- Does not include delay of Disproportionate Share Hospital (DSH) reductions (going into effect Oct. 2025)

HR1 also established a Rural Health Transformation Program (RHTP), a new program added late in legislative negotiations under the guise of helping to offset the impact of Medicaid cuts to rural hospitals and other providers. The RHTP creates a \$50 billion fund for which \$25 billion will be divided equally among states with approved applications and \$25 billion will be awarded at the discretion of the Center for Medicare and Medicaid Services. It is impossible to determine at this point how much, if any, funds New Jersey may receive.

The impact to the 800,000 New Jersey residents who receive Supplemental Nutrition Assistance Program (SNAP) food assistance, more than 60% of whom are children or seniors, is:

- Requiring state budget to raise \$100-\$300 million due to a new cost-sharing requirement for states, or risk eliminating the entire SNAP program for New Jersey
- Requiring county governments to find or tax an additional \$78 million annually due to decreasing federal reimbursement.

Following the enactment of the “One Big Beautiful Bill Act” (OBBBA, P.L. 119-21), Governor Phil Murphy signed Executive Order No. 393, directing State agencies to immediately evaluate the impacts of the spending law on their budgets, operations, and programs.

Under the executive order, all State agencies are directed to immediately review the OBBBA and its impacts on their budgets, operations, and programs, including services provided to New Jersey residents.

By October 1, 2025, State agencies are required to submit to the Governor’s Office a preliminary assessment of these impacts along with any related legislative measures they recommend the Governor support during the current annual session of the Legislature to protect the State’s finances and its residents’ interests.

By November 15, 2025, all State agencies are required to provide the Governor’s Office with a preliminary list of any non-legislative measures that they recommend considering addressing

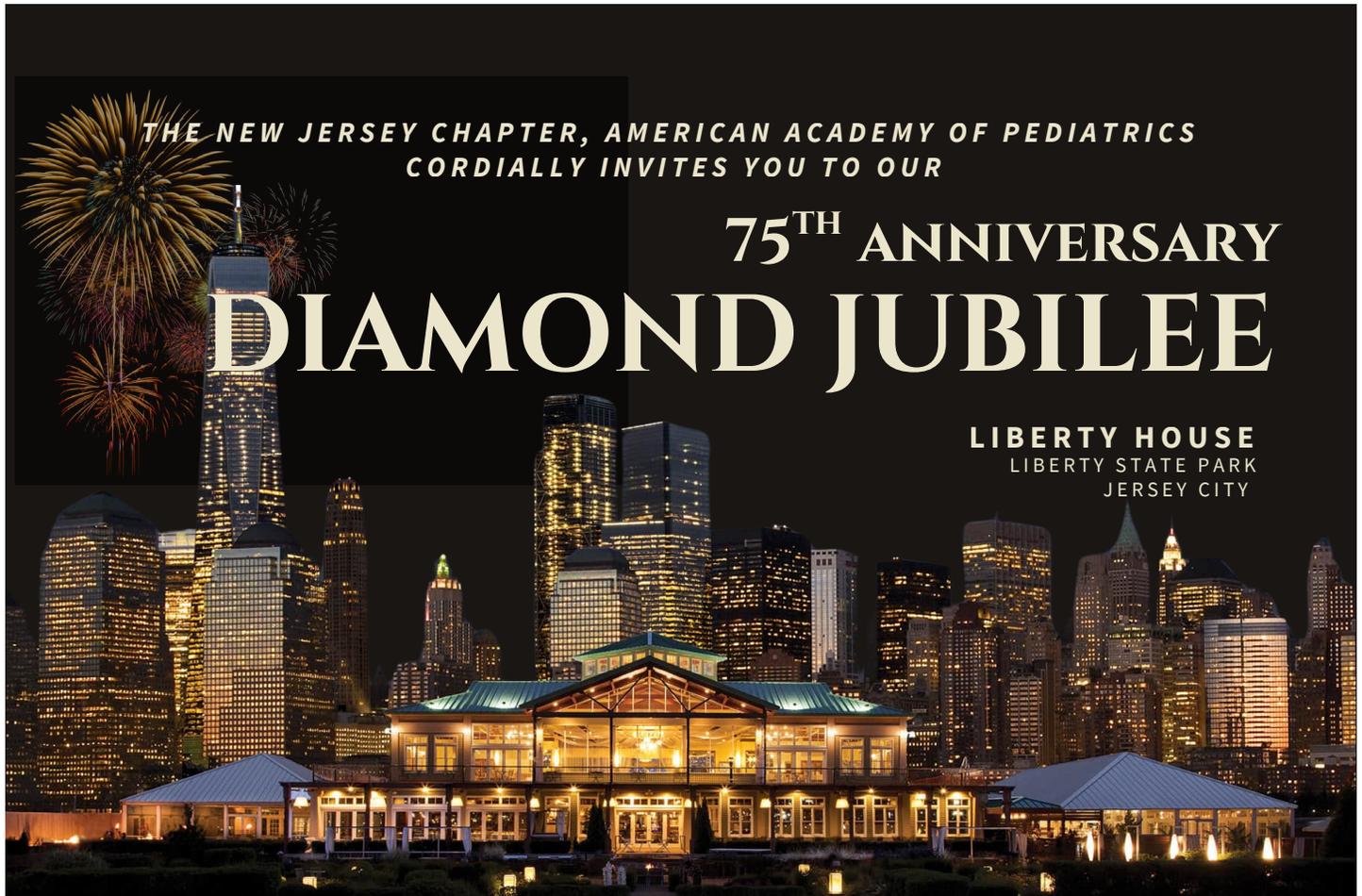
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the adverse impacts of the OBBBA on their budgets, operations, and programs, and on New Jersey's residents.

The Governor's Office will review the preliminary assessments and recommendations submitted pursuant to this Order and will coordinate responsive activities among State agencies. The Governor may also consider any additional legislation, gubernatorial measures, and cabinet-level actions to address the impacts of the OBBBA.

As the Medicaid changes become effective over a five-year period, with some going into effect immediately and others not going into effect until 2029, much of the responsibility of determining the State response will fall to the next Administration in Trenton. In November, New Jerseyans will elect either the Democratic candidate for Governor, Congresswoman Mike Sherrill or the Republican candidate for Governor, former Assemblyman Jack Ciattarelli. The entire New Jersey Assembly is also on the ballot this November but the Senate, in the mid-point of a 4-year term, is not.



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Iqra Fatima Baig, MD, MS

Affiliation:

PGY-1 Pediatric Resident Physician

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A nurse caught me off guard one morning, “Why are you struggling? I thought NICU is harder than nursery.”

I froze. Instead of responding with confidence, I gave excuses: about my fatigue, my learning curve, my reasons for taking a little bit longer with notes, double, triple checking my work. Later, I replayed that moment over and over in my head, frustrated that I hadn't stood up for myself. I wished I had countered with my truth:

“Well, actually, I am learning and thriving. I listen when nurses raise concerns, even for babies not technically under my service, because if a murmur is heard, it may need to be promptly investigated. I want nurses to feel valued, so I take the time to examine and offer reassurance or act proactively when needed. I took the time to personally review results with parents whose babies may need to be observed in the NICU for a short while due to mild difficulties transitioning to extrauterine life, because what may seem routine to us is never routine for families. I am still finding the balance between efficiency, comprehensiveness, and presence, but I refuse to let myself become numb to the needs of others.”

Residency is full of these moments. We are taught to advocate fiercely for patients, but rarely are we reminded to advocate for ourselves. Advocacy in this sense isn't about defensiveness: it's

about owning the value we bring, even in our imperfection.

It also means giving ourselves grace when we are tired. After one particularly long shift, I put my head down to rest before driving home, worried I was too exhausted to be safe on the road. I heard that someone who had witnessed me resting misinterpreted this as being “ready to quit residency.” What I viewed as responsibility (recognizing my limits) was misinterpreted as weakness. If you ever see a resident pause and close their eyes, please don't assume defeat. Sometimes it's a small act of responsibility, and a way to preserve the energy needed to keep showing up for our patients. Sometimes that pause is an act of care: for themselves, for their patients, and for the safety of everyone they will meet on their way home.

Learning to speak up for myself has been just as important as learning to be more efficient with notes or manage patients with a complicated hospital course. It means reframing self-doubt into self-recognition: *I am learning, I am growing, and I am showing up for my patients, families, and colleagues.*

Residency isn't about appearing effortless. It's about effort with integrity: being present for others while remembering to be present for ourselves.

As residents, we are growing into advocates for our patients and their families. But we are also learning to advocate for ourselves; to stand in the gap when perception doesn't match reality, and to remind ourselves that presence, attentiveness, and humanity are strengths, not liabilities. Both forms of advocacy are essential to becoming the physicians our patients, and our colleagues, deserve.



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WHY SOME CHILDREN WITH SPECIAL HEALTH CARE NEEDS ARE FORGOING CARE DUE TO DISABILITY DISCRIMINATION: WHAT CAN BE DONE?

Lauren Agoratus, M.A.

Recently, the American Academy of Pediatrics published “Disability-Based Discrimination and Forgone Health Care in Children with Special Health Care Needs” [1] and associated commentary on how this issue can be addressed [2].

The Scope of the Issue

The study looked at emergency room visits, hospitalizations, and forgone care. There are 14 million children with special health care needs (CSHCN) in the United States. 1 in 10 CSHCN have experienced disability discrimination (1.54 million children) [1]. This doubles the chance of forgone care, which has the potential to increase emergency room visits and hospitalization.

How Disability, Discrimination, and Forgone Care were Determined in the Study

Disability was described as a positive response to the question: “Does this child have health conditions that consistently and often greatly affect their daily activities during the past 12 months?” Disability discrimination used the definition from the

National Survey of Children’s Health which considered “being treated or judged unfairly because of the child’s health condition or disability.” Forgone care was defined as any time in the last 12 months that the child needed, but did not receive, healthcare.

Factors Affecting Disability Discrimination in Pediatric Healthcare

Older children were more likely to experience discrimination. It was also noted that children with public insurance were more likely to experience discrimination. Ableism in healthcare can occur in many ways. Disability discrimination may occur as lack of accessibility, insufficient insurance (including home nursing), provider bias, families avoiding care due to past negative experiences, or the impact of social determinants of health. Dr. Iezzoni’s work addresses disability and implicit bias which may be helpful for providers to self-assess [3]. Although research focuses on disability discrimination for adults, this adds to other work and shows the need for future studies on disability discrimination in the pediatric population.

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Provider Resources

The Child and Adolescent Health Measurement Initiative developed the Care Path for Kids. This child-centered approach helps providers work with families to “engage, plan, and improve care planning and outcomes in partnership with their child’s care team” [4]. First, providers can engage families more in their child’s care. Next, the provider and family can create the Family Foundation of Care documents. Finally, providers and families will partner to improve care and outcomes. Available tools include the Family Foundation of Care planner, the actual care plan, and the shared planning meeting.

Family Resources

Families of children with special health care needs may be aware of disability discrimination due to past experiences. This can be something as simple as providers only asking the family, not the child (even a youth/older child), how the child is feeling. Parents who experience disability discrimination due to their child’s condition can contact their Family-to-Family Health Information Center/Family Voices (F2FHICs/FV) in their state [5]. There are safeguards for children with special needs, including civil rights or other complaints they can file if needed. F2FHICs/FV can also help families develop effective communication with health care providers which benefits everyone, including children with special healthcare needs, and lessens the likelihood of disability discrimination.

More than 11% of families of children with special health care needs reported disability-based discrimination [6]. Providers may need to establish or rebuild trust with families through partnering and the use of care plan tools. Pediatric disability discrimination must be addressed. This will increase healthcare access, lower emergency room and hospital visits, and improve outcomes for children with special health care needs.

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- [2] Commentary <https://publications.aap.org/pediatrics/article/156/1/e2025071145/202043/Disability-Discrimination-Among-Children-With>

[3] Dr. Iezzoni’s work on implicit bias:

- *Physicians’ Perceptions of People with Disability and Their Health Care* <https://pubmed.ncbi.nlm.nih.gov/33523739/>
- *‘I Am Not the Doctor for You’: Physicians’ Attitudes About Caring for People with Disabilities* <https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00475>
- *What Some Physicians Say About Caring for Patients with Disability: Responses to Open-Ended Question to Nationwide Physician Survey* <https://aahd.us/wp-content/uploads/2024/04/PhysicianSurvey-PWD-DHJO-April24-2024.pdf>

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[5] Family-to-Family Health Information Centers/Family Voices <https://familyvoices.org/>



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Lauren Agoratus, M.A. Counseling is the State Coordinator of Family Voices NJ housed at the SPAN Parent Advocacy Network at <https://spanadvocacy.org/programs/f2f/>. She is the parent of a medically fragile young adult.

Charles T. Williams

As students return to school in the fall, parents will resume the daily routine of packing lunches. This presents an opportunity not only to support children's nutrition but also to promote sustainability and reduce environmental impact.

A typical school lunch can generate multiple pieces of single-use plastic, ranging from zipper bags, disposable utensils, wrappers, juice boxes, and individually packaged items. Over the course of a school year, a single student's disposable lunches could produce 67 pounds of waste [1]. Most of this material is non-recyclable and ends up in landfills, where it contributes to long-term environmental harm. An Australian study found that single-use plastic accounted for more than half of all packaging in lunchboxes of preschool and primary school students [2].

Small changes in lunch-packing habits can significantly reduce waste. Encouraging families to use reusable containers for sandwiches and snacks is a simple and effective first step. Stainless steel lunchboxes, durable plastic containers, and brown paper bags, which can be recycled, are widely available and easy to clean. Replacing single-use cutlery with metal or compostable utensils and swapping juice boxes for refillable bottles further reduces daily waste. For individually wrapped items, beeswax wraps or cloth provide reusable alternatives to foil and plastic wrap.

Beyond the packaging, the food itself also has an environmental impact. Whole foods that are sustainably farmed, such as fruits, vegetables, and homemade items, require less processing and packaging than store-bought pre-wrapped snacks. These foods also offer children the nutritional boost they need to maintain their energy throughout the school day. Buying in bulk

and portioning servings into reusable containers further reduces packaging waste and helps control portion sizes.

Parents can reinforce these habits by modeling them in their own routines. For example, bringing a refillable cup to a coffee shop instead of using a disposable one reduces waste while also promoting more sustainable habits. These choices not only lower environmental impact but can also be more cost-effective than purchasing meals or beverages from restaurants or convenience outlets.

As back-to-school routines settle in, the lunchbox becomes much more than just a container for food. It serves as a daily opportunity to teach environmental responsibility, reduce single-use plastic, and build lifelong habits that support both a child's long-term health and environmental sustainability.

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