

LARD MEETING MINUTES

September 15, 2005

Attendance:

Stacey Lavoie	OHSU Dietetic Intern
Elisa Martiram	Salud
Sue Plaster	Salud
Tiare Sanna	Washington
Heidi Suess	Multnomah
Char McKay	Multnomah/State
Janet Harris	Deschutes
Laura Spaulding	Deschutes
Elizabeth Binkley	Douglas
Judy Harvey	Jackson
Angie Treadwell	Umatilla/Morrow
Susan Gerig	Baker
Diane Cook	Warm Springs
Yvonne Iverson	Warm Springs
Jackie Lucas	Lane
Ai-Lan Whitson	Marion
Sandra Farley	Marion
Vivian Tillman	Wallowa
Mary Davis	State
Susan Greathouse	State
Karen Bettin	State
Michelle Bressler	State
Vernita Reyna	State

2006 Meeting Dates

LARD met three times during 2005 in January, May and September. Group confirmed that three meetings would also be acceptable for 2006 and agreed on the following dates:

- **Thursday, February 16, 1:00 to 4:00.** Group requested that FLPP sharing be the main agenda item following statewide FLPP implementation early in February. Sue Plaster invited LARD to meet at Salud Medical Center in Woodburn. Salud is a FLPP pilot and will have 4 months of FLPP experience prior February.

- **Thursday, June 15, 1:00 to 4:00.** Portland State Office Building.
- **October, at the statewide meeting,** date to be announced, breakfast meeting with a guest speaker from the conference.

Methamphetamine's Impact on Children

Guest Speaker: Karen Phifer, LCSW, CARES Northwest

Child Abuse Response and Evaluation Services, 503-331-2400

The acronym DEC is shorthand for drug endangered children. DEC could refer to any drug but currently; the most popular drug of choice in Oregon (excluding alcohol) is methamphetamine.

Methamphetamine is a derivative of ephedrine and is a very potent stimulant that interferes with the normal pleasure/reward activities of dopamine in the brain. It intensifies the feelings of pleasure and is highly addictive.

Drug use and abuse has been around for a long time. It is a know entity that was considered a lifestyle choice. Parental drug use without child neglect was not a reason for children services to become involved with a family. That is not the case with meth. It is a new environment with meth.

Meth can be made in the home from readily available ingredients and its production in home labs increased dramatically during the past few years. Meth recipes are available off of the Internet. The chemicals used in meth production pose a huge safety risk to children. Cooking or smoking meth in the home results in meth contamination on all surfaces, porous and nonporous. Children have ready access to dangerous ingredients and the drug residue on everything they touch or put in their mouth. In addition, fumes from cooking meth are heavier than air and congregate about two feet from the floor where young children spend time.

There is limited research on the consequences of meth exposure in utero or in childhood. Research on prenatal exposure to meth indicates that there is potential for visual, spatial and learning problems. The results are largely inconclusive since meth users rarely use only meth during the pregnancy. Most addicts are polysubstance abusers and there are many unknowns in regards to the long-term effect on children after exposure to multiple

substances during pregnancy. It is difficult to determine whether a characteristic such as short attention span is the result of genetics or drug influence. However, it appears that children's symptoms of meth exposure mirror those of adult users.

Meth highs can last for 6 to 12 hours. The downside of the high is incredibly difficult and users will do almost anything to maintain the feelings of pleasure and avoid the awful feelings that follow the high. Meth users often stay awake for days before they crash. The crash can last for 2 to 10 days when they are unable to be roused. During this state, children are left completely unsupervised.

Meth using adults often have baseline depression and severe agitation. They often develop psychosis, hallucinations and paranoid behaviors. These behaviors can be devastating to children. Mental health issues can result in domestic violence situations where children are hurt. Scary individuals become a routine part of a child's surroundings. Life can be fearful and loud.

In addition, libido is heightened and meth users are constantly seeking ways to satisfy their sexual urges. Children can be exposed to pornography and adult sexual behavior as well as become targets themselves.

Meth ingestion stimulates the sympathetic nervous system resulting in smooth muscle relaxation including those of the GI track. Saliva production also decreases making swallowing and eating more difficult. These factors contribute to a loss of appetite accompanied by extremely erratic eating patterns, if food is eaten at all. Severe dental caries and malnutrition can be a consequence of long-term meth use. When the adults in the household are using, there will not be food in the house. Then, binge eating will occur when they are coming down off the high. Children will begin mirroring these abnormal eating cycles.

Chaos permeates the child's environment. Children in these situations are at high risk for abuse and neglect. Odd eating patterns, long periods of unsupervised time and exposure to criminal behaviors are characteristic of their high risk situation.

DEC protocols are being developed to ensuring that DEC children get the services they need. These protocols will involve multidisciplinary teams that include children's services and drug enforcement. These protocols will

provide a standard of care for what should happen when a child is removed from a drug home. CARES Northwest is coordinating these services in the Metro area. Similar programs are on place throughout Oregon.

When a DEC child is removed from a drug home, they need to receive a child abuse evaluation in order to determine the extent of their exposures. A history is gathered and a thorough physical examination is conducted. Dental issues and delayed growth patterns are often seen. Urinalysis and lab work is done within 12 hours to attempt to quantify the level of meth exposure. There is no acceptable level for meth in a child's system.

Children coming into care often show signs of FTT, eating aversions, GI disturbances, developmental delays and sleep disturbances. They demonstrate difficulties concentrating in school. Intervention includes treatment of physical issues while developing age appropriate, positive interactions and routine schedules in a safe, comfortable and consistent environment. There is no pharmacological treatment for meth use or exposure.

In the WIC clinic, we can identify child abuse and drug treatment organizations in our community and make appropriate referrals as needed. DEC children enrolling in WIC services through foster care may need referral to the RD for assistance with feeding concerns.

Long-term outcomes for DEC are unknown at this time. There is a more work to be done.

Formula Update

Gentlease is a new formula manufactured by Mead Johnson. It is part of our bid contract and qualifies for rebates. No HP authorization or prescriptions are needed for issuance. Gentlease can be provided to participants upon request. Gentlease formulation is ¼ less lactose than Enfamil Lipil and is marketed as a substitute for Good Start. Samples can be ordered as part of the sample order. Gentlease is currently only available in 12-ounce powder and may need to be special ordered if not available on store shelves.

Susan Greathouse will be organizing a LARD workgroup on formula issues. The group will initially collaborate on the development of guidance for the use for special formulas and creation of a medical prescription form. If you are interested in participating with this workgroup, please contact Susan. Participation can be by conference call.

Multnomah County has developed a list of providers who write prescriptions for WIC. Elizabeth Berol-Rinder has developed a form that is faxed for the PMD to complete or the document can be given to a participant to take to the provider for renewals. A sample copy will be provided to Susan for the workgroup to review. Please send Susan any other forms that have been successfully used in this manner.

Heidi Suess requests that a list of standard formula packages be created including the maximum amounts allowed for infants and special children. A “cheat sheet” would be useful to show the number of ounces that are contained in a specific number of formula containers. This idea will be addressed by the formula workgroup.

The PDA pediatric practice group plans to revise the guidelines for feeding preterm infants. Please contact Susan if you would like to participate with this project.

Continuing Education

Susan Greathouse has 10 copies of an 85-minute DVD, “Feeding Children with Special Needs” from Harriet Cloud. It includes video clips and could be used as CE credits for ADA portfolios. The copies will be distributed through the state office. Please contact Susan if you are interested in reviewing this presentation.

Food Package Changes

As a result of this years State Technical Assistance Review (STAR) from the USDA Western Region Office, Oregon will be changing the method for automatic assignment of child food packages. Instead of TWIST assignment

of a child food package during the month when a child turns 12 months old, the automatic food package change will now need to happen during the month when a child turns 13 months old. WIC staff will have the option of manually changing the food package after the child's birthday. This change will occur with FLPP rollout.

Required Documentation

After our migration from paper charts to electronic records, it became evident that the appropriate location for required documentation in TWIST was not always clear. The "Required Documentation in TWIST" document was created to address this concern. This document was distributed electronically with the September LARD agenda and will be included in the new Risk Assignment training manual that is being developed by the state.

Karen Bettin facilitating a discussion that focused on the attributes of quality high risk care plans. High risk care plans need to be documented in the Progress Notes section of TWIST. This is the area where RDs are required to record the care plan for each high risk participant that they counsel. Placing the care plan in a consistent location assists with continuity of care when clients are seen by different staff in the same agency or transfer from clinic to clinic.

Best practices for writing high risk care plans include use of a SOAP format that incorporates a plan for what will happen during future contacts. In order for RD time to be used most effectively, it would be helpful if certifiers place notes in Progress Notes stating the reason for referral to the RD and any issues that are of particular concern. In addition, Progress Notes are also a useful location for documenting interactions that occur during IE appointments including information regarding items/issues to cover at the next visit.

Karen printed out examples of good care plans from TWIST that were shared with the group. Examples included:

Plan Disc form recs of 30 oz/d until closer to 9 mos & taking 3 meals/d. Work on cup. See goal set today under nut ed plan. Allow more self feeding w/ crax & soft pieces of food. Change FI pkg to cont w/ form

thru Jan (birth mon) d/t prematurity. Scheduled F2 in Nov to disc advancement of finger foods, check on cup use & check hgb (will be 9 mo)

Plan Disc with MOC ways to help JP eat appropriate amts (offer small portions) then give seconds, have JP drink water in b/w servings, offer hi fiber/hi bulk foods if JP still hungry. Disc wt gain. Praised efforts MOC made so far to normalize feeding behavior. FU 12/05 to monitor growth, development, and feeding behavior.

Plan 1) Cont to choose foods from all food groups 2) Enc mixing jc w/water in a 1:1 ratio and no more than 6-8 oz daily 3) Future RD visits only necessary if nutritional problems result from medical condition.

To print out a progress note, follow these steps in TWIST: Client Processes to Outputs to Reports to Nutrition Education to Miscellaneous to Progress Notes Summary

LARD members expressed concern that if a client is in the display mode, the progress notes section is unavailable. Request ability to add progress notes at any time. Request will be forwarded to the state office for consideration after FLPP implementation.

Group also requests that more options be added to goal status. Consider removing “not ready” (hopefully participant is selecting goal that they are ready to work toward) and set default goal status to “in progress”. Goal status should be updated at cert to “not achieved” or “achieved”. Update at follow-up visits if “achieved”. Realistic goals should be achievable in 6 months time frame.

2005 Risk Revision

Information regarding the nutrition risk revisions for 2005 was distributed electronically at the end of August and with the September LARD agenda. Time did not allow for discussion to occur at the meeting today. Please contact Vernita Reyna if you have questions.