equipment, and/or therapy services to learn best are not well served by exclusively remote education. Second, individual education plans are important tools for equity. To assure that children with disabilities receive quality education and are appropriately accommodated, individual education plans should proactively account for limitations on class sizes, minimization of group activities, and truncation of the school day. Education in the least restrictive environment, the legal standard, is the goal while assuring safety and mitigating risk. Third, retention of therapy and paraprofessional support in schools has to be prioritized as budget cuts tighten operating margins for school districts. A large-scale exodus of these professionals from the education sector would be catastrophic for children with disabilities.

In addition to those operational realities, 2 truisms should drive planning to reopen schools. First, keeping children with disabilities safe in schools will necessitate effort. Schools should plan for those who require specialized transportation, those who cannot wear a mask, and those who need cleaning of specialized equipment. Next, there should be creative approaches to replace the socialization and integration that children with disabilities receive in mainstream group academic activities such as art, physical education, and field trips, which are slated to be minimized as schools reopen. Children with disabilities are more isolated than their peers, and reopening plans must not exacerbate that reality.

Even before the pandemic, budget cuts made it difficult for schools to implement adaptations critical to optimize learning for children with disabilities. However, these children are not disposable and future legislative and operational efforts should focus on child health and well-being for all children.

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Ways to Support Low-Income, At-Risk Young Children During and After Coronavirus Disease 2019

To the Editor In an issue of JAMA Pediatrics, Dooley et al1 bring up the important issue of supporting low-income children during coronavirus disease 2019 (COVID-19) and suggest that US Congress should increase investments in evidence-based programs (eg, home visiting and Head Start) and digital learning. Expanding evidence-based programs in the early intervention (EI) and preschool school systems may be more challenging than we thought, even before COVID-19. For instance, approximately 170 000 low-socioeconomic status (SES) children aged 3 or 4 years who were eligible for state-run preschools in California were not enrolled in state-run preschools. Governor Newsom wanted to expand 10 000 preschool spots2 after he took office but unfortunately did not, in part because of limited school facility capacities and teacher shortage. As a result, a large fraction of $100 million of education funds remain unused.

The EI and preschool systems for low-SES and at-risk children will face 2 challenges in the upcoming years owing to the likely repercussions of COVID-19: (1) a high rate of parent unemployment rate that contributes to family instability and (2) the need to support young children at home without the presence of a specialist/teacher owing to social distancing. To turn this pandemic crisis into an opportunity, we need to think beyond expanding existing evidence-based programs but instead ideating new ways to deliver such programs in a family-centered manner with the consideration of the larger economic environment.

One intriguing, related question is whether we can systematically teletrain and pay low-SES parents to deliver part-time preschool education or EI at home. Training and paying low-SES parents to deliver EI/part-time preschool education at home solves 2 major problems. First, it offers employment to many jobless parents. Approximately 26 million people have already lost their jobs during the pandemic crisis; many of these low-income parents are now jobless. Directly paying parents who want to and are capable of delivering EI/preschool education at home may provide a more stable environment for both the children and parents.

Second, many research studies have already shown that, with support, parents can successfully learn and implement EI strategies at home.3,4 Training parents to deliver EI and preschool curriculums for at-risk children at home could decrease the demand for space and support personnel and enable continual support for at-risk children in face of social distancing.
This is just a thought designed to prompt more creative ideas. As suggested by Dooley et al, we will need more creative solutions to meet the mounting needs of young children and their families during and after this pandemic crisis.

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In Reply In our article published in May 2020, we highlighted the need for innovative ways of delivering education, health, and social services owing to the disruptions caused by the coronavirus disease 2019 COVID-19 pandemic. As the pandemic progresses, many school districts have implemented virtual learning during the fall semester. We appreciate Wong’s identification of a novel way to deliver preschool and early intervention services to children and directly engage parents through employment. Training parents to deliver services could help overcome the challenges that young children face with the virtual learning environment, including attention span, curricular content, and the need for parent supervision even if content is available online. One factor to consider with respect to this approach would be that students would miss the in-person interaction and socialization with their peers that occurs in a classroom setting that can also be beneficial for development.

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Maternal Elimination Diet and Symptoms of Cow’s Milk Allergy in Breastfed Infants

To the Editor The Special Communication by Munblit et al, “Assessment of Evidence About Common Infant Symptoms and Cow’s Milk Allergy,” concluded that recommendations to manage common infant symptoms as cow’s milk allergy (CMA) are not evidence based, especially in breastfed infants who are not directly consuming cow’s milk. Analysis of the authors suggested that for more than 99% of the infants with proven CMA, breast milk from a cow’s milk–free diet and reappeared at least twice when cow’s milk–consuming mother contains insufficient β-lactoglobulin levels to trigger an allergic reaction. Although the authors admitted limitations in their analysis, it should be further noted that the analysis was based on indirect evidence; it compares thresholds of proteins needed to induce allergic reaction in older children than breast-fed infants with the concentration of a single cow’s milk component in breast milk. In fact, this is not evidence based, and one should look at more direct evidence.

As described in the article, a high rate of infants (44%) with CMA have been reported with symptoms while exclusively breastfed. Another study also reported CMA in exclusively breastfed infants and concluded that either very low β-lactoglobulin levels or other proteins could have caused the allergic symptoms in these infants. However, true evidence-based medicine is based on randomized clinical trials, but unfortunately there are only a few small and old studies regarding CMA and maternal elimination diet. Cant et al showed that eczema was improved in 6 of 37 children (16%) when their mothers avoided egg and cows’ milk and worsened again when these were reintroduced. Moreover, Jakobsson et al demonstrated that in 23 of 66 infants (35%), colic disappeared when mothers were put on a cow milk-free diet and reappeared at least twice when cow’s milk was reintroduced. In contrast, a smaller study conducted in 20 mothers did not show benefit regarding infantile colic, but it should be noted that in this study, soy milk was used as placebo, and infants with CMA may also react to soy. Altogether, these small studies suggest potential benefit in maternal elimination diet for a significant proportion of infants with CMA.

I agree with the authors that the evidence for advising maternal cow’s milk exclusion to manage symptoms in breastfed infants is weak but disagree that the clinical trial evidence would not support benefit for some infants with CMA. The issue can only be solved by contemporary, large, randomized double-blind clinical trials.