THE Georgia Pediatrician

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Evelyn Johnson, MD, FAAP, President
www.GAaap.org

Georgia Chapter
American Academy of Pediatrics

From the President

Happy Spring to All!!
Well it is supposed to be Spring. The AAP annual Legislative Conference is in the Spring in Washington, DC. But it was literally freezing with the wind chill there. So "walking up to the Hill" was a bit of a challenge. I love the Georgia AAP and all the challenges and success that await us in this lovely state, but having the chance to represent our members and state at national events is really exciting. Without the opportunity to compare your situation to your colleagues in other states, you simply miss out on appreciating the great things that are happening here and the future opportunities available to us.

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First, it has been fantastic to pat ourselves on the back after such a successful state legislative session, but it was even sweeter to describe this experience to my colleagues across the US. We all worked exceptionally hard during the last session and continued that through this year with the oversight of our fearless leader Rick Ward, and Betsy Bates, our lobbyist. We found the niche —business model—that allowed us to grab the attention of our legislators and convince them how crucial keeping Georgia's kids well would be inevitably a monetary savings in the long run for the state. Keeping kids insured and adequately compensating physician practices allows kids to stay well and keeps them out of ED. It seemed like such a simple message, but the approach was so important. Thank you to each of you who contacted your legislators and let's keep the communication open with them throughout the year. An invitation to visit your office will give them an even clearer picture of what we do.
The AAP Annual Leadership Forum (ALF) in Elk Grove, Illinois in March was another powerful meeting of pediatricians—both general and subspecialists, and chapter executive directors. The chapters are so diverse in their structure, yet our goals are the same: to provide the best care, every time for every child. Some have staffs of 1, some of 4-5 and some have staffs of 20. This year we were nominated for an award in the Very Large Chapter category, and it ended up being a very, very tight race between our chapter and Texas. While we are sure we faced a major challenge with Medicaid parity in 2015, Texas faced a heart-wrenching challenge with the "internment" of unaccompanied minors, and moms/children in their state. We thought we had it rough taking on the state, but taking on the federal government—well, I have to tip my hat to that effort and so their outcome as winner in the Very Large Chapter category. ALF as you recall gives us (every pediatrician) the opportunity to address a policy that we feel needs updating (or initially addressed) on a national level. The amount of time that goes into reviewing all the submissions and staying within parliamentary standards is truly a herculean activity. We were well represented, from the number of resolutions submitted, to "scoring" of the resolutions, to our own Bob Wiskind serving as parliamentarian and keeping us civil.

Evelyn Johnson MD, FAAP
President

And on my second trip to the annual Legislative Conference in DC this year, I was again to experience the passion of our colleagues as we trek into the "not always friendly" political arena. This 2 ½ day training provides invaluable insight and direction into the world of Congress. Last year we were assigned the task

Inside this issue.....

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From the President...Continued

of lobbying for reauthorization of CHIP, and I cannot express in words how great it felt when as we were parting back to our homes, Congress was actually voting on that important program and it indeed passed. Most recently another topic we were challenged with at the 2015 training, was regulation of e-cigarette refill packaging, and hearing that too passed recently is truly special. This year the ask involves the Reauthorization of the Child Nutrition Act. As you may recall this funding covers WIC, as well as summer meal programs for kids, and free breakfast and lunches. The Senate has already passed out of the Agriculture Committee unanimously a bipartisan bill: The Improving Child Nutrition Integrity and Access of 2016. This was not the AAP's initial foray into this large budget item, as Dr. Sandy Hassnick had been involved closely in testifying to the committee. Our "ask" today for the Senators was to pass this bipartisan bill, and to the Congressmen, to build on and improve on the key points that the Senate had included in their bill. Fortunately, our Senators' and Congressmen staffers were well versed in the topics and our task was not one of convincing them of the positives, but offering personal experiences that illustrated the positive benefits of these programs for our kids, and pregnant moms. Hearing the experiences that some of the state delegations had was astonishing. I am happy to report that our pediatric colleagues from across the country stood their ground and I do believe there are staffers and hopefully members of Congress who tonight have a clearer understanding of how these programs keep our kids healthy from the start and keep them healthy and functioning well in school, and ultimately deliver them as healthy adults with less chronic disease that erodes our economic system

I hope those who are involved on our QI Projects are enjoying the experience, and your practice is seeing the benefits.

Back on the local front, we are into all the QI projects now. I hope those who are involved on our QI Projects are enjoying the experience, and your practice is seeing the benefits. We have a number of webinars coming up this spring and summer: Georgia Newborn Screening Updates, Public Health Update on the Reporting of Neonatal Abstinence Syndrome, Developmental and Autism Screening, Georgia's Minor's Rights to Reproductive and Behavioral Health Service and more!. You can check out dates/times on our website. And of course, Peds by the Sea is right around the corner on June 8-11. If you haven't already, make your reservations soon as hotels are filling up.
Oh, and don't forget to get outside and enjoy--whether it's relaxing or exercising. Your choice, just have fun!! Peace.

Evelyn Johnson, MD, FAAP
Chapter President
Brunswick

Public Health News & Chapter Updates

Pointers on HPV Vaccine for Pediatric Practices

There are safe and effective vaccines recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) to protect against certain strains of Human Papillomavirus (HPV) that cause cancers in males and females, as well as genital warts. Right now across the nation, almost half of our youth is protected through vaccination, but we can do better. Most parents who hear about the opportunity to prevent HPV infection and cancers want their children protected. Chances are that parents in your practice want this level of care, too.

...almost half of our youth is protected through vaccination, but we can do better.

Pediatric office staff have the opportunity to help prevent cancer. Here are some steps you may want to pass on to them:

Understand Why Its Important
Every year in the United States, 27,000 people still get cancer caused by HPV. That's one person every 20 minutes of every day, all year long.
- HPV causes cancers of the mouth or throat and anus in men and women, as well as cancer of the penis in men AND cancers of the cervix, vagina, and vulva in women.
- There are many more pre-cancers of the cervix requiring treatment that can have lasting effects on a woman's fertility.

HPV is so common that almost everyone will be infected at some point.
- We have no way of knowing who will go on to get cancers caused by HPV once they are infected.
- Most people infected with HPV will never know they are infected.
- Even if someone waits until marriage to have sex, or only has one partner in their entire life, they could still be exposed if their partner has been exposed.

The HPV vaccine is effective! It prevents infection with the most common and aggressive HPV types that cause cancers.

Make a Strong Recommendation
Bundle the adolescent vaccines and give a strong recommendation for boys and girls age 11-12. This is as simple as saying (while handing them the VIS);
- Today your child needs 3 vaccines; HPV, Tdap, HPV and Meningococcal. Do you have any questions for the doctor?

Or
- Today your child is due for 3 vaccines. They're designed to protect your child from the cancers caused by HPV and from meningitis, tetanus, diphtheria, & pertussis. Do you have any questions for the doctor?

Adolescents may not want to get three vaccines in one visit, but we know patients this age don't come to the office that often, so giving the 3 vaccines in one visit is the best way to make sure they are protected.
Giving three vaccines at one visit is safe and the protection we are offering adolescents is important and can save lives.

Finish the 3-Dose Series
Starting the series is an important step, but three shots are required for full protection. So before the patient leaves the office after HPV vaccination #1, make sure to set appointments for doses 2 & 3.
Make sure that systems are in place to remind patients of their vaccine appointments.
If a patient misses an appointment, a system to flag and recall patients is important.

(Original article published on the American Academy of Pediatrics webpage)

EPIC® Immunization Program is ready to schedule your 2016 Program!

The EPIC® Immunization program is off to a great start this year. The 2016 curriculums are updated with the 2016 immunization schedule, new immunization data and great tools and resources for your practice. EPIC Immunization offers six curriculums to meet your staff education needs: Childhood, Adult, Combo, Women's Health, School, and Coding for Childhood Immunizations (GA Chapter AAP Members Only).
EPIC® is a physician led; peer-to peer immunization education program designed to be presented in the private physician office and involves the participation of the complete medical team (provider, nurse, medical assistant, office manager, etc.). The program is free, offers CME and contact hours for participating physicians and nurses, and provides a valuable resource box filled with useful immunization tools for your office.
Start planning to have your in-office EPIC® Immunization Program. We are scheduling programs for 2016 NOW!
Visit the GA EPIC website (gaepic.org) or EPIC Facebook page (Educating Physicians in their Communities) to receive up-to-date information or resources. For more information or to request an EPIC program, contact the EPIC staff: Janna McWilson, MSN, RN, Program Director at 404-881-5081 or Shanrita McClain, Program Coordinator at 404- 881-5054.

The program is free, offers CME and contact hours for participating physicians and nurses, and provides a valuable resource box filled with useful immunization tools for your office.

Five Hospitals Now "Baby Friendly"

Georgia has five Baby Friendly Hospitals and many others are working toward that goal. One criterion to becoming Baby Friendly is to, "Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic". This is not always an easy task since hospital staff may not be aware of all the breastfeeding services in their community. Finding

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services such as WIC, support groups, breastfeeding classes, and private lactation assistance has just gotten easier with ZIPMilk. ZIPMilk now has over 300 listings of physicians, lactation consultants, support groups, etc. for families looking for breastfeeding assistance and information. If you would like to list yourself as a breastfeeding supportive physician just go to the website, www.ZIPMilk.org. Start referring your moms to this site today.

Schedule a EPIC Breastfeeding Program for your practice today!

The EPIC Breastfeeding Education Program is ready to visit your practice. If you haven't had a program recently please contact Arlene Toole, atoole@gaaap.org to request a program or go to our website www.gaepic.org to download an EPIC program request form. Remember our programs are free!

Plans are on underway to begin a pilot to screening all infants born in Georgia for Pompe and MPS1 early this summer.

Newborn Screening Update

The Georgia AAP has been tracking several Georgia Department of Public Health (DPH) issues related to newborn screening. The following is a summary of these issues. If you have any questions, please contact Fozia Khan Eskew at the Georgia AAP via email at feskew@gaaap.org or via phone at 404-881-5074.

Pompe & MPS1: Plans are on underway to begin a pilot to screening all infants born in Georgia for Pompe and MPS1 early this summer. Pompe and MPS I are both progressive, inherited lysosomal storage disorders. Although there is no cure for the conditions, monitoring and treatments are available. Pompe disease is a disorder of glycogen storage. Infants who are affected can have enlarged hearts and profound muscle weakness progressing to death if untreated. MPS I is a multisystem disorder with variable presentations including an early onset neurodegenerative form. MPS I symptoms may include developmental delay, coarse features, skeletal anomalies, recurrent infections, and organomegaly. Results will NOT appear on the newborn screen report as this is a pilot project. If the results are normal, notification will not be sent. If the results are abnormal, Emory Newborn Screening Follow-Up Program will fax a letter notifying you of the results, and we will call the provider listed on the NBS card.

SCID: Plans to screen for Severe Combined Immunodeficiency (SCID) should be implemented by mid to late April 2016. During the pilot phase of screening, results will not appear on the NBS report. The Emory Newborn Screening Follow-Up Program will fax a letter notifying you and call the provider listed on the NBS card regarding screening if screening results require further investigation. SCID is an inherited condition that prevents children from fighting off routine infections. Because their immune system is not functioning properly, children with SCID usually die by the age of two from infections without prompt treatment. Screening for SCID can also detect other conditions associated with low T cells. If diagnostic testing is requested, parents and health care providers are asked to take certain precautionary measures such as avoiding administration of live vaccines - **no rotavirus vaccine, avoid** daycare or contact with any source of infection, use only leuko-depleted, irradiated, CMV negative blood products if transfusions are needed.

Cystic Fibrosis Testing: A national backlog currently exists for the cystic fibrosis (CF) mutation analysis kit after a voluntary recall of all kits was made due to a manufacturing defect by the vendor. The Georgia Public Health Laboratory (GPHL) has not been able to perform the CF mutation analysis on specimens with elevated levels of the primary marker (immuno-reactive trypsinogen, IRT) since April 1st. The GPHL is working with DPH to conduct repeat screenings on infants screened with the affected kits and will announce when testing will resume. We will continue to keep you updated on this issue.

Georgia WIC News

The Georgia AAP continues its long partnership with the Georgia Women, Infants & Children Nutrition Program. This year our work involves providing medical expertise and consultation on WIC policies for children on special formulas, creation of an additional prescribing algorithm for children age (1 and older), and enhancing relationships with practices and hospitals by providing outreach visits. Thank you to our members for your continuous feedback on helping improve collaboration between pediatric practices and WIC. Your feedback is always appreciated and necessary for this partnership.

Need a WIC workshop in your practice?
Do you have questions about WIC? We are currently providing WIC workshops to practices and hospitals in the metro Atlanta area. If you are interested in receiving an update on WIC policies in your practice, please contact Kylia Crane, RD, LD to schedule a workshop at kcrane@gaaap.org or 404-881-5093.

School-Based Health Centers: Key Concepts & Status in Georgia

The School Based Health Center (SBHC) is a model of health care delivery that has been recognized as an effective means of providing quality healthcare for children that can significantly reduce barriers to health care for those living in poor communities.[1-3] SBHCs offer increased access to quality care for students by eliminating barriers such as cost, transportation, and hours of operation, and the lack of knowledge around how to manage one's health and when to access care. In addition, SBHCs provide a sense of security to parents who rest assured in the knowledge that their child's health care is covered at no or low cost; to school leaders who recognize that prompt attention to student illness means a faster return to the classroom and thus improved academic performance; and to employers who appreciate that employee productivity is affected when they are unable to attend to their sick children.

Since school is where children spend a large majority of their time daily, the SBHC offers an opportunity for pediatricians to extend themselves beyond the boundaries of their offices and transform their approach to provide care...

Although the majority of school based health centers are on school property, a small number are set up in other settings such as mobile health centers or telehealth centers. Services offered at SBHCs include routine wellness checks and sports physicals, immunizations, diagnosis and treatment of acute and chronic illnesses and injuries, mental, behavioral health, and family counseling, nutrition counseling, school-wide health education and wellness programs, and specialist/community agency referrals. Many centers also offer additional services such as dental care and laboratory testing.

The number of comprehensive school-based health centers has increased significantly over the past 15 years with the latest National Census of SBHCs in 2013-2014 reporting a total of approximately 2315 SBHCs operating throughout the country.[4] The first School Based Health Center developed in Georgia is the Whitefoord Elementary School Health Clinic, followed by the Coan Middle School Health Clinic several years later. These SBHCs were the only two in Georgia until 2013, when the Emory University Department of Pediatrics created the Urban Health Program (later renamed PARTNERS for Equity in Child and Adolescent Health) to decrease health disparities with an emphasis on expanding School Based Health in the state. There are now 12 School Based Health Centers in Georgia with several more slated to open by the 2016-2017 school year.

The Georgia School Health Alliance (www.gasbha.org), an affiliate of the national advocacy group, School Based Health Alliance, was formed in late 2012. The Alliance's mission is to develop community partnerships to advocate for, and provide technical assistance to, those interested in opening a school based health center.

Since school is where children spend a large majority of their time daily, the SBHC offers an opportunity for pediatricians to extend themselves beyond the boundaries of their offices and transform their approach to provide care in the context of the children's developmental, psychological, social , intellectual, and physical needs. Beyond working directly in a SBHC, other methods for pediatricians to become involved in school based health include working as a consultant to the school, assisting with health education of students, providing in-service training of school staff on relevant health topics, directly communicating with schools on a specific student's medical condition, or advocating for patients through activities as members of School Advisory Councils and School Boards. Additionally, pediatricians can further promote wellness for students as well as school staff by providing guidance on school nutrition, development and implementation of emergency medical plans, and advocating for an optimal school environment.

Pediatricians can become a crucial link between the SBHC and the community. Health care providers working in SBHCs should integrate and coordinate with other pediatric medical home practices in the community to ensure that care is not frag-

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Food May Be Making Your Patients & You Sick

In our current age, perhaps the biggest danger from food is its overconsumption; however, foodborne illness is an immense, and yet overlooked, problem. Each year, 1 in 6 Americans gets sick by consuming contaminated foods or beverages. The CDC estimates that each year roughly 48 million people get sick from a foodborne illness, 128,000 are hospitalized, and 3,000 die. According to the 2011 estimates, the most common foodborne illnesses are caused by Norovirus and by the bacteria *Salmonella*, *Clostridium perfringens*, and *Campylobacter*. [1] In addition to getting sick or possibly dying from foodborne illness, it may lead to the development of chronic problems like irritable bowel syndrome in many who recover. [2]

During this past year, the restaurant chain Chipotle foodborne outbreaks led to over 500 people becoming sick in 13 states. The outbreaks were due to numerous pathogens, including Norovirus, *Salmonella* and 2 different strains of *E coli*. In 2009 in Georgia, the peanut butter foodborne illness affected at least 74 people across 46 states. In the last few months, all of the following have been reported [3]:

- Hawaii macadamia nuts linked to *Salmonella*
- Kansas sprouts linked to *Salmonella*
- Oregon oysters linked to Norovirus
- Minnesota sprouts (Jack and the Green Sprouts) linked to *E coli*
- Tennessee blue cheese (Mayfair) linked to *Listeria*
- California raw (organic unpasteurized) milk linked to *E coli*

The Chipotle outbreaks may be linked to the company's emphasis on locally acquired "healthy" foods or, as the restaurant claims, "food with integrity." These foods are raised without hormones or antibiotics and animals are treated humanely (eg. cage-free). The use of more extensive sources for foods may make it more difficult to supervise the quality of the foods at all levels.

The Chipotle outbreaks may be linked to the company's emphasis on locally acquired "healthy" foods or, as the restaurant claims, "food with integrity."

From a food safety standpoint, handling of food with clean hands and cooking the food appropriately are the most important factors in food safety.

Suggestions for dining at restaurants: [4]

- Look at Health Department food inspection scores, which should be displayed conspicuously.
- Consider having discussions with the restaurant managers about food safety.
- Report incidents of concern (usually, county health departments and state departments of public health want to know of potential problems).
- Recognize that there's a risk of foodborne infection whenever you eat out, just as there is a risk of injury while driving to the restaurant. Use caution when driving and choosing restaurants.

Jay Hochman, MD

Several Important Points to Remember at Home:

- Wash fruits and vegetables before using them.
- Wash hands with soap and water after touching raw meats, fish and eggs. Also wash the utensils thoroughly and use clean towels for drying since they can carry bacteria and viruses.
- Thaw frozen food in the refrigerator, not on the counter.
- Do not reuse food that has been unrefrigerated for hours.
- Use a separate container for baby food, rather than dipping the spoon back into the jar while feeding the baby.
- Do not refreeze food after thawing.
- Clean the counter during food preparation and after meals with a disinfectant.
- Be aware organic products do not necessarily increase food safety. Fertilizers can be cow or chicken manure, which can contain disease-producing bacteria.
- Be aware food dating on products indicates when food is at highest quality but does not indicate food safety. [5] Milk, for example, will last in the refrigerator five to seven days beyond its typical expiration date. Discard any food if it smells or tastes odd, or if it is discolored or showing signs of mold or spoilage.

These pointers are important steps in reducing illnesses from contaminated or mishandled food. When on vacation out of the country, most individuals exercise are careful about what they eat to avoid getting sick. Yet, the foods we eat at home come from all over the world and the rate of foodborne illness is high even in those who do not travel. Take these precautions everyday.

I would like to thank Stan Cohen who provided background information for this article. More information can be found on Nutrition4Kids.com on this topic.

Jay Hochman, MD
Chair, Committee on Nutrition
Georgia AAP
GI Care For Kids
Blog: Gutsandgrowth.wordpress.com

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Right-sizing Pediatric Care

"Everything has got its right size. When it is its right size and well run it's the tops." -Agatha Christie

I love doing check-ups on infants and newborns, as I hold and play with them as I ask their parents about routine issues of feeding, sleeping and development. As I think about the future of my practice and our profession, however, I realize that I may need to do less well child care and instead focus more on the patients and families where my training, knowledge and skills will be most impactful. Well-trained and closely supervised mid-level providers or nurses can provide routine newborn care while I free my appointment time for complicated infants and children.

Pediatricians should react by making their offices more convenient, offering appointments earlier in the day and later in the evening, and working to get the simple sick visits, such as strep throat and ear infections in and out of the office quickly.

No matter which hat I wear (managing partner of my practice, Chair of The Children's Care Network or leadership in the Georgia AAP), my thoughts often turn to right-sizing care for our patients. To reduce errors, nurses should follow the "Five Rights" of medication administration: Right Patient, Right Drug, Right Dose, Right Route, and Right Time. Similarly, pediatricians should think about the following Rights for their patients:

Right Location
The rise of retail-based clinics is much lamented among Pediatricians. The attraction for parents is obvious—convenience. They value their child being seen when they want and where they want. Pediatricians should react by making their offices more convenient, offering appointments earlier in the day and later in the evening, and working to get the simple sick visits, such as strep throat and ear infections in and out of the office quickly. These appointments are short and easy and provide an immediate financial rush. This type of care can be provided (some would argue just as well) outside the Pediatric office. The more a practice plans for and depends on these types of visits, the harder it will be to adapt to changes in the medical marketplace.
Access to care for children looks very different depending on where you live in Georgia. In Atlanta, access to pediatric specialists, outside of Medicaid, is readily available, but wait times may be long. In cities with children's hospitals, some pediatric specialists are available locally while others are not. In rural areas, specialty care is almost always a long drive away. As a Pediatric community, we have a responsibility to make sure that specialists' time is used wisely. Primary Care Providers (PCP) in Atlanta have been spoiled by easy access to specialists and have grown less comfortable managing minor chronic conditions, such as headaches and chronic abdominal pain, and frequently send these low acuity patients to specialists. Continued efforts to coordinate care between PCP and specialists will result in management, which can be done in the Medical Home, especially after the specialist makes the initial diagnosis and treatment recommendations. Following this procedure will free the specialist to focus on the patients who need his/her expertise.


Robert Wiskind, MD

Right Provider
I know a solo practitioner who does everything during the patient visit, from taking the child's vitals to administering vaccines. While most of us have delegated these and other tasks to our staff, we often continue to spend time doing things that do not require the knowledge and skills of a physician. Ideally, there should be a hierarchy in clinical care with medical assistants acting up to the level of their training, nurses providing care that medical assistants are not qualified to do, mid-levels above that level and physicians at the top. In some ways, the physician should act as the consultant, addressing diagnosis and treatment issues that are beyond the training and experience of the staff.
The model of care in the United Kingdom is often used to contrast the U.S. system. The majority of care for children is provided by General Practitioners; the pediatrician is truly a specialist, treating children with illnesses or conditions requiring a higher level of care. I don't expect that we will adopt this model, but I do think pediatricians would be well served by more clearly defining our role as child experts and ceding some care to other providers when our level of expertise is not needed.

Right Team
In recent years, Mental Health issues have become a much bigger part of daily pediatric practice. ADD, anxiety, depression and eating disorders are part of an increasing number of patient visits. Many pediatricians do not feel adequately trained to treat these conditions. Close relationships with mental health professionals, either within the practice or as consultants, is essential to managing these patients. We should also work to include schools, religious institutions, and community groups, with the physician acting as the captain of the team, directing resources to maximize patient benefit.
Determining what is the right size for you and your practice is a very personal decision. It requires self-examination and the ability to recognize your strengths and acknowledge your weaknesses. It may be painful, but I am confident that it is worth the effort and positions you to do what is right for your patients.

Robert Wiskind, MD, FAAP
Past President, Georgia AAP
Atlanta

Meet the Board: Tania Smith, MD, FAAP

Tania Smith, MD, FAAP is a primary care pediatrician in Albany, Georgia. Dr. Smith currently serves as the Chapter's District 16 Representative.

Birthday: August 8th

Hometown: Oakland, California

Education: Cate School, Carpinteria, CA(boarding school/high school), Yale University, B.S. Biology, Morehouse School of Medicine, M.D., Kaiser Permanente Northern California--pediatrics residency program

Family: 17 yr. old son Jarrett

Pet(s): 8 yr. old Chinese Crested Powderpuff dog-- Jock

Inspiration: Jesus Christ and my mother

Hobbies: shopping, party and event planning, working with church youth group, amusement parks and roller coasters
Bad Habits: expect others to be as dedicated and work as hard as I do

Greatest Accomplishment: opening solo practice and planning to build a new office building, and being a single parent of a wonderful, intelligent teenager

Favorite Saying: I can do all things through Christ which strengthens me

Favorite Movie: Best Man

Who would play you in a movie: mother

Favorite Food: seafood

Favorite Restaurant: Cheesecake Factory, Joe's Crab Shack and other good seafood restaurants

Role Model/Idol: Jesus Christ and my mom

Dream Vacation: Dominican Republic or Hawaii with my son and extended family, with no cell phones or social media

Pet Peeves: lazy people, and people who mistreat pets and/or children

Three things always found in your refrigerator: turkey bacon, eggs, Coke Zero

Best kept secret: I'm really shy

Most memorable moment: opening my own office

Luxury Defined: massages, pedicures, and relaxation

Place you'd most like to be stranded: the mall in Hawaii

Why is Chapter membership important to me: I enjoy spending time with other people dedicated to excellent medical care for children and the general well being of children

Prevention of Child Abuse Survey Findings

In 2010, the American Academy of Pediatrics (AAP) published a clinical report titled "The Pediatrician's Role in Child Maltreatment Prevention," which outlines what the pediatrician can do to assist in preventing child abuse. The report addresses how pediatricians can recognize risk factors and provide anticipatory guidance with regards to child abuse and its related topics.

Many studies have addressed the comfort level of physicians once abuse is diagnosed, how accurately physicians interpret exam findings, and physicians' knowledge about sexual abuse. It is unknown how many pediatricians are providing education to caregivers regarding child abuse prevention, including topics of physical abuse, infant crying, intimate partner violence (IPV), depression, discipline, and sexual abuse.

In February, the Georgia Chapter of the AAP sent email invitations to its members and Emory University School of Medicine pediatric residents requesting their participation in a brief survey about these issues. Survey questions were created to address most of the topics listed under the "Guidance for the Pediatrician" section of the article. There were a total of 74 participants with not all participants completing the survey in its entirety. A link to the AAP clinical report was provided at the end of the survey.

Ninety-five percent of pediatricians knew how to report child abuse, but only half felt comfortable in doing so.

The majority of pediatricians who completed the survey were general pediatricians who have been in practice for more than 10 years. Although most pediatricians were only slightly familiar with the AAP clinical report, they agreed that focusing on topics related to child abuse, relative to other topics, was very important. Eighty-one percent of respondents reported feeling prepared to discuss child abuse issues with caregivers; however, most (70%) stated they needed additional training. The most common place for pediatricians to learn about child abuse prevention is during their residency training.

A minority of participants felt very comfortable addressing child abuse topics directly with caregivers. Ninety-five percent of pediatricians knew how to report child abuse, but only half felt comfortable in doing so. Information and resources about child maltreatment and its prevention were present in only a small percentage of pediatric offices.

Pediatricians routinely addressed, risk factors, including parental support systems, toilet training expectations, effective forms of discipline, and safe/unsafe touch. Pediatricians asked about a family history of physical abuse, sexual abuse, and substance abuse when a need was perceived. Other selected inquiries related to infant crying (caregivers' perceptions, strategies used to cope, teaching alternative responses) and sexual abuse prevention. Physicians also selectively asked if parents had difficulty caring for the child and how they disciplined their child. Although pediatricians inquired about IPV and maternal depression when they perceived a need, rather than on a routine basis, the majority of pediatricians knew how to respond to reports of IPV (74%) and maternal depression (88%).

Child abuse is a preventable problem. Barriers that pediatricians face in providing anticipatory guidance include the physician's discomfort and lack of understanding about the topic of child abuse.

Increased knowledge and training may help with resolving these issues and empower physicians to ask difficult questions. Although the majority of training occurs during residency, it is important to continue medical education. There are creative ways to incorporate the assessment and prevention of child abuse in the pediatric office. For example, utilizing screening tools to be completed in the waiting room may assist in alleviating physician discomfort, time constraints, and the inability to screen privately. These tools can also prompt parents and caregivers to discuss specific concerns, such as infant crying and sexual abuse prevention. Questionnaires can be given routinely, and not selectively, which may increase the opportunity to educate and intervene.

As pediatricians, we spend months and years building relationships with our patients and their families. It can be potentially challenging to break that bond if child abuse allegations arise. It is vital to keep in mind, however, that as mandated reporters, we have an obligation to prioritize the needs and safety of each child. We are in a unique position to have frequent conversations to address risk factors of maltreatment. By recognizing our important role as pediatricians, we can potentially prevent child abuse from occurring.

Andrea Z. Ali-Panzarella, DO, MPH, FAAP
Fellow, Child Abuse Pediatrics,
Emory University School of Medicine,
Atlanta

2016 Legislative Update

This was one of the more successful session for the Georgia AAP in recent memory. All 3 of our major issues came out in our favour:

Increase in Medicaid rates: We were gratified that the $26.2M (state funds and $81.4M total funds with the federal match added) was included in the Medicaid budget. This will raise Medicaid rates on 26 more CPT codes to 2014 Medicare rates, effective July 1, 2016. Thank you all for your efforts on this milestone legislation. This was done as part of our coalition with the FP's, IM's and OB's via their societies, and their advocacy has been indispensable to our efforts.
Medical Cannabis: HB 722, we objected to the inclusion of autism as one of the "medically qualifying conditions" for which CBD oil could be legally used in Georgia. The bill failed on the last day of the session as the Senate refused to take it up.
PA prescribing of hydrocodone, SB 115: This bill would have given PA's the right to prescribe 15 day supply of hydrocodone, a Schedule II drug. We opposed the bill, and cited concerns about the increasing prevalence of NAS and adolescent opioid addiction. It passed the Senate but the House committee chair refused to take it up. It was then attached to other bills on the final days, in hopes of getting it thru in the rush of last-minute bills. **It failed due to strong House opposition.**

Please remember to thank your state representative and state senator this spring for their support. And if they have been a friend to our issues please consider supporting them in their upcoming election, whether it be the primary or in the fall.

Here's the final status of other bills we followed:

HOUSE BILLS

HB 219: Swimming pools, Would exempt private pools (e.g. country clubs, condos, etc.) from pool inspections carried out by Dept. of Public Health. Passed House; in Senate Committee. DPH has concerns that this will remove many pools from their oversight and therefore degrade their ability to monitor adequately for safety; however they worked out those concerns. **Passed. (However, Gov. Deal vetoed.)**
HB 649: LC Licensure, Rep. Cooper, Marietta, Would establish state licensure of lactation consultants. **Passed.**
HB 727: Fireworks: Rep. Battles, Cartersville: Seeks to give cities and counties right to limit days and hours when fireworks can be shot off. **Passed.**
HB 859: Firearms: Rep. Jasperse, Jasper; Would permit licensed gun owners over 21 to carry guns on college campuses, w/some exceptions. **Passed. (However, Gov. Deal vetoed.)**
HB 873: Sudden Cardiac Arrest Prevention, Rep. Clark. Would require schools to post information and provide education on SCD and its warning signs, especially in athletic venues. Did not crossover. Converted to HR 1254, which "encourages" schools to adopt and implement SCA & return to play policies; and asks DPH to endorse a SCA prevention education course. **Passed.**
HB 900: Prescription drug monitoring, Rep. Cooper, Marietta, Would permit review of doctors prescribing record by their authorized office personnel. **Passed**
HB 997: Preceptor tax credit: Would change from a tax deduction, to a tax credit, which is more favourable to the physician preceptor. **Failed.**

SENATE BILLS

SB 158: Rental Networks, Sen. Burke, requires disclosure and certain prohibitions when plans use "rental networks" without disclosing to physician. Key bill for MAG this session. **Passed.**
SB 302, Provider Directory Accuracy: Sen. P.K. Martin, Alpharetta: Would require insurance plans to publish and maintain accurate directories of providers in their networks. **Passed.**
SR 974: Create Study Committee on issue of "prohibiting surprise billing". Originally this was a bill (SB 382) but the industry succeeded in converting this to a study committee. **Passed.**

For more information on these or other bills, contact Rick Ward, at the Chapter office, at jrice@gaaap.org. Thanks to the members of the Legislative Committee for their efforts during the session and to all our members who contacted their legislators about our issues. Your support and participation in the legislative process is vitally important to our advocacy.

Melinda Willingham, MD, FAAP
Chair, Legislative Committee
Clarkston

School-Based Health Centers...continued

mented or competes with other providers. Likewise, community Pediatricians should also be aware of the SBHC model in order to collaborate efficiently with SBHC Providers to ensure patients have an appropriate medical home.

In 2008, a survey was conducted by the Georgia Chapter of the American Academy of Pediatrics Committee on School Health to determine pediatricians' knowledge and support of School-Based Health Centers (SBHCs) as a means to increase access to health-care for underserved children and adolescents. Of the 142 re-spondents, only 28% were familiar with SBHCs, but 52% were supportive of SBHCs as a model to increase access to healthcare for children. Forty percent reported having volunteered in a school or a daycare center. Our goal is to increase the number of pediatricians involved in SBHCs.

We welcome everyone interested in School Health to join our Committee. Please contact us or Shanrita Mcclain, Chapter staff liaison for the School Health Committee (smcclain@gaaap.org) for more information.

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1. Brindis CD, Sanghvi RV. School-based health clinics: Remaining viable in a changing health care delivery system. *Annu Rev of Publ Health.* 1997;18:567-87.
2. Brindis C, Klein J, et al. School-based health centers: accessibility and accountability. *J Adol Health.* 2003; 32:98-107.
3. Fisher M, Juszczak L, et al. School-based adolescent health care: Review of a clinical service. *Adolescent Health Care* 1992;146:615-621.
4. National Assembly on School-Based Health Care. School-Based Health Centers: National Census School Year 2013-2014. Available on line at: http://censusreport.sbh4all.org Accessed March 12, 2016.

Pediatric Foundation Golf Tournament Held in April

The Jim Soapes Charity Golf Classic, the Pediatric Foundation of Georgia primary fund raiser, was held this year in the Spring at one of Georgia's premier golf courses, Cherokee Run Golf Course in Conyers. There were over 60 golfers in attendance.

And the Winner is……The team from the Children's Hospital of Georgia, Augusta won the tournament this year. Pictured here (from left): David Freeman, Thomas Freeman, Jeff White, & Charlie Linder. Drs. Freeman & Linder combined to make a super rare double eagle, which was the highlight of the round.

"If We Can Just Move the Hole Over Here".....Dr. Randy Barfield (far right) and his team are always a great addition to the tournament. He's joined here (from left) by John Kelly (holding the cup cutter), Jim Ingvoldstad, & Charles Barfield.

Healthcare of Children who have Experienced Homelessness: New Focus on Children of Veterans

Homelessness:

Our society is currently facing a crisis in homelessness:

Between 2007–2013:

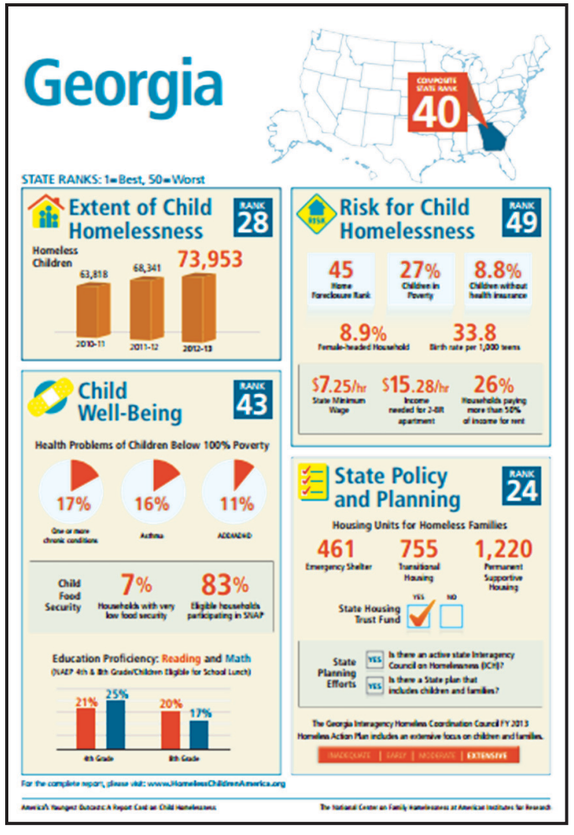
- The number of families who moved from stable housing to shelters increased by 38.5%
- Of all homeless families, 35.8% had children

Children who are homeless:

- Are 2.5 times more likely to have health problems and 3 times more likely to have severe health problems, especially asthma;
- Are less likely to have health insurance coverage and more likely to use the emergency room (ER) for all health care needs;
- Are more likely to be hospitalized and have longer hospital stays;

Are 2-5 times more likely to suffer trauma and emotional stress such as food insecurity, living insecurity, family insecurity as well as neglect and abuse;

The emotional and physical effects of homelessness leave a lasting impact on children that can result in Toxic Stress and adverse health outcomes as adults. It is our responsibility as pediatric healthcare providers to understand the health care needs of this group of children, identify them as early as possible, and refer for appropriate services, in order to reduce the potential adverse effects and promote resilience and well-being for the children and their families.



It is our responsibility as pediatric healthcare providers to understand the health care needs of this group of children...

In 2010 Innovative Solutions for Disadvantage and Disability (ISDD) received funding from HRSA, under the Healthy Tomorrows Partnership of the AAP, to respond to this set of issues by establishing *Healthcare without Walls: A Medical Home for Homeless Children* (HWW) and developed a 2-pronged approach:

1. Establishing a Medical Home for the children
2. Establishing a health literacy program for the mothers to help them become familiar with the healthcare needs of their children and to understand and navigate the healthcare delivery system

The impact of HWW over the 5 years of the project accomplished the following:

- Health insurance rates of children increased from 81% prior, to 98%
- Fully-vaccinated immunization rates increased from 62% to 87%;
- ER visits for non-urgent health concerns were drastically decreased;
- All children participating in the HWW clinic were referred to a primary care provider in the community for ongoing care and treatment
- Mothers reported improved understanding and greater confidence in dealing with the health care of their children and the health care delivery system

Homeless Veterans

In a November 2015 report, the US Department of Housing and Urban Development (HUD) stated that, 564,708 people in the United States were homeless on a given night in January 2015, of whom 47,725 (8.5%) were veterans. In fact, a female veteran is

(Continued on page 15)

Healthcare of Homeless children...

four times more likely than her civilian counterpart to be homeless. Also, veterans are more likely suffer from post-traumatic stress disorder (PTSD), and are more likely to abuse alcohol, and/or live in a domestically violent household. Significantly, the children of veterans are at an increased risk for adverse social, mental health, developmental and educational outcomes, which further compounds the effects of homelessness and insecurity.

Response to the challenge

In 2015, ISDD was awarded another five year grant from HRSA under the Healthy Tomorrows Partnership of the AAP, to establish *Healthcare Without Walls – Veterans*: *A Medical and Mental Health Home for Children of Veterans who have experienced homelessness (HWW-V)*.

Goals of the program

- Establish a Medical and Mental Health Home for the children for the early identification and treatment of medical, developmental, mental health, and behavioral challenges;
- Develop improved access to primary, specialty and mental health care for the children;
- Increase health literacy for the parents
- Increase understanding of the unique needs of this vulnerable population among pediatric and behavioral health practitioners

Observations relevant to Pediatric Practice:

- It is important to understand the impact of military service and deployment on family life, and on child health and development
- Children of veterans, especially those who have experienced homelessness, are at greater risk for mental health challenges, therefore, it is important to explore the parents' concerns about their child's emotional and behavioral health
- It is important to be sensitive to the fact that family priorities, such as the need for employment and stable housing may take precedence over routine, preventive care for their children
- If pediatricians identify children of veterans who are experiencing homelessness it would be appropriate to refer them to our program by contacting Laura Wells, Program Director, at (404) 310-8129 or email lauraw@isdd-home.org

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Breastfeeding Matters: The Role of the Pediatrician

Do you feel frustrated that you can't spend the time you would like helping and supporting mothers with breastfeeding? Are you worried that you and your office staff don't have the knowledge and skills to help mothers with breastfeeding problems? You are not alone. Data has shown that only about 40% of mothers are meeting their breastfeeding goals.[1] The CDC Healthy People 2020 has set breastfeeding goals for the United States to meet to help improve the health of mothers and infants.[2] The table below shows the goals and the national breastfeeding rates for infants born in 2011. You can find out how your state is doing by checking the Breastfeeding Report Card.[3]

Category	Goal	Rates
Any breastfeeding during birth hospitalization	81.9%	79.2%
Exclusive breastfeeding at 3 months of age	46.2%	40.7%
Any breastfeeding at 6 months of age	60.6%	49.4%
Exclusive breastfeeding at 6 months of age	25.5%	18.8%
Any breastfeeding at 12 months of age	34.1%	26.7%

The women in the United States are almost meeting the goal for breastfeeding initiation, but continuing breastfeeding for 6-12 months seems to be a more difficult goal to accomplish. The AAP PediaLink has a new on-line course called "Breastfeeding Matters, The Role of the Pediatrician" with 2 hours of CME credit. It covers the office based care of the breastfeeding mother-infant couple. It covers the following topics:

1. Newborn (3-5 day) visit, using RNs with breastfeeding training to perform most of the visit, and the pediatrician providing supervision
2. Two week well care visit
3. One month visit with discussion of return to work
4. Two month well care visit with discussion of the use of cold medicines
5. Outpatient care of the late preterm breastfeeding infant
6. Billing for visits related to lactation problems

This course allows you to learn more about office based support for breastfeeding mothers and infants in an on-line format to help breastfeeding mothers and infants reach their breastfeeding goals.

1. Odom EC, Li R, Scanlon K, Perrine CG, and Grummer-Strawn L. Reasons for Earlier Than Desired Cessation of Breastfeeding. Pediatrics. 2013: 131; e726-732.
2. Centers for Disease Control and Prevention. Healthy People 2020. http://www.cdc.gov/breastfeeding/policy/hp2020.htm
3. Centers for Disease Control and Prevention. Breastfeeding Report Card 2014. http://www.cdc.gov/breastfeeding/data/reportcard.htm

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CALENDAR

*Visit the Chapter website for more information regarding these events...**www.GAaap.org***

Webinar: *The Zika Virus: What It Is and How to Protect Against It,* June 21, 2016 12:30pm – 1:30pm

Webinar: *Georgia's Minor's Rights to Reproductive & Behavioral Health Services*, June 22, 2016 12:30pm – 1:30pm

Webinar: *Safe Vaccine Storage and Handling: It's not Cool to be Hot!,* June 29, 2016 12:30pm – 1:30pm

Pediatrics on the Perimeter
Fall CME Meeting
September 22-24, 2016
Westin Atlanta North, Atlanta
404-881-5091

Georgia Pediatric Nurses & Practice Managers Associations Fall Meetings
October 14, 2016
Cobb Energy Center, Atlanta
404-881-5067