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Georgia Chapter

The GEORGIA Pediatrician

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President's Letter

The Mental Health Challenge



Hugo Scornik, MD, FAAP

A 14-year-old boy with no previous mental health concerns screens positive for depression during his routine well child exam. Upon further questioning, he states that he is feeling down, has lost interest in school and his grades are suffering. There is more stress at home since his father lost his job. He is also worried that when

he returns to in-person school, he could catch Covid-19 and unwittingly infect his parents. He has begun to have frequent headaches and stomach aches. He denies suicidal ideations.

Most pediatricians feel that we are seeing an increase of children with anxiety and depression due to the Covid-19 pandemic. Although we do not yet have robust data to verify this suspicion, we can look to how children were affected by previous disasters for guidance. In a study conducted 6 months after the terrorist attacks of September 11, 2001, involving a representative sample of more than 8,000 students in grades 4 through 12 attending New York City public schools, 27% met criteria for one or more probable psychiatric disorders.¹ Perhaps even more concerning, the vast majority (87%) of all students reported at least one ongoing symptom that persisted 6 months after the event. I fear that this pandemic will also have significant effects on pediatric mental health for years into the future.

The Georgia AAP has taken steps to focus on this issue. Improving mental and behavioral health for children was one of our top advocacy priorities in this year's "Blueprint for Children". We strongly support increasing resources devoted to children's mental health care in our state. In addition, we have recently launched a project called Behavioral Health Too! (BH2), to better connect pediatricians with mental health resources in their community. (See p. 3).

Improving mental and behavioral health for children was one of our top advocacy priorities in this year's "Blueprint for Children". ... In addition, we have recently launched a project called Behavioral Health Too! (BH2), to better connect pediatricians with mental health resources in their community.

A primary focus will be to build relationships between pediatricians and their local Community Service Boards. Behavioral Health Too! was a product of our growing partnership with the Georgia Dept. of Behavioral Health and Developmental Disabilities. At our winter board meeting, we invited Commissioner Judy Fitzgerald to give a presentation on how the department works to improve the mental health of Georgia's children. We also of course, maintain a close partnership with the Georgia Council for Child and Adolescent Psychiatry and a liaison from their society always attends our board meetings.

I am also pleased to announce that the Chapter has hired our first Behavioral Health Coordinator, Hannah Smith, and we welcome her to our team. In addition, Fozia Eskew brings her years of experience to the BH2 project as do a dedicated committee of pediatrician member advisors. The Georgia Chapter also aims to increase our CME offerings related to mental health. For example, during our virtual Spring Symposium we featured a "Mental Health Morning" which included three lectures about children's mental health and one on physician wellbeing. In addition, we have created a Task Force on Physician Wellness. This new group will work to address the mental health challenges faced by us pediatricians during the Covid-19 pandemic.

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Given the broad nature of this pandemic's impact, almost all children would benefit from some interventions in the office. The importance of discussing proper sleep, regular exercise, and a healthy diet with every family cannot be overstated. We need to remember to screen for depression as recommended by Bright Futures guidelines. Pediatricians can also help guide families on how to safely resume their pandemic-interrupted routines, as the health emergency allows. Included in this routine is the return to in-person school attendance. Helping families make up for the lost education suffered during the 2020-2021 school year is certainly a daunting challenge.

Given the broad nature of this pandemic's impact, almost all children would benefit from some interventions in the office. The importance of discussing proper sleep, regular exercise, and a healthy diet with every family cannot be overstated.

I do believe that pediatricians are in an excellent position to provide mental health support for children through the medical home. I also believe that most children will persevere. In their book on children's mental health, Sam Goldstein and Robert Brooks discuss the case of a 5-year-old boy who watched helplessly while his younger brother drowned.² Shortly thereafter, that same boy began to lose his sight due to glaucoma. His family was impoverished and could not afford the medical therapies the boy needed, and the boy became blind. By the time this boy was a teenager, both of his parents had died. Eventually, the boy was interred in a state institution for the blind.

That boy's name was Ray Charles, who was born in Albany, Georgia and would go on to become a world-renowned musician. Children can overcome great obstacles. Eventually, with the help of Georgia's pediatricians, I am hopeful that the word that will come to mind when thinking about children and their response to the Covid-19 pandemic will be resilience.



Hugo Scornik, MD, FAAP

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¹ Hoven CW, Duarte CS, Lucas CP, et al Psychopathology among New York city public school children 6 months after September 11. *Arch Gen Psychiatry*. 2005.

² Sam Goldstein and Robert Brooks, *Handbook of Resilience in Children*, edited by Sam Goldstein and Robert Brooks, 2013.



Chapter Launches *Behavioral Health Too!* Project

The Chapter is excited to announce a new project in mental/behavioral health to address these important issues facing our members and their patients. We are calling the project *Behavioral Health, Too!* (BH2) to highlight the importance of mental health in the overall health of the child. The project came out of the realization that for most children and adolescents, their pediatrician is the first professional they encounter for help with a mental health problem.

Our first task is to learn the needs of our members for their patients with behavioral and mental health concerns. Additionally, we will seek to identify how children, youth, and their families who utilize behavioral and mental health services in their school or through community service boards also engage with the child or youth's medical home. The project is supported by a grant from the Georgia Department of Behavioral Health and Developmental Disabilities and will especially focus on strengthening connections between pediatricians and their local Community Service Boards as a resource for providing these services. Georgia has 26 Community Service Boards and each of them are individually named. For a list, please visit <https://dbhdd.georgia.gov/locations/community-service-board>.

Additionally, BH2 will promote a behavioral/mental health system that supports children and adolescents, identifies opportunities to include peer support and or lived-experience as a valuable service, and simplifying access to local services. BH2 will initially focus on the Albany CSB (called Aspire Behavioral Health & Developmental Disabilities) and the Dublin CSB (Community Service Board of Middle Georgia), we will soon expand this work to the rest of the state and the other CSBs in Georgia.

To help guide our work in BH2 we have organized a Physician's Advisory Committee. If you have a special interest in behavioral/mental health and are interested in serving on the committee, please contact the Chapter's Mental Health Coordinator, Ms. Hannah Smith at hsmith@gaaap.org.

And look for our survey on this topic coming soon!

The project came out of the realization that for most children and adolescents, their pediatrician is the first professional they encounter for help with a mental health problem.



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Nutrition Update Spring 2021



Jay Hochman,
MD

Several important nutrition articles have been published recently which may be of interest to Georgia pediatricians.

1. Poorly conceived allergy testing.

(NEJM 2020; 383: 2462-2470) YV Virkud et al report on a 2 year-old who presented with seizure and hypocalcemia which happened due to unnecessary dietary restrictions.

The authors make several key points:

- Nutritional rickets is NOT a historical relic. Vitamin D deficiency appears to be increasing in high-income countries despite food-fortification strategies.
- There are frequent misdiagnosis of food allergies. "Clinical and laboratory testing is severely limited by poor specificity...approximately 20 to 25% of children have positive IgE blood tests to specific food allergens, even though the true prevalence of IgE-mediated food allergy is likely closer to 6 to 8%."
- Avoid indiscriminate use of IgE blood testing. Allergen panels are "particularly problematic, because they often uncover false positives and lead to unnecessary food avoidance." Individual IgE testing can be used to help confirm a diagnosis after an allergic reaction to a food trigger.
- The most accurate diagnostic tool is an oral food challenge.
- In children with food allergies, supplements are often needed to avoid micronutrient deficiencies and a low threshold is needed for involvement of dieticians.
- Early introduction of foods can reduce incidence of allergies and periodic reassessment is needed to determine if a child has outgrown an allergy.



2. Prenatal exposure to 'Forever Chemicals' associated with increased susceptibility to liver injury in children. (Hepatology 2020; 72: 1758-1770)

Background/Methods: Per- and polyfluoroalkyl substances (PFAS) are widespread and persistent pollutants that have been shown to have hepatotoxic effects in animal models. Human evidence is scarce, however. PFAS chemicals have myriad industrial/household applications which include nonstick cookware and products that confer resistance to stains. Some refer to PFAS as "forever chemicals" due to their decades-long half-lives.

N Stratakis et al used data from 1105 mothers and their children (median age 8.2 years) from the European Human Early-Life Exposome cohort. **Key findings:**

- High prenatal exposure to PFAS resulted in children who were at higher risk of liver injury (odds ratio, 1.56; 95% confidence interval, 1.21-1.92)
- PFAS exposure is associated with alterations in key amino acids and lipid pathways characterizing liver injury risk.

3. Growth in inflammatory bowel disease – better late than never. (Inflamm Bowel Dis 2020; 26: 1880-1889)

In this retrospective observational longitudinal cohort study with 3007 patients with IBD from the ImproveCareNow Network, N Gupta et al found a high rate of continued linear growth after expected growth plate closure (15 years in females, 17 years in males). **Key findings:**

- 80% manifested continued growth beyond the time of expected growth plate closure, more commonly in CD (81%) than UC (75%; $P = 0.0002$)
- Median height gain was greater in males with CD (1.6 cm) than in males with UC (1.3 cm; $P = 0.0004$), and in females with CD (1.8 cm) than in females with UC (1.5 cm; $P = 0.025$)

My take: This study provides additional information about delayed skeletal maturation in the pediatric population with inflammatory bowel disease. Interestingly, the rate of continued growth with ulcerative colitis was nearly as high as with Crohn's disease.

Nutrition Update

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4. Celiac disease is not increased in children with constipation. (J Pediatr 2020; 227: 77-80) In this study, AC Fifi et al found that celiac disease was not more prevalent in Colombian children with functional constipation (n=203) than in matched healthy controls (n=419). Patients were recruited from public schools. **Key finding:**

- The overall prevalence of celiac disease in the entire cohort was 0.6%. Of those with functional constipation, 1 (0.5%) was diagnosed with celiac disease, and 3 (0.7%) of the control patients. The authors note that some prior publications (references 11 and 12) have found a slightly increased risk of celiac disease in children with constipation.



5. Body mass index in childhood and cardiometabolic measurements. (Pediatrics 2020; DOI: <https://doi.org/10.1542/peds.2019-3666>). In this study, K Lycett et al followed 5107 infants from birth. **Key findings:**

- At age 6 to 7 years, compared with those with a healthy weight, children with overweight had higher metabolic syndrome risk scores by 0.23 SD units (95% confidence interval 0.05 to 0.41) and with obesity by 0.76 SD units (0.51–1.01), with associations almost doubling by age 10 to 11 years. Thus, overweight and obesity from early childhood onward were strongly associated with higher cardiometabolic risk at 11 to 12 years of age.
- In addition, obesity but not overweight had slightly higher outcome carotid intima-media thickness (0.20–0.30 SD units) at all ages.

Jay Hochman, MD

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Firearm Safety for Pediatricians



Sofia Chaudhary, MD, FAAP

A 12-year-old boy with a gunshot wound (GSW) to the chest is wheeled into the trauma bay, unresponsive, pulseless, undergoing CPR, who subsequently dies. The patient's 6-year-old brother found their father's gun while playing and pointed it at the patient. The parents now face the shattering loss of their older son and also the psychological impacts for their younger son, the second victim.

Tragedies such as this one have become too familiar for emergency departments across the US as the number of pediatric firearm deaths continue to climb annually.

Firearms are the second leading cause of pediatric death in the US and took the lives of over 1,700 and injuring more than 6,500 children and teens (ages 0-17) in 2019.¹ Homicide accounted for a majority of these deaths, but 40% were from firearm-assisted suicide and 5% from unintentional injuries. Middle schoolers and high schoolers in the US are now more likely to die from a gun than from any other cause, including motor vehicle collisions.² Additionally, 4.6 million children in the US live in a home with at least one unlocked and loaded gun – double the rates of firearm exposure from a decade earlier.³ Access to an improperly stored firearm in the home increases the risk of both pediatric unintentional firearm injury and firearm assisted-suicide by 2-5 times.⁴⁻⁷

These risks have been amplified by the increase in the number of homes with guns and the record number of gun sales during the COVID-19 pandemic, with sales exceeding all of 2019 sales by August 2020.⁸ As a result, during the peak of stay-at-home orders, there was a 43% increase in pediatric unintentional shootings in March and April, when compared to the average gun deaths for the same two months over the last 3 years.⁹ Along with access to an unlocked gun at home, social isolation, increased stressors, and lack of timely access to mental health services have all been independent risk factors for youth firearm-related suicide.¹⁰ Suicide attempts

have been 1.5 times higher in teens during the pandemic compared to previous years.¹¹ Locally, we have seen the impacts of COVID-19 on gun violence as Children's Hospital of Atlanta cared for almost 100 pediatric GSWs in 2020, which is a 50% increase compared to 2019 and a 140% increase

compared to 2018!¹² 40% of these firearm injuries in the past year were unintentional and almost all were preventable.

So what can we as pediatricians do to help change the narrative of pediatric gun violence?

Providing Firearm Safety Counseling

Forty-nine percent of Georgians live in homes with guns. When gun-

owning parents in the metro-Atlanta area were asked, more than 50% do not store their guns locked AND unloaded.¹³⁻¹⁵ Additionally, 23% of gun-owning families believed they could trust their child with a loaded gun and 75% believed their children could distinguish a real from a fake gun, when in reality only 41% could.¹⁶ When 1,246 parents in a large survey study were asked about pediatricians providing firearm safety counseling: 66% agreed that the pediatrician should ask about guns in the home, 75% agreed the pediatrician should advise on safe storage (71% were gun owners), but only 13% had ever had a firearm safety conversation with their pediatrician.¹⁷

The American Academy of Pediatrics recommends that pediatricians and other child healthcare professionals provide firearm safety counseling and ask parents to store all guns **locked and unloaded with the ammunition stored separately and locked**. The recommendation is to store guns in either a **lockbox or gun safe and to store out of sight**.¹⁸ Each of these safety practices are modifiable risk factors for unintentional injury and pediatric firearm-related suicide. Even motivating 20% of all parents who store one gun unlocked to now store all of their guns locked could save up to 135 pediatric lives and prevent up to 323 pediatric shootings.¹⁹

Middle schoolers and high schoolers in the US are now more likely to die from a gun than from any other cause, including motor vehicle collisions. Additionally, 4.6 million children in the US live in a home with at least one unlocked and loaded gun – double the rates of firearm exposure from a decade earlier.

Firearm Safety for Pediatricians

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Considerations for firearm safety conversations:

- Keep the conversation neutral and respect the parent's position on firearm ownership
- Pair counseling with discussion of other injury risks (e.g. ingestions, falls)
- Tailor guidance to high-risk groups: Adolescents, children with mental health concerns, adolescent history of substance abuse, prior suicidal ideation, history of family violence. *For high-risk groups, discuss storing guns outside of the home (e.g., gun clubs, with a relative or friend). Firearms are the most common means for teen suicide and suicide is the second leading cause of death for teenagers.*
- Encourage parents to ask about guns in the home of places their child/teen may visit. **40% of unintentional injuries happen at a friend's home.⁵**

Let's work together to prevent injuries and death due to firearms in Georgia!

Sofia Chaudhary, MD, FAAP

Pediatric Urgent Care Physician
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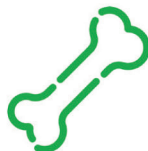
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Stephen Miller, MD
Sports Medicine Pediatrician

Stephen Miller, MD, is board-certified in pediatrics and sports medicine. He trained in pediatrics at Duke University Medical Center and later in pediatric sports medicine at Children's Hospital of Akron. Prior to joining Children's, Dr. Miller practiced pediatric sports medicine in Virginia Beach, VA. He has more than 15 years of experience serving as a high school team physician covering football, wrestling and gymnastics. Dr. Miller's clinical interests include adolescent back pain, throwing-related injuries and concussions. He sees patients at Children's at Fayette.



Nancy Sokkary, MD
Pediatric and Adolescent Gynecologist

Nancy Sokkary, MD, is a fellowship-trained Pediatric and Adolescent Gynecologist. She received her medical degree at the University of New Mexico School of Medicine and completed her residency in Obstetrics and Gynecology at Kaiser East Bay in Oakland, CA. Following residency, Dr. Sokkary completed a Pediatric and Adolescent Gynecologist fellowship at Baylor College of Medicine/Texas Children's Hospital. Dr. Sokkary's clinical interests include abnormal menses and puberty, complex contraception, ovarian masses, and pre-pubertal vaginitis. She cares for patients at the Center for Advanced Pediatrics in Atlanta.



Michelle Tutmaher, DO
Pediatric Neurologist

Michelle Tutmaher, DO, is a board-certified Neurologist with a special certification in child neurology. She received her medical degree at Kansas City University and completed her general pediatrics training at Children's National Medical Center in Washington, D.C. She recently completed her child neurology residency at Emory University School of Medicine/Children's Healthcare of Atlanta. Dr. Tutmaher's clinical interests include headache, developmental delays and epilepsy. She sees patients at the Center for Advanced Pediatrics in Atlanta.



Solve One Problem



Robert Wiskind
MD, FAAP

The Martian (2015), tells the story of Mark Watney, an astronaut abandoned on Mars during an emergency evacuation when his crewmates think he has died. Surviving alone for years, he is eventually rescued and returns to earth. The movie closes with Watney speaking to a class of astronaut candidates where he is asked if he thought he would die on Mars. His reply:

Yes. It's space. It's filled with chance, circumstance and bad luck. It doesn't cooperate. At some point, I promise, at some point every single thing is gonna go south on you, and you'll think: this is it. This is how I end. And you can either accept that or you can get to work. That's all it is. You simply begin. Solve one problem. Then the next one, then the next. You solve enough problems and you get to come home.

The COVID pandemic has been a life-or-death battle for far too many people. For pediatricians it has presented challenges that often seemed overwhelming, but we responded by solving one problem at a time and continuing to serve our patients.

While most students have resumed in-person learning, there has been considerable debate over the past year about how and when children could safely return to the classroom. Throughout that time, administrators, teachers, students and parents did a phenomenal job of adjusting on the go to optimize learning while maintaining safety. There will be much research in the years to come about the impact the pandemic had on learning, school performance and child mental health. I hope we don't forget the sacrifices and innovations created out of necessity in the almost instantaneous conversion from in-person to distance learning. Informal PDSA cycles became the norm, with families making adjustments and assessing if the new arrangements could work for them. The learning environment was not ideal, but it proved how resilient our patients and their families can be and should make them more confident to face future challenges.

Pediatricians also were forced to rapidly change many aspects of their practices. Almost overnight, new schedules and procedures were created as we worked to continue providing essential care while protecting the safety of ourselves, our staff, our patients and their families. Primary Care practices saw a precipitous drop in sick visits which has continued for over a year. We worked hard to make sure that patients continued to come in for their check-ups and immunizations, with some offices doing visits outside or in cars. While rates of

infections and injuries will likely increase as children resume going to school and camp and we eventually stop wearing masks routinely, it is not clear if the pandemic has changed parents' habits and their willingness to monitor minor illnesses at home before coming to the doctor's office.

Prior to the pandemic, telemedicine (TM) was just beginning to make inroads into pediatric care; most practices quickly implemented TM platforms to continue caring for children when an in-person visit was not essential. It will be interesting to see if TM remains a large part of most pediatric practices. It certainly offers convenience for families and allows the pediatrician to see the child in the home environment, which can be particularly helpful when managing mental health conditions. TM obviously cannot match the in-person physical exam and many times the personal connection is tenuous during virtual visits where it is difficult to read and respond to non-verbal cues and engage younger patients.

The AAP proved to be equally nimble over the past year. At the national level, led by the incomparable Dr. Sally Goza, the AAP worked tirelessly to address pediatricians' needs for PPE, information about the various clinical presentations of COVID-19, financial support for practices and advice on safely continuing to care for patients. The AAP was the country's voice on behalf of children and made sure they were not ignored during the pandemic. The Georgia Chapter was our champion at the state level, keeping everyone informed with weekly e-mail updates.

In The Martian, when it looks like rescue efforts have failed, Mark writes to his mission commander and asks her to visit with his parents:

Please tell them that I love what I do and I'm really good at it. And I'm dying for something big and beautiful and greater than me.

Our professional lives are dedicated to the health of children, something equally big, beautiful and greater than us. We serve that higher purpose daily by solving one problem at a time.

Robert Wiskind, MD, FAAP

Chapter Past President
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Resident Corner: Digital Media Use in Children



Kathryn (Kate) Peralta,
MD

Prior to the Covid-19 pandemic, pediatricians all over the world had concerns about the amount of time children were spending on digital media. When countries went into lockdown, however, it became less of a priority compared to the more immediate concerns of housing, food, access to medical care, and education.

Dr. Jenny Radesky, an expert on children and media at the University of Michigan, told countless parents not to feel guilty about allowing more screen time during the lockdowns. Lately, she has expressed some regret. Estimates of children's screen time have doubled during the pandemic. There is now a concern that, as we shift back to normalcy, there will be major withdrawal.

A child now spends an entire workday in front of a screen - not including online learning. As pediatricians, we are aware that this kind of screen time can lead to increased risk of sleep disturbances and obesity. We should be aware, however, that excessive digital media use can lead to behavior problems such as inattention, delays in developmental milestones, and loss of emotion regulation. In teenagers who are at risk, it can lead to increased anxiety and depression. It can diminish school

performance, potentiate early sexual socialization, and lead to income loss (through in-game or in-app purchases), cyber bullying, and exploitation. Digital media use by children can also lead to privacy violations, as a child may not understand the value of keeping personal information private. Nor do they

understand that mobile device derived data is collected and sold to third parties.

Some of the greatest violators of children's online privacy are their parents. "Sharenting" in the digital age can lead to identity theft, humiliation, privacy violations, and future discriminations. More than 90% of 2-year-old children already have an online presence. 80% of babies have an online presence.

To be fair, there are a great many advantages to having a child explore and eventually master the use of digital media. Gamification

theory has been applied to educational models and has proven to increase learning and retention of various subjects at school. Interactive media has been designed to help children with physical or intellectual disabilities communicate. During the pandemic, digital media helped children socialize with the friends they could not see in person. There are valuable social networks for youth with disabilities and those who identify as LGBTQI to find a supportive community. As digital media becomes increasingly diverse, it also helps children learn about, understand, and empathize with marginalized groups. Furthermore, digital media is inextricably connected to educational and work environments.

How do parents and providers navigate the complexities of digital media to encourage habits and activities that are safe and beneficial for children? First, we should assess parental media use. Like diet and activity, parental media use is a strong predictor of child media use. 27% of parents reported feeling addicted to their mobile devices. Heavy parental use of mobile devices is associated with fewer verbal and nonverbal interactions between parents and children. A child depends on these interactions for emotional connection as well as early childhood development of language, cognition, and social skills. Children under age 2 lack attention skills, memory, and

**Oh yes, we know it keeps them still,
They don't climb out the window sill,
They never fight or kick or punch,
They leave you free to cook the lunch
And wash the dishes in the sink—
But did you ever stop to think,
To wonder just exactly what
[TV] does to your beloved tot?**

-Charlie and the Chocolate Factory



Digital Media Use in Children

Continued from previous page.

symbolic understanding to learn from digital media as they do from in-person interactions.

Therefore, the AAP continues to discourage any amount of screen time for children under two years of age, and no more than two hours total screen time for children older than two. Not all screens are created equal, however. A good app for children should be developmentally appropriate and interactive. It should involve various types of learning and involve others. Digital media should not replace physical activity or interfere with healthy social interactions. Providers should encourage parents to understand the applications their child are using, set limits on digital media use to encourage unstructured, unplugged and off-screen play time, and create tech-free zones, such as the dinner table and bedroom. In households that attempt to place limits on digital media use, children have significantly less screen time. Providers should also provide resources to help parents navigate this complex world.

With any luck, we can reduce digital media use, without resorting to Chocolate Factory antics.

Kathryn (Kate) Peralta, MD

Pediatric Resident, PGY-3

Pediatric Resident Representative, Georgia AAP

Augusta University

Augusta



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July 22-24, 2021

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Georgia Chapter





Let's Catch-Up: Immunizing Children with Delayed Immunizations and Post-Vaccination Serologic Testing

Georgia recently marked the one-year anniversary of the shelter-in-place executive order issued in April 2020 to stop the spread of COVID-19. During the COVID-19 pandemic, some families were concerned about possible exposures in medical offices and thus delayed medical care for their children. Consequently, children did not receive recommended medical interventions including immunizations at the recommended intervals.

Immunization is critical in preventing diseases, especially for infants exposed to hepatitis B virus (HBV) at birth. During the pandemic, many hepatitis B-exposed infants did not complete the Hepatitis B (HepB) vaccine series at the recommended 6-month age mark or did not complete post-vaccination serologic testing at 9-12 months of age. These delays left HBV-exposed children at risk of developing HBV and delayed the identification of HBV-infected infants.

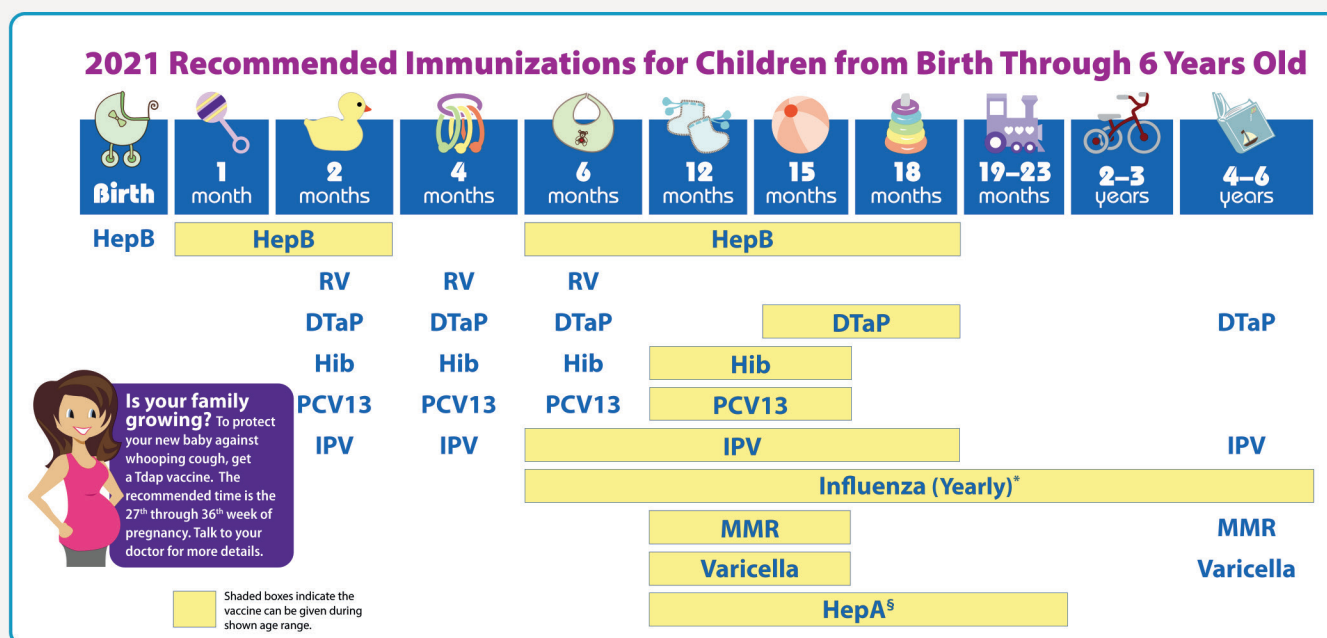
It is important for all children, including HBV-exposed infants, to catch-up urgently on their recommended immunizations to ensure they are protected against vaccine preventable diseases. Incorporating the activities below into your practice can help catch-up children with delayed immunizations:

References: [cdc.gov/mmwr/volumes/70/wr/pdfs/mm7006a1-H.pdf](https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7006a1-H.pdf)
Image: [cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf](https://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf)

- Adhere to the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule for children and adolescents
- Check the child's immunization status/history at all medical appointments
- Administer missing immunization dose(s)
- Recall infants and children that are not up-to-date for immunizations
- Contact the parent/guardian of HBV-exposed infants to schedule or provide a laboratory order for post-vaccination serologic testing (PVST)
 - * The PVST is recommended at 9-12 months of age and must include the hepatitis B surface antigen (HBsAg) and hepatitis B surface antibody (anti-HBs)

For more information contact the Georgia Immunization Program by phone at (404) 657-3158 or visit dph.georgia.gov/immunization-section.

Tracy Kavanaugh, MS, MCHES
Perinatal Hepatitis B Program Coordinator
Acute Disease Epidemiology Section
Georgia Department of Public Health
Atlanta





Memorial Health Dwaine & Cynthia Willett Children's Hospital of Savannah Now Open

After years of planning and construction, the Memorial Health Dwaine & Cynthia Willett Children's Hospital of Savannah opened for patients on March 9, 2021. The completed hospital is 90,000 square feet and was built at a cost of approximately \$66 million. "The Children's Hospital of Savannah has all of the services and technology we need to provide exceptional care for kids," said Dr. Brad Buckler, physician-in-chief. Highlights of the new facility include an 18-room emergency department with two resuscitation rooms, four operating rooms with two induction rooms where parents can stay with their child while they are put to sleep, a pediatric imaging unit with MRI and CT capabilities and sedation suites, a 14-room pediatric intensive care unit and more. A team of 108 pediatric providers including 40 pediatric specialists will provide care at the Children's Hospital of Savannah. Also, our Savannah colleagues Steve Thacker, MD & Alison Niebanck, MD will serve as Program Chairs for *Pediatrics By the Sea*.



Pictured: Ribbon cutting ceremony for Memorial Health Dwaine & Cynthia Willett Children's Hospital of Savannah (L to R) Todd Isbell, Chief Nursing Officer Memorial Health; Dr. Brad Buckler, Physician In Chief Memorial Health Dwaine & Cynthia Willett Children's Hospital of Savannah; Jackie Rabinowitz; Heather Newsome, Assistant Chief Nursing Officer Memorial Health Dwaine & Cynthia Willett Children's Hospital of Savannah; Karla Italiano and her daughter; Cynthia Willett; Shayne George, CEO Memorial Health; Hugh Tappan, President of HCA Healthcare's South Atlantic Division



Supporting Youth to Transition to Adult Models of Care Gets an Update



Charrelle Coates, MD

Many of my patients come to my office from their local pediatrician seeking to access care after aging out of their medical home. Youth are often relieved and grateful to know there is somewhere they can go to access the care they need as they complete their developmental journey to adulthood. Some youth just need follow-up on medication management while others have more complex care needs that may or may not still include the involvement of their parents.

Recently, I reached out to the Chapter to connect and identify ways I can support adolescent medicine in Georgia. It was comforting to learn that the Chapter and staff from the Maternal Child Health Section of the Georgia Department of Public Health have been working on educating pediatricians around the various resources available to support successful healthcare transitions. This experience led me to consider sharing this with you so that we can all best support youth and their families in achieving independent living - both in their day-to-day lives and in their ongoing healthcare needs.

The pediatric medical home is meant to be the safe space for the developing and growing child, but the AAP's own Periodicity Schedule ends at age 21. With the continuation of health insurance coverage through the age of 26 for

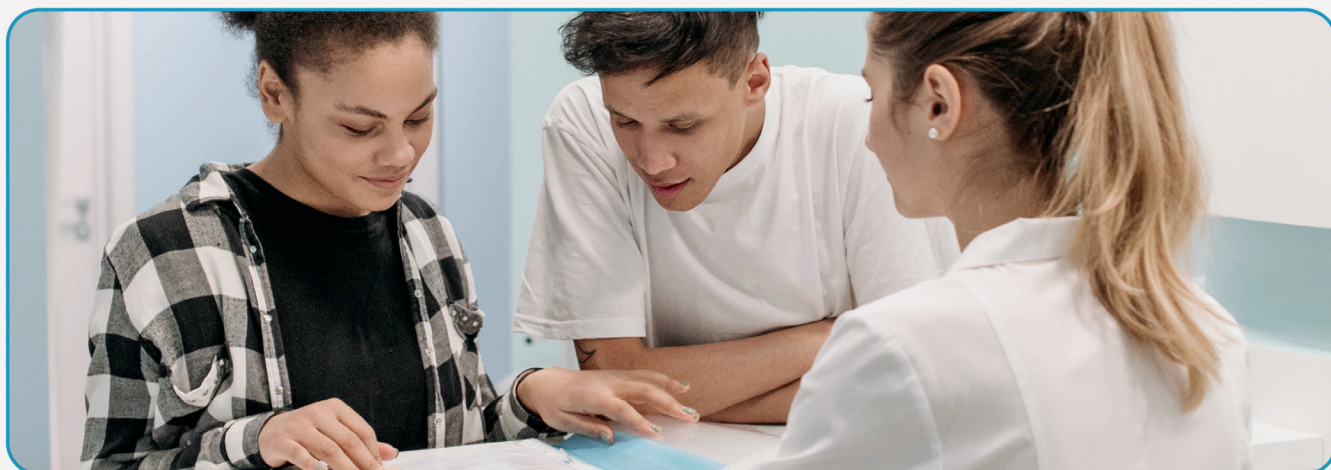
those with private insurance and opportunities for those in foster care to continue coverage through the age of 27, access to health insurance has become less of a barrier in continuing to receive needed care. Our move, however, to meet these opportunities with practice policies that engage adolescents and young adults so that they can master

navigating the health care system is lagging - especially as this age group is still developing a prefrontal cortex. It is time for us to level up.

The first step in leveling up is to explore Got

Transition® atgottransition.org and the many resources it has to offer. I recommended reviewing How to Implement the Six Core Elements of Health Care Transition offered by Got Transition®. This guide outlines how to put into practice the Six Core Elements of Health Care Transition™ 3.0. If your practice is part of a hospital system, there is a revamped guide for each model of care to enhance healthcare transitions: Transitioning Youth to An Adult Health Care Clinician, Transitioning to An Adult Approach to Health Care Without Changing Clinicians, and Integrating Young Adults into Adult Health Care. The updated Six Core Elements lead you through opportunities to make small steps in your practice for big impacts in successful healthcare transitions for the youth, young adults, and their families that you serve.

The pediatric medical home is meant to be the safe space for the developing and growing child, but the AAP's own Periodicity Schedule ends at age 21.



Youth to Adult Care Transition Update

Continued from previous page.

While there is much to be done, and Got Transition® is only a starting place, this fresh look at the Six Core Elements supports you through the process of healthcare transitions step-by-step and with minimal additional effort:

1. Transition Policy

A sample transition policy statement that can easily be adapted to your practice

2. Tracking and Monitoring

A sample transition flowsheet is available to better help track each individual patient's process of transition

3. Readiness

A tool which allows you to assess objectively the readiness of the youth, parents, and your own staff which can be an essential tool in the transition process

4. Transition Planning

The Sample Plan of Care can help youth map out their care goals and how to achieve those goals once they leave your office

5. Transfer of Care:

The Sample Transfer letter allows you to take a direct step to support your patient whether your patient is just heading to a different practice within your health system or headed to a practice across town; this letter can go a long way to keeping youth on the right path to continued good health.

6. Transfer Completion:

The Sample Healthcare Transition Survey can help you look at how your patients achieved this important process along with helping you continue to make practice improvements

1

POLICY/GUIDE

Develop, discuss, and share transition and care policy/guide

AGE 12-14

2

TRACKING & MONITORING

Track progress using a flow sheet registry

AGE 14-18

3

READINESS

Assess self-care skills and offer education on identified needs

AGE 14-18

4

PLANNING

Develop HCT plan with medical summary

AGE 14-18

5

TRANSFER OF CARE

Transfer to adult-centered care and to an adult practice

AGE 18-21

6

TRANSITION COMPLETION

Confirm transfer completion and elicit consumer feedback

AGE 18-23

Lastly, if your office needs help in understanding how these resources can help you in managing the healthcare transition of the youth in your practice, please feel free to reach out to the Chapter or be on the lookout for our CME and CEU activities that we will be offering to Chapter members. We continue to collaborate with the Georgia Department of Public Health on this important issue and can identify local resources that can help you support youth and their families continue to access healthcare into their adulthood.

Charrelle Coates, MD

Vice Chair, Adolescent Medicine Committee, Georgia AAP
Adolescent Medicine-Pediatrics
Memorial Health University Medical Center
Savannah

References:

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Georgia Chapter

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Looking Ahead:



Join us for our upcoming virtual events!

Ga Pediatric Nurses & Practice Managers Association Spring *On-Demand* Meeting

May 2-31, 2021

Register Here: gaaap.org/spring2021pn

Pediatric Infectious Disease & Immunization Webinar Series

Register Here: register.gotowebrinar.com/register/4957005651279968013

- June 2, 2021, 12:30 – 1:30 pm: Red Book Update – *David Kimberlin, MD, FAAP*
- June 9, 2021, 12:30 – 1:30 pm: Vaccine Hesitancy in Light of COVID-19 – *Capt. Amanda Cohn, MD, FAAP*
- June 16, 2021, 12:30 – 1:30 pm: COVID-19 Vaccine Update for Children – *Evan Anderson, MD, FAAP*

Pediatrics by the Sea, Hybrid (Virtual & In-Person) CME Meeting

July 22-24, 2021

The Ritz-Carlton, Amelia Island, FL

Register Here: gaaap.org/pediatrics-by-the-sea-2021

EPIC Immunization Webinars are Held Regularly

Register Here: surveymonkey.com/r/3WYBCPY

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Visit the Chapter Website for details on Chapter events. www.GAap.org
Call (404) 881-5020 for more information.