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Georgia Chapter

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

The GEORGIA Pediatrician

A Publication of the Georgia Chapter of the American Academy of Pediatrics

President's Letter

Angela Highbaugh-Battle, MD, FAAP

Greetings, Georgia-AAP! My name is Angela Highbaugh-Battle, and I am the new president of this wonderful organization. I am a general pediatrician and have practiced in a multi-specialty group in St. Marys for the last 3 years. Prior to moving to St. Marys, I was in a solo-private practice in Hazlehurst for 12 years. Leaving my rural practice has been my most difficult professional decision. The impetus for the change was my realization that I needed to establish much better work-life balance. I have found this change to be beneficial for my family and am pleased that I took the leap. Making a major career change usually means putting yourself first for at least a time. Pediatricians are natural advocates, but we have to remember that in addition to advocating for the children to whom we provide care, we have to advocate for ourselves.

The last over 2 years of this pandemic have been, in a word, trying, for all of us. While the pandemic persists, we are now in the position to start to make decisions about what comes next. Perhaps, the silver lining is that each of us now has the opportunity to re-evaluate the importance of various aspects of our personal and professional lives. Hopefully, we are all taking the opportunity to put our own needs first for a change.

The AAP recently hosted its Annual Leadership Forum which brings together chapter leaders from every state. One of the tasks of the Forum attendees is to select resolutions which will guide AAP priorities. One resolution which was added during the Forum was generated from discussion of members of our district. (District X includes Georgia, Florida, Alabama, and Puerto Rico). Our new Vice-President, Nicola Chin, MD of Atlanta, Legislative Committee Chair, Melinda Willingham, MD, our very own Immediate Past President of the AAP, Sally Goza, MD, and Executive Director, Rick Ward were part of the discussion. The resulting resolution entitled Supporting Pediatrician Advocates Experiencing Adversity was the top resolution. Pediatricians have been pushed emotionally, physically, mentally, and financially during this pandemic. We are facing a youth mental health crisis, increasing vaccine hesitancy, and even reemergence of certain vaccine preventable diseases. I appreciate the work each of you does daily to promote the health of the children of Georgia. For many of us, the work is now more challenging than ever. As we broach this new phase of the pandemic response, please use the opportunity to assess the toll of your work and advocacy on your mental well-being. This may be the time to become involved in a Chapter committee that aligns with a child health topic for which you are passionate. This may also be the time to decline an activity that is no longer fulfilling to you. Additionally, you may have a colleague that would benefit from a comforting word or just a listening ear. We can support each other in our quest onward. I encourage each of us to be present and enjoy the hilarious moments that are presented to us as pediatricians on a daily basis. I had a very intelligent 3-year-old educate me that his dinosaur was a Tyrannosaur Rex rather than just a T. Rex as I suggested. I hold on to these special moments because sometimes, I need a reminder to smile.

Pediatricians have been pushed emotionally, physically, mentally, and financially during this pandemic. We are facing a youth mental health crisis, increasing vaccine hesitancy, and even reemergence of certain vaccine preventable diseases.

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Next, I will ask each of you to take the opportunity to continue to use your voice to advocate for children and the pediatricians who care for them at the local, state, and national levels. We have to continue to build coalitions both within and outside of the Chapter to solve some key pediatric issues. Our Injury, Violence, and Poison Prevention Committee is chaired by Dr. Kiesha Fraser Doh. The epidemic of gun violence that is gripping our nation continues to need thoughtful and creative solutions. I can hardly bear to watch local news because of the daily stories of young people who are senselessly losing their lives. The Committee is working on a Toolkit for members to help strengthen our awareness, knowledge, and understanding of interventions available now. Our newly renamed Environment Health and Climate Change Committee will now be led by Dr. Anne Mellinger-Birdsong. The distinguished members of this committee have been sounding the alarm on the negative effects a polluted environment and altered climate can have on our children. I am looking forward to more education in this area. Our Mental Health Committee, led by Dr. Evan Brockman has been working feverishly to provide education to pediatricians on providing care to our patients struggling with mental health issues. Additionally, the Chapter is working to ensure that pediatricians all over the state have access child and adolescent psychiatrists via a consult line. I could fill pages with all of the work that is being done. There is so much work to do and we have great people doing it. We need even more pediatricians to join committees to broaden our ability to effect change.

I look forward to leading this Chapter into the next phase of advocacy and activities. I am excited about upcoming Webinars and CME Conferences. Our educational sessions are delivered by terrific local and national faculty. A considerable amount of work goes into planning a panel of lectures to update and enhance daily practice. Please plan to attend. The immersive experience always leaves me feeling relaxed and ready to get back to having a positive impact on the health of children. Additionally, I am reminded what a great group of people pediatricians are. Thank you for the opportunity to introduce myself. I look forward to getting to know more members and growing our advocacy efforts. Please let me hear from you if you have suggestions or comments.

Angela Highbaugh-Battle, MD, FAAP
President, St. Marys

See and Be Seen

Michael J. Ramsey, MD, FAAP

It's been a tough few years.

For most of us, the pandemic has brought one of the most challenging times in our careers. The physical demands of protecting and monitoring our own health constantly were layered on top of intellectual demands of maintaining a mastery of constantly changing information about COVID-19, its treatment, and its prevention. We have been called on to provide reassurance to our patients, families, and friends when we, ourselves, have been unsure and unsettled. In that spirit, I would like to say something to you that you cannot hear enough.

Thank you.

Thank you for wearing a mask and protective gear every day, sweating while taking care of sick children.

Thank you for taking time to explain why someone didn't meet guidelines for a COVID test at that time.

Thank you for pressing to obtain a COVID test when you felt it was important, but the family and patient did not.

Thank you for explaining over and over quarantine guidelines, interpreting every unique exposure situation, and being incredibly consistent.

Thank you for working with your staff to implement new protocols and procedures, and then revising them again and again as more information became available.

Thank you for making the hard decisions of bringing someone into the office or treating them at home.

Thank you for worrying over your practice's bottom line, trying to keep people employed when there were few patients to be seen.

Thank you for digging in and getting the work done when you were overwhelmed with the number of patients needing care during a surge in cases.

Thank you for your grace and resilience as friends, family, and partners got sick and you had to pick up extra duties at work and home.

Thank you for persevering, and for still being here.

An important part of preventing burnout is to recognize the mission of what we do when its implementation gets hard. We need to make sure that our colleagues feel seen, that they know that we understand what they are going through.

I know what you are thinking – "Of course they know – I'm going through it, too! Why do I need to say anything?" Even though we are going through the same challenges, there is immense power in verbalizing to others that their burdens are noted and appreciated. We desire to be seen, to be understood. No one understands more about what we have gone through than other pediatricians. We are uniquely able to know the depth of what our colleagues have experienced these past two years. Nothing, therefore, can be more meaningful than to be appreciated by someone who truly understands.

An important part of preventing burnout is to recognize the mission of what we do when its implementation gets hard. We need to make sure that our colleagues feel seen, that they know that we understand what they are going through.

I write this with humility, knowing that I have not done this nearly enough. My desire is to see and be seen, to know and be known. Taking care of children is difficult under the best of conditions, and you do it with unparalleled compassion and competence. As we shift into a new phase of this pandemic, may we take the time to help our colleagues who are struggling. In doing so, we also help ourselves.

Thank you for all you do every single day.

Michael J. Ramsey, MD, FAAP
Vice Chair, District X, American Academy of Pediatrics
Dothan, Ala.

Mercer University and Georgia Department of Public Health Partner on Infant Mortality Initiative

Jacob C. Warren, PhD, MBA, CRA

An exploratory look into the root causes of infant mortality in rural Georgia is underway as part of a cooperative initiative with Mercer University School of Medicine's Center for Rural Health and Health Disparities (CRHHD) and the Georgia Department of Public Health (DPH) Maternal and Child Health (MCH) Section.

Despite evidence that racial and ethnic disparities in infant mortality persist in many rural communities throughout Georgia, more than 75% of the state's rural counties do not have a birthing hospital. From 2014-2018, the infant mortality rate (IMR) in Georgia was 7.43 deaths per 1,000 live births; however, rural counties have disproportionately high IMRs. As shown in Figure 1, rural counties are more likely to have IMRs both above the state average and more than 1.5 times the state average. In addition, all counties that have more than two times the state average are rural. Further, 11 of the 12 Georgia counties in which the IMR was at least five times as high in black babies as in non-Hispanic white babies were rural.

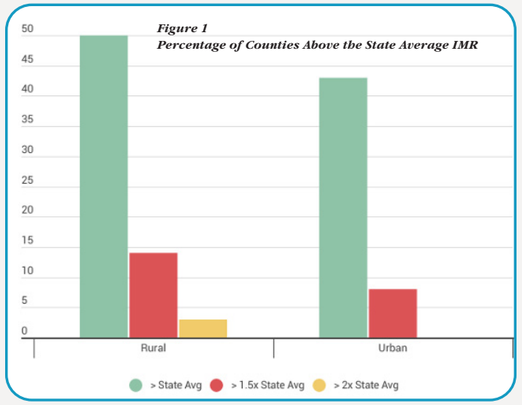


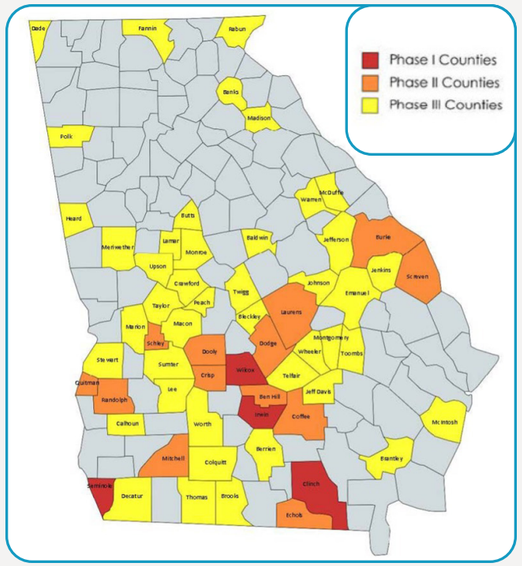
Figure 1
Percentage of Counties Above the State Average IMR

Addressing these disparities and understanding the underlying factors driving infant mortality in rural Georgia is a top priority for CRHHD and DPH. The team developed a comprehensive environmental scan to study the factors contributing to infant mortality disparities within rural communities throughout the state.

The initiative will be rolled out in three phases. In Phase I, focus groups will be conducted in the three rural counties with the highest reported IMRs, as well as the rural county with the highest disparity in African American infant mortality. These focus groups will delve into the dynamics of healthcare, prenatal and postnatal care, and the social determinants of health within these highly impacted communities.

The results of these focus groups will guide the pace and tone of Phase II, in-depth interviews with key community members and stakeholders to gain further detail on the factors affecting infant mortality. Phase II counties will include all rural counties with a reported IMR at least 1.5 times the state average.

Building on the crucial elements of Phases I and II, Phase III will conduct surveys of community members, healthcare providers, and other key stakeholders in all rural counties with a reported IMR above the state average.



Phase I Counties: Clinch, Irwin, Seminole, Wilcox
Phase II Counties: Ben Hill, Burke, Clinch, Coffee, Crisp, Dodge, Dooly, Echols, Irwin, Laurens, Mitchell, Quitman, Randolph, Schley, Screven, Seminole, Wilcox.
Phase III Counties: Baldwin, Banks, Ben Hill, Berrien, Bleckley, Brantley, Brooks, Burke, Butts, Calhoun, Clinch, Coffee, Colquitt, Crawford, Crisp, Dade, Decatur, Dodge, Dooly, Echols, Emanuel, Fannin, Heard, Irwin, Jeff Davis, Jefferson, Jenkins, Johnson, Lamar, Laurens, Lee, Macon, Madison, Marion, McDuffie, McIntosh, Meriwether, Mitchell, Monroe, Montgomery, Peach, Polk, Quitman, Rabun, Randolph, Schley, Screven, Seminole, Stewart, Taylor, Telfair, Thomas, Toombs, Twiggs, Upson, Warren, Wheeler, Wilcox, Worth

In addition to the three phases of primary data collection, secondary data sources will provide important information about access to care, underlying health conditions, and broader social determinants of health within the 60 rural counties being examined.

The project will create actionable recommendations to guide strategic planning and decision-making regarding rural infant mortality prevention in Georgia. If you are interested in learning more about the project, or if you live or practice in one of these counties and wish to participate in the project, please contact Dr. Jacob Warren, Endowed Chair and Director of CRHHD, at Warren_JC@Mercer.edu.

Jacob C. Warren, PhD, MBA, CRA
Rufus C. Harris Endowed Chair
Director of the Center for Rural Health and Health Disparities
Mercer University School of Medicine

Why We Should Start School Later

Brandon M Seay, MD, MPH, FAAP

While seeing patients in a pediatric clinic during the pandemic, pediatricians may have noticed one advantage to patients attending classes online. Being able to wake up around 1 hour before school starting and being able to make it to class on time makes it possible for teenagers to get 1-2 more hours of sleep than they usually would. Undoubtedly, this extra time can be an advantage in helping them perform better academically. This result of the pandemic points out one of the biggest changes that can be made to help adolescents in the state of Georgia, delaying school start times to allow students to get more sleep on a nightly basis.

As per the National Sleep Foundation, the proper amount of sleep for high school students is between 8.5-9.5 hours per night There is a biological delay in melatonin onset in teenagers that makes it difficult for them to get to sleep before 10-11pm. For adolescents to get the proper amount of sleep they need to wake up between 7-8 a.m. When school start times are before 8:30 a.m., getting a proper amount of sleep is almost impossible for adolescents.

For many school districts in Georgia, the school start time is before 8:30 AM and puts students at risk for increased obesity, metabolic dysfunction, lower levels of physical activity, anxiety, depression, impairments in judgement, risky behaviors, decreased motivation, impairments in executive function, and lower academic achievement. By delaying school start times, we hope to increase the total amount of sleep each student gets. The benefits include improved performance on testing, decreased tardiness, decreased motor vehicle accidents, and improved athletic performance.

This past summer, the Atlanta Public Schools had wanted to start high school earlier (7:45 a.m.!), but, when there was a public outcry against this time change, the school system changed course and delayed high school start times. This action shows the value of being an advocate for high school students and speaking out in their interest. The Atlanta Public Schools is a good start, but all over the state of Georgia, there are high school students who must wake up at 5-6 a.m. to get on their bus to get to school on time. With high schoolers not able to get to sleep before 10 p.m., getting the recommended amount of sleep is impossible for most students.

In pediatrics, we are in a unique position to not only educate about the importance of sleep for our patients, but also to advocate for it publicly at PTA meetings, school board meetings, or with local legislative representatives. Our voice can be very influential and needs to be heard.

Our goal for the entire state of Georgia should be to have all high schools start classes after 8:30 a.m. This change will help students perform academically and improve their overall health.

Brandon M Seay, MD, MPH, FAAP
Pediatric Pulmonologist and Sleep Specialist
Children's Physician Group Pulmonology at Scottish Rite

Nutrition Update Spring 2022

Jay Hochman, MD

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

1. New Hemoglobin and Ferritin Thresholds for Iron Deficiency in 1 yr-olds

E Mantadakis. J Pediatr 2022; 245: 12-14. (Editorial) Serum Ferritin Threshold for Iron Deficiency Screening in One-Year-Old Children nutrition.

N Mukhtarova et al. J Pediatr 2022; 245: 217-221. Serum Ferritin Threshold for Iron Deficiency Screening in One-Year-Old Children

Key points:

- This study included 3153 infants, with 698 included in the final analysis.
- 11.4% had iron deficiency, 3.5% had iron deficiency anemia, 8.2% had anemia, and 76.9% were normal.
- "The authors showed that the hemoglobin threshold of 110 g/L that is currently recommended for diagnosing anemia at 1-year-old well-child visit corresponds with a very low serum ferritin (4.42 mcg/L)."
- In a previous study, TARGet Kids!, "a higher serum ferritin was associated with higher cognitive function, with a serum ferritin of 17 mcg/L corresponding with the maximum level of cognition."
- Thus, current hemoglobin levels and ferritin need to be revised. Neither a hemoglobin of 11.0 g/dL nor a ferritin of 12 mcg/L is sensitive in detecting iron deficiency in toddlers.
- In the U.S., only ~40% of anemia in toddlers is attributable to iron deficiency; thus, checking a ferritin can help determine if iron supplementation is worthwhile.
- These articles make a strong argument for a ferritin threshold of at least 18 mcg/L, and for checking ferritin along with a hemoglobin. Iron deficiency anemia is a late indicator of iron deficiency and relying on hemoglobin alone could have irreversible detrimental effects on cognition.

2. Avoidant Restrictive Food Intake Disorder (ARFID): A Downside of Diet Therapies

C Melchior et al. Clin Gastroenterol Hepatol 2022; 20: 1290-1298. Open Access. Food Avoidance and Restriction in Irritable Bowel Syndrome: Relevance for Symptoms, Quality of Life and Nutrient Intake

HB Murray, K Staller. Clin Gastroenterol Hepatol 2022; 20: 1223-1225. Associated editorial. Open Access: When Food Moves From Friend to Foe: Why Avoidant/Restrictive Food Intake Matters in Irritable Bowel Syndrome

Background: Often dietary therapies are implemented to improve gastrointestinal symptoms in conditions like irritable bowel syndrome. However, in addition to potential nutrient deficiencies, these diets may trigger anxiety around eating and provocation of eating disorders.

Key points:

- In total, 13.2 % of the patients reported severe food avoidance and restriction, and in these patients all aspects of quality of life were lower ($P < .01$) and psychological, GI, and somatic symptoms were more severe ($P < .05$).
- "The sine qua non of ARFID is a reduction in food intake, in terms of volume and/or variety, not primarily motivated by body image disturbance"
- "Motivations behind changes in eating in ARFID need to be 1 or more of 3 prototypical presentations: (1) fear of aversive consequences (eg, IBS symptoms), (2) a lack of interest in eating or low appetite, and (3) sensitivity to sensory characteristics of food (eg, taste, texture, smell)"
- "Weight suppression has similar deleterious health effects as is seen in anorexia nervosa, including cardiac abnormalities and bone mineral density loss"
- "Up to 90% of patients in IBS reporting avoidance of specific foods"
- These articles further emphasize the point that nutritional counseling is important for restrictive diets and that most of these diets are intended to be liberalized after several weeks. That is, foods are reintroduced gradually to determine which foods need long-term avoidance.

Continued from previous page.

3. Medical Therapy on the Horizon for Obesity

AM Jastreboff et al NEJM 2022; DOI: 10.1056/NEJMoa2206038. Tirzepatide Once Weekly for the Treatment of Obesity

The new tirzepatide trial, called SURMOUNT-1, included more than 2,500 adult volunteers (w/o diabetes). Nine out of 10 lost weight, and on the highest dose, 15 mg, they lost an average of 52 pounds each. Depending on the dose, the average weight loss was 15-21.% This medication is likely to cost in the vicinity of $1600 per month. Another obesity treatment approved last year called semaglutide, from Novo Nordisk, provides an average of up to about 15% weight loss.

4. Bridles Secure NG Tubes

JA Lavoie et al. JPEN 2022; https://doi.org/10.1002/jpen.2409. Nasogastric Bridles are Associated with Improved Tube-Related Outcomes in Children

Children with bridled NGTs were compared to their non-bridled NGT counterparts (all results below with p values <0.02):

- 16.67 times less likely to experience ≥1 dislodgement (OR=0.06)
- 2.5 times less likely to have one more ED visit (OR=0.4)
- 4.76 times less likely to require one more radiographic exposure (OR=0.21)

Please contact me at jhochman@gicareforkids.com with questions and suggestions.

Jay Hochman, MD
Vice Chair, Committee on Nutrition, Georgia Chapter AAP
Blog site: gutsandgrowth.wordpress.com

Our Mission

Robert Wiskind
MD, FAAP

After storming the beach at Normandy in the beginning of Saving Private Ryan (1998), Captain Miller and his men are charged with finding James Ryan, whose 3 brothers recently died in combat. The military commander wants to make sure that one son survives to return to his family. During their search for Ryan, the soldiers come across a German machine gun entrenched at the top of a hill. The men are reluctant to take on this difficult task, saying "Why don't we just go around the thing? We can still skip it and accomplish our mission." Miller responds "You just want to leave it here so they can ambush the next company that comes along? Our objective is to win the war."

These are difficult times to be child advocates as Georgia and other states pass legislation harmful to children and the activist U.S. Supreme Court limits hard-earned rights. It is tempting to avoid these difficult issues and focus only on the child in front of us in the exam room. We can't leave the fight, however, to the next generation of Pediatricians and leaders but need to act now in hopes of guaranteeing the freedom and health of our patients.

By ignoring 50 years of precedence and overturning Roe v. Wade, the Supreme Court has allowed states to restrict severely or totally ban access to safe abortions. Unless overturned, Georgia's 2019 law banning abortion once the fetus has a heartbeat (around 6 weeks gestation) will go into effect. Many girls and women do not even know they are pregnant until after that 6-week mark - meaning they will be denied access to a procedure that is significantly safer than carrying a pregnancy to term.

We must have frank conversations with our teen patients (and their parents, as appropriate) making sure they understand their limited options should they become pregnant. Consistent condom use must be discussed with all sexually active teens and combined with another form of birth control (oral contraceptives or LARC).

On 6.24.22, the AAP president Dr. Moira Szilagyi wrote that "the American Academy of Pediatrics (AAP) this morning reaffirmed our longstanding policy supporting adolescents' right to access comprehensive, evidence-based reproductive healthcare services, including abortion. Today's ruling means that in many places in the United States, this evidence-based care will be difficult or impossible to access, threatening the health and safety of our patients and jeopardizing the patient-physician relationship.

"In the wake of this ruling, the AAP will continue to support our chapters as states consider policies affecting access to abortion care, and pediatricians will continue to support our patients."

In my opinion, every female should have Plan B available to take after unprotected intercourse and Pediatricians should become comfortable prescribing medical abortion pills (or referring to someone who can provide this to our patients before 6 weeks of gestation). Another option, in my opinion, would be to recommend sexually active females take a pregnancy test every month to ensure they can detect a pregnancy while they still have an option to terminate it.

Despite overwhelming evidence that the proliferation of firearms makes everyone less safe, Georgia has some of the weakest gun laws in the country. There are no restrictions on assault rifles or large capacity magazines, no safe storage requirements, no limits on concealed carry, no waiting period to buy a gun, no requirement to have a license to carry a gun, no red flag laws and no restrictions or regulations on gun show sales.

In addition to advocating for common sense policies to reduce gun violence, we should continue to discuss guns frequently in the exam room. Tell parents that guns in the home are far more likely to shoot a family member than an intruder. Counsel families not to have guns in the home; if they do have guns, make sure they know the importance of safe storage and additional protections like trigger locks. All medical offices should be gun-free zones and we should encourage businesses to do the same (at least until the Supreme Court takes away that right).

Due to recent legislation, Georgia prevents transgender youth from playing sports on teams that match their gender identity and denies them the benefits of physical activity and being part of a team. Legislation has been introduced, but failed to pass so far, which would prevent trans children from getting gender affirming care. We must remain open to discuss gender and sex with all patients and support them as they navigate a hostile world.

After locating Ryan, Miller and his men try to hold a strategic bridge against a German advance. Most of the men die, including Miller. With his last breath, Miller implores Ryan to "Earn this. Earn it." The movie closes with Ryan, visiting Miller's grave 50 years later, saying "I hope that at least in your eyes I've earned what all of you have done for me." At the end of my career as a Pediatrician, I hope that I will have earned the trust placed in me by patients and families and the opportunity to impact positively their lives and those of future generations. That is my mission.

Robert Wiskind, MD, FAAP
Past President, Georgia AAP
Peachtree Park Pediatrics, Atlanta

Sports Medicine Committee Update & PPE Reminders for 2022-2023 School Year

Shelley Street Callender,
MD, CAQSM, FACP, FAAP

I. PPE form changes

In May, the Georgia High School Association (GHSA) changed from using the 5th edition of the Sports Preparticipation Physical Evaluation (PPE) form for Sports Clearance for 2022-2023 School Year – to the older 4th edition, copyright 2010. This change was based on their desire to remove the question of gender identity on the history form, found on the 5th edition.

As of August 1, 2022, they have changed to an adapted version of the 5th edition, with the change of the "sex assigned at birth" to being open ended and omission of the gender identification question. These forms are available at https://www.ghsa.net/forms in English and Spanish and can be accessed at https://d31hzlhk6di2h5.cloudfront.net/20220815/db/34/b9/a4/7f1f6bc1aad9008094b576fa/GHSA_PPE-Form-English_fillable_Revised.pdf

This version has been shared with the AAP and we want to provide the following reminders:

- The AAP continues to endorse and encourage use of the 5th edition in its original form.
- Additionally, for clarification members are reminded that ONLY the Medical Eligibility Component of the PPE Form should be submitted to the school or recreational association. The PPE forms include HIPAA protected information and should be retained by your office in the student-athlete's medical file. Therefore, do not forward the History Form (which includes the question on gender) nor the Physical Examination form to the school.

Steps for completion of the PPE forms:

1. The student athlete or parent is encouraged to fill out the History form and turn it into their pediatrician prior to the medical examination.
2. The physician reviews the history form and asks clarifying questions during the physical examination. Physicians are encouraged to use the PPE 5th edition Physical Examination form. After the examination, the physician determines if the student athlete is cleared for medical eligibility, has restrictions, or should be examined by a specialist for any medical concerns that arise during the visit.
3. The ONLY form that should be submitted to the school or recreational association is the Medical Eligibility form. The History form and Physical Examination form should be retained by the practice in the student-athlete's medical file

II. Concerns regarding mass school physicals

This practice continues and is strongly discouraged by the AAP due to the variability of sport physicals that are occurring outside of the youth's medical home. Also, when schools provide these physicals, they have access to all parts of the PPE forms, not just the Medical Eligibility form as previously discussed. We encourage you to share with your families that, even though mass school physicals may be convenient, they should be aware of the risk involved. This issue is being followed by the AAP and other organizations and we will continue to advocate for the sports physical to be conducted within the medical home.

III. We need you!

Lastly, we are looking for general pediatricians to join our committee! The committee is open to all Chapter members. If you an interest in sports medicine and would like to join or have questions, please contact Kylia Crane, RDN, LD at the Chapter office at kcrane@gaaap.org.

Shelley Street Callender, MD, CAQSM, FACP, FAAP
Sports Medicine Committee, Chair
Georgia AAP

Mental Health Matters

Evan Brockman, MD, MPH, FAAP

"What's the point of having a voice if you're gonna be silent in those moments you shouldn't be?" This quote from Starr Carter, the 16-year-old protagonist of Angie Thomas's award-winning novel, The Hate U Give, immediately springs to mind while reflecting on many issues faced in pediatrics today.[1] As pediatricians, we are ideally positioned to be advocates for children's health in ways both small and grand. For example, we all are aware that the ongoing pandemic continues to exacerbate the mental health crisis facing our youth. One in five children in Georgia experiences a mental health condition prior to age 18 and yet fewer than half receive timely services.[2] One solution to address unmet child mental health needs and be a voice for children is to integrate a degree of mental health care into the primary pediatric medical home.

The fundamental nature of primary care, which is to promote and track healthy child development, forms a foundation from which to detect emerging mental health issues. Managing or co-managing mental health care in the context of the family unit and with a pediatrician's expert knowledge of co-occurring medical conditions benefits patients and results in better health outcomes. Moreover, research shows commonly occurring conditions such as anxiety and depression can be prevented or ameliorated by early intervention[3]. As pediatricians become more comfortable and confident in the role of identifying and addressing mental health concerns, the burden of late adolescent and adult mental health disorders will also be reduced[4].

Bright Futures provides the forms and materials that pediatric professionals need to cover preventive health visits and screenings effectively.[5W] In July, an implementation tip sheet for promoting relational health was added. Early Relational Health (ERH) begins during pregnancy and is established by 1 year of age. The AAP notes differences between the toxic-stress framework, a problem focused model based on what happens biologically in the absence of mitigating factors, and the strength-based relational health framework, which promotes the skills needed to respond to future adversity in a healthy, adaptive manner. Both models are useful as pediatric health professionals effectively counsel and treat emotional and behavioral concerns including attachment disorders, disruptive behavior, and attention deficit/hyperactivity, anxiety and mood, and eating and sleep disorders.

For those who are interested in learning more, the Chapter offers a variety of ways to help members improve confidence and competency, whether it be performing a mental health screen or a diagnostic assessment, initiating treatment of common mental health conditions, or accurately coding for better reimbursement. Below are a few examples. Be sure to check out the Chapter website for registration details and other related events.

- An ECHO on Early Relational Health and the Pediatrician's Role in Infant Mental Health, August 26.
- A webinar titled Integrating Behavioral Health Screenings for Better Health Outcomes, October 19. As part of a five-year HRSA grant, and in collaboration with DBHDD, Georgia Department of Early Care and Learning (Decal), the Georgia Department of Public Health (DPH), and Augusta Children's Hospital faculty, an ECHO of two cohorts covering Anxiety and Depression launched in August with future cohort classes expected to follow.
- Pediatrics on the Parkway Fall CME meeting, November 17 at Cobb Galleria in metro Atlanta offers a full afternoon seminar dedicated to supporting mental health in adolescents.

If you are interested in effecting change at the state level, you may wish to join the Behavioral Health Physician Advisory Group. This committee was established in October 2020 for the purpose of supporting the Chapter's work related to behavioral and mental health. Now, at the two-year anniversary of that initial meeting, the group consists of highly engaged physicians around the state plus two talented Chapter staff and meets monthly to discuss various methods to improve behavioral and mental health care for children and adolescents in Georgia. We cover topics from post-partum depression to ERH to best practices for implementing screening, school mental health, bias in mental health assessment/intervention, barriers to treatment, and more. All perspectives are welcome. For more information, please contact Hannah Smith, MHS, Coordinator for Behavioral Health Services, at HSmith@gaaap.org.

Improving bi-directional communication with partnering healthcare professionals is one critical issue that our committee continues to tackle. Health outcomes improve when communication among providers improves. The key is understanding and building upon local trusted resources. Many pediatricians utilize safety net services offered by local Community Service Boards (CSBs). If you have not seen our CSB guide, please check it out on the Chapter website. This guide, in partnership with the Department of Behavioral Health and Developmental Disabilities (DBHDD), provides information on how CSBs operate and what specific services can be found at each of the 26 CSBs around the state.

During the 2022 state legislative session, the Georgia Assembly passed the Mental Health Parity Act. Signed into law by the governor in April, the new law, which took effect July 1, 2022, is based on the first-year recommendations from the state's Behavioral Health and Innovation Commission. This law ensures that, for the first time in Georgia, public and private health insurance plans must cover behavioral health equitably with physical health. Georgia families will have better access and coverage of mental health services. Given that early intervention is key to positive health incomes and

Mental Health Matters

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that roughly half of all mental illnesses start prior to age 18, this is a paradigm shift for practicing pediatricians in the state and another strong reason to integrate services in your practice setting.

The new law also provides a system for mandatory reporting of compliance by insurance companies, outlines measures to increase the training and number of allied mental health professionals in the state, improves training of law enforcement officers when responding to mental health related calls, and contains legal verbiage to ensure adequate funding for enforcement of the law. More reforms are anticipated to roll out over the next four years.

As we enter the back-to-school season, behavioral and mental health visits will increase. Be ready to address the concerns of your patients and their families within the setting of the medical home. Whether by joining a Chapter committee, becoming involved in the local school and community or through state level advocacy, or by finding the extra 10 minutes that a family needs, your voice is essential. Please speak up for kids. This is not the time to be silent.

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Chair, Behavioral Health Committee, Georgia AAP

Vaccine Updates Fall 2022: What do I Need to Know as I Move into Fall?

Iyabode Akinsanya-Beysolow, MD, MPH, FAAP

Monkeypox (orthopoxvirus), first discovered in humans in 1970,[2] spread for decades in a few countries, particularly in areas with tropical rainforests. Currently, cases[1] are spreading in cities and countries around the world. Though most cases in the US have been identified in adults, there have been reports in children.

How is it spread?

Anyone can get monkeypox.

Human-to-human spread (the more common transmission route) occurs through prolonged physical contact with the infected person's rash or with materials/objects that were in contact with the rash (e.g., contaminated clothing, bedding). Other means of spread include large respiratory droplets from infected people. We are still learning how easily this occurs.

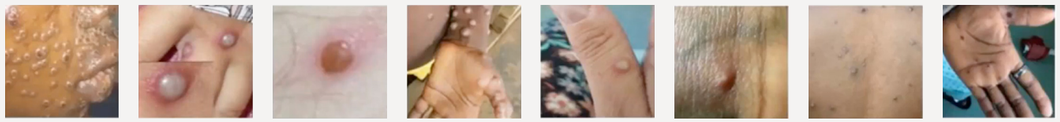
Due to prolonged, close physical contact, monkeypox can be spread during sexual contact. We are still learning whether the virus passes through semen or vaginal fluids; hence currently, we cannot call it an STD.

Animal to human spread[3] (rodents, non-human primates) to humans can occur through scratches, bites from infected animals and from eating undercooked meat. Transmission can occur from infected people to animals.[20]

How does monkeypox present?

- Incubation Period: The infected person does not have symptoms and may feel fine. Lasts approximately 1-2 weeks. *A person is not contagious during this period.* Physicians are currently recommended to monitor patients for up to 21 days.
- Prodrome: These symptoms may include fever, malaise, headache, sore throat, or cough, and (in many cases) swollen lymph nodes in the submandibular & cervical, axillary or inguinal regions, on both sides of the body or just one. *A person may be contagious during this period.* Instruct patients to isolate if they develop symptoms.
- Rash: In some recent monkeypox cases, people have presented with a rash without a recognized prodrome. The rash can look like pimples or blisters on the hands, mouth, and face, but also on other parts of the body, including genitalia and anus[5]. It can be confused with rashes in other illnesses, including varicella, zoster, herpes simplex virus, allergic skin rashes, hand, foot, and mouth disease (enteroviruses) or molluscum.

Many recent cases have only had localized lesions and not a diffuse rash. Lesions typically progress from papules, macules, vesicles, and pustules to scabs. *A person is contagious until after all the scabs on the skin have fallen off and a fresh layer of intact skin has formed underneath.* Decisions regarding discontinuation of isolation should be made in consultation with the local or state health department.



Source: pictures from DPH Monkey pox provider webinar slides 8/8/22 slide 10)

Who is at increased risk for severe disease from monkeypox?[6]

Though anyone can get monkeypox, some young children (<8 years of age), pregnant or immunocompromised individuals, and individuals with a history of atopic dermatitis or eczema may be at significantly increased risk for severe outcomes.

Can I test for it?

- Yes. Clinicians should test patients with rash consistent with monkeypox, including firm or rubbery lesions, well-circumscribed, deep-seated, and often develop umbilication during the pustular stage.

Testing in the State of Georgia[7]:

- Submit specimens to commercial labs Commercial Testing Guidance for GA Providers 07.20.2022 or to the Georgia Public Health Laboratory GA Health Alert Network (HAN) 06.13.2022
- Advise patient to isolate at home[19] until results can be received, except for medical care. If positive, isolate for 21 days.
- Providers must report any positive results immediately to public health by calling 1- 866-PUB-HLTH.
- For infection control in healthcare settings, visit https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-healthcare.html.

Vaccine Updates

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Are treatments available for children?

- Most people will recover on their own in 2 – 4 weeks without the need for antivirals.
- Antivirals[8a,b](Tecovirimat, oral or IV administration) may be requested for children and adults at high risk for severe disease or complications under the expanded access investigational new drug pathway.

Is there a vaccine available for children and teens?

Yes. CDC recommends vaccination for people exposed to monkeypox and at high risk for infection or severe complications. The preferred vaccine is JYNNEOS, authorized (EUA)11 August 9, 2022, for people < 18 years of age. Live, non-replicating, a two-dose vaccine, 28 days (4 weeks) apart. Maximum immune protection may not be reached until two weeks after the second dose.

Dosing:

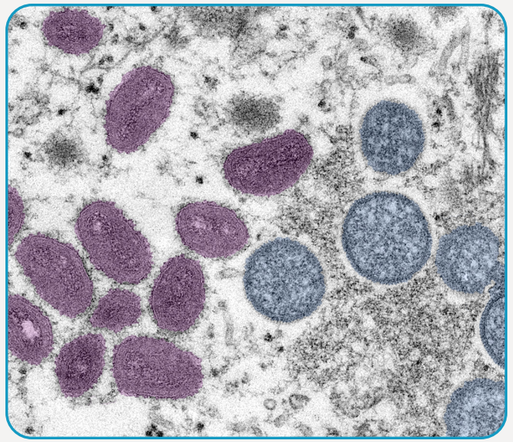
Standard regimen: **subcutaneous route of administration.**

Dose-volume: **0.5mL.**
Standard regimen is the FDA-approved dosing regimen.

Since August 9, 2022, the standard regimen has been authorized for people aged <18 years under an Emergency Use Authorization (EUA).

Special considerations include recommendations for intradermal dosing for administration in people with atopic dermatitis, eczema or other exfoliative skin conditions (https://www.cdc.gov/poxvirus/monkeypox/interim-considerations/special-populations.html)

- Alternate vaccine: ACAM2000 vaccine,9 single-dose. There are more limitations on the use of this vaccine, including not being recommended for people who are severely immunocompromised.
- No data on the clinical efficacy or effectiveness of JYNNEOS or ACAM2000 vaccines in the current outbreak are available. Because of these limitations, people who are vaccinated should continue to take steps to protect themselves from infection by avoiding close, skin-to-skin contact, including intimate contact, with someone who has monkeypox.



Cynthia S. Goldsmith, Russell Regnery, CDC
https://www.cdc.gov/poxvirus/monkeypox/response/2022/index.html

- See full interim guidance10 from the CDC's Advisory Committee on Immunization Practices (ACIP), including VIS, EUA Fact sheets, storage and handling, preparation and administration guidelines.

Can I administer it with other vaccines?

Yes. Currently, there is no data on administering the JYNNEOS vaccine simultaneously with other vaccines. Because JYNNEOS is a live, attenuated non-replicating orthopoxvirus, JYNNEOS typically may be administered without regard to the timing of other vaccines. This includes simultaneous administration of JYNNEOS and other vaccines on the same day but at different anatomic sites if possible.

Because of the observed risk for myocarditis after receipt of ACAM2000 orthopoxvirus vaccine, mRNA and Novavax COVID-19 vaccines and the unknown risk for myocarditis after JYNNEOS, people, particularly adolescent or young adult males, might consider waiting four weeks after orthopoxvirus vaccination (either JYNNEOS or ACAM2000) before receiving a Moderna, Novavax, or Pfizer-BioNTech COVID-19 vaccine12. However, if an orthopoxvirus vaccine is recommended for prophylaxis in an outbreak, orthopoxvirus vaccination should not be delayed because of the recent receipt of a Moderna, Novavax, or Pfizer-BioNTech COVID-19 vaccine; no minimum interval between COVID-19 vaccination with these vaccines and orthopoxvirus vaccination is necessary.

Resources:

- https://www.cdc.gov/poxvirus/monkeypox/clinicians/faq.html
- https://www.immunize.org/monkeypox/
- https://www.immunize.org/express/issue1640.asp#IZX1

Vaccine Updates

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Other vaccine news:

Additional COVID-19 vaccine, Novavax

- Novavax COVID-19 vaccine (Novavax, Inc) is a protein subunit adjuvanted vaccine. Authorized[18] under a EUA, July 2022, for people 18 years and older. ACIP recommends[19] a 2-dose primary series, each dose separated by 3-8 weeks. For details on dosing, scheduling, storage and handling, visit: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

- Currently, a booster dose using any COVID-19 vaccine is NOT authorized for adults who receive a Novavax primary series.

- Three doses are recommended in the primary series for moderately or severely immunocompromised people with mRNA COVID-19 vaccines (Pfizer-BioNTech and Moderna). Only two doses of Novavax are recommended at this time in this population.

Other vaccine updates:

At the June 2022 ACIP meeting, ACIP voted to approve the following recommendations. The CDC Director has adopted these. These recommendations become official once published in MMWR. Detailed guidance on use is forthcoming, pending MMWR publication.

Flu vaccine updates 2022-23 season:

- ACIP recommends13 that adults aged ≥65 years preferentially receive one of the following influenza vaccines: quadrivalent high-dose inactivated influenza vaccine (HD-IIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted inactivated influenza vaccine (aIIV4). If none of these three vaccines is available at an opportunity for vaccine administration, then any other age-appropriate influenza vaccine should be used.

- Proposed updates discussed at the June 2022 ACIP meeting14: All flu vaccines for the 2022-23 season will be quadrivalent, and the Influenza A (H3N2) and Influenza B/Victoria components will be updated. All standard-dose unadjuvanted IIV4s are now approved for ages six months and older.

New vaccine: PCV15

- The FDA licensed PCV15 (Vaxneuvance, Merck) on June 17 for use in children beginning at six weeks of age. PCV15 includes all serogroups in PCV13 (Prevnar 13, Pfizer), plus two additional serogroups. PCV15 may be used[13,15] as an option to PCV13 (13-valent pneumococcal conjugate vaccine) for children aged <19 years according to currently recommended PCV13 dosing and schedules.

New MMR vaccine

- MMR vaccine (Priorix, GSK) was first licensed in Germany in 1997 and is approved in over 100 countries. ACIP recommends[13,16] it may be used according to currently recommended schedules and off-label uses as an option to prevent measles, mumps, and rubella. Official guidance pending MMWR publication.

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Chair, Chapter's EPIC Immunization Advisory Committee

References

1. Case counts: https://www.cdc.gov/poxvirus/monkeypox/response/2022/us-map.html and https://www.cdc.gov/poxvirus/monkeypox/response/2022/world-map.html.
2. https://www.cdc.gov/poxvirus/monkeypox/about.html
3. Monkeypox in animals: https://www.cdc.gov/poxvirus/monkeypox/veterinarian/monkeypox-in-animals.html
4. https://www.healthychildren.org/english/health-issues/vaccine-preventable-diseases/pages/what-is-monkeypox.aspx
5. https://www.cdc.gov/poxvirus/monkeypox/symptoms.html
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Georgia Chapter

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Looking Ahead:
Join us for our upcoming events!

Pediatrics on the Parkway Fall CME Meeting
November 17-19
Cobb Galleria Centre, Atlanta

Pediatric Foundation of Georgia's Jim Soapes Charity Golf Tournament
April 26, 2023
Cherokee Run Golf Club, Conyers

Winter Symposium (in collaboration with the Georgia OB/GYN Society)
February 4, 2023
Atlanta Buckhead Marriott, Atlanta

Pediatrics by the Sea, Summer CME Meeting
June 14-17, 2023
The Ritz-Carlton, Amelia Island, FL

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Visit the Chapter Website for details on Chapter events. www.GAaap.org
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