Happy Spring to All!!

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

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First, it has been fantastic to pat ourselves on the back after such a successful state legislative session, but it was even sweeter to describe this experience to my colleagues across the US. We all worked exceptionally hard during the last session and continued that through this year with the oversight of our fearless leader Rick Ward, and Betsy Bates, our lobbyist. We found the niche—business model—that allowed us to grab the attention of our legislators and convince them how crucial keeping Georgia’s kids well would be inevitably a monetary savings in the long run for the state. Keeping kids insured and adequately compensating physician practices allows kids to stay well and keeps them out of ED. It seemed like such a simple message, but the approach was so important. Thank you to each of you who contacted your legislators and let’s keep the communication open with them throughout the year. An invitation to visit your office will give them an even clearer picture of what we do.

The AAP Annual Leadership Forum (ALF) in Elk Grove, Illinois in March was another powerful meeting of pediatricians—both general and subspecialists, and chapter executive directors. The chapters are so diverse in their structure, yet our goals are the same: to provide the best care, every time for every child. Some have staffs of 1, some of 4-5 and some have staffs of 20. This year we were nominated for an award in the Very Large Chapter category, and it ended up being a very, very tight race between our chapter and Texas. While we are sure we faced a major challenge with Medicaid parity in 2015, Texas faced a heart-wrenching challenge with the “internment” of unaccompanied minors, and moms/children in their state. We thought we had it rough taking on the state, but taking on the federal government—well, I have to tip my hat to that effort and so their outcome as winner in the Very Large Chapter category. ALF as you recall gives us (every pediatrician) the opportunity to address a policy that we feel needs updating (or initially addressed) on a national level. The amount of time that goes into reviewing all the submissions and staying within parliamentary standards is truly a herculean activity. We were well represented, from the number of resolutions submitted, to “scoring” of the resolutions, to our own Bob Wiskind serving as parliamentarian and keeping us civil.

And on my second trip to the annual Legislative Conference in DC this year, I was again to experience the passion of our colleagues as we trek into the “not always friendly” political arena. This 2½ day training provides invaluable insight and direction into the world of Congress. Last year we were assigned the task...
Public Health News & Chapter Updates

Points on HPV Vaccine for Pediatric Practices

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

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

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

Understand Why It's Important

Every year in the United States, 27,000 people still get cancer caused by HPV. That's one person every 20 minutes of every day, all year long.

- HPV causes cancers of the mouth and throat and anus in men and women, as well as cancer of the penis in men AND cancers of the cervix, vagina, and vulva in women.
- There are many more pre-cancers of the cervix requiring treatment that can have lasting effects on a woman's fertility.
- HPV is so common that almost everyone will be infected at some point.
- We have no way of knowing who will go on to get cancers caused by HPV once they are infected.
- Most people infected with HPV will never know they are infected.
- Even if someone waits until marriage to have sex, or only has one partner in their entire life, they could still be exposed if their partner has been exposed.
- The HPV vaccine is effective! It prevents infection with the most common and aggressive HPV types that cause cancers.

Make a Strong Recommendation

Bundle the adolescent vaccines and give a strong recommendation for boys and girls age 11-12. This is as simple as saying (while handing them the VIS):

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

Adolescents may not want to get three vaccines in one visit, but we know patients this age don't come to the office that often, so giving the 3 vaccines in one visit is the best way to make sure they are protected.

Giving three vaccines at one visit is safe and the protection we are offering adolescents is important and can save lives.

Finish the 3-Dose Series

Starting the series is an important step, but three shots are required for full protection. So before the patient leaves the office after HPV vaccination, it is important to make sure to set appointments for doses 2 & 3.

Make sure that systems are in place to remind patients of their vaccine appointments.

If a patient misses an appointment, a system to flag and recall patients is important.

For more information or to request an EPIC program, contact the EPIC staff: Janna McKelvey, MSN, RN, Program Director at 404-881-5051 and the EPIC® Immunization Program Coordinator at 404-881-3054.

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

More information.

Vaccine immunization schedule...Continued

From the President...Continued

I am happy to report that our pediatric colleagues from across the country stood their ground and I do believe there are staffers and hopefully members of Congress who tonight have a clearer understanding of how these programs protect our kids healthy from the start and keep them healthy and functioning well in school, and ultimately deliver them as healthy adults with less chronic disease that erodes our economic system.

Back on the local level, we are into all the QI projects now. I hope those who are involved on our QI Projects are enjoying the experience, and your practice is seeing the benefits.

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

The EPIC® Immunization program is ready to schedule your 2014 Program!

The EPIC® Immunization program is off to a great start this year. The 2016 curriculum is updated with the breastfeeding immunization schedule, new immunization data and great tools and resources for your practice. EPIC Immunization offers six curriculums to meet your staff education needs: Childhood, Adult, Contraception, Women’s Health, Family, and Coding for Childhood Immunizations (GA Chapter AAP Members Only).

EPIC® is a physician led, peer-to-peer immunization education program designed to be presented in the private physician office and involves the participation of the completing care team (provider, nurse, medical assistant, office manager, etc.). The program is free, offers CME and contact hours for participating physicians and nurses, and provides a valuable resource tool filled with useful immunization tools for your office.

Start planning to have your in-office EPIC® Immunization Program. We are scheduling programs for 2016 NOW!

Visit the GA EPIC website (gapeic.org) or EPIC Facebook page (Educating Physicians in their Communities) to receive up-to-date information or resources. For more information, contact the EPIC staff: Janna McKelvey, MSN, RN, Program Director at 404-881-5051 and the EPIC® Immunization Program Coordinator at 404-881-3054.

Five Hospitals Now “Baby Friendly”

Georgia has five Baby Friendly Hospitals and many others are working toward that goal. One criterion to becoming Baby Friendly is to, “Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic”. This is not always an easy task since hospital staff may not be aware of all the breastfeeding support services in their community. Finding...Continued (on page 4)
Schedule a EPIC Breastfeeding Pro-
gram for your practice today!
The EPIC Breastfeeding Education Program is ready to visit your practice. If you haven’t had a program recently please contact Arlene Toole, atoole@gaaap.org to request a program or go to our website www.gaepic.org to download an EPIC program request form. Remember our programs are free!

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

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

Pompe & MPS1: Plans are on underway to begin a pilot to screening all infants born in Georgia for Pompe and MPS1 early this summer. Pompe and MPS1 are both progressive, inherited lysosomal storage disorders. Although there is no cure for the conditions, monitoring and treatments are available. Pompe disease is a disorder of glycogen storage. Infants who are affected can have enlarged hearts and profound muscle weakness progressing to death if untreated. MPS 1 is a multi-system disorder with variable presentations including an early onset neurodegenerative form. MPS 1 symptoms may include developmental delay, coarse features, skeletal anomalies, recurrent infections, and organomegaly. Results will NOT appear on the newborn screening report as this is a pilot project. If the results are normal, notification will not be sent. If the results are abnormal, Emory Newborn Screening Follow-Up Program will fax a letter notifying you of the results, and we will call the provider listed on the NBS card.

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

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

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

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

School-Based Health Centers: Key Concepts & Status in Georgia
The School Based Health Center (SBHC) is a model of health care delivery that has been recognized as an effective means of providing quality healthcare for children that can significantly reduce barriers to health care for those living in poor communities. 1,2 SBHCs offer increased access to quality care for students by eliminating barriers such as cost, transportation, and hours of operation, and the lack of knowledge around how to manage one’s health and when to access care. In addition, SBHCs provide a sense of security to parents who rest assured in the knowledge that their child’s health care is covered at no or low cost; to school leaders who recognize that prompt attention to student illness means a faster return to the classroom and thus improved academic performance; and to employers who appreciate that employee productivity is affected when they are unable to attend to their sick children.

Although the majority of school based health centers are on school property, a small number are set up in other settings such as mobile health centers or telehealth centers. Services offered at SBHCs include routine wellness checks and sports physicals, immunizations, diagnosis and treatment of acute and chronic illnesses and injuries, mental, behavioral health and family counseling, nutrition counseling, school-wide health education and wellness programs, and specialist/community agency referrals. Many centers also offer additional services such as dental care and laboratory testing. The number of comprehensive school-based health centers has increased significantly over the past 15 years with the latest National Census of SBHCs in 2013-2014 reporting a total of approximately 2315 SBHCs operating throughout the country. The first School Based Health Center developed in Georgia is the Whitesfield Elementary School Health Clinic, followed by the Coon Middle School Health Clinic several years later. These SBHCs were the only two in Georgia until 2013, when the Emory University Department of Pediatrics created the Urban Health Program (later renamed PARTNERS for Equity in Child and Adolescent Health) to decrease health disparities with an emphasis on expanding School Based Health in the state. There are now 12 School Based Health Centers in Georgia with several more slated to open by the 2016-2017 school year. The Georgia School Health Alliance (www.gsaoha.org), an affiliate of the national advocacy group, School Based Health Alliance, was formed in late 2012. The Alliance’s mission is to develop community partnerships to advocate for, and provide technical assistance to, those interested in opening a school based health center.

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

It’s hard to treat what you can’t see...
Diatherix’s Gastrointestinal Panel identifies up to 13 pathogens all from a single swab!

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According to the 2011 estimates, the most common foodborne illness, 128,000 are hospitalized, and 3,000 die. Estimates that each year roughly 48 million people get sick from sick by consuming contaminated foods or beverages. The CDC overconsumption; however, foodborne illness is an immense,

In our current age, perhaps the biggest danger from food is its Food May Be Making Your Patients & You Sick

• Oregon oysters linked to Norovirus
• Recognize that there’s a risk of foodborne infection when-
• Report incidents of concern (usually, county health depart-
• Look at Health Department food inspection scores, which
Suggestions for dining at restaurants: [4]

The Chipotle outbreaks may be linked to the company’s emphasis on locally acquired “healthy” foods or, as the restaurant

claims, “food with integrity.” These foods are raised without hormones or antibiotics and animals are treated humanely (e.g. cage-free). The use of more extensive sources for foods may make it more difficult to supervise the quality of the foods at all levels.

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

Suggestions for dining at restaurants: [4]

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

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

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

I would like to thank Stan Cohen who provided background information for this article. More information can be found on Nutritions4Kids.com on this topic.

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

References
2. Cesare Cremon et al. “Salmonella Gastroenteritis During Childhood in a Risk Factor for Infectible Bowel Syndrome in Adult- hild” Gastroenterol 2014; 147: 69-77

For care that both you and your patients can feel great about, visit choa.org/CPG or call 404-785-DOCS (3627).

SPECIALTIES INCLUDE: Aerodigestive, allergy and immunology, anesthesia, apnea, cardiothoracic surgery, child protection, craniofacial, critical care, cystic fibrosis, dentistry, diabetes and endocrinology, emergency medicine, gastroenterology, genetics, hepatology, hematology/oncology, hospitalists, infectious diseases, nephrology, neurology, neuropsychology, neurosurgery, nutrition, orthodontics, otolaryngology, pain management, primary care, pathology, psychiatry, plastic surgery, psychiatry, pulmonology, radiology, rheumatology, sedation services, sleep, surgery, transplant, and urgent care.
Right-sizing Pediatric Care

“Everything has got its right size. When it is its right size and well run it’s the tops.” — Agatha Christie

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

Pediatricians should react by making their offices more convenient, offering appointments earlier in the day and later in the evening, and working to get the simple sick visits, such as strep throat and ear infections in and out of the office quickly. No matter which hat I wear (managing partner of my practice, Chair of The Children’s Care Network or leadership in the Georgia AAP), my thoughts often turn to right-sizing care for our patients. To reduce errors, nurses should follow the “Five Rights” of medication administration: Right Patient, Right Drug, Right Dose, Right Route, and Right Time. Similarly, pediatricians should think about the following Rights for their patients:

Right Location
The rise of retail-based clinics is much lamented among Pediatricians. The attraction for parents is obvious—convenience. Pediatricians should think about the following Rights for their patients:

Right Provider
I know a solo practitioner who does everything during the patient visit, from taking the child’s vitals to administering vaccines. While most of us have delegated these and other tasks to our staff, we often continue to spend time doing things that do not require the knowledge and skills of a physician. Ideally, there should be a hierarchy in clinical care with medical assistants acting up to the level of their training, nurses providing care that medical assistants are not qualified to do, mid-levels above that level and physicians at the top. In some ways, the physician should act as the consultant, addressing diagnosis and treatment issues that are beyond the training and experience of the staff.

The model of care in the United Kingdom is often used to contrast the U.S. system. The majority of care for children is provided by General Practitioners; the pediatrician is truly a specialist, treating children with illnesses or conditions requiring a higher level of care. I don’t expect that we will adopt this model, but I do think pediatricians would be well served by more clearly defining our role as child experts and ceding some care to other providers when our level of expertise is not needed.

Right Team
In recent years, Mental Health issues have become a much bigger part of our daily pediatric practice. ADD, anxiety, depression and eating disorders are part of an increasing number of patient visits. Many pediatricians do not feel adequately trained to treat these conditions. Close relationships with mental health professionals, either within the practice or as consultants, is essential to managing these patients. We should also work to include schools, religious institutions, and community groups, with the physician acting as the captain of the team, directing resources to maximize patient benefit.

Determining what is the right size for you and your practice is a very personal decision. It requires self-examination and the ability to recognize your strengths and acknowledge your weaknesses. It may be painful, but I am confident that it is worth the effort and positions you to do what is right for your patients.

Robert Wiskind, MD
Past President, Georgia AAP
Atlanta

Meet the Board: Tania Smith, MD, FAAP

Tania Smith, MD, FAAP is a primary care pediatrics in Atlanta, Georgia. Dr. Smith currently serves as the Chapter’s District 16 Representative.

Birthday: August 8th
Hometown: Oakland, California
Education: Cate School, Carpinteria, CA (boarding school/high school); Yale University, B.S. Biology, Morehouse School of Medicine, M.D., Kaiser Permanente Northern California--pediatrics residency program

Family: 17 yr. old son Jarrett
Pets: 8 yr. old Chinese Crested Powderpuff dog—Jock

Inspiration: Jesus Christ and my mother
Hobbies: shopping, party and event planning, working with church youth group, amusement parks and roller coasters

Bad Habits: expect others to be as dedicated and work as hard as I do

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

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

Favorite Movie: Best Man

Who would play you in a movie: mother

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This program is a continuing P.E.R.E.P. activity as defined by the American Academy of Pediatrics in order to maintain ongoing education in pediatrics. Georgia Chapter, American Academy of Pediatrics designates this Live Activity Series for maintenance of AAP CME Category 1 Credit(s). Physicians should claim only those credit commensurate with the extent of their participation in the activity.

This continuing education activity was co-sponsored by the Georgia Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.

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Prevention of Child Abuse Survey Findings

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

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

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

The majority of pediatricians who completed the survey were general pediatricians who have been in practice for more than 10 years. Although most pediatricians were only slightly familiar with the AAP clinical report, they agreed that focusing on topics related to child abuse, relative to other topics, was very important. Eighty-one percent of respondents reported feeling prepared in the waiting room may assist in alleviating physician discomfort, time constraints, and the inability to screen privately. These tools can also prompt parents and caregivers to discuss specific concerns, such as infant crying and sexual abuse prevention. Questionnaires can be given routinely, and not selectively, which may increase the opportunity to educate and intervene.

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

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

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

Increase in Medicaid rates: We were gratified that the $26.2M state funds and $81.4M total funds with the federal match added was included in the Medicaid budget. This will raise Medicaid rates on 26 more CPT codes to 2014 Medicare rates, effective July 1, 2016. Thank you all for your efforts on this milestone legislation. This was done as part of our coalition with the FP’s, IM’s and OB’s via their societies, and their advocacy has been invaluable to our efforts.

Medical Cannabis: HB 722, we objected to the inclusion of autism as one of the “medically qualifying conditions” for which CBD oil could be legally used in Georgia. The bill failed on the last day of the session as the Senate refused to take it up.

PA prescribing of hydrocodone, SB 115: This bill would have given PA’s the right to prescribe 15 day supply of hydrocodone, a Schedule II drug. We opposed the bill, and cited concerns about the increasing prevalence of NAS and adolescent opioid addiction. It passed the Senate but the House committee chair refused to take it up. It was then attached to other bills on the final day, hopes in getting it thru in the rush of last-minute bills. It failed due to strong House opposition.

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

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

HOUSE BILLS
HB 219: Swimming pools, Would exempt private pools (e.g. country clubs, condos, etc.) from pool inspections carried out by Dept. of Public Health. Passed House; in Senate Committee. DPH has concerns that this will remove many pools from their oversight and therefore degrade their ability to monitor adequately for safety; however they worked out those concerns. Passed. (However, Gov. D. vetoed.)

SENATE BILLS
SB 158: Rental Networks, Sen. Burke, requires disclosure and certain prohibitions when plans use “rental networks” in disclosing to physician. Key bill for MAG this session. Passed. SB 302, Provider Directory Accuracy: Sen. P.K. Martin, Alpharetta: Would require insurance plans to publish and maintain accurate directories of providers in their networks. Passed. SB 974: Create Study Committee on issue of “prohibiting sur- prise billing”. Originally this was a bill (SB 382) but the industry succeeded in converting this to a study committee. Passed.

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

Melinda Willingham, MD, FAAP
Chair, Legislative Committee

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Pediatric Foundation Golf Tournament Held in April

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

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

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

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Georgia Medicaid EHR Incentive Program

PAGE 13 VOLUME 25, ISSUE 2, SPRING 2016

PAGE 12 VOLUME 26, ISSUE 2, SPRING 2016

School-Based Health Centers…continued

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References
Homelessness: New Focus on Children of Veterans

Homelessness:
Our society is currently facing a crisis in homelessness:
Between 2007–2013:
• The number of families who moved from stable housing to shelters increased by 38.5%
• Of all homeless families, 35.8% had children
Children who are homeless:
• Are 2.5 times more likely to have health problems and 3 times more likely to have severe health problems, especially asthma;
• Are less likely to have health insurance coverage and more likely to use the emergency room (ER) for all health care needs;
• Are more likely to be hospitalized and have longer hospital stays;
• Are 2-5 times more likely to suffer trauma and emotional stress

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

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

Response to the challenge
In 2015, ISDD was awarded another five year grant from HRSA under the Healthy Tomorrows Partnership of the AAP, to establish Healthcare Without Walls – Veterans: A Medical and Mental Health Home for Children of Veterans who have experienced homelessness (HWW-1).

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

Observations relevant to Pediatric Practice:
• It is important to understand the impact of military service and deployment on family life, and on child health and development;
• Children of veterans, especially those who have experienced homelessness, are at greater risk for adverse social, mental health, and behavioral challenges;
• Children of veterans who have experienced homelessness it would be appropriate to refer them to appropriate services, in order to reduce the potential adverse effects and promote resilience and well-being for the children and their families.

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

In 2010 Innovative Solutions for Disadvantage and Disability (ISDD) received funding from HRSA, under the Healthy Tomorrows Partnership of the AAP, to respond to this set of issues by establishing Healthcare without Walls: A Medical Home for Homeless Children (HWW) and developed a 2-pronged approach:
1. Establishing a Medical Home for the children
2. Establishing a health literacy program for the mothers to help them become familiar with the healthcare needs of their children and to understand and navigate the healthcare delivery system

The impact of HWW over the 5 years of the project accomplished the following:
• Health insurance rates of children increased from 81% prior, to 98%
• Fully-vaccinated immunization rates increased from 62% to 87%;
• ER visits for non-urgent health concerns were drastically decreased;
• All children participating in the HWW clinic were referred to a primary care provider in the community for ongoing care and treatment;
• Mothers reported improved understanding and greater confidence in dealing with the health care of their children and the health care delivery system

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

(Continued on page 15)
| Webinar: The Zika Virus: What It Is and How to Protect Against It, June 21, 2016 12:30pm – 1:30pm | Pediatrics on the Perimeter
Fall CME Meeting
September 22-24, 2016
Westin Atlanta North, Atlanta
404-881-5091 |
| --- | --- |
| Webinar: Georgia’s Minor’s Rights to Reproductive & Behavioral Health Services, June 22, 2016 12:30pm – 1:30pm | Georgia Pediatric Nurses & Practice Managers Associations
Fall Meetings
October 14, 2016
Cobb Energy Center, Atlanta
404-881-5067 |
| Webinar: Safe Vaccine Storage and Handling: It’s not Cool to be Hot!, June 29, 2016 12:30pm – 1:30pm | |