President’s Letter

Beginning with the End in Mind

Many years ago, a friend introduced me to my first leadership/management book, The Seven Habits of Highly Effective People. Some may consider it an “oldie-but-goodie” as there have been many leadership books to follow, but it has served me well and has helped to guide my decision making over the years. I won’t recite all of the habits, but the one that has always been a touch point for me is "Begin with the end in mind". Over the years, this habit has forced me to think seriously about my goals and the expected outcomes for the activities that I initiate. Sometimes I am bullied by the moment and step into an activity without thinking seriously about the “what” and the “why”, but mostly, I’m able to keep this sentiment in mind as I begin a new task.

For most pediatricians, Fall is a time of renewal. As we exhale after surviving the “back to school rush” and send our patients off to begin their school year, whether it is PreK, Middle School, High school or college, we hope that we have prepared them for success over the upcoming year. While this is a time-honored tradition for school readiness, early brain science tells us that preparing for success at school and beyond begins long before the PreK visit takes place. As pediatricians, we have always understood the importance of the earliest interactions for young children, so we get the concept of beginning with the end in mind. However, newer science helps us understand that while previous generations debated the influence of nature vs nurture, we now recognize that there is much more of a dance between genetics, environment and experience than previously believed. As the brain is hard wired for social, emotional, intellectual, and developmental trajectories by the age of 5, we have a narrow window to significantly impact the life course of our patients.

The environment in which children develop, including family, extended family, neighborhood, community and culture impacts health, but also brain development and even genetics. In other words, healthy, nurturing relationships and environments are critical to health and development. Pediatricians have felt this, but science has finally caught up!

There is an old adage that says when you know better, you should do better. This is what we know. Brains are built over time starting with simple skills that provide the foundation for more complex skills. While a strong foundation in the early years improves the odds of positive outcomes, a weak foundation increases the odds of later difficulty. Neuronal growth explodes in the first few years of life, with 700 new synapses formed every second, but after this period of rapid increase, the brain needs to become more organized and efficient to function properly. Early experiences determine which circuits are reinforced through frequent use and which are pruned through lack of use during reorganization. While, the extraordinary plasticity of the young human brain provides unlimited possibilities, it is this very characteristic that makes the brain vulnerable to negative experiences. Persistent adversity, also known as toxic stress, leads to weakened brain architecture and impaired abilities. Stress is not necessarily negative. In fact, positive stress, like the stress that occurs when a child falls on the playground and is comforted by adult, is normal and an essential part of healthy development and building resilience. Even though tolerable stress may be severe, such as the loss of a parent, when it is time limited and buffered by a caring adult who helps the child adapt, the brain and body can recover. However, toxic stress occurs when the stressor is long lasting and unremitting. When there is no adult support, it can disrupt the development of the brain and other organ systems.

Continued on next page.
Understanding the impact of early experiences on the young child is important, but the child is a part of a family. This is why screening families for social determinants of health has become such an important point of discussion in pediatrics. There are many types of social determinants including food insecurity, homelessness, environmental toxins, and stress to name a few. When focusing on more comprehensive services for the family, we help to equip them to raise a child who is resilient and capable of thriving in any environment - a two-generational approach. Adverse Childhood Experiences (ACES) provide another lens for discussing toxic stress and adversity. The seminal study on ACES looked at 3 types of abuse - physical, sexual, and emotional; 2 types of neglect - physical and emotional, and exposure to household dysfunction in the form of alcohol/substance abuse, incarceration, domestic violence, parental separation/divorce, and mental illness. The study found that ACES are common, often unrecognized or concealed, and they transform the early experiences into organic disease. Children with 3 or more ACES experience 3x the risk of academic failure, 6x the risk of behavior problems, 5x the risk of attendance problems and a host of other lifelong physical and mental health consequences. We know that adversity goes beyond the items from the initial study and can include factors such as poverty and discrimination.

Managing all of our patients’ needs in the 15 minute visit can feel overwhelming, but as experts in children’s health, we are called to be advocates for our patients. How do we get babies off to their best start? Consider any of the following steps. Make sure that your practice supports breastfeeding dyads. If you are not screening for maternal depression and/or social determinants, consider adding these steps to your process. Designate a staff member to identify local community resources for addressing social determinants and mental/behavioral health services for children and families. Direct families to high quality early learning providers. Incorporate evidence-based programs that support early brain development and parent engagement such as Reach Out and Read. Speak on behalf of our patients to local and state agencies, and lawmakers. I know that we are exhausted by the sheer volume of stuff that must be completed on any given day, but remember that when we invest in our patients, we invest in our communities. We’ve got this!

As pediatricians, we have always understood the importance of the earliest interactions for young children, so we get the concept of beginning with the end in mind.
Cancer is complex.

That’s why your patients deserve access to the most powerful treatments.

**Partner with Emory Proton Therapy Center.**

The only proton therapy center in Georgia. Where your patients can receive an advanced form of radiation, to better protect nearby healthy tissue and reduce side effects. **So patients can get back to their lives beyond cancer treatment.**

Winship at Emory has multidisciplinary teams who will work with you to create a personalized treatment plan. Give your patients the peace of mind they have every option possible.

For cancer patients, the right partner can make all the difference.

To refer a patient, visit [emoryhealthcare.org/protonreferral](http://emoryhealthcare.org/protonreferral).
growing our team and leading the way in pediatrics

At Children’s Physician Group, we are dedicated to reaching more children with the pediatric care and expertise that is unique to us. To help achieve the best outcomes for children, we continue to recruit new talent. Today, Children’s Physician Group is made up of more than 850 physicians and advanced practice providers representing more than 30 pediatric specialties.

Join us in welcoming four new and talented physicians committed to our goal of making the kids in Georgia better today and healthier tomorrow.

Learn more at choa.org/cpg or call 404-785-DOCS (3627).

Paul Chai, MD
Chief, Cardiothoracic Surgery

We are excited to announce Paul Chai, MD will be joining Children’s on May 13 as the new Chief of Cardiothoracic Surgery and Co-Chief of Cardiac Services. Dr. Chai comes to Georgia from New York-Presbyterian where he led their congenital heart surgery, pediatric heart transplant and mechanical assist device services. Dr. Chai completed his residency and fellowship training at Duke University Medical Center. His areas of expertise include pediatric congenital heart disease, cardiac surgery and cardiothoracic surgery.

Satyanarayana Gedela, MD
Chief, Neurology

Join us in welcoming Satyanarayana Gedela, MD as the new Division Chief of Pediatric Neurology and Practice Director of Children’s Physician Group—Neurology. Dr. Gedela came to Children’s by way of Nationwide Children’s Hospital where he served as Medical Director of the Epilepsy Surgery Program as well as the Epilepsy Monitoring Unit. He completed his residency and fellowship training in child neurology at Children’s Hospital of Pittsburgh of UPMC. His area of expertise includes epilepsy.

Sonal Patel, MD
Pediatric Gastroenterologist

Sonal Patel, MD joined Children’s in April by way of the Ann and Robert H. Lurie Children’s Hospital of Chicago. Dr. Patel received a Doctorate of Medicine at Northeastern Ohio Medical University. She completed her residency training in pediatrics at Riley Hospital for Children, followed by a fellowship in Gastroenterology, Hepatology and Nutrition at Ann and Robert H. Lurie Children’s Hospital of Chicago. Dr. Patel has specific interests in general gastroenterology and inflammatory bowel disease.

Fawwaz Shaw, MD
Pediatric Cardiothoracic Surgeon

Fawwaz Shaw, MD joined Children’s by way of West Virginia University where he served as Surgical Director of Extracorporeal Life Support at WVU Medicine Children’s Hospital. Dr. Shaw graduated from the American International School of Medicine in Georgetown, Guyana and completed residencies in Family Medicine and General Surgery at the University of Tennessee Health Sciences Center in Memphis, TN. He completed his Cardiothoracic Surgery residency at the University of Washington and his Congenital Cardiac Surgery residency at Seattle Children’s Hospital. His clinical interests include neonatal heart surgery, adult congenital cardiac surgery, extracorporeal life support and surgical education.
Do you remember the moment in your life when you made the decision to take the first step towards becoming a physician? For some of you, that day was in high school. For others it may have been during or after college. No matter when you made the decision, one thing all pediatricians have in common is that our ultimate goal was to become a physician. So how can it be that the now ubiquitous term “provider” has crept into current language to refer to a profession known for its rigorous pathway and for carrying such tremendous responsibilities? That question was at the heart of a discussion between our Chapter President, Dr. McFadden and me. With her encouragement, I put my concerns into writing and we asked the Chapter to sponsor a Resolution on our behalf.

I have realized that there are three main issues with this term: the commodification of the physician - patient relationship, the assumption that patients are the equivalent of consumers and the depersonalization of physicians.

Healthcare as we all know is a business. Compare the “delivery” of healthcare to the delivery of a pizza. To the business owner, each cardboard pizza box has an associated profit margin based on the weight of ingredients in the box. The only thing that really matters is the amount of food in the box, not the specific contents. Pepperoni or pepperoncini - it’s a sunk cost. To the chef, however, the exact specifics of the order are crucial. Placing anchovies instead of artichokes could cost him his job if the customer were allergic to either. The chef is looking out for the customer and the owner is looking out for the boxes. This analogy is very imperfect. We as physicians are concerned with the exact needs of a patient based upon our personal knowledge of their disease, their family structure, their occupation and their ability to manage their health. We are not selling cardboard boxes of random ingredients. The foundation of our work is grounded in our relationships with people.

To examine the fallacy that patients are consumers, imagine for a moment that you are a diabetic driving on Route 66 in the Arizona desert. Suddenly, your insulin pump malfunctions and you notice early signs of hypoglycemia. You see a pizza parlor! You don’t care what kind of pizza they sell, you have got to eat something or go into a coma. So, you buy a pizza. Did you really have a choice? No, you had to go to the pizza shop in front of you when you had an urgent need for food. Consumers of pizza would research and plan in advance to dine in a highly rated gourmet restaurant - but, to the stranded or starving, one has to take the pizza one is given. Patients similarly are not consumers, as the choices they have are often outside of their control. Insurance status, zip code and health literacy are just three examples that determine options for many patients.

Lastly, let’s talk about depersonalization. In the late 1980’s, advocates for persons with disabilities started to encourage the use of “person first” language. Thus, instead of “sicklers” or “diabetics” with all the bias those terms may give, we say “a child with sickle cell disease” or “a woman with diabetes.” Think back to your goal of becoming a physician. Did you ever think, “Hey, I’m going to provider school to become a provider?” Of course not. We don’t call lawyers “malpractice suit providers,” teachers “grade providers,” police officers “ticket providers” - so why are we now faced with being “healthcare providers” instead of “physicians”? It is not a term applied to any other profession that serves the public. It should not be used for physicians. To call a physician a provider is to demean their knowledge and their expertise – their conscience and their calling. It reduces our vocation to the equivalent of handing out identical cardboard boxes with a profit margin attached. It denies our personhood and our value to the families and communities we serve. It undermines our professional identity.

Resolution 53, which states that Academy Fellows shall not be referred to as “providers,” was written in conjunction with Dr. Robert Wiskind, submitted by the Georgia Chapter and endorsed by the AAP at the Advanced Leadership Forum in March of 2019. We are not going to respond to the word “provider” anymore. We are physicians.

Patricia Lantis, MD
Pediatric Hospitalist,
Assistant Professor, Emory School of Medicine, Atlanta
New Georgia School Vaccine Requirement for 11th Graders

The Georgia Department of Public Health (Ga DPH) has adopted an amendment to Rule 511-2-2-02, “Immunization Required.” The immunization rule change took effect June 12, 2019. The new Georgia school entry requirement states that students entering or transferring into the 11th grade, as of July 1, 2020, will need proof of a meningococcal conjugate booster (MCV4) dose, unless their first dose was received on or after their 16th birthday.

Meningococcal disease is a rare but dangerous disease that strikes healthy young people without warning. Meningococcal infections can be treated with antibiotics, but even with treatment, about 10-15% of people who get sick will die. Another 20% will survive but suffer lifelong disabilities such as kidney damage, loss of arms or legs, hearing loss, or brain damage. Because of the rapid progression and ominous sequelae of the disease, Harry Keyserling, MD and Infectious Disease Committee Chair at the Georgia AAP, supports the Georgia DPH in the amendment to the School Requirement Rule. Dr. Keyserling states, “the booster dose of meningococcal vaccine offers the best protection during the high risk 16 to 21 year age range.”

In 2005, ACIP recommended routine MCV4 vaccination for all adolescents at age 11 or 12 years to protect them from meningococcal disease as older teens. Georgia implemented the requirement for the first dose of MCV4 for the 2014-2015 school year. The peak age for meningococcal disease is 16 through 21 years. Studies have indicated that the protection provided by MCV4 wanes within 5 years following vaccination. For this reason, in 2010, ACIP recommended an MCV4 booster dose to provide continuing protection during the age of increased meningococcal incidence.

Georgia is one of sixteen states that now requires two doses of MCV4 at elementary and secondary school entry points. Sheila Lovett, director of DPH’s Immunization program says, “This disease acts quickly and unpredictably, and could be fatal to an otherwise healthy child within 24 hours. We never want a parent or their child to experience this type of pain and suffering, especially when the disease is vaccine preventable.”

For more information contact Noreen Dahill at ndahill@gaaap.org.
Waldon Garriss III, MD addresses the attendees at the Chapter’s Transition of Care conference in May at the Wellstar Development Center, Atlanta. The meeting addressed the different facets of care for those with special healthcare needs and their transition to adult care.

During Pediatrics by the Sea, Peter Rowe, MD, Baltimore, presented on Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) in Children & Adolescents. He is joined here by Chapter President Terri McFadden, MD, Chapter staff Froza Eskey & National AAP President Elect Sara Goza, MD.

We were pleased to have Senate President Pro Temp, Butch Miller, Gainesville (left) and Frank Berry, DCH Commissioner, stop by Pediatrics By the Sea and visit w/Terri McFadden, MD.

Pediatrics By the Sea attendees stretch at sunrise before participating in the Peds on the Run 5K.

Helping Around the Globe: Past President Jan Soapes, MD, Dacula, recently traveled to Kenya on a medical mission. She is pictured here with local physician Samuel Jameel, MD.

---

2019-2020 Chapter Resident Program Delegates

Congratulations to the following residents on their new leadership role as a Georgia Chapter American Academy of Pediatrics (AAP) Program Delegates! We look forward to getting them involved with the Chapter.

- **Navicent Health**
  - **Mercer University**
  - **Elliott Gordon, MD**
  - Medical School: St. George’s University School of Medicine

- **Morehouse School of Medicine**
  - **Margaret Ridge, MD**
  - Medical School: Meharry Medical College

- **Medical College of Georgia at Augusta**
  - **Desiree Rodriguez, MD**
  - Medical School: San Juan Bautista School of Medicine

- **Memorial Health University**
  - **Medical Center/Mercer University School of Medicine (Savannah) Program**
  - **Ashley Broud, MD**
  - Medical School: Rowan University School of Medicine

- **Assistant Program Delegate**
  - **David Patch, MD**
  - Medical School: St. George’s University School of Medicine

- **Emory University**
  - **Kate McGlancy, MD, MPH**
  - Medical School: Emory University School of Medicine
A 14-year-old female was recently discharged from the hospital after fainting during a spring choir concert. She is tachycardic (94 bpm) at baseline, but her heart rate goes up to 130 or higher when standing. Her blood pressure is 104/72. She has chronic abdominal pain, loose stools, and heartburn. She vomits easily if emotionally upset. She has missed more than 20 days of school this semester either because of morning fatigue, or because of dysmenorrhea; she may not pass eighth grade even though a bright student. She was well until she had the flu in November and never recovered fully. She quit the volleyball team because any exercise drains her energy for days.

Does the general pediatrician manage her? Or refer to specialists? If so, which ones?

While the differential diagnosis is broad, and she needs an extensive medical workup, consider a diagnosis of myalgic encephalomyelitis-chronic fatigue syndrome (ME-CFS).

How does the general pediatrician make this diagnosis? The patient must have three core symptoms and one minor symptom. Core symptoms include the following:

1. Greatly diminished ability to do activities that were usual before the illness, along with fatigue, lasting 6 months or longer.
2. Worsening of symptoms after physical or mental activity that would not have caused a problem before illness (post exertional malaise).
3. Sleep problems, particularly nonrestorative sleep. Problems falling asleep or staying asleep or hypersomnolence.

Minor symptoms include:

1. Problems with memory and thinking (“brain fog”).
2. Symptoms worse while standing or sitting upright (orthostatic intolerance).

Many other known medical conditions may overlap with these symptoms, but their presence does not exclude ME-CFS. It is possible for example for a patient to have both Irritable Bowel Syndrome and ME-CFS, or migraines and ME-CFS, POTS (postural tachycardia syndrome) co-occurs commonly. ME-CFS may begin gradually or may have acute onset. It commonly begins after an acute illness such as flu or mononucleosis, but it is not chronic mono. Other triggers may include trauma, overexertion, chronic sleep deprivation, or toxin exposure. It may remit and relapse, with the average recovery time being 4 to 5 years. It is 3 or 4 times more likely in adolescent girls than boys. Menstruation exacerbates symptoms. While this may affect all ages, race, and socio-economic groups, there are two peak ages for onset: 11 to 19, and 30 to 39. Clinical and laboratory research has documented that this is a systemic physical disease, not a psychological illness, though co-morbid psychological distress is common.

When suspected, an extensive diagnostic workup is indicated, for “rule-outs.” Beyond
ME-CFS: A Clinical Challenge

Continued from previous page.

physical exam and history, check thyroid studies, CBC, ESR, ferritin, ANA, B12, folate, vitamin D3, C-reactive protein, and UA, and possibly more as indicated by symptoms. Consider specialty consults if indicated, e.g. neurology, cardiology, rheumatology, GI, sleep medicine.

There is no known cure or verified treatment for this condition with medical care being supportive and symptomatic. Even before the six-month diagnostic window is complete, it is essential to provide accommodations for schooling for children or teens who are unable to tolerate full-day attendance. A letter to the school may be important, emphasizing these symptoms are not school phobia or malingering, and a decreased work-load may be important. At the same time, it is important for the patient to remain engaged in education, for social connections and preparation for adult functioning. Education of the school system and ongoing collaboration between the family, patient, educators, and physician is key.

I recommend office visits every 1 to 3 months, prioritizing treatment goals based on patient symptoms. It is especially important that patients learn how to pace activities to avoid “push and crash cycles” (chunking down large tasks and taking frequent breaks). Remind them to avoid vigorous exercise and refer to a knowledgeable rehab therapist (PT) to arrive at activity goals. From first day of diagnosis, stress the importance of avoiding over-exertion, which can speed up improvement and prevent crashes. Address sleep hygiene, recommend sleep aids like melatonin, but avoid benzodiazepines for sleep. For comorbid depression and anxiety, refer to a therapist who is aware that this is a medical disorder at the root, and that the psychological symptoms can in turn worsen medical symptoms. Memory and concentration problems may respond to ADHD medication. Orthostatic intolerance may require evaluation from cardiology, who can treat POTS if present.

Most of all, these children and teens, and their families, need a doctor who will listen sympathetically, not dismiss their symptoms, and stay with them for the duration, as long as it takes for recovery.

Robert Pendergrast, MD, MPH
Professor, Pediatrics
Director, Adolescent Medicine
Augusta University, Children’s Hospital of Georgia

References:

SAVE on VACCINES

Physicians’ Alliance of America (PAA) is a nonprofit Group Purchasing Organization that uses the purchasing power of more than 10,000 member practices nationwide to negotiate discounts and preferred terms for the products and services practices use every day.

- Free Membership
- Best Prices on Vaccines
- Vaccine Rebate Program
- 20+ Discount Pricing Agreements
- Superior Customer Service

Join Today!
PhysiciansAlliance.com/join
866-348-9780
Is Your Practice Breastfeeding Friendly?

Have you noticed that more of your patients are breastfeeding? You aren’t imagining things-breastfeeding rates in Georgia are increasing. Many mothers, however, still don’t reach their breastfeeding goals, while studies cite lack of support from health care providers as one of the reasons for not meeting them. Georgia families need physicians who can actively support breastfeeding. Yet, between 43% and 50% of pediatricians, neonatologists, obstetricians/gynecologists, and family medicine physicians don’t feel they are adequately prepared for clinical evaluation of breastfeeding problems and for clinical treatment of them. These statistics aren’t surprising, as there is little or no formal instruction on breastfeeding and human lactation in medical schools. The EPIC Breastfeeding Program is here to help fill this gap for practicing physicians and can either jumpstart your practice or be the impetus for small improvements. The modules and resources of the EPIC program can help you develop your skills and further develop your practice. Here are some ways EPIC can help you better support breastfeeding families:

Start at the beginning!
We know that a mother’s prenatal intention to breastfeed is strongly influenced by input from and support of her physician. If you see expectant parents, encourage them to breastfeed and answer any questions they might have about breastfeeding. Another good place to start is to track breastfeeding rates in your practice. Knowing what your patient population is doing can be helpful at setting practical goals to help mothers adhere to AAP recommendations for breastfeeding: exclusive breastfeeding until 6 months of age and then continued breastfeeding until at least age 1. Through our modules, we can help train support staff and providers to have open-ended conversations about infant feeding that assesses an expectant mother’s breastfeeding intention in a comfortable, non-pressured way.

Look at your practice environment.
What are you currently promoting? Do parents see formula companies represented in your practice? Do you still provide free formula gift packs or have formula marketing materials in your waiting area? Ensuring that your patient education is free of commercial influence is an important step in supporting informed feeding choices for all new families, whether breastfeeding or not. Our resource kit includes samples of well-designed and up-to-date patient education materials in English and Spanish.

Put it in writing.
Collaborate with staff to develop a written breastfeeding policy for your practice. We can provide examples and guidance. A clear policy can ensure that your staff are supported when they return to work by providing space, time and supplies to express milk for their babies, which will increase both their job satisfaction and performance.

Offer culturally competent feeding care.
Different cultures have varying beliefs and customs relating to infant feeding. Knowing them and providing appropriate anticipatory guidance can improve your practice and your customer satisfaction ratings. Do you and your staff encourage breastfeeding in the waiting area and provide a private place if desired? Having posters and signs welcoming and encouraging breastfeeding can help parents feel comfortable and supported. We provide samples in our Resource Kit.

Triage breastfeeding concerns easily.
Your phone triage nurses should be provided with training and resources to provide evidence-based recommendations to families calling for advice. Our Resource Kit includes the AAP published Breastfeeding Telephone Triage and Advice book, 3rd edition. Our one-hour breastfeeding education programs can provide this education, as well as continuing education hours for nurses and physicians at no cost to your office.
Is Your Practice Breastfeeding Friendly?

Continued from previous page.

Make it part of the visit.
Our training will also help guide you in incorporating breastfeeding into routine care. Learn what effective breastfeeding looks like; what mothers’ common concerns are, and what strategies to employ that preserve breastfeeding and milk production if or when problems arise. Learn about milk expression and how to support mothers when they return to work or school. Our program also provides resources on coding, billing, and documentation so you can be paid for the work that you do!

Learn who else can help.
When further breastfeeding expertise or peer support is indicated, it’s helpful to be familiar with lactation support in your community and where families can find it. Also, more and more pediatricians, obstetricians, and family practice physicians, whose practices see many newborns, are directly hiring or contracting with lactation consultants to provide care in the office. Georgia is one of the first states to license lactation consultants. Accessible breastfeeding support can help your practice attract new and growing families.

Schedule your EPIC Breastfeeding Program today.
Let us provide you with resources to make your practice more breastfeeding friendly. We offer convenient, physician-led, peer-to-peer breastfeeding education in your office or hospital. Our modules are one-hour sessions held during lunch or any time that is more convenient. Each program site receives a free Breastfeeding Resource Kit as part of the presentation, with resources for you, your staff and your patients. The three topics to choose from include Breastfeeding Fundamentals, Supporting Breastfeeding in the Hospital, and Advanced Breastfeeding Support. Free continuing education is provided. Complete an online program request form at www.GaEPIC.org or call the program office at 404-881-5068. The EPIC Breastfeeding Program is brought to you by the Georgia Chapter, American Academy of Pediatrics with support from the Georgia Department of Public Health.

Tarayn Fairlie, MD, MPH
Chair, EPIC Breastfeeding Education Program Advisory Committee
Kaiser Permanente, Tucker

Georgia WIC Medical Advisory Committee: Members Wanted!

The Georgia AAP is looking for members throughout the state to join us on the WIC Medical Advisory Committee formed to assist the Georgia WIC Program on issues that impact pediatric practices and your patients. We have been involved with revising the medical documentation forms, reviewing special formulas for the formulary, and providing feedback on information that needs to be shared with practices. This committee usually meets three times a year, twice by conference call, and once face to face in Atlanta. If you have interest in helping us assist WIC along with a passion for infant and child nutrition, we would love for you to join us! Come one, Come all!

If you would like to join, or have any questions regarding WIC or other nutrition related topics please contact Kylia Crane, RDN, LD, Nutrition Coordinator at kcrane@gaaap.org or (404) 881-5093.
This article is an interview with Division of Family and Children Services Director Tom Rawlings by Dr. Michelle Zeanah. Editor’s note: Tom Rawlings was sworn in February 2018 as the director of the Georgia Division of Family and Children Services after serving six months as interim director. The son of a Sandersville physician, Rawlings was the first full-time juvenile judge in the five-county Middle Judicial Circuit. He was named by two governors as Director of the Office of Child Advocate and is an international expert on child welfare.

Michelle Zeanah is a pediatrician in Bulloch County. She has focused exclusively in behavioral pediatrics since 2016. Zeanah serves as an at-large member on the DFCS State Advisory Board. Georgia’s Department of Public Health and the General Assembly have recognized her child advocacy work.

Q: What is the state of foster care in Georgia?

Tom Rawlings (TR): It’s good, and we are doing things to make it better. We have around 13,500 children in the foster care system. We are working on ways to ensure children’s safety without the trauma of removing them from their families, when possible, through several initiatives. They have already helped us bring the number of children in foster care below the peak and reverse the rapid increase of recent years.

One major initiative we are preparing to implement next year is the state’s plan for the Family First Prevention Services Act (FFPSA) of 2018 – the most significant child welfare legislation in decades.

Q: How has foster care changed as a result of these issues?

TR: While alcohol remains the substance most often abused, substances such as opioids and methamphetamine pose tougher challenges because their addiction patterns are more vexing, extending the time children spend in foster care while their parents try to get sober.

Our foster care system has nearly doubled over the last decade, and we’ve had to adapt as our children’s needs expand. Children are not “one size fits all,” and each child has unique needs. Our goal is always to ensure that every child is safe and well cared for. As the system grows, it’s more difficult finding placements that can meet the needs of every particular child, so we’re doing a deep-dive into solutions as we make some systematic changes under FFPSA.

Q: What are the major issues DFCS faces?

TR: The Division has a large foster care population and continues to need foster homes. We’re also looking at what kind of changes will be made to our group homes under the Family First Act, as we will only be able to place children with significant needs in those facilities. FFPSA requires that states primarily use family settings for foster homes, so we will be ramping up our efforts to recruit new families and retain existing ones.

We also need to focus on creating true “therapeutic” foster care programs for children and youth with developmental disabilities and mental health issues that cause them to act out. These youth deserve to be in a home with foster parents, trained in resolving behavioral crises, and to have access to excellent behavioral health care.
Child Welfare in Georgia: Current DFCS Priorities

Continued from previous page.

**Q: How has this changed?**

**TR:** FPSPA is new, so it will shift what child welfare systems look like across the country. Additionally, the issues families are facing now are more exacerbated than in the past. Substance abuse negatively impacts mental health issues which, in turn, makes instances of abuse or neglect more likely.

**Q: How can pediatricians and DFCS work together to improve access to healthcare and healthcare of children in foster care?**

**TR:** We are piloting a medical provider network in partnership with CHOAs that gives us more resources locally. We hope to expand that pilot in the future so that we can serve more rural communities. Additionally, we always want to be sure that the medical community helps us look for signs of abuse or neglect, and that they educate those in their communities about warning signs and how to report suspected abuse or neglect. Call 1-855-GACHILD (424-2453) any time; reports are taken 24 hours a day, seven days a week.

**Q: What do you see as the gaps in medical services to children? What is the plan for addressing those gaps?**

**TR:** We see gaps in services in more rural parts of the state. We continue to advocate for more resources and encourage our partners to as well. Many of our children need services that they have to drive hours to receive, and I know this is difficult for foster parents and our staff. Another is psychological services, again, especially outside of cities. But the state can also make some structural changes itself in how mental health is offered that will better provide appropriate services for each child’s needs.

**Q: In the past several years, DFCS has made substantial changes to how abuse is reported and how families apply for healthcare assistance such as Medicaid, PeachCare for Kids and Planning for Healthy Babies. What are the system changes that DFCS is most proud of?**

**TR:** We’ve made significant improvements in many aspects of customer service, specifically closing the gap between three formally separate healthcare programs. In partnership with several other state agencies, the Division piloted and implemented a new integrated eligibility system, known as Georgia Gateway, in 2017. This system integrates eligibility for five social benefit programs - Supplemental Nutrition Assistance Program (SNAP or food stamps); Temporary Assistance for Needy Families (TANF); Women, Infants and Children (WIC); Medical Assistance programs; and Childcare and Parent Services (CAPS). As part of the streamlining process, we integrated Medicaid, PeachCare for Kids and Planning for Healthy Babies into one system and one application process. Prior to Georgia Gateway, parents had to apply separately when losing health coverage from one of the programs. Now, families no longer have this added step. Instead, they can automatically switch from one program to another when appropriate. This streamlined system has made service delivery to customers more efficient.

**Q: As the new DFCS Director, what are your top priorities for the agency?**

**TR:** One of my top priorities is to create a just culture where everyone’s voice is heard and staff in every level of the agency are treated respectfully. It’s a concept embraced by many hospitals where, instead of assigning blame, everyone sees out mistakes as opportunities for learning and making systemic improvements. Another priority is to ensure that children don’t have to go through any undue trauma and can be kept in their communities with relatives or kin, rather than entering the foster care system.

**Q: What are some things/initiatives/activities on the horizon that would be of interest to Georgia’s pediatricians/medical community?**

**TR:** We will be building more community collaboratives around the state through our State of Hope initiative. To learn more about this initiative and how it’s bringing community thought leaders to the table, visit: www.dfcs.ga.gov/state-hope. We also need for our pediatricians to let us know what changes they believe the system needs to improve outcomes for children. We welcome innovative ideas to help create stronger community support systems statewide.
Julie, a 6-month-old female, was brought to my office with concerns that her right eye was a little different than the left eye. No history of photophobia or eye discharge. She was a full-term delivery with no complications noted at birth. Mother’s prenatal labs were normal.

On exam, Julie’s vitals were normal for her age. Her weight, height, and head circumference were at the 50th percentile. She is meeting all her milestones and is in general a healthy infant. I noticed a white reflex and sluggishly reactive pupil of the right eye compared with the red reflex and briskly reactive pupil of the left eye.

“Newborn infants should be examined using inspection and red reflex testing to detect structural ocular abnormalities, such as cataract, corneal opacity, and ptosis.” (Pediatrics, January 2016, volume 137, N. 1)

### TABLE 1

**Periodicity Schedule for Visual System Assessment in Infants, Children, and Young Adults**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Newborn to 6 mo</th>
<th>6–12 mo</th>
<th>1–3 y</th>
<th>4–5 y</th>
<th>6 y and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ocular history</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>External inspection of lids and eyes</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Red reflex testing</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Pupil examination</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Ocular motility assessment</td>
<td>—</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Instrument-based screening&lt; when available</td>
<td>—</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>c</td>
</tr>
<tr>
<td>Visual acuity fixate and follow response</td>
<td>x³</td>
<td>x</td>
<td>x</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Visual acuity age- appropriate optotype&lt; assessment</td>
<td>—</td>
<td>—</td>
<td>x⁴</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

- b: The American Academy of Ophthalmology (AAO) has recommended instrument-based screening at age 6 mo. However, the rate of false-positive results is high for this age group, and the likelihood of ophthalmic intervention is low. A future AAO policy statement will likely reconcile what appears to be a discrepancy.
- c: Instrument-based screening at any age is suggested if unable to test visual acuity monocularly with age-appropriate optotypes.
- e: Visual acuity screening may be attempted in cooperative 3-y-old children.
- f: Development of fixating on and following a target should occur by 6 months of age; children who do not meet this milestone should be referred.
The Importance of Visual System Assessment

Continued from previous page.

I referred my patient to a pediatric ophthalmologist who was able to see the infant the next day. A more detailed ophthalmological exam showed glaucoma caused by retinoblastoma.

"Retinoblastoma is the most common primary intraocular malignancy of childhood and accounts for 10 to 15 percent of cancers that occur within the first year of life. Retinoblastoma typically presents as leukocoria in a child under the age of two years. Untreated retinoblastoma is a deadly disease; however, with advances in treatment, survival in the contemporary era is >95 percent. Prompt referral to an oculocentric oncologist and appropriate management by a multidisciplinary team are necessary to optimize visual outcome and survival.

Treatment of retinoblastoma is aimed at achieving the following goals:

• Eradication of the disease to prevent mortality
• Preservation of vision to the greatest extent possible
• Prevention of late sequelae, particularly subsequent neoplasms

First-line therapeutic options include local and systemic chemotherapy, cryotherapy, laser photocoagulation, and enucleation. The choice of initial treatment is based on the tumor size and location, presence or absence of vitreous or subretinal seeds, patient age, and the visual prognosis." (Retinoblastoma: Treatment and Outcome, by Paul Kaufman, M.D., Jonathan Kim, M.D., and Jesse Berry, M.D., May 2018, Up-To-Date)

Although retinoblastoma is a rare condition, early detection can lead to better outcomes. I encourage you to examine the eyes of your patients: don’t forget your ophthalmoscope!

Fortunately, in the state of Georgia, we have great resources at the Emory Eye Center. They have a Retcam which can give a larger view of the retina. Their Ocular Oncology and Pathology service includes a pediatric retina surgeon, pediatric oncologist, radiation oncologist, genetics counselor and a host of consultants.

As the chair of the Early Career Physician Section of the Georgia Chapter of the American Academy of Pediatrics, my goal is for every young pediatrician in Georgia to feel connected and heard. Please let me know how I can best serve you. Looking forward to seeing you at the fall meeting, Pediatrics Just Off Peachtree in October.

Sylvia Washington, MD, FAAP
Chair, Early Career Physician Section, Georgia AAP
Floyd Primary Care, Rome
Steroids...an Easy Fix with Possibly Dire Consequences

Systemic corticosteroids are prescribed more and more frequently for a wider range of less severe conditions. As a pediatric hematologist oncologist, I find this growing trend in medicine to be increasingly worrisome. Steroids are potent anti-inflammatory/immunosuppressive medications that are the mainstay of therapy for many pediatric disorders. Short and long-term side effects, along with possibly masking or delaying a more serious underlying diagnosis, can have serious consequences for a young patient. Today, more than ever, physicians are worried about the abuse potential of narcotics and stimulants, the side effects of psychotropic medications, and antibiotic resistance. We should be worried about every medication we prescribe because every medication, from acetaminophen to chemotherapy to steroids, can have life-altering consequences.

Steroids bind the cell surface glucocorticoid receptor, and the complex is then translocated to the nucleus where it modifies the transcription of thousands of genes. The anti-inflammatory/immunosuppressive effects are due to alterations in leukocyte activation, proliferation, trafficking, apoptosis, and synthesis of inflammatory mediators (IL-1, IL-6, TNF, etc.).

Toxic and metabolic side effects from short and long term systemic steroid use may be musculoskeletal, endocrine, gastrointestinal, cardiovascular, neuropsychiatric, dermatologic, or ocular.⁴

- Musculoskeletal: osteoporosis, osteonecrosis, myopathy
- Endocrine: hyperglycemia, dyslipidemia, weight gain, cushingoid features, adrenal suppression, growth suppression
- Gastrointestinal: gastritis
- Cardiovascular: hypertension, coronary artery disease, ischemic heart disease, heart failure, sudden death
- Ophthalmologic: cataract, glaucoma
- Neuropsychiatric: mood changes/lability, irritability, depression, anxiety, cognitive/memory impairment, inattention, psychosis, delirium, dementia
- Dermatologic: acne, hair loss, skin atrophy, striae, bruising, delayed wound healing

Steroids absolutely play a vital role in the treatment of many general pediatric illnesses and conditions. Asthma, severe allergic conditions, severe eczema, severe EBV infection with airway compromise, severe cases of poison ivy, and Bell’s palsy are all unequivocal indications for systemic steroids. Serious and often indolent disorders of autoimmune, hematologic, oncologic, endocrine, or neurologic etiology, however, may mimic many common pediatric complaints. I see and hear about patients prescribed a course of prednisone with or without antibiotics for rashes, lymphadenitis, sinus infections, viral upper respiratory infections, pneumonia without wheezing, “bronchitis,” and EBV or Henoch-Schlein purpura with only minor to moderate symptoms.

I understand why providers prescribe systemic steroids...they work. They decrease inflammation and make people feel better, regardless of the cause of inflammation. It is a prescription you can hand a patient that is not an antibiotic or a controlled substance, and studies show that patient satisfaction improves if they receive a prescription medication. It looks like the practitioner is doing something with seemingly few consequences. As a pediatric oncologist, all I can think of are the consequences because I have seen them.

I have seen multiple patients with leukemia or lymphoma initially missed or misdiagnosed, prescribed empiric systemic steroids (with an excellent response) who finally come to my office with advanced leukemia or lymphoma. Many of these patients present with advanced disease and are now pretreated. Their cancer
has already been exposed to a potent chemotherapy drug and may now be resistant to them. This practice has huge, sometimes fatal consequences because steroids are the backbone of many of our pediatric leukemia and lymphoma treatment protocols. They are lymphotoxic. They kill lymphoblasts. Given enough exposure to steroids, however, a lymphoblast can downregulate the cell-surface steroid receptor and become steroid-resistant. Leukemia patients who receive systemic steroids prior to starting their formal therapy are up-staged and often require intensification of their chemotherapy regimen. More intense therapy means more severe side effects and a greater risk of morbidity or mortality. Because steroids treat leukemia and lymphoma, inappropriate administration outside of a controlled setting can induce tumor lysis syndrome, a life-threatening condition. Very simply, inappropriate steroid use in someone with possible leukemia or lymphoma increases his or her risk of death.

If it sounds like I’m trying to scare you, I am. As physicians, we should be afraid of everything we prescribe. Whether prescribing antibiotics, opioids, or even steroids, we should feel confident that they are absolutely indicated and that the benefits of treatment outweigh potential risks.


Eric Ring, MD
Assistant Professor of Pediatrics
Pediatric Hematology and Oncology
Children's Hospital of Georgia at Augusta University
The Community Access to Child Health (CATCH) Program is a national initiative of the AAP that supports pediatricians to collaborate within their communities to advance the health of all children. Through the CATCH Program, pediatricians are empowered to identify promising solutions that work in their individual communities. In each district, Chapter CATCH Facilitators (CGFs) and District Residents Liaisons (DRLs) provide technical assistance to pediatricians and pediatric trainees/residents who have an idea to address child health issues (e.g., oral health, obesity prevention, mental health) and develop grant proposals. Once funded, CATCH facilitators and liaisons provide ongoing support to grantees. CATCH recently changed its grant cycle from twice per year to once per year. The change takes effect on November 1, 2019 when the Call for Proposals (CFP) will be released.


NEW CATCH APPLICATION TIMELINE

- November 1, 2019
  Calls for Proposals Opens

- January 15, 2020
  Calls for Proposals Closes

- February 3, 2020
  Scoring Opens

- February 23, 2020
  Scoring Closes

- March 16, 2020
  Applicants Notified

- May 1, 2020
  Project Start Date

Donate Now!

The gift that keeps on giving! Join us as we round out our year-long 25th anniversary celebration of CATCH! Your gift supports awesome CATCH projects such as Kids’-Doc-On-Wheels (KDOw), an innovative initiative to expand access to children and families, developed by Georgia’s very own, Dr. Lynette Wilson Phillips.
CATCH Grantee Spotlight

The first-of-its-kind in Georgia, Kids’ Doc-On-Wheels, Inc. (KDOM) provides comprehensive mobile pediatric medical, dental, and behavioral health care to children 0 to 18. The majority of the children served are underserved, under-insured, and do not currently have a designated primary care physician. KDOM addresses the complex health issues and academic underachievement of children by providing access to care through a state-of-the-art mobile school-based telehealth center. Here at KDOM, we put the wheels on wellness and are actively closing the gap in healthcare disparities. Our experience within the community has been rewarding, fulfilling, and positively received. In the words of Dr. Lynette Wilson-Phillips, “Because we take quality healthcare to children, research shows that our focus on healthy nutrition habits, physical activity, behavioral health, reading proficiency, asthma treatment and management, and diagnosis and treatment of chronic conditions, will produce healthier adults 15-20 years from now. KDOM has the potential to shift healthcare in adults by increasing access to quality healthcare for children and teens.”

Currently, KDOM is partnered with the Dekalb County School District and the YMCA’s of Metro Atlanta’s Early Head Start Programs. KDOM is also considering potential expansion to more rural communities including the Macon, Savannah and Fort Valley areas. The medical mobile unit is designed to provide families with comprehensive healthcare, and is staffed by a pediatrician, nurse practitioner, mental health counselor, and medical assistant. Moreover, our telehealth services, through the iCare Center kiosks installed at the schools, enable children to have access to a physician throughout their entire school day. As a result, Kids’ Doc-On-Wheels has provided over 10,000 children in Georgia with access to high quality healthcare services.

Let’s Catch Up!

This year brings several changes in the makeup of the Georgia CATCH team. Dr. Katherine Duncan and I are your newest CATCH Chapter facilitators (CCFs). Dr. Leslie Rubin, our long-standing CATCH advocate, has advanced in the ranks and is serving as the district-level CATCH facilitator (DCF) covering the entire District X region. Seated at GAAAP headquarters, Ms. Cordia Starling serves as the CATCH Committee Liaison (CCL). Additionally, there will be 2 new District X Resident Liaisons (DRL) who will cover AL, FL, GA, and PR. We want to see more CATCH projects here in GA and are excited to support you in developing your ideas, projects, and partnerships. Connect with us early to CATCH us up on your ideas and to review any questions you may have about the grant application. We look forward to hearing from you!


We love to hear about the great work that our CATCH pediatricians and residents are doing and have done! Do you have a grantee story to share? Consider sharing a blurb, video, or link to your grantee/project.

And, of course, if you’ve got a great idea for a CATCH project, be sure to reach out to us for technical assistance as you prepare to apply during the upcoming grant cycle opening November 2019!

Lillian Lewis Debnam MD, MPH, FAAP
CATCH Chapter Facilitator, GAAAP
Assistant Professor of Clinical Pediatrics
Morehouse School of Medicine | Morehouse Healthcare, Atlanta

Katherine Duncan
CATCH Chapter Facilitator, GAAAP
Associate Pediatric Residency Director
Director of Pediatric Advocacy & Global Health
Mercer School of Medicine, Atlanta
Looking Ahead:

- **October 10-12, 2019**
  Pediatrics “Just Off” Peachtree Fall CME Meeting
  Atlanta Marriott Buckhead Hotel and Conference Center, Atlanta, Georgia

- **October 25-29, 2019**
  AAP National Conference & Exhibition
  New Orleans, LA
  Georgia AAP Reception
  Sunday, October 27, 5:00 p.m.

- **March 5, 2020**
  Legislative Day at the Capitol
  The State Capitol, Atlanta

- **April 22, 2020**
  The Jim Soapes Charity Golf Classic for the Pediatric Foundation of Georgia
  Cherokee Run Golf Club, Conyers

- **June 17-20, 2020**
  Pediatrics by the Sea Summer CME Meeting
  The Ritz Carlton, Amelia Island, Fla.

The Georgia Pediatrician is the newsletter of the Georgia Chapter/American Academy of Pediatrics

**Editor:** Alice Little Caldwell, MD | **Email:** acaldwell@augusta.edu

@Georgia Chapter of the American Pediatrics | @GArchapterAAP

1350 Spring St, NW, Suite 700, Atlanta, Ga 30309 | P: 404.881.5020 F: 404.249.9503

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