

Georgia Chapter

American Academy of Pediatrics
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The GEORGIA Pediatrician

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President's Letter

Countering Toxic Stress



Hugo Scornik, MD, FAAP

I will never forget the empty stare of the little boy I saw early in my career. He was just shy of his third birthday and was not talking or growing because of severe emotional and physical neglect. DFACS was called and he was removed from this environment and placed into a foster home. What do we know about that boy's future and how best to intervene?

Toxic stress is defined by the Harvard Center for the Developing Child as a child experiencing strong, frequent, or prolonged adversity without adequate adult support. The Georgia Chapter, in partnership with the national AAP, leads a quality improvement collaborative that helps physicians address childhood toxic stress. Called the Addressing Social Health and Early Child Wellness (ASHEW) project, there are fourteen Georgia pediatric practices who participated in Phase I. The group is now launching into phase II, guided by Fozia Eskew, who is the Chapter's lead staff in charge of this important work.

Although I am certainly not an expert, I find the science regarding childhood toxic stress to be very interesting. Consider the work of the Bucharest Early Intervention Project. Back in 1989, after the fall of the brutal Romanian dictator Nicolae Ceausescu, 170,000 children were discovered to be living in 700 overcrowded, impoverished institutions across the country. These children were exposed to hunger, cold, and a general lack of care. It was in this setting that investigators from Harvard, the University of Minnesota, and Tulane began to study 136 of these institutionalized children. The children were followed for more than sixteen years. Findings showed that institutionalization in this harsh setting led to profound deficits in multiple domains, including cognitive, socio-

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emotional, brain activity on EEG, brain structure, alterations in reward sensitivity and processing, and a greatly elevated incidence of psychiatric disorders and impairment¹.

Fast forward to 1998 and another landmark study which focused on adverse childhood experiences (ACEs). In California, 17,000 adults were questioned on negative experiences they may have suffered early in life, such as being the victim of abuse, neglect, or witnessing violence. This study revealed a strong and dose-dependent relationship between ACEs and many of the leading causes of adult death including heart disease, cancer, and lung disease. In a 2012 technical report, the American Academy of Pediatrics summarized the research into the mechanisms underlying toxic stress by noting observed disturbances in genomic function, brain structure and connectivity, metabolism, neuroendocrine function, immune function, and the microbiome.²

Yet, the deleterious effects of ACEs are only part of the story. Nurturing experiences in childhood have been shown to be protective. For example, responsive interactions between caregiver and child, such as the "serve and return" response when a caregiver responds appropriately to a baby's babble or gestures, can positively influence brain architecture³. According to an AAP report released this year, what is emerging is a new dynamic model of disease and wellness resulting in an "ongoing but cumulative and reciprocal dance between ecology and biology which leads to changes at the molecular, cellular, and behavioral levels."⁴ The report emphasizes the value of safe, stable, and

Continued on next page.

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nurturing relationships early in life as a cornerstone to healthy child development.

There are many ways that we pediatricians can promote meaningful caregiver interactions. One strategy, validated by substantial research, is to implement Reach Out and Read. I have heard Reach Out and Read described as a parenting program disguised as a book giveaway. Although most pediatricians would like to participate, financial barriers do exist. Fortunately, Georgia's Reach Out and Read organization has resources and a team of employees, managed by executive director Amy Erickson, who are ready to help. If you are interested in more information, please go to their website or contact our Chapter office.

As families struggle to recover from the collective trauma caused by Covid-19, the work pediatricians do every day to combat toxic stress takes on a renewed significance.

The Georgia AAP actively promotes work in early child development through projects such as ASHEW as well as our advocacy efforts. The Chapter's Early Education and Childhood Section is chaired by Dr. Melissa Boekhaus and the medical director of Reach Out and Read is our immediate past president Dr. Terri McFadden. Ultimately, as the recent AAP report points out, what will be needed is a comprehensive public health approach involving not just the medical community, but also our colleagues in public health and support from local and national leaders. As families struggle to recover from the collective trauma caused by Covid-19, the work pediatricians do every day to combat toxic stress takes on a renewed significance.



Hugo Scornik, MD, FAAP

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Community Rotation Reflection



Bayley Bennett, MD

"It takes a village" is a phrase often used to describe raising a child. The phrase signifies that nurturing the growth and development of a child is not solely the job of one person or parent, but the responsibility of the entire community. Throughout my experience on my Community Pediatrics rotation, this adage has truly come to fruition. A child is much more than a product of their parents and family, but also of their environment and community. On the other side of the same token, a pediatrician cannot successfully promote the health and well-being of a patient without collaborating with others in the community.

As pediatricians, we cannot do this alone. We write prescriptions, make referrals, and give anticipatory guidance; however, these are surface-level fixes for the deep-rooted issues that some of our patients and families face—poverty, food insecurity, violence, and racism to name a few. Children are more than their problem list on Epic, and family struggles go beyond what is shared on the Family Resource survey or in a 15-minute visit. I used to work in a microcosm, only thinking of my own objectives—obtain the history, complete my physical, develop a differential diagnosis, write orders, and provide the needed assurance and guidance for my developing and growing patients. I wanted what was best for them and attempted to do everything in my power to provide that for them, but I was not fully utilizing the resources that already existed around me. Sometimes our patients need the help of a social worker or a behavioral health specialist. Other times a nurse navigator is necessary or a chaplain who can help a family through a difficult time. There are also many people who have dedicated their lives to providing for their communities who work outside of the hospital or clinic—at food pantries, juvenile justice centers, and family resource centers.

Sometimes the ideas of one passionate person can kickstart change in a community; however, real change requires collaboration, joint decision-making with patients and families, and meeting the community where they are. I hope

to never forget this lesson as I continue to practice the art of medicine. I will strive to identify the specific needs and goals of each patient and

their family. Most of all, my goal is to listen—to listen to what my patients and their families say and need. But also, to try and hear those things that are left unsaid. Maybe one day, after building trust and developing a true relationship with them, they will feel comfortable bringing those things to me.

Bayley Bennett, MD

Emory Pediatrics, PGY-2
Atlanta

Sometimes the ideas of one passionate person can kickstart change in a community; however, real change requires collaboration, joint decision-making with patients and families, and meeting the community where they are.



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Nutrition Update Winter 2022



Jay Hochman,
MD

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

1. Worrisome Outcomes of Youths with Type 2 Diabetes.

TODAY study group. NEJM 2021; 385: 416-426. This prospective "TODAY2" study annually followed 500 participants from the TODAY trial (2011). The age of the participants was 26.4 ± 2.8 years, and the mean time since the diagnosis of diabetes was 13.3 ± 1.8 years. The population was representative of the U.S. Key findings:

- The cumulative incidence of hypertension: 67.5%
- The incidence of dyslipidemia: 51.6%
- The incidence of diabetic kidney disease: 54.8%
- The incidence of nerve disease: 32.4%.
- The prevalence of retinal disease: 13.7% (2010 to 2011) and 51.0% (2017 to 2018)

2. Transient Elastography Helpful for Chronic Liver

Disease/Fatty Liver Disease. AM Banc-Husu, LM Bass. JPGN 2021; 73: 141-144 Elastography is most useful when values are at the very low and very high end. Low values provide a lot of reassurance against significant fibrosis and high values indicate a high likelihood of significant liver fibrosis; values in the middle are more difficult to interpret. For example, with non-alcoholic fatty liver disease: >9 kPa distinguishes advanced fibrosis.

3. No Great Way to Monitor Celiac Disease After Diagnosis.

K Payne et al. JPGN Reports: 2021; 2 (3): pe097. This clever study examined follow-up intestinal biopsies in 39 children with both celiac disease and eosinophilic esophagitis (EoE). It is a clever design because generally children with celiac disease, unlike children with EoE, do not need routine follow-up biopsies. Key findings:

- 8/14 (57%) of patients with normal tTG-IgA levels had evidence of active disease on biopsy
- 9/15 (60%) of patients with no evidence of CD on biopsy had abnormal tTG-IgA levels
- Among the 18 who had been receiving a gluten free diet (GFD) for at least 2 years, 94% (17/18) had normal duodenal biopsies after 2 years, and 83% (15/18) had normal tTG-IgA values after 2 years

Overall, this study confirms that tTG-IgA levels are not optimal for monitoring. Current guidelines recognize this issue and recommend repeat biopsy in patients with persistent or relapsing symptoms even with negative serology.

4. Hot Study on Hot Dogs. KS Stylianou et al. Nature Food 2021; 2: 616-627. Open access: "Small targeted dietary changes can yield substantial gains for human health and the environment" In this study, the authors developed the Health Nutritional Index to quantify marginal health effects in minutes of healthy life gained or lost of 5,853 foods in the US diet. The study estimated that substituting 10% of daily caloric intake from beef and processed meats for a mix of fruits, vegetables, nuts, legumes and select seafood could reduce your dietary carbon footprint by one-third and allow people to gain 48 minutes of healthy life per day. One of the attention-grabbing estimates was that each hot dog one ingests could cost a person 36 minutes off their lifespan. Based on their findings, the researchers suggest:

- Decreasing foods with the most negative health and environmental impacts including high processed meat, beef, shrimp, followed by pork, lamb and greenhouse-grown vegetables.
- Increasing the most nutritionally beneficial foods, including field-grown fruits and vegetables, legumes, nuts and low-environmental impact seafood.

Related study: GBD 2017 Diet Collaborators. Lancet 2019 May 11;393(10184):1958-1972. Health effects of dietary risks in 195 countries, 1990-2017: a systematic analysis for the Global Burden of Disease Study 2017. Slides below from AAP Nutrition Symposium (William Balistreri, MD): "The Paramount Health Challenge for Humans in the 21st Century"

Effects of unhealthy diets - Global Burden of Diseases (GBD) study

GBD 2017 Collaborators, Lancet 393:1958, 2019

- Evaluated consumption of foods & nutrients in 195 countries; quantified impact of suboptimal intake
- ~20% of deaths (~11M) worldwide assoc with poor diets; most deaths due to CV disease, cancer, Type 2DM

One-Fifth Of Deaths Worldwide Tied To Poor Diets

GBD Collaborators, LANCET 393:1958, 2019

"...consuming vegetables, fruits, fish, whole grains was strongly associated with a longer life..."

"People who skimp on such healthy foods more likely to die before their time"

Jay Hochman, MD

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



Adding Cytomegalovirus to Newborn Hearing Screening: A Challenge in Preventing Hearing Loss



Heather Koehn,
MD, MMHC

The most common sequela of congenital Cytomegalovirus (CMV) infection is sensorineural hearing loss. The presentation of congenital CMV infection can vary widely from completely asymptomatic at birth to multiorgan system failure. Approximately 10-15% of children, who are initially asymptomatic, will develop sensorineural hearing loss. This hearing loss, which develops at an average of 44 months of age, can be unilateral or bilateral, mild or severe, and in many cases, progressive.¹ A unique feature of congenital CMV related sensorineural hearing loss is the potential to treat with pharmacologic therapy, as opposed to other types of sensorineural hearing loss, which are only treatable with amplification (via hearing aids or cochlear implantation).

Several studies have been conducted regarding the use of intravenous ganciclovir, oral valganciclovir, and even intratympanic antiviral agents. Of these studies, promising improvements in hearing outcomes with oral valganciclovir with less neutropenia than intravenous ganciclovir therapy were noted.² Most studies agree that early intervention, even before one month of age, is ideal for improving outcomes.

The challenge, and some will say the controversy, is targeting therapy to those patients who will benefit. Screening has proven challenging because of the multistep process and coordination of care required. In Georgia, CMV is not currently included on the standard newborn screen. Instead, potential candidates for treatment are identified through secondary channels. The first is the newborn hearing screen which is universally performed as recommended by the AAP within the first month of age. At our institution, children who are identified with a failed newborn hearing screen are referred to an otolaryngologist who orders CVM testing via urine or saliva sample. The child should also get a diagnostic auditory brainstem response to further characterize the type and extent of the hearing loss. This screening process must be completed within the first three weeks of life to identify a congenital CMV infection before referring the child for consideration of treatment with valganciclovir.

This timeline of staged screening misses the patients who are asymptomatic at birth but go on to later develop hearing loss.

Without universal screening, there is not an effective way to identify these children and potentially prevent irreversible

hearing loss. By the time these patients present, the hearing loss may be so severe that a cochlear implant is their only option, and their language development may also be delayed.

We have come so far as a nation to have all fifty states include a newborn hearing screen. Now, as

we learn more about the unique nature of congenital CMV related hearing loss, we are called to continue to evaluate the screening process and consider that all congenital hearing loss does not necessarily fit the previously accepted screening protocol. Perhaps, Georgia should mimic states such as Connecticut, Iowa, New York, Utah, and Virginia who perform statewide targeted screening of CMV for newborns who fail the hearing screen.³ The National CMV Foundation also announced that Minnesota is slated to become the first state to enact universal CMV testing for newborns.

Or, perhaps we need to look beyond newborn screening all together at those who are investigating prenatal interventions and vaccine development in pursuit of prevention.

Until we learn more about the prevention, transmission, and pathophysiology of congenital CMV related hearing loss, we must continue to use the most current data available for screening and treatment. This is why both the Children's Hospital of Georgia in Augusta and Children's Healthcare of Atlanta pediatric otolaryngologists are committed to identifying those with failed hearing screen and testing for CMV and referring those who are positive for consideration of antiviral therapy. Together, we will continue to pursue excellence in early hearing loss identification and intervention to improve outcomes for all children in Georgia.

Heather Koehn, MD, MMHC

Assistant Professor of Pediatric Otolaryngology
Augusta University, Children's Hospital of Georgia
Augusta

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- ³ www.nationalcmv.org National CMV Foundation. accessed Dec 22, 2021.

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Rodrigo Mon, MD
Pediatric General Surgeon

Rodrigo Mon, MD, is a pediatric general surgeon who joined Children's Healthcare of Atlanta in Oct. 2021. After obtaining a medical degree from Ignacio A. Santos School of Medicine, he completed a general surgery residency at the University of Iowa. After several years in private practice, Dr. Mon made the decision to expand his academic training by obtaining a fetal surgery/research fellowship and a surgical critical care fellowship at the University of Michigan. Most recently, he completed a pediatric surgery fellowship at Children's National Hospital-George Washington University.

Dr. Mon's clinical interests include neonatal surgery and fetal surgery. He performs surgery at Scottish Rite Hospital.

- **Medical school:** Ignacio A. Santos School of Medicine, Monterrey, Mexico
- **Residency:** General surgery, University of Iowa, Iowa City, IA
- **Fellowship:** Fetal surgery/research, University of Michigan, Ann Arbor, MI
- **Fellowship:** Surgical critical care, University of Michigan, Ann Arbor, MI
- **Fellowship:** Pediatric surgery, Children's National Hospital-George Washington University, Washington DC



Heather Short, MD
Pediatric General Surgeon

Heather Short, MD, joined Children's as a pediatric general surgeon in Oct. 2021. After receiving her medical degree from Mercer University School of Medicine, Dr. Short completed her general surgery residency at Emory University School of Medicine. During her residency training, she completed a two-year research fellowship within the Emory University Department of Pediatric Surgery under Mehul Raval, MD. Her research fellowship focused on clinical outcomes research, specifically enhanced recovery after surgery (ERAS) in children and anti-reflux surgery in infants. In 2021, Dr. Short completed her pediatric fellowship at Emory University School of Medicine.

Dr. Short's areas of interest include minimally invasive surgery, neonatal surgery and colorectal surgery. She performs surgery at Scottish Rite Hospital.

- **Medical school:** Mercer University School of Medicine, Macon, GA
- **Residency:** Emory University School of Medicine, Atlanta, GA
- **Fellowship:** Emory University School of Medicine, Atlanta, GA

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Choosing Wisely



Robert Wiskind
MD, FAAP

During *Indiana Jones and the Last Crusade* (1989), the third in the *Raiders of the Lost Ark* series, Indy joins his father on his life-long search for the Holy Grail, surviving trials and adventures to finally come face-to-face with the ancient Knight who guards the Grail in a chamber full of goblets. The Knight says that drinking from the Grail will grant eternal life but warns that drinking from one of the other goblets will be fatal. Indy's captor drinks from a fancy cup and meets a gruesome death. The Knight dryly states, "He chose...poorly." When Indy correctly sips from the humble Grail, the Knight beams and says, "You have chosen wisely."

Since 2012, the Choosing Wisely campaign has identified tests and procedures in a variety of medical fields that have limited value and should be avoided. Over the past two pandemic years, we have all been faced with many choices and, I hope, chosen wisely more often than poorly.

We all made the wise choice to enter Pediatrics and have the chance to follow children and their families for the first 20+ years of their lives. Over 1700 Pediatricians in Georgia have chosen to join the Georgia AAP and support an organization that fervently advocates for us and the children we serve.

Most of us made the wise choice to provide the COVID-19 vaccine in our practices and encourage it for all adults and eligible children. Most of them have chosen to be vaccinated, protecting themselves, their family and the community. Unfortunately, a significant minority of eligible adults have chosen to forego the vaccine for themselves and their children, despite overwhelming evidence that the vaccine is safe and effective and that COVID presents a real threat to the health of children. This poor choice is a major reason that the pandemic has persisted and that we remain far from the return to normal that everyone desires.

More troubling, some physicians (including Pediatricians) have counseled against getting immunized. They have also spread misinformation about COVID, the vaccine and measures (such as masking and social distancing) that keep

everyone safe. It is imperative that we choose to be vocal during the pandemic and champion the recommendations of the AAP and CDC while drowning out the negative voices.

The pandemic has accelerated the increase in mental health conditions in children and teens. Fortunately, most of us have identified the needs in our communities and made the choice to step in and fill the care gaps. No matter the practice setting, asking about anxiety, depression and other concerns is always appropriate. This action acknowledges the inseparable

connection between mental and physical health while facilitating comprehensive care. Many in primary care have also chosen to treat these conditions when resources are not available or affordable in the community, living up to the true ideal of the medical home.

Over 1700 Pediatricians in Georgia have chosen to join the Georgia AAP and support an organization that fervently advocates for us and the children we serve.

The Georgia Legislature is in session and the campaign for Governor and other statewide offices has begun. Our elected leaders at the state and national level too often choose poorly when it comes to protecting the health, safety and wellbeing of children. Fortunately, as voters we get to choose our representatives. Discussing individual candidates may not be appropriate in the exam room, but we should all choose to promote voter engagement, participation, and encourage patients and their family members to prioritize child health issues when voting. A recent AAP campaign urged all to "Vote like children's futures depend on it." Vote-ER (<https://vot-er.org/>) works to integrate voter registration into the health care delivery system and provides resources to help clinicians facilitate participation in the election process.

To reach the Knight and the Grail chamber, Indy first must take a literal leap of faith and trust in the wisdom of his father. Daily, we ask patients and their parents to have faith in our knowledge, compassion and commitment to keeping them safe and healthy. We earn their confidence through dedication and focus, always seeking to choose wisely.

Robert Wiskind, MD, FAAP

Past President, Georgia AAP
Peachtree Park Pediatrics
Atlanta



NICU Verification Program Update

The Georgia Department of Public Health (GA DPH) has approved the American Academy of Pediatrics (AAP) NICU Verification Program as a third-party surveying agency to verify NICU facilities' level of care and provide documentation needed for state designation. The AAP is the leading authority in NICU verification, having developed the standards for each level of care as outlined in the AAP 2012 policy statement Levels of Neonatal Care. Participating in the AAP NICU Verification process will help a facility elevate the quality of neonatal care by obtaining an objective, collaborative, and consultative review of the facility's personnel and resources by leading experts in neonatal care. Recognizing the importance of NICU verification, the GA DPH will also subsidize a portion of the verification survey cost. Please visit the AAP NICU Verification Program website at aap.org/nicuverify or email NICUverify@aap.org for further information.



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Musing Of A Retired Pediatrician (Or Back When I Was Young)

1943--my parents would call that a good year (perhaps). Amidst the raging war in Europe, the rationing of sugar, meat, gasoline and other commodities in the US, I joined the family. I always wanted to be a doctor, from the time I first knew what a doctor was and did. My role model was the only woman physician in southern Ohio--Dr. Ann. How I wanted to be like her!! If I were honest, I would admit that at times I malingered in order to make a visit to her.

Dr. Ann steered us through the usual childhood maladies--chicken pox, measles, mumps, rubella. We didn't think much of these except that we had to keep the windows covered with measles, as the word of the day was that "measles could damage your eyes." These diseases were a rite of passage for all kids, and it usually passed through the family week after week.

However, we had a serious regard for scarlet fever. I remember when my younger sister had the disease, and the house was quarantined for 2 weeks. There was a large red sign on the front door stating QUARANTINED. All the library books had to be "fumigated" by burning sulphur in a closed-up room. And

my sister, who went through a total skin desquamation, could not return to school until all the dead skin had peeled from her body, a process which took several weeks.

But the disease we most feared was polio. Even without the internet or TV, we knew about iron lungs, and crippled children. Kids were not permitted to go to swimming pools, as there was fear that the disease was harbored there. We couldn't play with our cousins (one of whom contracted polio). We knew that there was no medicine to cure this. So, when the vaccine became available in 1955 everyone was SO grateful. Families went to the schools on the weekend and received the liquid vaccine on a sugar cube repeated monthly over 3 months (I think). A polio vaccine card (similar to the CDC COVID vaccine card) that my father had kept sits on my dresser to prompt my gratitude for medical science. Yet in the Wierton Daily times of June 1959, health commissioners issued a statement noting "area's apathy toward polio shots held shame." Some things never change.

Ruth Brown, MD

Retired Pediatrician, Decatur



**Anna Shaw
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Emily A. Brandt, MD
Board-Certified Developmental
Behavioral Pediatrician



Lauren A. Buono, PhD
Pediatric Neuropsychologist



Nancy E. Carnevale, MD
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How do you care for yourself when others are depending on you?



Katherine Duncan,
MD, MSPH

Year three into a global pandemic, fatigue is part of the new normal. Pediatricians have counseled families on risk reduction, advocated for adherence to well checkups and the childhood vaccine schedule, grieved with patient families and coworkers who've lost loved ones to COVID. There's been reading to stay current on new information about COVID-MISC and new COVID strains, service on new special committees, social media posts and appearances on traditional news sources to discuss guidelines for sports participation and school safety. Practices were restructured to provide safe care and administer COVID vaccines. We've led our teams and in our communities.

This sentiment is common and dangerous. In healthcare, we regularly put others' welfare above ourselves.

Dr. Abigail Cruz and I recently spoke to Mercer Pediatric residents about patient care and wellness. We discussed challenges our patients face, how other clinics address social concerns, and what we can do differently to better serve families (Stein Berman et al., 2018). Daily we witness consequences of societal inequity, and it's hard to pause ongoing advocacy projects to focus on more immediate pandemic concerns. Residents voice the belief that our families deserve to be healthy and happy, to have rest and wellness "because they are human."

Flipping the question, "Do physicians deserve to be healthy and happy, to have rest and wellness?" was met with outcry of "no" and skepticism. I asked, "Aren't we human? Don't we deserve these things too?" A couple of senior residents replied that we are 'healthcare heroes,' somehow superhuman, with neither the same limitations nor the same basic needs as others. What right have we to rest when others are suffering?

This sentiment is common and dangerous. In healthcare, we regularly put others' welfare above ourselves. There is a pride among us to be those who give the most, who work the most selflessly, who leverage ourselves against systemic failures and poor patient outcomes. We celebrate frugality, efficiency, ingenuity – we are experts at making the best of scarce resources. But at what cost? Depending on the study, nursing and physician suicide completion is 30-100% higher than that of the general population (Anderson, 2018; Davidson et al., 2020; Farmer, 2018). Burnout is common, both harming patient care (Baer et al., 2017) and leading to physician "drop-out," (Kwon, 2017) when healthcare workers quit to pursue non-clinical careers.

In a profession that selects specifically for highly talented and

skilled individuals who put others first, what can we do to preserve and sustain ourselves?

First, we must move forward from the fantasy of the superhuman physician. Burnout is not just fatigue. In her reporting on war zone medicine, Janine di Giovanni discusses moral injury, trauma that occurs when we bear witness to wrongs that we are powerless

to correct, or when we are forced to make impossible decisions valuing one life above another (di Giovanni, 2021). Harvard psychiatrist Bessel van der Kolk describes the inevitable cost of trauma in his book *The Body Keeps the Score* (van der Kolk, 2014). Physicians can choose not to

acknowledge the trauma we face, but we cannot escape its effects.

Second, to prioritize everything is to prioritize nothing. Wellness must be planned in place of some other goal, not sprinkled on top as a module or a meditation class. Best results in workplaces are achieved when resilience training is coupled to systemic supports (Rasool et al., 2021). Finite time and attention must be acknowledged to achieve an environment that allows for rest and balance. To keep up with all current projects and add-on pandemic efforts is unsustainable. From a practice standpoint, this could be stakeholders gathering to acknowledge and celebrate accomplishments to-date, reviewing or re-evaluating your clinic or department's mission and values, and collaborating to decide which projects are more currently important, and which might be paused for now.

Finally, we must align wellness to the mission. Healthcare workers are incredibly mission-oriented, so the wellness of the individual must be understood as integral to achieving other shared goals. Physician and nursing shortages across the country demonstrate that we are a finite resource. Training takes time, and we are well-served to sustain those with experience for as long as we can. In the axiom "the margin IS the mission," sustaining an experienced team is part of that margin.

As we begin the new year, I encourage you to be kind to yourself, accept your humanity, make wellness a priority, and find ways to integrate wellness into our mission for everyone, not just patients. Friends and advocates, be well.

Katherine Duncan, MD, MSPH

Co-Chair, Physician Wellness Committee, Georgia AAP
Macon



Pediatric Medical Facility Recognition Process: The Time is Now



Natalie E. Lane, MD

Hospital trauma, stroke, and cardiac center designation are all rigorous programs that have the capacity to change outcomes for patients in emergencies. The state of Georgia has established all three programs under the administrative direction of the Department of Public Health, Office of Emergency Medical Services and Trauma. Additionally, the Georgia Department of Public Health, Office of Women and Children oversees the designation process for hospitals providing labor and delivery services. The designation process ensures that institutions are following established standards of care designed by respective professional organizations with additional input by state professional clinical experts. Institutions voluntarily commit to the standards and undergo an initial approved designation and routine review to ensure that they comply. They are additionally required to submit metrics on outcomes on their efforts and select patient populations. There are often tiered designations based on the capabilities of the willing participant institutions. Ultimately, the designation process helps to ensure a coordinated, timely, safe, and appropriate delivery of care for patients who may suffer from an acute traumatic, stroke, cardiac or obstetrical event.

Although the state's trauma designation system includes Children's Healthcare of Atlanta - Egleston, Children's Healthcare of Atlanta - Scottish Rite, and Children's Hospital of Georgia, there is no established designation process to date that addresses the level of care provided at institutions seeing children in an emergency setting for medical illness or other non-trauma related cases. The National Pediatric Readiness Survey of 2013¹ revealed that trauma designation does not necessarily confirm readiness for pediatric patients presenting for any type of emergency care.²

Georgia has five excellent pediatric hospitals with pediatric emergency departments that collectively see about 350,000 children annually (50-300/day/ED). However, data from the National Pediatric Readiness Survey of 2013 has identified that about 90% of the 30 million children who seek care in emergency settings across the country are seen in emergency departments that see less than 15 patients a day. Preparedness in the form of pediatric clinical leader presence and oversight, supportive services, adequate equipment, supplies and

medications, established guidelines, policies, protocols, pediatric knowledge and skills competency evaluations, pediatric disaster preparedness, pediatric safety measures, and quality assurance, is not uniformly provided in all emergency departments seeing children. The aforementioned items are linked to improved care and outcomes for children in the emergency setting and have been expertly defined as elements related to pediatric readiness³. Those institutions with a designated pediatric physician and /or nurse clinical leader were found to be most ready.

In 2006, the Institute of Medicine report on "Emergency Care of Children: Growing Pains" identified that emergency care for children across the nation was uneven.⁴ The increasing need for public sector agencies to develop performance measures to better inform and guide organizational decisions prompted the Emergency Medical Services for Children (EMSC) program, a federally funded program in all 50 states and territories, to establish relevant performance measures. The most recent performance measures of 2017 include the establishment of a pediatric medical facility recognition program. Performance Measure 04 states that by 2022, 25 percent of hospitals be

Summary of Current EMSC Performance Measures

EMSC 01	The degree to which EMS agencies submit NEMSIS compliant version 3.x data to the State EMS Office.
EMSC 02	The percentage of EMS agencies in the state or territory that have a designated individual who coordinates pediatric emergency care.
EMSC 03	The percentage of EMS agencies in the state or territory that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
EMSC 04	The percentage of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies.
EMSC 05	The percentage of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric trauma.
EMSC 06	The percent of hospitals with an Emergency Department (ED) in the state or territory that have written interfacility transfer guidelines that cover pediatric patients.
EMSC 07	The percent of hospitals with an Emergency Department (ED) in the state or territory that have written interfacility transfer agreements that cover pediatric patients.
EMSC 08	The degree to which the state or territory has established permanence of EMSC in the state or territory EMS system.
EMSC 09	The degree to which the state/territory has established permanence of EMSC in the state/territory EMS system by integrating EMSC priorities into statutes/regulations.

https://media.emscimprovement.center/documents/2018_PM_FactSheet20180110.pdf

The EMSC Innovation & Improvement Center (EIIC) is supported in part by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) Maternal and Child Health Bureau Emergency Medical Services for Children grant number U07MC29829. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

The Time is Now...

Continued from previous page.

recognized as part of a statewide, territorial, or regional standardized program and be able to stabilize and/or manage pediatric medical emergencies. This is but one of nine national performance measures that guide Georgia EMSC. There are only 17 states with established pediatric medical facility recognition programs. Our neighboring states of Tennessee and South Carolina are among those seventeen. Literature has supported the benefits in states with pediatric medical facility recognition programs.⁵

In the fall of 2019, members of the Georgia Emergency Medical Services for Children (EMSC) Committee met in Atlanta at the Department of Public Health, Office of EMS and Trauma, with national representatives from the Health Resources and Service Administration (HRSA), and the National EMSC Data Analysis Resource Center and the EMSC Innovation and Improvement Center (EIIC), the national administrative organization housed at Baylor University Medical Center. Representatives from the national program included Theresa Morrison-Quinata, Branch Chief, EMSC, HRSA; Eduardo Zamora, Research & Evaluation Specialist, NEDARC; Diane Fendya, Trauma/Acute Care Specialist, EIIC; and Rachael Adler, State Partnership Co-Lead, EIIC, and others assisted in the meeting. Deliberations addressed opportunities and challenges and proceeded to develop workgroups to address the performance measures EMSC 02, 03, and 04. COVID interrupted some of the momentum towards the intended goals. Still, efforts continue, and representatives from various state organizations including the Georgia EMSC, Georgia AAP, Georgia College of Emergency Physicians (GCEP), Georgia Pediatric Health Improvement Coalition (GA-PHIC), Georgia Hospital Association (GHA), Georgia Emergency Nurses Association, Georgia Trauma Commission, Georgia Office of Rural Health, representatives from Children's Hospital of Georgia, Children's Healthcare of Atlanta, Piedmont Columbus Regional Children's Hospital, serve as stakeholders in the process. These representatives meet monthly in various working committees to help develop criteria and engage institution and organizational leadership to determine the best methods of rollout and marketing for this recognition.

A key hurdle was to initially establish the permanence of the designation process in State Rules and Regulations, which

has been achieved as of July 2021. Next, and ongoing, is the development of the criteria needed to be designated as a Pediatric Readiness Center (PRC) with levels I, II, or III. The highest readiness is level I. Criteria are being drafted, and efforts will be

made to test and fine-tune the criteria by piloting it in various interested institutions. The timeline is short, and there is some allowance due to COVID.

What does this mean for the pediatricians and their families and emergency medical services personnel who routinely have to make decisions regarding the best emergency department

for the ill or injured child? The hope is that through a designation process that hospitals will become more engaged with the care provided for children statewide. Clear tier designation allows pre-hospital personnel to understand better the availability of appropriate pediatric resources and capable personnel. Families and pediatricians can feel more comfortable and understand better the level of care provided at any emergency department that may choose to undergo designation because of the rigorous process and criteria that will need to be met. Data from the pediatric readiness survey indicates that Georgia does well. In 2013, the overall and median readiness score for participating hospitals in Georgia was 71% (national median was 69%). There is still work to be done; often in pediatric disaster preparedness and the presence of a nurse/physician leader. Ensuring that daily care for children is done well ensures improved morbidity and mortality and will hopefully make the state better prepared when a disaster strikes that affects children disproportionately. The "time is now" to strengthen collective knowledge about this program and encourage support for its adoption and ultimate success.

Please do not hesitate to reach out for more information by contacting myself as chair of the Georgia EMSC Committee or Norma Campbell, Program Manager, GA EMSC.

Natalie E. Lane, MD

Chair, Georgia AAP Emergency Medicine Committee

Norma Campbell

Program Director, Georgia EMSC
Office of EMS
1680 Phoenix Blvd, Ste 200, Atlanta, GA 30349
770-996-6179

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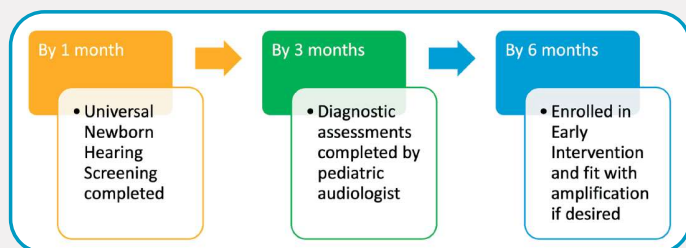
World Hearing Day is March 3rd



Paula Harmon,
MD FAAP

World Hearing Day is March 3rd, 2022! To raise awareness about hearing health, the Georgia State University Leadership Education in Neurodevelopmental and related Disabilities (LEND) Pediatric Audiology program would like to share information regarding childhood hearing loss.

Childhood hearing loss is the most common birth defect and 3 out of every 1000 babies born are diagnosed with hearing loss. Approximately 5 out of every 1000 children between ages 3-17 have hearing loss that can impact their growth and development if these guidelines are not met or concerns are addressed directly¹. The Early Hearing Detection and Intervention (EHDI) guidelines are as follows:



There are several types of hearing loss including conductive, sensorineural, mixed and central. Conductive hearing loss is most likely temporary, secondary to middle ear effusion or eustachian tube dysfunction. Sensorineural hearing loss is a permanent type of hearing that generally does not improve but can be progressive. Sensorineural hearing loss refers to dysfunction of the inner or outer hair cells of the cochlea or the auditory nerve. Mixed hearing refers to sensorineural hearing loss with a conductive component. Central hearing loss is due to damage to the central auditory nervous system.

Know the signs! New parents are often overwhelmed with the number of things they need to remember as their baby is growing and developing. Be sure to remind them about the importance of developmental screening and monitoring.

- If baby isn't startling, turning to sound sources consistently by 6 months, babbling or starting to say two syllable words by one year of age, attempted speech is delayed or unclear, the child needs to be seen by pediatric audiologist for a diagnostic evaluation. A combination of tympanometric and otoacoustic emissions and auditory brainstem response screenings only take a few minutes to an hour, are painless and can be performed even on sleeping infants.¹ Behavioral observation testing can begin before one year of age and conditioned play hearing tests can often be utilized by 24 months. Four in every 1000 children who were not necessarily born with hearing loss, on average develop a hearing loss by the time they start kindergarten¹, so

regular screenings and diagnostic testing are key to ensuring a child doesn't fall behind on their language development and social skills due to an undiagnosed hearing loss.

Kids who are at risk- While genetic factors can play a part for half of cases in babies, we must remember, especially in the time of COVID that maternal infection is a large factor in congenital hearing loss even if there is no family history of hearing loss. Children who have experienced acquired illnesses, particularly with prolonged high fevers (like meningitis), ototoxic treatments and frequent ear infections should have a diagnostic hearing test by 2-2.5 years.¹ It is important not to wait until children are in school for them to get another hearing screening or test because they could be missing out key elements of language development.

Risks for school age kids: Risks for older children, while still including infections, primarily include noise exposure and recreational activities. Any time a child experiences a head injury they need undergo a precautionary hearing test. Children who are involved in highly noisy activities such as marching band/drumline, recreational hunting and dirt biking or All-terrain Vehicle driving/riding should wear hearing protection either disposable or custom made to protect their hearing. Evidence suggests that some of the 14.9% of hearing loss that is developed in children and adolescents by the time they turn 19 is preventable.¹

COVID-19 and kids with hearing loss: Having optimal auditory input is essential for speech and language development. Using a mask or face covering and maintaining social distance of at least 6ft are important mitigation strategies to reduce the spread of COVID-19.³ However, wearing a face covering can reduce the integrity of the auditory signal for children with hearing loss. Research has shown that a face covering can decrease audibility by as much as 12dB.³ Consequently, the volume of the speaker's voice is reduced, things sound muffled and the clarity of speech signal is compromised. A few important steps to assist with speech understanding while wearing masks and keeping a safe distance include:

- Getting the child's attention before speaking
- Reducing Background Noise
- Using of Visual Supports
- Checking Amplification Devices

These strategies were important even before COVID 19 but are critical now as we try to make early learning environments safe and reduce the spread of the virus.

Paula Harmon, MD FAAP

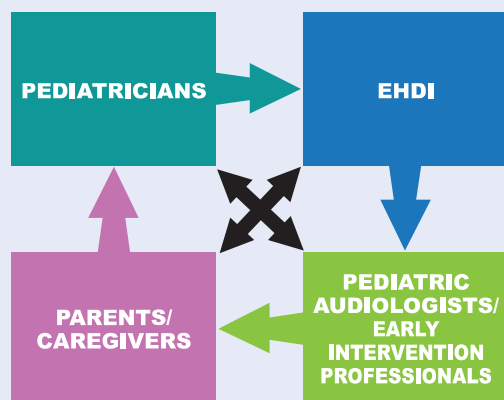
EHDI Physician Champion, Georgia AAP
Pediatric Ear Nose and Throat of Atlanta
CHOA Medical Director of Hearing Loss

COVID-19

IS IMPACTING PEDIATRIC HEARING HEALTH



What Do We Do?



Helpful Resources

From the American Academy of Pediatrics (AAP):
https://downloads.aap.org/AAP/PDF/BF_EHDI_TipSheet.pdf

From the National Center for Hearing Assessment and Management (NCHAM):
<https://www.infanthearing.org/components/>

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Work Together for the Following:

1-3-6 Rule	<p>Ensure national Early Hearing Detection and Intervention (EHDI) guidelines are met:</p> <ul style="list-style-type: none"> • Hearing screening by 1 month of age. • Identification of hearing loss by 3 months of age. • Enrollment in early intervention by 6 months of age. <p>If you see a child who has not been screened or has not had appropriate diagnostic testing, immediate referral to audiology is warranted.</p>
	<p>Obtain results of newborn hearing screening and any diagnostic hearing testing. If you do not have the results, contact the birthing hospital and/or your state EHDI coordinator at: https://www.infanthearing.org/states/index.html</p>
	<p>Communicate with parents/caregivers about results of hearing screenings and diagnostic hearing tests to ensure understanding and appropriate follow-up.</p>
	<p>Make necessary referrals to local pediatric audiologists and your state early intervention (EI) program, as well as to other specialists, such as speech-language pathologists, otolaryngologists, ophthalmologists, geneticists.</p>
	<p>Take parental concerns about hearing seriously and act quickly regarding medical management and making appropriate referrals.</p>
	<p>Know risk factors for childhood hearing loss so that any potential congenital, later-onset, or acquired hearing loss is not overlooked: http://www.infanthearing.org/ehdi-ebook/2015_ebook/10-Chapter10RiskMonitoring2015.pdf</p>
	<p>Flag charts of children who need follow-up regarding hearing loss and/or those with risk factors for hearing loss.</p>
	<p>Identify local hearing health and education professionals, as well as resources for yourself and for families regarding hearing loss.</p>

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Photo Review: 2021 Pediatrics on the Parkway



During the Pediatrics on the Parkway meeting, this year's 2021 Chapter Award Winners were recognized. Pictured here (from left) with Chapter leaders: Drs. Terri McFadden, Past President; Angela Highbaugh-Battle, Vice President; Hugo Scornik, President; COVID Healthcare Hero Award Stephen Thacker, Savannah; Public Health Award recipient Susan McWhirter, Columbus; Young Physician of the Year David O'Banion, Atlanta; Outstanding Achievement Award Sally Goza, Fayetteville; Denmark Lifetime Achievement Award Wendell Todd, Atlanta; and Ms. Jennine Holloway, Ga. Dept. of Public Health. *Not Pictured: COVID Healthcare Heroes Award: Drs. Jane Wilkov, Decatur; and Evan Anderson, Atlanta; and the Friend of Children Award winner: the Kevin Kisner Foundation, Aiken, SC.*



The Legislator of the Year Award (House) was Representative Teri Anulewicz, shown here with the Chapter's Betsy Bates and Rick Ward. *Not Pictured: Senator Kay Kirkpatrick, MD who won the Senate Legislator of the Year Award.*



The Pediatric GI Seminar was outstanding thanks to the wonderful faculty we were so privileged to have: (from left) Jose Garza, MD; Jessica Buzenski, PhD; Barbara McElhanon, MD; Tatyana Hofmekler, MD; & Steven Liu, MD.



One of the best parts of an in-person meeting: the opportunity to see friends! (Sally Goza, MD; Edward Clark, MD; Tammy Williams, MD; Marshelyn Yeargin, MD; and Hugo Scornik, MD.)

2021 Pediatrics on the Parkway

Continued from previous page.



The conference brought together Terri McFadden, MD; Nicky Chin, MD; Jon Poplar, MD; Jennifer Fowlkes-Callins, MD; and Susan McWhirter, MD.



The Chapter Breastfeeding Committee chair Tatyana Hofmekler, MD (third from left) presented “Beyond Breastfeeding-Friendly” during the plenary. She is joined here by Angela Highbaugh-Battle, MD, Program Chair Judson Miller, MD and Jay Polokoff, MD.



National faculty Jenny Radesky, MD, Ann Arbor, Mich., gave two wonderful talks on Screen Time and Digital Health. She is joined here by the Program Chair, Jud Miller, MD.



Several pediatric residents participated in the Poster Presentation session. Pictured here: (l to r) Zach West, MD (Emory); Christina Ramos, MD (Augusta); and Thomas Offerle, MD (Emory).



This year the Resident Competition was presented in the format of Who Wants to be a Millionaire. The contestants were Blake Vander Wood, MD of Emory and Yvonne Ibe, MD of Augusta University. Emory is this year's winner! They are pictured here with Terri McFadden, MD (Emory) & April Hartman, MD (Augusta University).



Pediatrics by the Sea

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Summer 2022 Meeting

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The Georgia Department of Public Health has added a feature to the GRITS system to better address the risks of lead poisoning to children. This is an additional feature that was requested by pediatricians throughout Georgia to facilitate and enhance the process of alerting pediatricians to a child's lead exposure risk due to housing conditions.

As you enter or check childhood immunizations in the GRITS system, you will see:

- A new lead risk message based on where the child lives
- A new button to open the blood lead test reporting feature
- A blood lead testing history

New Lead Risk Messaging

Houses built prior to 1978 have a potential to contain lead-based paint. A new data model estimates the potential risk level for lead exposure based on the predominate age of housing within the child's zip code. This risk level determines what message appears for each child. These messages provide instructions on whether a child needs to be tested or if a simple screening questionnaire should be used to determine if testing is needed.

New Blood Lead Test Reporting for the Portable Analyzer

In-office blood lead test results are now able to be reported into GRITS, eliminating the need to report into SENDSS. Lab-analyzed tests are sent directly to the Georgia Department of Public Health, but all tests analyzed on the Lead Care 2 portable analyzer need to be reported regardless of the resulting value. Look for the new button to open the blood lead reporting feature.

New Blood Lead Testing History

GRITS has the capability to record a child's blood lead testing history, making case management and patient care easier, even with provider changes.



Georgia Registry of Immunizations Transactions & Services (GRITS) can be found at: grits.state.ga.us

The Georgia Department of Public Health's screening guidelines for childhood lead can be found at: dph.georgia.gov/lead-screening-guidelines-children.

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Looking Ahead: Join us for our upcoming events!

Legislative Advocacy Webinar

March 1, 2022 from 6:00 – 7:30 pm

Pediatric Foundation of Georgia The Jim Soapes Golf Classic

April 27, 2022
Cherokee Run, Conyers

Pediatrics by the Sea Summer CME Meeting

June 15-18, 2022
The Ritz Carlton, Amelia Island, Fla.

Pediatric Infectious Disease and Immunization Conference

April 9, 2022
Savannah Marriott Riverfront, Savannah

Georgia Pediatric Nurses & Practice Managers Association Spring Meeting

May 13, 2022
Macon Marriott City Center, Macon

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

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The Georgia Chapter of the American Academy of Pediatrics is incorporated in the state of Georgia.

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