

Georgia Chapter

American Academy of Pediatrics

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President's Letter

Echoes from History



Hugo Scornik, MD, FAAP

Mark Twain once famously said, "History does not repeat itself, but it often rhymes." We can trace the beginnings of the profession of pediatrics in the United States back to the early 20th century, a very challenging time for Georgia's children. Because of non-existent federal child labor laws and harsh economic conditions, many children, some as young as six years old, were forced to forego school

and work long hours in Georgia's textile mills. The leading causes of death at the time were typhoid, malaria, smallpox, measles, scarlet fever, whooping cough, and diphtheria. There were few vaccines and no antibiotics. The writings of physician and author William Carlos Williams further illustrate medicine's limits at the time, "The moment I put my stethoscope to the little boney chest, the whole thing became clear. The infant had a severe congenital heart defect, a roar when you listened over the heart that meant, to put it crudely, that she was no good, never would be." It was in this difficult environment that a few noble physicians began to specialize in the care of children.

The American Academy of Pediatrics was founded in 1930. Dr. Isaac Abt, the AAP's first president, explained the reasons for founding this new organization, "Infant mortality was still too high, total facilities for treating children were inadequate, teaching was not everywhere of the best, and many children were failing to receive the benefits of preventive measures." Georgia's pediatric society probably existed even before the establishment of the AAP, purportedly being the first state organization of pediatricians in the country. There were seven physicians from Georgia among the national AAP's first 304 charter members. Over the years, Georgia's pediatric society evolved into today's Georgia Chapter of the AAP, with each new generation of pediatricians working to

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move children's health forward, navigating everything from ear infections to measles, autism to teen smoking, child abuse to the historic Covid-19 pandemic. Although recent events have once again reminded us of our limitations, we must also acknowledge how far pediatric medicine has advanced, and how rapidly these advancements have been made.

As we look back, we gain perspective. During this tragic Covid pandemic, we could hear disturbing echoes from pandemics past—smallpox, yellow fever, Spanish flu, polio, AIDS. The rise in social discord, the spread of misinformation, a distrust of vaccinations, and the heart-breaking loss of life, unfortunately, have all happened before. But also, just like the previous generations of physicians that practiced before us, today's pediatricians willingly put their own health at risk as they successfully cared for thousands of children from across the state, while still managing to counsel families on how best to protect themselves from the virus. When future generations

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look back on us, I think they will admire how we persevered.

Back in 1903, the Georgia state legislature passed a bill to establish a state Board of Health, the precursor to today's Department of Public Health. This board, although severely underfunded, managed to develop a bacteriological lab in the basement of the state capitol, of all places, where they manufactured and distributed typhoid vaccine and diphtheria antitoxin, to help fight both diseases, which were raging.

As we look back, we gain perspective. During this tragic Covid pandemic, we could hear disturbing echoes from pandemics past—smallpox, yellow fever, Spanish flu, polio, AIDS. The rise in social discord, the spread of misinformation, a distrust of vaccinations, and the heart-breaking loss of life, unfortunately, have all happened before.

I like to imagine an early 20th century physician of that time. There weren't many women physicians; almost all were men.¹ This early physician begins his day with a visit to the capitol to discuss the importance of this new lab with his legislators. He then walks downstairs and picks up several doses of vaccine and antitoxin, placing them in his doctor's bag, before rushing out to make a house call. There, he finds a family of five, living in squalid conditions, worried about their febrile little girl. The doctor examines and carefully treats the sick child. Then, he convinces a few others in the family to take the typhoid vaccine. After repacking his bag, he says his goodbyes and departs for his next appointment. His work is not glamorous, and the hours are long, but he is driven by his dedication to improving the health and lives of his patients, especially the children. I recognize that physician. He might not yet have known it, but that is a pediatrician.

Hugo Scornik, MD, FAAP

¹Dr. Leila Daughtry Denmark graduated from the Medical College of Georgia in 1928 (the third woman graduate) and practiced pediatrics in the Atlanta area for 73 years. She was in the first intern class at Eggleston in 1928. She helped develop the pertussis vaccine in the early 1930's and published two papers about her work in the American Journal of Diseases of Children (1936, 1942). Today, there are more female pediatricians nationwide than male pediatricians. It seems fitting to mention Dr. Denmark as a pioneer of pediatrics in Georgia as well as one of the first female pediatricians in the state.



HPV Vaccination Starting at 9 Years of Age



Robert A. Bednarczyk, PhD

Human papillomavirus (HPV) vaccine uptake remains suboptimal in the United States and consistently trails that of other routinely recommended adolescent vaccinations. In 2020, 58.6% of 13-17-year-olds in the US were up-to-date for HPV vaccination, compared to 89.3% who received at least 1 dose of quadrivalent meningococcal conjugate vaccine (MCV4) and 90.1% who received at least 1 dose of tetanus, diphtheria, and acellular pertussis vaccine (Tdap). This pattern is mirrored in Georgia, where 54.9% of 13-17-year-olds are up-to-date for HPV vaccination, compared to 96.2% who received at least 1 dose of MCV4 and 90.8% who received at least 1 dose of Tdap.¹

One strategy to improve HPV vaccine uptake is to start vaccination at the earliest opportunity. The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination for adolescents and young adults: "Children and adults aged 9 through 26. HPV vaccination is routinely recommended at age 11 or 12 years; vaccination can be given starting at age 9 years."^{2,3} While striving for the same goal – HPV vaccine series completion by 13 years of age, the American Academy of Pediatrics (AAP) recommendation is slightly different: "The AAP recommends starting the series between 9 and 12 years, at an age that the provider deems optimal for acceptance and completion of the vaccination series."⁴ Similarly, the American Cancer Society (ACS) recommendation reads, "The American Cancer Society recommends that boys and girls get the HPV vaccine between the ages of 9 and 12."⁵ These slight differences in wording can lead to differences in interpretation, with the use of "can be" in the ACIP recommendation potentially indicating that starting HPV vaccination at 9 years of age is a secondary recommendation to starting at 11 years of age.

A prior analysis using 2016 National Immunization Survey-Teen (NIS-Teen) found that only 36.9% of US adolescents had initiated HPV vaccination prior to 13 years of age, with only 15.8% fully up-to-date by their 13th birthday.⁶ We are currently updating this analysis using 2020 NIS-Teen data; preliminary findings are that 55.1% of US adolescents had initiated HPV vaccination prior to 13 years of age, with 29.1% fully up-to-date by their 13th birthday. Concomitant with this increase, the 2020 NIS-Teen data also shows that for younger birth cohorts, there is a greater level of HPV vaccine initiation before 11 year of age – 4.9% for 13-year-olds in 2020 compared to 3.1% for 17-year-olds in 2020. These data highlight the opportunity for vaccinating adolescents starting at 9 years of age (Bednarczyk, unpublished data).

The strategy of recommending HPV vaccination starting at 9 years of age has been shown to reap benefits, in terms of increased HPV vaccine coverage in both clinical trial settings^{7,8} and practice-based quality improvement initiatives.⁹ First, as adolescents age, attendance at routine well-care and preventive services visits declines, so initiating HPV vaccination at 9 years of age offers more

opportunity to complete the vaccine series.¹⁰ Second, this can simplify the number of vaccines recommended at a given visit, with the first dose of HPV vaccine administered at 9 years, the second HPV vaccine dose administered at 10 years, and the Tdap and MCV4 vaccine administered at 11 years. It has been documented that receiving fewer vaccines per visit is appealing to adolescents, their parents, and their healthcare providers.^{11,12} Finally, provider recommendations and discussions with parents about HPV vaccine have been reported as being easier when conducted at 9 years of age, as sexual activity is less of a concern.¹¹

There are numerous resources available from the National HPV Vaccination Roundtable (hpvroundtable.org/resource-library) to support HPV vaccination in general, and starting at 9 years. Additionally, in the state of Georgia, HPV Cancer Free GA (hpvcancerfreega.org) – the state-level working group to reduce the burden of HPV-related cancers – is actively working across the state to support efforts to increase HPV vaccine uptake for Georgia adolescents. These commitment by these organizations highlights the importance of HPV vaccine uptake, especially starting at 9 years of age, as well providing support to reach these goals to maintain the health of Georgia adolescents and adults.

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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



Optimizing Care with a Multidisciplinary Approach in Children with Tracheostomies



Ajay S. Kasi, MD



Kara K. Prickett, MD

Advances in medicine and technology have increased survival of medically complex children for whom tracheostomy and/or home mechanical ventilation is required. In addition to structural airway diseases, the indications for tracheostomy have broadened to include neurological and pulmonary diseases. These increasingly complex patients may have a challenging time finding a medical home and may benefit from multispecialty and multidisciplinary care. Following tracheostomy placement, most children remain inpatient for several weeks to be medically stabilized while their family and caregivers receive extensive education and training on home tracheostomy care and ventilator management. Application for and approval of home medical equipment and skilled home healthcare nursing also takes place during the stay. Children with tracheostomies (CwT) are managed by several specialists including the otolaryngologist, pulmonologist, gastroenterologist, feeding therapist, and speech therapist. Each area of care interacts with another and influences the overall health of the child. Additionally, coordination of care among disciplines can be complicated and challenging for the patient and the family; therefore, a coordinated comprehensive multidisciplinary approach to care is vital to ensure the best outcomes.

The Technology-Dependent Pulmonary Clinic at Children's Healthcare of Atlanta is a multidisciplinary program for children with chronic respiratory failure caused by a variety of disorders. Most children in this clinic have a tracheostomy and/or require home mechanical ventilation. This clinic consists of a pediatric pulmonologist, otolaryngologist, respiratory therapist, nurse coordinator, and social worker. This collaborative care model aids in consolidating patient care and facilitating multidisciplinary evaluations for ventilator weaning and tracheostomy decannulation. During outpatient clinic visits, the pulmonologist and respiratory therapist may adjust ventilator settings to ensure optimal oxygenation and ventilation, assess readiness to perform a brief trial off the ventilator, and assess tolerance of a speaking valve to facilitate speech. The otolaryngologist evaluates the tracheostomy and stoma health, assesses the child's readiness to breathe through the natural upper airway, and potentially adjusts the tube size to facilitate ventilation or use of a tracheostomy tube cap or speaking valve. Developmental progress with feeding and communication milestones is also assessed. Additional evaluations may be coordinated during a short inpatient stay following endoscopic airway evaluation and tracheostomy tube sizing. The nurse coordinator partners with the patient, medical equipment company, pharmacy, and home nursing agency to ensure medications, medical equipment, and

supplies are available for home use. The social worker addresses potential barriers to care, insurance navigation, facilitates school attendance, and helps ensure that the child is receiving outpatient rehabilitative services such as occupational, physical, and speech therapies.

Despite substantial family caregiver training and skilled home healthcare nursing, CwT experience high mortality rates that could be related to progression of underlying diseases, acute illnesses, and tracheostomy-related accidents (TRA). Mortality due to TRAs such as accidental decannulation, mucus plugging, and hemorrhage is potentially preventable, generally occurs outpatient, and contributes significantly to overall mortality. To reduce accidental mortality, a high-fidelity simulation-based tracheostomy education program for family caregivers was implemented at Children's in 2017. One of the first of its kind, this program includes a "smart" mannequin that can mimic 3 tracheostomy emergency scenarios with the aim of educating family caregivers to manage urgent situations at home and prevent escalation to life-threatening emergencies. Implementation of simulation-based tracheostomy education has considerably reduced mortality due to TRAs in the past 3 years. The knowledge and confidence that caregivers gain through the program may help them better identify and manage TRAs at home.

The goal of comprehensive multidisciplinary care in CwT is to provide consistent and coordinated care that aligns with established guidelines, improves quality of life, reduces mortality and morbidity, and optimizes outcomes. Approximately 10-12 tracheostomy decannulations are facilitated through this clinic each year. With advances in home ventilation and monitoring strategies, CwT are surviving into adulthood. With our partnership with Emory University, we help patients aged 21 years and older transition care to the Emory Pulmonology and ENT clinics.

For more information on the Technology-Dependent Pulmonary Clinic and to refer patients for evaluation, please visit choa.org/medical-services/pulmonology.

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Nutrition Update Spring 2022



Jay Hochman,
MD

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

1. There were a series of influential articles on adolescent nutrition from The Lancet (November 2021):

GC Patton et al. Nourishing our future: the Lancet Series on adolescent nutrition. doi.org/10.1016/S0140-6736(21)02140-1

SA Norris et al. Nutrition in adolescent growth and development. doi.org/10.1016/S0140-6736(21)01590-7

LM Neufeld et al. Food choice in transition: adolescent autonomy, agency, and the food environment. doi.org/10.1016/S0140-6736(21)01687-1

D Hargreaves et al. Strategies and interventions for healthy adolescent growth, nutrition, and development. doi.org/10.1016/S0140-6736(21)01593-2

Some of the key points:

- “Tackling adolescent nutrition presents an unparalleled opportunity to interrupt intergenerational cycles of malnutrition and respond to the urgent challenges of planetary change”
- Adolescents are “growing up at a time of momentous shift—ie, rapid urbanisation, climate change, food systems shifting towards foods with an increased caloric and decreased nutritional value, the COVID-19 pandemic, and growing socioeconomic inequality. The consequences of these changing contexts have profound impacts on adolescent nutrition and development”
- Food choices by adolescents in modern communities is more heavily influenced by convenience and autonomy; in more traditional communities, family and community priorities often supersede individual considerations of adolescents
- “Even in less food-insecure contexts, social isolation is resulting in negative trends among some adolescents, such as reported weight gain, poor eating habits, and stress eating”
- “Adolescence (10–24 years of age) is “characterised by transition, exploration, and openness to change [good and bad], offering opportunities for radical shifts in diet, physical activity, and other risks for non-communicable diseases. This same novelty-seeking and openness to change also makes adolescents a vulnerable group to commercial exploitation and other unhealthy influences, with lifelong and intergenerational consequences”
- “Greater government fiscal and policy action to both restrict the availability of highly processed foods and enhance healthy and diverse adolescent diets is urgently needed”

2. Another terrific article is from The NY Times (12/29/21, Gretchen Reynolds): “The Year in Fitness: Shorter Workouts, Greater Clarity, Longer Lives”

Key points:

- “The familiar goal of 10,000 daily steps, deeply embedded in our activity trackers and collective consciousness, has little scientific validity. It is a myth that grew out of a marketing accident, and a study published this summer further debunked it, finding that people who took between 7,000 and 8,000 steps a day, or a little more than three miles, generally lived longer than those strolling less or accumulating more than 10,000 steps.”
- “Exercise also has a disproportionate impact on our odds of enjoying a long, healthy life. According to one of the most inspiring studies this year, overweight people who started working out lowered their risk of premature death by about 30 percent even if they remained overweight, with exercise providing about twice as much benefit as weight loss might...Exercise enhances our brain power, too, according to other, memorable experiments from this year”
- In a recent study, “active people reported a stronger sense of purpose in their lives than inactive people...In effect, the more people felt their lives had meaning, the more they wound up moving, and the more they moved, the more meaningful they found their lives.”

3. Most kids referred for bariatric surgery don't get surgery. F Qureshi et al. JPGN 2021; 73: 677-683. Longitudinal Outcomes in Adolescents After Referral for Metabolic and Bariatric Surgery

In this single-center retrospective study (2015-2020), only 22% underwent bariatric surgery after referral.

- Reasons for not having surgery: 171 (62%) did not return for a 2nd visit, 28 (10%) were considered non-adherent to clinical recommendations, 14 (6%) had insurance denials, 16 (6%) had psychological contraindications including recent suicidal ideation
- Of interest, long-term follow-up was poor in both those who had surgery (40% at 1 yr) and those who did not have surgery (<20%). This is concerning due to risk of complications, especially after surgery.

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

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E-cigarette Update



Alice Little Caldwell,
MD, MPH, FAAP

Although it is unclear how much e-cigarette use and vaping declined during the pandemic, 2.55 million youth currently use a tobacco product according to the National Youth Tobacco Survey.¹ Since 2009 when the

FDA began to regulate tobacco under the Family Smoking Prevention and Tobacco Control Act, the tobacco and, more recently, the e-cigarette industry have attempted to maneuver around existing

barriers meant to protect adolescents from tobacco and nicotine initiation. Since 2017, e-cigarettes have become the number one nicotine and tobacco product used by youth, thanks in part to targeted advertising campaigns aimed at teenagers and young adults. Initially billed as cessation methods, e-cigarettes have become the cooler and “safer” way to use tobacco, oftentimes without kids realizing they are inhaling a tobacco product. With countless sweet flavors and menthol to ease the harsh test of tobacco, along with the size and discreteness of the devices and the lack of tell-tale smoke, adolescents and young adults have been easy targets for Big Tobacco and the E-cigarette Industry. The FDA set a deadline in 2020 for all new tobacco product manufacturers to apply for authorization to continue selling their products through “premarket tobacco product applications (PMTA),” to show these new products were not harmful and had the potential for some health benefits (such as for cessation). Since the PMTA required extensive documentation and scientific studies, many small manufacturers found ways to circumvent the application process by advertising their products as Tobacco-Free, “highly purified nicotine” or synthetic nicotine and, therefore, not under the jurisdiction of the FDA. Almost all nicotine comes from the tobacco plant; however, nicotine can be synthesized from precursor compounds in a complicated, expensive process or extracted from nightshade plants, such as eggplant and tomato, although found in much lower quantities than in tobacco. Synthetic nicotine is at least 4 times more expensive than nicotine from tobacco and is half as potent (due to having equal parts of the two stereoisomers of nicotine – the S isomer is the psychoactive part of nicotine with the R isomer having no or low psychoactive properties). Giant retailers like Amazon, Walmart and Target have prohibitions against selling on-line tobacco products; however, these newer products, because they are labelled as “tobacco-free” or containing synthetic nicotine, skirt these tobacco restrictions. Dr. Robert Jackler at Stanford has written a White Paper on ‘Marketing of

“Tobacco-Free” and “Synthetic Nicotine” Products.”² The latest news, however, is that President Biden signed into law on March 15, 2022, a spending bill that gives the FDA full authority to regulate synthetic nicotine.

Many smokers or e-cigarette users say they can't stop smoking or vaping because nicotine is a stress reliever

In other news: Many smokers or e-cigarette users say they can't stop smoking or vaping because nicotine is a stress reliever. The Truth Initiative has announced a new campaign, “Breath of

Stress Air,” to combat ads from the tobacco and e-cig industry that equate tobacco and nicotine use with mental well-being and stress relief. Puff Bars has advertised that their brand can cause people “to stay sane” and to destress from “zoom calls, parental texts and WFH [Work from Home] stress.”² For people who are addicted to nicotine, withdrawal from nicotine can lead to agitation, depression and nervousness. A stressful situation plus a need for a nicotine fix lead to “stress relief” when the person finally satisfies their addiction by vaping or smoking. Quitting vaping or smoking benefits mental health, according to the Truth Initiative. 65.3% of youth who use a tobacco product want to quit and 60% have tried to quit in the last 12 months.² As pediatricians, we can help our adolescent patients by educating them against the dangers of nicotine and tobacco, preventing their experimentation with them and helping those already addicted to quit. In addition, we should ask parents about their smoking and vaping habits and encourage cessation and avoidance of second and thirdhand smoke exposure.

Several apps may be useful in getting adolescent patients to quit:

- Not On Tobacco: Visit [Lung.org](https://www.lung.org) or call 1-800-LUNGUSA (1-800-586-4872)
- Smokefree TXT – Text QUIT to IQUIT (47848) – National Cancer Institute
- I-800-QUIT-NOW (1-800-784-8669)
- QuitSTART App – free to download on iTunes and Android or visit teen.smokefree.gov
- This is Quitting: Truth Initiative E-Cigarette Quit Program – text DITCHVAPE to 88709 or visit truthinitiative.org/quitcigarettes

Alice Little Caldwell, MD, MPH, FAAP

Georgia Chapter E-Cigarette Champion

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Is This the End?



Robert Wiskind
MD, FAAP

The Best Exotic Marigold Hotel (2011) tells the story of English seniors moving to a retirement home in India, seeking adventure or an affordable existence. Their host, while young and inexperienced, is exuberant and eternally optimistic as he juggles his personal and professional responsibilities. Near the end of the film, he reassures his girlfriend that their problems all have solutions, saying “everything will be all right in the end... if it’s not all right then it’s not yet the end.”

This quote has been variously attributed to an Indian proverb, a Brazilian author and John Lennon. Regardless, it encapsulates the attitude of most parents, and Pediatricians, that childhood illness and drama will work itself out. During the pandemic, it has been difficult to define the end, but I remain confident that we will eventually emerge having learned valuable lessons about ourselves, society and caring for children.

Years from now, the lessons from the COVID pandemic may become clearer; while inside the storm it has been difficult at times to make sense of sometimes conflicting information. Once the end is reached, I expect some conclusions will be apparent:

- More than 1 million Americans will have died, many of them unnecessarily
- Vaccines were the major factor in ending the pandemic, but vaccine refusal prolonged the course and resulted in significant morbidity and mortality
- Common-sense public health measures like masking, social distancing, isolation/quarantine and cancelling large gatherings work (including school during the first year when infection rates were high and vaccines not yet available)
- Denigrating public health, science and expertise is dangerous and has a cost

The pandemic forced us to closely examine how we practice Pediatrics. Within medicine, our field has always been in the forefront in the discussion of work/life balance; the past two years have intensified that debate. While stress and burnout have led too many excellent physicians to retire early, it has also caused many to reevaluate their priorities and adapt their practices.

Simply stated, trying to go back to the way Pediatric care was delivered in early 2020 may not be possible. Parents are demanding more options, finding and maintaining staff continues to be an issue and telehealth is here to stay. The economics of private practice coupled with the increased responsibilities of running a small business is driving many to look for larger affiliations, while

retail-based clinics continue to chip away at routine patient visits. Practices must continually adapt rather than digging their heels in and refusing to change until the bitter end.

Each year, when the Georgia Legislature begins meeting in January, I eagerly look forward to the end of the session when our political leaders will stop proposing and passing laws that are harmful to children and families.

The current session has seen some steps forward, including improvement in mental healthcare, plans to continue bringing Medicaid payments into parity with Medicare, coverage of donor breast milk under Medicaid for ICU babies and the addition of vaping to indoor smoking bans. However, the list of bad proposals is long and includes:

- Preventing schools and local governments from requiring masks to combat COVID
- Limiting the ability of government-funded entities (including schools) to require COVID vaccination (or any vaccination in the most radical proposals)
- Excluding transgender girls from participating in school sports
- Criminalizing gender-affirming care for transgender youth
- Allowing almost everyone to carry a concealed weapon without a license
- Restricting access to medical abortions

I hope to live long enough to see a future where Georgia politicians recognize an obligation to represent their entire district (or all of Georgia), not just the often-slim majority that elected them. Eventually, I trust that policy makers will seek to balance individual rights with communal responsibility. To reach that goal, we must support and vote for candidates who share our values and work to ensure that every eligible voter is able to participate in elections without hinderance.

In 1968, Martin Luther King said, “We shall overcome because the arc of the moral universe is long, but it bends toward justice.” In the end, I believe that children will receive what they are due and that our society will work to value their health and safety. During dark times, I hope to remain optimistic that we have not yet reached the end and confident that things truly will work out eventually.

Robert Wiskind, MD, FAAP

Past President, Georgia AAP
Peachtree Park Pediatrics
Atlanta



5 Good Ways to Support Breastfeeding Parents in Your Practice



Sylvia Washington,
MD, FAAP

According to the 2018 CDC National Immunization Study, the initiation rate of breastfeeding in the United States is 84%, and the continuation rate of breastfeeding at 6 months is 56%. In my community, Floyd County, Georgia, the initiation rate of breastfeeding is about 70%, and continuation rate of breastfeeding at age 6 months is 30-40%. As part of the Breastfeeding Friendly Pediatrician Program, I would like to see more successful breastfeeding parents! Most parents understand that “breast is best,” and there are multiple medical benefits of breastfeeding, yet they struggle to succeed at breastfeeding.

I became a pediatrician because I love to help people. I am passionate about the health and well-being of children! Whether it’s immunizations, breastfeeding, or any other topic, I want to show parents my love for their children. One of my favorite books is the Five Love Languages by Dr. Gary Chapman. The five love languages are five different ways of expressing and receiving love: **words of affirmation, quality time, receiving gifts, acts of service, and physical touch.** Not everyone communicates love in the same way, and, likewise, people have different ways they prefer to receive love. I used these 5 languages to teach about breastfeeding:

1. Words of affirmation: Breastfeeding is hard. When my children were infants, I was in pediatric residency. I didn’t really have a plan since I was a formula-fed infant. I knew that I wanted to breastfeed for the first week or so, but I am glad my pediatrician encouraged me every step of the way. For the first 6 months of life, during each health check, she would point to my son’s growth curve and say, “That’s all you, Mama! You did it!”

2. Quality time: Breastfeeding provides the perfect opportunity for quality time between parents and their infant. Encourage mothers to read to their infant, sing a song, and just talk to their babies during breastfeeding. Enjoy every moment!

3. Receiving gifts: In my office, I keep breast shields, lanolin cream, bra inserts, and vitamin D drops which I give as gifts to my breastfeeding parents. These low-cost items make a big difference, and it lets them know that, as their pediatrician, I am thinking about them!

4. Acts of service: One of my best memories is the time when my former pediatric group (Albany Area Primary Care in Albany, GA) attended a school board meeting to advocate for breastfeeding on school property. There were talks of banning breastfeeding mothers from sports events and school events due

to indecent exposure. As a group of pediatricians, we each gave testimony on the benefits of breastfeeding and fully supported the parents who chose to breastfeed at school events.

5. Physical touch: Part of my training to be a Breastfeeding Friendly Pediatrician includes evaluating the infant’s latch. It’s crazy how many incorrect/shallow latches I’ve seen in past months. I simply reposition the baby, and like magic, the latch improves, and mothers appreciate this simple gesture.

So, in summary, love makes the difference. In my area, I would love to see the rate of breastfeeding increase, and I would encourage you to find ways to love and support your patients as well.

Sylvia Washington, MD, FAAP

District I Representative, Georgia AAP
Floyd Primary Care, Rome



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Changing the Narrative: From Vaccine Hesitancy to Vaccine Acceptance



Iyabode Akinsanya-Beysolow,
MD, MPH, FAAP

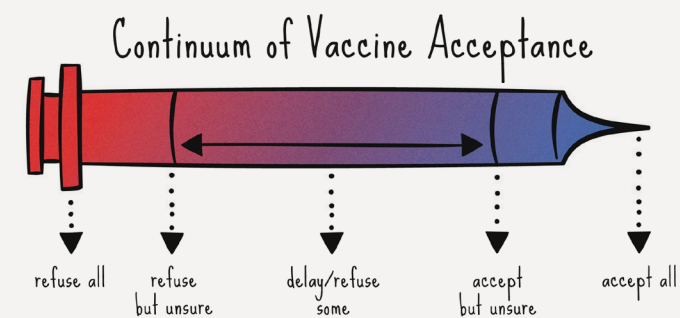
As I reflect on our role as pediatric health care providers (HCPs) in Georgia and across the US during this historical period beginning in early 2020, I can only imagine how the story will be told of the COVID-19 pandemic and its impact on our lives and that of our patients.

We applaud colleagues' efforts to provide safe and effective COVID-19 vaccines for our children and adolescents in record time and the parents and children enrolled in clinical trials. We applaud the determination of pediatric health care providers across Georgia who quickly set up office systems and protocols to integrate COVID-19 vaccines into their already stressed and short-staffed offices, all accomplished while conducting routine vaccine catch-up and well-child check-up campaigns for the numerous children who lagged due to the pandemic.

Pediatric HCPs continue to do this work under a cloud of increasing vaccine hesitancy, misinformation, growing mistrust of science and the government, and the ever-increasing political and racial divide that has permeated this country over the last two years.

How do we move the needle towards vaccine acceptance from vaccine hesitancy not only for COVID-19 vaccines but all childhood vaccines?

Vaccine hesitancy is not new. It is seen on a global scale. The World Health Organization (WHO) SAGE Working Group, WHO 2012, (www.ncbi.nlm.nih.gov/pmc/articles/PMC5355208/#bib0020) describes it as "Vaccine attitudes can be seen on a continuum, ranging from total acceptance to complete refusal. Vaccine-hesitant individuals are a heterogeneous group in the middle of this continuum. Vaccine hesitant individuals may refuse some vaccines, but agree to others; delay vaccines or accept vaccines but are unsure in doing so..."



Graphic Source:
<https://coronavirus.jhu.edu/vaccines/report/building-trust-in-vaccination>

We move toward vaccine acceptance by:

1. Gaining understanding from our entire patient population and community:

Taking the time to understand questions and concerns about the disease and vaccines from our patient families; answering their questions in a non-judgmental manner, for both those who choose to vaccinate their children and those who currently say "I will definitely not vaccinate". There are many unknowns about COVID-19, and, understandably, some people are concerned about the vaccines. Showing our understanding of their concerns before giving them the facts may lessen their anxiety.

(Kempe et al. Parental Hesitancy About Routine Childhood and Influenza Vaccinations: A National Survey. *Pediatrics* July 2022; 146 (1) and Jacobson et al. Vaccine Hesitancy. *Mayo Clinic Pro.* November 2015;90(11):1562-1568)

Tools:

- **C.A.S.E. approach²:** [https://www.mayoclinicproceedings.org/article/S0025-6196\(15\)00719-3/pdf](https://www.mayoclinicproceedings.org/article/S0025-6196(15)00719-3/pdf)
- **Motivational Interviewing⁵:** <https://pubs.niaaa.nih.gov/publications/practitioner/youthguide/aapadolescenthealthupdatebmi.pdf>

2. Acknowledging that misinformation, disinformation, and mal-information exist and lead to vaccine hesitancy. (CISA: <https://www.cisa.gov/mdm>)

The WHO designated vaccine hesitancy in 2019 as one of the ten leading threats to global health. Unfortunately, hesitancy has contributed to lower rates of childhood vaccination and associated outbreaks of vaccine-preventable diseases, including mumps, measles, pertussis.

(Kempe et al. Parental Hesitancy About Routine Childhood and Influenza Vaccinations: A National Survey. *Pediatrics* July 2020; 146 (1)

- **Listen** to misinformation circulating in your community and patient population via monitoring social and traditional media and through one-on-one conversations with your patients and parents. Misinformation is not static and is ever-changing.
- **Address** misinformation by providing factual information via:
 - your organization's social media platforms (without directly countering/responding to misinformation),
 - in-person sessions or virtual meetings with a group of parents and teens and
 - one-on-one conversations during office visits.

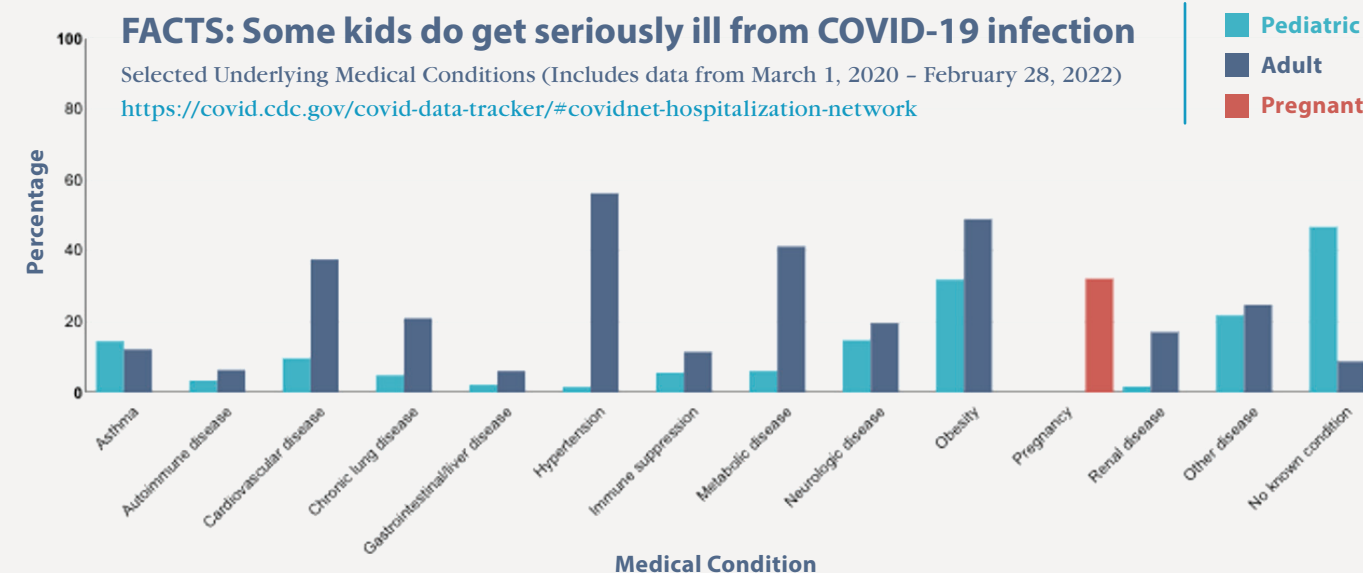
Changing the Narrative...

Continued from previous page.

- **Share accurate, precise, and easy-to-find information** that addresses common questions. Involve your patient population and their parents in developing pro-vaccine messaging.
- **Use trusted messengers** to boost your credibility and the likelihood of being seen and believed over misinformation. You may not always be the trusted messenger in your setting; is it your colleague, a nurse, the office manager, a front office staff member, or a family in your practice?

Tools:

- **CDC: How to address COVID-19 Vaccine Misinformation** (www.cdc.gov/vaccines/covid-19/health-departments/addressing-vaccine-misinformation.html)
- **Greater than COVID: Greater than COVID: Conversations (videos) with HCP** (<https://www.chop.edu/centers-programs/vaccine-education-center/making-vaccines/prevent-covid>)



3. Realizing that not all parents think alike.

The impact of the pandemic has been felt differently across population groups.

This pandemic has magnified long-standing racial and ethnic inequalities, primarily driven by social determinants of health (where we work, live, play, and the effect on our health)

- We saw this difference play out as some witnessed and participated in school board meetings in our respective communities. We saw how people perceive the risk and severity of COVID-19 disease differently and subsequently their willingness to adhere to guidelines from school or government officials. Parents on both sides of the divide passionately debated the importance/non-importance of masks, vaccines, etc., as we navigated the balance between the importance of children remaining in an in-person school environment and protecting them from COVID-19 disease. Unfortunately, those who have had family members and friends die from this deadly disease were sometimes labelled as 'fearful' for wanting masking to continue during the height of the Omicron wave at that

time. In contrast, those who objected to masks saw it as a nuisance or felt their rights were being infringed upon and did not see the necessity of masking.

- Remember that this pandemic has disproportionately affected Non-Hispanic Black, Hispanic, and Non-Hispanic American Indian/Alaska Native children with increasing incidence of cases and deaths in their communities, higher hospitalization rates, and a disproportionate number of MIS-C cases in these populations. As of March 1, 2022, a review of MIS-C cases reported by Health departments show that 58% of the reported patients with race/ethnicity information available occurred in children who are Hispanic/Latino or Black, Non-Hispanic.

(<https://covid.cdc.gov/covid-data-tracker/#mis-national-surveillance>)

What is encouraging is the knowledge that pediatricians have always looked out for all their patients, have consistently shown empathy, love and care to every patient and family of all races and ethnicities and always endeavored to provide equitable health. That is one way we can heal this division in our state, country, and in our practices.

Changing the Narrative...

Continued from previous page.

4. Brainstorming and implementing strategies to improve health equity in your practice. Making COVID-19 and all vaccines more available and accessible for all our patients.

- As an example, as you schedule vaccine clinics, consider the lifestyles of families. Are there perhaps essential workers or families where both parents work outside of the home in your patient panel who cannot afford to take off work to bring their child in for a vaccine or well-child check-up during the middle of the day?
- Determine how you can provide vaccines and well-checks at more accessible times. (Example: evening or Saturday clinics.)

It is important to remember that, in numerous studies, parents continue to believe that a caring and concerned pediatrician is still the most important source for information regarding their children's health.

([www.academicpedsjnl.net/article/S1876-2859\(20\)30583-0/fulltext](https://www.academicpedsjnl.net/article/S1876-2859(20)30583-0/fulltext))

5. Making a solid recommendation for vaccination. Vaccines do work. (<https://covid.cdc.gov/covid-data-tracker/#vaccine-effectiveness-breakthrough>)

- Share your knowledge as a pediatric health care provider, what you know about the science of vaccines, how vaccines work, the benefits of vaccination and potential side effects. Understand that many parents who initially opt to 'wait and see' come around later and vaccinate their children.
- Learn about the serious but rare risk of myocarditis both after mRNA COVID-19 vaccines and also the risk after COVID-19 disease. Share how our colleagues at the CDC/ACIP have adjusted vaccination schedules to increase the primary vaccine dosing interval as an attempt to mitigate some of this risk from COVID-19 mRNA vaccines, and that they will continue to follow emerging data closely.

(CDC: Interim clinical considerations for the use of COVID-19 vaccines in the US: <https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html>)

- Promote the medical home as the preferred site for vaccination, particularly as COVID-19 vaccines for those under five years are on the horizon.
- Encourage more pediatricians to become COVID-19 vaccinators and advocate for easier registration, vaccine supply, and logistical processes.

6. Continuing to Promote proven mitigation strategies if COVID-19 cases increase in the future in your community:

- wearing masks
- social distancing
- staying up-to-date on COVID-19 vaccines

Remember that pediatricians continue to be the # 1 trusted source by parents for matters related to their children's health (Kempe et al. Parental Hesitancy About Routine Childhood and Influenza Vaccinations: A National Survey. Pediatrics July 202; 146 (1)).

Use your voice and status. Involve children and teens in the conversation – listen to and validate their feelings/concerns about the pandemic and vaccines.

([https://www.academicpedsjnl.net/article/S1876-2859\(20\)30583-0/fulltext](https://www.academicpedsjnl.net/article/S1876-2859(20)30583-0/fulltext)).



And finally, take time for self-care for yourself and encourage likewise for your staff and communities. Acknowledge the mental health impacts of the pandemic and provide avenues to promote building resilience in your practice setting.

Iyabode Beysolow, MD, MPH, FAAP

Chair, EPIC Immunization Advisory Committee, Georgia AAP
Georgia Chapter Immunization Representative, AAP
Smyrna



2022 State Legislative Session Summary



Melinda Willingham, MD

The Georgia General Assembly adjourned on April 4 ending its annual 40-day session. As usual, this session was a mix of good and bad, from the Chapter's perspective, though with more disappointing legislation than we have seen in recent years. This was driven by election year politics and GOP primary challenges to incumbents.

This year we again cooperated with our primary care coalition colleagues (family medicine, internal medicine, DO's, and OB-Gyn) to present a Legislative Advocacy Webinar (LAW) on March 9. It featured three physician legislators—Drs. Michelle Au, Kay Kirkpatrick, and Mark Newton to provide their unique perspectives. It also included reporters Greg Bluestein (Atlanta J-C) and Andy Miller (Georgia Health News) speaking on "Healthcare as a Political Issue." It was a wonderful event with nearly 100 in attendance and provided a fascinating view of the legislative process as it impacts healthcare in Georgia.

Here is a summary of the legislation we followed during this year's session, the Chapter position and final outcome. The Governor has until May 16 to sign or veto all bills (if he hasn't already.)

- a. Vaccines:** SB 345. COVID Vaccine Prohibitions. Prohibits public entities from requiring Covid vaccine passports. Does not affect private entities or public health orders by Governor; and sunsets 6-30-23. Opposed. Passed.
- b. Mental Health:** HB 1013. Support. Passed & signed by the Governor. Enforces "mental health parity" by insurers, imposes 85% MLR spend ratio on Medicaid CMO's, directs Governor's office to establish common formulary for drugs for mental health conditions, etc.
- c. PA/NP Prescribing:** HB 369. Would have permitted writing for Schedule II drugs. Opposed. Failed.
- d. Guns:**
 - i. SB 259. Would permit guns in houses of worship & courthouses. Oppose. Failed.
 - ii SB 319. Permit-less concealed carry. Oppose. Passed & signed by Gov.
- e. Lead Poisoning:** HB 1355, updates the state's lead poisoning law, reducing triggering level to CDC standards. Support. Passed
- f. Masks:** SB 514. Opposed. Passed & signed by Governor. Prohibits schools from requiring masks without an "opt-out" for parents.
- g. Raw milk:** HB 1175. Opposed. Passed. Sets up DOA regulations for unpasteurized milk with only "direct-to-consumer" sales permitted, and delays implementation to 7-1-23.
- h. Smoke Free/ Vaping:** HB 1348. Support. Failed. Would have added vaping products to the state's smokefree law.

- i. Teen Driving Bill:** SB 510. Would make change to current law re on who may ride with teen driver during first 6 months of license. Opposed. Failed.
- j. Transgender children & sports participation:** SB 435. Opposed. Failed as separate bill, but language added to HB 1084 establishing a study committee on issue and requests the Georgia High School Association to formulate rules to govern.
- k. School Recess:** HB 1283. Support. Passed. Requires public elementary schools to schedule daily recess for children K-5.

Fiscal Year 2023 budget

(Begins July 1, 2022 and ends June 30, 2023). (Like other bills, it still must be signed by the Governor). We supported all listed below.

- a.** \$85M to eliminate Attestation. This means all physicians in Medicaid program, regardless of specialty, will be paid "enhanced rates."
- b.** Included language to file waiver to eliminate 5-year residency requirement for Medicaid for legal immigrant children.
- c.** \$\$ for Medicaid coverage of human donor milk for NICU infants
- d.** \$\$ for extended Medicaid coverage for post-partem mothers
- e.** \$\$ for "fast track" Medicaid enrollment process
- f.** \$148M for "value-based" purchasing by Medicaid. (We're not sure exactly what this means, so we'll do some investigation.)

Thank you to all who followed the session and especially those of you who reached out to your state representative and/or senator. Remember 2022 is an election year and the primary election is Tuesday, May 24. Be sure to vote and if you support your state rep and/or state senator, consider a financial contribution to them. We need to ensure that reasonable, capable people are in the General Assembly to protect the healthcare of our patients and our ability to deliver great care to them.

Melinda Willingham, MD

Chair, Legislative Committee
Georgia AAP



“Learn the Signs. Act Early.” Program Revised



Jennifer Zubler, MD, FAAP

The CDC’s “Learn the Signs. Act Early” program recently revised their developmental milestones for use in developmental surveillance (monitoring) by early childhood professionals and clinicians at health supervision visits (HSVs). The article “Evidence-Informed Milestones for Developmental Surveillance Tools” (<https://publications.aap.org/pediatrics/article/149/3/e2021052138/184748/Evidence-Informed-Milestones-for-Developmental>) in the March 2022 edition of Pediatrics details the revision process.¹ Following its release, there was great interest from the media and the public. We hope the resulting discussions will lead to improvements in early identification of developmental delays and disabilities.

Some of key points to know about these revisions:

Developmental disabilities are common. 1 in 6 children (3-17 years of age) has a developmental disability and it is estimated that 1 in 44 (8-year-olds) have autism.²⁻³ Early intervention for developmental disabilities can improve skills, future school performance, and long-term self-care. Many children, however, are not identified or linked to services before age 5. Although it is never too late to provide interventions and support, the earlier a child is identified, the sooner targeted interventions and supports can start.

CDC’s Milestone Checklists are tools for developmental surveillance, not screening. Surveillance is a longitudinal process that involves assessing strengths, risks, and protective factors; taking a developmental history; eliciting concerns; observing milestones and behaviors; examining the child; documenting and communicating findings; and applying clinical judgment.⁴ Since 2004, CDC’s free milestone checklists have been available to support developmental surveillance at HSVs from 2 months-5 years of age. The American Academy of Pediatrics recommends developmental surveillance at each HSV and universal developmental screening using validated tools at specific ages (9-, 18-, and 30-months and autism screening at 18- and 24-months) and whenever there is a concern.

Early identification processes are imperfect, best practices for developmental surveillance are not established, and universal screening is far from universal. In 2016, 63% of pediatricians self-reported doing developmental screening.⁵ It is unknown what percent of pediatricians do additional screening when concerns arise during surveillance or at other times. Even when children have concerning screenings, they are not always referred for early intervention services or further evaluation for many reasons, including lack of access to services. Families value and can benefit from learning about their child’s strengths and areas that need support, even if services are not easy to obtain.

The revisions to CDC’s milestone checklists for developmental surveillance are intended to clarify next

The revisions to CDC’s milestone checklists for developmental surveillance are intended to clarify next steps if a child is missing milestones or if there are other developmental concerns.

steps if a child is missing milestones or if there are other developmental concerns. For parents, next steps may be talking with their child’s doctor or self-referring to their state’s early intervention services. For clinicians, next steps may be developmental screening to clarify the risk of (not diagnose) developmental delays and/or referring to Georgia’s Early Intervention program (“Babies Can’t Wait” or preschool special education services) and appropriate evaluations.

The checklists were revised based on available evidence and user feedback, including families and pediatricians. The major revisions included adding a 15- and 30-month checklist, removing vague language and duplicated milestones, adding open ended questions, and including milestones that most (75% or more) children would be expected to achieve based on clinical experience and interpretation of published normative data and supportive evidence (rather than average age milestones often used in developmental milestone lists, which only half of children would be expected to achieve).

The checklists are communication tools to help pediatricians and families discuss children’s development at HSVs. They contain much more than milestones. The checklists share tips to support children’s development, inform families about recommended HSVs and universal screening ages, and advise families to discuss any developmental concerns, (not just concerns about milestones) and ask about screening when there are concerns. Since the checklists are not screening tools, they are not validated against diagnostic evaluation tools. The milestones, open ended questions, and “act early” message, however, were tested with families to ensure clarity and relatability. The checklists do not contain all possible milestones children may exhibit.

“Learn the Signs. Act Early.” Program Revised

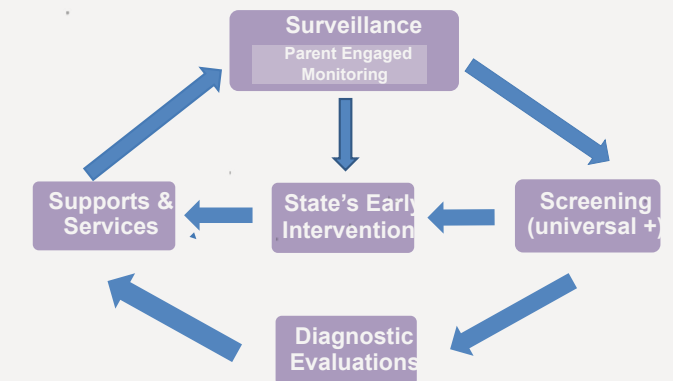
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CDC’s Milestone Checklists



www.cdc.gov/ActEarly/Materials

Early Identification & Intervention



The aim of the revisions was to provide clearly written milestones reflecting what most children would be expected to achieve so that clinicians and families can spend less time addressing concerns around vague or average age milestones, and more time on other concerns or those not captured by milestones. Developmental screening should be considered if there are any concerns, regardless of milestone achievement.


The work pediatric offices do around early identification is important and appreciated by families. Using CDC’s milestone checklists can support clinicians in having regular discussions about development. These discussions can go a long way toward establishing trusting relationships with families, in which they feel comfortable discussing developmental concerns.

Jennifer Zubler, MD, FAAP

National Center on Birth Defects and Developmental Disabilities
Centers for Disease Control and Prevention
Atlanta

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 Centers for Disease Control and Prevention


Learn the Signs. Act Early.


“Learn the Signs. Act Early.”

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 [Español \(Spanish\)](#)

 Families: During COVID-19 you can still schedule appointments for well-child visits, developmental screening, and immunizations. Continue to monitor your child's development between visits.



The Breastfeeding-Friendly Pediatrician Certification Program



Tarayn Fairlie
MD, MPH, FAAP, IBCLC

More and more families in Georgia are initiating breastfeeding - you may have noticed this trend in your practice - yet for many of us, the lactation knowledge we gained in residency has not been greatly added to over the years (other than perhaps our own personal experience). You may also have noted that today's parents are sometimes more informed about breastfeeding and may be asking you more questions than in the past. More families are also choosing to provide expressed milk to their babies - some exclusively. You might feel unequipped to advise these families or wondering if the advice you give helps them reach their goals. It's not as simple as "breast or bottle?" anymore.

We on the Chapter Breastfeeding Committee want to support you in your efforts to help your patients and their families to meet AAP breastfeeding recommendations and, more importantly, their own breastfeeding goals. While breastfeeding is an important public health issue, we provide care to individual families each day who need our clinical guidance on breastfeeding and lactation issues. Hospitals in Georgia have been working hard to improve their practices, but especially during the pandemic, most stays are short and then the dyad is even more reliant on community support. You do not have to become a lactation consultant or breastfeeding medicine expert to engage in potentially better practices, which support breastfeeding in the outpatient setting and ultimately increase breastfeeding exclusivity and duration.

In partnership with the Georgia Breastfeeding Coalition, we have created a new program to recognize outpatient pediatricians who have chosen to continue their lactation education and can demonstrate some of the strategies outlined in the 2017 AAP Clinical Report, The Breastfeeding-Friendly Pediatric Office Practice. We will recognize certificants widely on the Chapter website and the Georgia Breastfeeding Coalition website, as well as on social media (follow the program on Facebook and Instagram at @gabfpeds) and will provide graphics packages for their own use as well. The seven practices candidates are asked to demonstrate include the following:

1. Assess & provide guidance on growth that supports breastfeeding goals
2. Incorporate breastfeeding observation into routine care
3. Educate families about milk expression, storage, & maintaining lactation after return to work
4. Provide noncommercial breastfeeding educational resources for parents
5. Refer to community breastfeeding resources
6. Monitor breastfeeding rates in your patient panel
7. Discuss breastfeeding during prenatal visits and at each well-child visit

We have had robust response to the Breastfeeding Friendly Pediatrician Certification Program, which was launched last year, and now count 50 applicants who have been working through the process. We are grateful for the first handful of candidates who have helped us develop a process which yields a certification which is both reasonable to achieve but also meaningful.

There are five steps in the confidential process (applicants are assigned a number and all documents submitted must be de-identified): complete an interest form; a self-assessment to check your own practice pattern against current best practice; document at least 3 hours of breastfeeding/lactation CME in the past year (most candidates are using the EPIC Breastfeeding Education series to meet this need); the application, in which candidates document a minimum of four and up to seven breastfeeding-friendly practices; and an "open-book" breastfeeding knowledge test, which candidates can complete over the course of a month.

We are pleased to announce our first cohort of Breastfeeding-Friendly Pediatricians, which will surely have expanded by the time this article is in print, so please visit the Chapter website at www.GaAAP.org/breastfeeding to see the complete up-to-date list and learn more about the process. We invite all our outpatient colleagues to participate. Our committee, Chapter staff and partners at the Georgia Breastfeeding Coalition will guide and support you in the process.

Tarayn Fairlie, MD, MPH, FAAP, IBCLC
General Pediatrician, Kaiser Permanente
Chair, Breastfeeding Committee, Georgia AAP
Tucker

The Breastfeeding-Friendly Pediatrician Certification Program

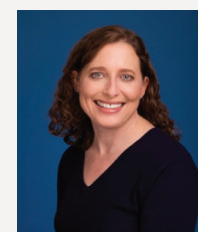
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Monica Moore, MD

Monica Moore, MD, of Premier Wellness, serves patients across the state in her virtual pediatric practice. "Staying relevant and up to date on current evidence-based medicine is extremely important to me and motivates me to constantly explore

ways to grow personally and professionally. The breastfeeding certification program is an excellent opportunity to expand my fund of knowledge and provide the necessary tools to continue providing exceptional care to my patients," said Moore.



Rebecca Kolesky, MD

Dr. Kolesky attended undergraduate and medical school at the University of California, San Diego and completed her Pediatric Residency training at Children's Memorial Hospital at Northwestern

University in Chicago. She worked for one year in the Neonatal Intensive Care Unit before moving to Atlanta with her husband in 2005 and joining Dekalb Pediatric Center in Decatur.

"I chose to be a part of the Breastfeeding-Friendly Pediatrician Certification Program to emphasize my commitment to helping my patients and families successfully breastfeed. I had multiple struggles breastfeeding my first child but stuck with it and ended up being successful."



Hiral Lavania, MD, IBCLC

Dr. Lavania is the creator of One Family Pediatrics. The practice is dedicated to providing accessible, individualized healthcare to children and adolescents and empower parents with knowledge about their child's well-being.

"I want parents to be able to find a safe, trusted resource where they can find breastfeeding-friendly pediatricians."



Donna Yeiser, MD

Dr. Yeiser is a Columbus native who credits her dream of becoming a pediatrician to her fifth-grade teacher. After she attended the Medical College of Georgia, she moved to Charleston, South Carolina, for residency at the Medical University

of South Carolina. Dr. Yeiser returned to Columbus and was a partner of West Georgia Pediatric Partners until starting Columbus Pediatric Associates in 2016.

"The obvious answers to why breastfeeding is important are the nutritional value, immunity boosting effect, and decrease in certain chronic medical conditions."



Save the Date!
Pediatrics by the Sea

Summer 2022 Meeting
June 15-18, 2022
The Ritz-Carlton
Amelia Island, Florida

.....
Rated Top 10
Child-Friendly Resorts
in the U.S.A.
- Child Magazine
.....

Georgia Chapter

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Photo Review: Pediatric Infectious Disease and Immunizations in General Pediatrics Meeting

The Chapter held the Pediatric Infectious Disease & Immunizations in General Pediatrics meeting on April 9 at the Savannah Marriott Riverfront, Savannah. The meeting had over 50 attendees and covered a variety of infectious disease & immunization topics.



(l to r) Past President Ben Spitalnick, MD (Savannah), Melissa Boekhaus, MD (Mableton), Ramona Cawley, NP-C (Tifton), Vice-President Angela Highbaugh-Battle, MD (St. Mary's), Flavia Rossi, MD (Tifton), Elizabeth Reece, MD (St. Mary's), and Program Chair Steve Thacker, MD (Savannah) are all smiles after another wonderful conference.



The meeting featured a great presentation on infectious rashes by pediatric dermatologist Mary Spraker, MD (Emory). Always a pleasure to have her present!



We were excited to have medical students from Mercer-Macon join us for the meeting. The future of Pediatrics is bright!



(l to r) Ayman Al-Jabi, MD (Brunswick) is joined here by faculty members Mobeen Rathore, MD (Jacksonville) and Dr. Thacker.

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Child Psychologist



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



Lauren A. Buono, PhD
Pediatric Neuropsychologist



Nancy E. Carnevale, MD
Board-Certified Developmental
Behavioral Pediatrician



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Looking Ahead: Join us for our upcoming events!

Mental Health Webinar Series

May 18: Understanding & Implementing
Trauma Informed Care in Pediatric
Settings

July 20: Never Too Early: Promotion,
Prevention, and Interventions to
Support Early Childhood Mental
Health

Oct 19: Integrating Behavioral Health
Screenings for Better Health
Outcomes

Georgia Pediatric Nurses & Practice Managers Association Spring Meeting

May 13, 2022
Macon Marriott City Center, Macon

Webinar: Do You Know the Latest Info? Vaccine Storage & Handling

June 2, 2022

Pediatrics by the Sea Summer CME Meeting

June 15-18, 2022
The Ritz Carlton, Amelia Island, FL (Live)

Pediatrics on the Parkway November 17-19

Cobb Galleria Centre, Atlanta (Live)

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.