

Georgia Chapter

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



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President's Letter



**Angela
Highbaugh-Battle,
MD, FAAP**

Wow, it is officially Spring!

In Georgia, Spring always means lots of pollen. Usually, it also means a decrease in respiratory viruses—we will see if this is true for 2023 because it was not true in 2022. Our offices will be full of four-year-olds coming for pre-K vaccines and the form 3300. Everyday seems to be an opportunity for a step towards normalcy as the end of the Public Health Emergency draws near. While my kids are getting to engage in typical childhood activities like

field trips, school concerts, and field day, I am finding that certain things in medicine are not normalized yet. We are all dealing with shortages of medications like antibiotics and stimulants. Additionally, we are still dealing with a mental health crisis that the pandemic revealed to the nation at large. As we work to help our practices more comfortably accommodate children with mental health needs, I would like to share some ways that I have been working to improve how I manage these patients.

I am so pleased that I was able to participate in the Anxiety and Depression ECHO offered through the Georgia Mental Health Care Access in Pediatrics program (GMAP). GMAP includes a series of ECHO's to educate pediatricians and public health nurses and a soon-to-be-open, tele-consultation line with access to Child and Adolescent Psychiatrists (CAPs). Since the training, I feel more confident in my approach to patients with mental health concerns and their families.

I am also planning to participate in the upcoming ECHO® on Early Childhood Relational Health, a field which has also been called Infant and Child Mental Health. I know that if I have more education, I can provide a better service. An additional perk to my participation in the ECHO's, is that I can access the tele-consult line for non-emergent complex cases. This tele-consult line should go live in the coming months and I am sure it will serve as a lifeline to those of us in parts of the state with limited access to specialists. I encourage each of our members to participate in the GMAP program

The Georgia AAP has recently sought to engage the professional societies of the Child and Adolescent Psychiatrists, Psychologists, Licensed Professional Counselors (LPC), Marriage and Family Therapists (MFT), and Licensed Clinical Social Workers (LCSW) by forming a coalition of the associations of our 6 groups. Knowing one another and understanding our pain points should allow us to advocate collectively to ensure our patients are getting appropriate services.

by signing up to attend an ECHO®. Also, please let the Chapter Mental Health Committee know if there are additional topics that could benefit frontline pediatricians.

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Despite these adjustments, I still find it difficult to get my patients into therapy in an acceptable timeframe. A suggestion that arose from our collaboration with the mental health providers is to start to build my own local referral network. I must admit this has been a slow process. The therapists are so busy, that getting on the phone with me does not always seem to be a priority, but I am working to build my network. I even have the back-office number for a therapist in town who gave me permission to use the number for kids in particular need of services. It felt like I was given a bar of gold on the day I got that phone number!

We all know there are not easy solutions to the mental health crisis. Issues like lack of workforce, reimbursement, and stigma hinder our ability to gather all the support our patients need. As one pediatrician, in one small community, I hope that educating myself, phoning a friend when in need, and building a network to ensure access to services for my patients, will lead to more well-adjusted and resilient kids.

I hope to start to make some in-person office visits to build relationships in the coming months. I am optimistic that better communication between myself and the therapists in my community will lead to my patients getting appropriate services in a more timely manner. We all know there are not easy solutions to the mental health crisis. Issues like lack of workforce, reimbursement, and stigma hinder our ability to gather all the support our patients need. As one pediatrician, in one small community, I hope that educating myself, phoning a friend when in need, and building a network to ensure access to services for my patients, will lead to more well-adjusted and resilient kids. I encourage you to utilize these Chapter resources like GMAP, our numerous mental health webinars, and our knowledgeable Chapter staff to find a way forward in your community. Our kids are counting on us.



Angela Highbaugh-Battle, MD, FAAP



2023 State Legislative Update



Melinda Willingham,
MD, FAAP

On March 29, the Georgia General Assembly adjourned its 2023 session “Sine Die.” As we have written in some many years, the session contained some disappointments and some wins for pediatricians and the children we care for.

The week prior, SB 140, which would prohibit doctors from providing gender affirming care to minors by prohibiting hormone replacement therapy. (Puberty blockers would still be allowed.) Doctors would be subject to sanction by the state medical board, including license revocation, and subject to criminal and civil penalties. We opposed this bill as an unwarranted intrusion on the doctor-patient relationship, and our assertion that these youth and their families deserve compassionate care as they went through the process of their treatment of gender dysphoria. Unfortunately, the Governor promptly and privately signed the bill. The second disappointment was the passage of SB 1, which would permanently ban public entities, including schools, from requiring COVID vaccination to enter or receive service. We also strongly opposed this bill as needlessly tying the state’s hands in dealing with a possible resurgence of COVID and sending the wrong signal about vaccines to the general public. As we write this, it is on the Governor’s desk for signature, and we have urged him to veto this measure.

The 2023 session has been characterized by more straight-party line votes than we have seen in many years. The gender-affirming care bill and SB 1 are two examples.

2023 is the first year of the “biennial session” which means that all bills that did not pass this year will be eligible for re-consideration in 2024. As a final note, we urge all of our members to “get to know” your state representative and state senator. The summer is the perfect time to do this. When we have personal relationships with our elected officials our advocacy power is maximized. Thanks to all the Legislative Committee members for their diligent meeting attendance and involvement during the session.

Melinda Willingham, MD, FAAP

Chair, Legislative Committee

A quick review of our major issues and bills from this session:

1. **HB 266, would eliminate current requirements for vaccines for children to attend school.**
Died in committee.
2. **Scope of Practice:**
HB 557, would have allowed PA's and NP's to write for Schedule II drugs to adults on emergency 5-day basis. Failed. (The original bill would have permitted them to write for minors but after our advocacy, that was struck from subsequent versions.)
3. **Gun Safety & Injury Prevention:**
HB 161, makes it an offense to make a firearm accessible to a child, i.e. “safe storage.” Died in committee. However, a hearing was held late in the session and Sofia Chaudhary, MD of the Chapter Injury Prevention Committee testified in support of the bill. And did a great job!
5. **Medicaid rate increase:**
Some good news here: Together with partners in our PCP Coalition, we advocated and received \$18.4M state funds (about 3x that in total) in the state FY2024 budget to increase Medicaid rates for codes 99213 and the 99214 to 2021 Medicare levels. These are increases of 21.4% and 18.8% respectively.

BREAKING NEWS:

On May 5, 2023, Governor Kemp, in signing the FY 2024 budget, issued 132 line-item vetoes, totaling \$230M in state funds. Among them were 22 Medicaid rate increases for various providers serving Medicaid patients. Sorry to say, the \$18.4M that the legislature had included for rate increases for PCP's (99213 & 99214) was among them. This was an unusual and somewhat unprecedented action that took many by surprise—including legislative GOP leaders who had worked on the budget. This is disappointing news and we trying to learn if this could possibly be reversed in the future, or adjusted in the January mid-year budget.



A Doctor for Five Minutes



Robert Wiskind
MD, FAAP

In *Field of Dreams* (1989), farmer Ray Kinsella builds a baseball diamond in the middle of his cornfield where Shoeless Joe Jackson and other long-dead players have the chance to enjoy the game again. Midway through the movie, Ray goes in search of Archie “Moonlight” Graham who only played one inning in the field in the majors and never had a chance to bat. He learns that Graham left baseball to become a physician in a small Minnesota town where he cared for generations over a long and distinguished career. Ray returns to his cornfield game along with a young Archie who finally gets his time at the plate. Soon afterwards he turns back into the old doctor to help Ray’s daughter who is choking on a chunk of hot dog. After saving the young girl, Ray realizes that Archie can’t go back to his younger, ball-playing self. He apologizes and says that it must have been a tragedy to only spend five minutes as a pro player. Archie responds “Son, if I’d only gotten to be a doctor for five minutes ... now that would have been a tragedy.”

As a Pediatrician, my professional life is broken into short episodes. While some patient encounters are lengthier, most are problem-oriented and quick. Sometimes it is a challenge to connect during these brief visits, but I make an effort to comment on a child’s shoes, ask about their birthday party or close the visit with a high five. Most importantly, I always hope to make my patient smile, either with a comment or a silly look. I have stopped wearing a mask routinely during check-ups and realize how much I missed seeing smiles when they were hidden. Walking past a patient in the hall I usually wave hello and am rewarded with a response most of the time. Children are so resilient; they will smile and wave goodbye, even after we have hurt or frightened them during the visit.

The five minutes, or less, that we spend on anticipatory guidance during an encounter produce greatly unseen, and unknown, benefits. How could you calculate the SIDS tragedies which have been avoided when we repeatedly talk about safe sleep during every visit in the first 6 months of life? Similarly, it may seem unnecessary to always ask about car/booster seats, bike helmets and firearm safety, but those efforts have undoubtedly saved lives and spared families from anguish.

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The 2023 Georgia Legislature continued the recent trend of passing bad legislation harmful to children. Measures included restricting transgender youth from receiving evidence-based, gender-affirming care (and criminalizing the act of providing appropriate care) and permanently banning schools and other government entities from mandating the COVID vaccine. It is easy to become discouraged as our state continues to show antipathy towards science, physicians and the health and safety of children. Yet, I continue to engage with my elected officials. The five minutes spent calling, texting, or sending an e-mail may not change their mind about a particular bill, but engaging develops a relationship and increases the chance that they will consult you in the future and listen carefully to your concerns.

At least once a week I have a resident or student working with me. Talking about patients with these learners forces me to examine my assumptions and methods so that I can be sure I am teaching evidence-based, current recommendations. Each teaching moment, no matter how brief, is an opportunity to challenge myself and encourage them to pursue science, medicine and, I hope, Pediatrics. Similarly, when a parent asks me a question, I try not to simply give my standard answer. I will often pause for a moment to collect my thoughts, wondering about the best way to share information. Sometimes I can anticipate the next question, but often I am surprised to learn about their concerns. The extra few minutes working on shared understanding is time well spent.

Dr. Graham summarizes his brief time playing baseball by saying, “You know, we just don’t recognize the most significant moments of our lives while they’re happening. Back then I thought, well, there’ll be other days. I didn’t realize that was the only day.” Fortunately, most of us will have long careers caring for children. Those days will be well spent if we focus on making every 5-minute encounter meaningful to ourselves and the families we serve.

Robert Wiskind, MD, FAAP

Past President, Georgia AAP
Peachtree Park Pediatrics
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Chapter Members Attend the AAP Advocacy Conference



**Alice Little Caldwell,
MD, MPH, IBCLC, FAAP**

The three-day AAP Legislative Conference began Sunday morning March 26, 2023, at the Capital Hilton in Washington, D.C. with official introductions by Sandy Chung, AAP President, and Melinda Williams-Willingham, Chair of the AAP Committee on Federal Government Affairs. Over 300 pediatricians from across the country attended. Over two days, we learned about how to be an effective advocate for children, and heard from Admiral Rachel Levine, the Assistant Secretary of Health, and the first two pediatricians in the history of the U.S. Congress, Representatives Kim Schrier (Washington State), and Yadira Caraveo (Colorado).

On Monday, we learned the particulars of our advocacy subject: legislation to protect children (18 and under) from the manipulative practices of social media companies, whose aim is to prolong the amount of time children and teenagers spend on social media. These companies use continuous scrolls (with uninterrupted messages making it hard to stop looking at the next post), auto play (one video leads directly into another video), and pushes (enticements to check on new posts). These manipulative techniques were designed for adult users, not children and teenagers, who do not have the experience, maturity, and insight to understand how they are being manipulated. With the use of algorithms, social media sites predict what the user is interested in and send “related” content to the user. An adolescent interested in diet and exercise may be directed to sites about body image and weight loss - even to sites that could lead to disordered eating. The algorithms make it hard for a user to stop. Throughout this process, data is collected on youth and advertisements are being formulated for each child.

While the internet and social media can be beneficial, fun, informative and a way to learn and stay in touch and socialize with others, some safeguards are necessary. Just as rules and regulations make our highways safer, guardrails on social media can protect privacy and individual data of children and protect youth from dangerous websites. The digital ecosystem is too hard for busy, stressed parents to police on their own so updated legislation is needed.

In the Senate, the Kids Online Safety Act (KOSA) narrowly missed passage last year. The current bill, the Children’s Online Privacy Protection Act (COPPA), which dates from 1998, has loopholes that enable social media companies to skirt rules necessary to protect children and applies only to children under age 13. As KOSA and CTOPPA (updated to include teens through age 17) come up before Congress and the Senate, they should receive bipartisan support. Pediatricians should contact their House Representative and Senators and voice support for these bills.

Each pediatrician at the conference had the opportunity to meet with their House Representative. The Georgia team met with staffers from both Senator Jon Ossoff’s and Senator Raphael Warnock’s offices, who listened attentively and asked insightful questions. We even had a photo op with Senator Warnock on the steps of the Capitol! We encourage more Georgia pediatricians to come to the 2024 Legislative Conference.



Drs. Alice Little Caldwell, Swati Chandhoke, Tory Prynn, Jonathan Goodin, Anna Rodenbough, Senator Warnock, Anne Mellinger-Birdsong, Sagar Mehta, Jennifer Zubler, Shirley Hao, Nicky Chin. Missing are Drs. Marissa Bass, Sally Goza, and Melinda Williams-Willingham.



Drs. Sally Goza, Tory Prynn, Jennifer Zubler, Marissa Bass, Shirley Hao, Sagar Mehta, Alice Little Caldwell, Anna Rodenbough, Swati Chandhoke, Jonathan Goodin, Melinda Williams-Willingham, and Nicky Chin.

Alice Little Caldwell, MD, MPH, IBCLC, FAAP

**Associate Professor of Pediatrics, Medical College of Georgia
Member, Executive Committee, AAP Section on Tobacco Control
AAP Georgia Chapter E-Cigarette Champion
Augusta**



Nutrition Update Spring 2022



Jay Hochman,
MD

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

1. American Academy of Pediatrics Recommends Obesity Medications for 12 yr olds and older

SE Hampl et al. *Pediatrics* 2023 e2022060640. "Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity"

Selected recommendations:

- In children 10 y and older, pediatricians ... should evaluate for lipid abnormalities, abnormal glucose metabolism, and abnormal liver function in children and adolescents with obesity (BMI \geq 95th percentile) and for lipid abnormalities in children and adolescents with overweight (BMI \geq 85th percentile to <95th percentile).
- Pediatricians ...should offer adolescents 12 y and older with obesity (BMI \geq 95th percentile) weight loss pharmacotherapy... as an adjunct to health behavior and lifestyle treatment.
- Pediatricians ... should offer referral for adolescents 13 y and older with severe obesity (BMI \geq 120% of the 95th percentile for age and sex) for evaluation for metabolic and bariatric surgery

**Most of the lost weight is regained within one year if medications are stopped. (Ref: JPH Wilding et al. *Diabetes, Obesity and Metabolism* 2022. <https://doi.org/10.1111/dom.14725>. "Weight regain and cardiometabolic effects after withdrawal of semaglutide: The STEP 1 trial extension")

2. IBS Diet Therapies Comparison in a Randomized Trial

A Rej et al. *Clin Gastroenterol Hepatol* 2022; 20: 2876-2887. "Efficacy and Acceptability of Dietary Therapies in Non-Constipated Irritable Bowel Syndrome: A Randomized Trial of Traditional Dietary Advice, the Low FODMAP Diet, and the Gluten-Free Diet"

In this study (n=99 adults with non-constipation IBS) a traditional IBS diet was compared with a Low FODMAP diet (LFD) and with a Gluten-Free diet (GFD). Traditional diet advice (TDA) (per UK NICE guidelines) includes "adopting healthy, sensible eating patterns such as having regular meals, never eating too little/too much, maintaining adequate hydration, and reducing the intake of (1) alcohol/caffeine/fizzy drinks, (2) fatty/spicy/processed foods, (3) fresh fruit to a maximum of 3 per day, (4) fiber and other commonly consumed gas-producing foods (eg, beans, bread, sweeteners, etc), and (5) addressing any perceived food intolerances (eg, dairy).

Key findings:

- The primary end point of \geq 50-point reduction in IBS-symptom score was met by 42% (n = 14/33) undertaking TDA, 55% (n = 18/33) for LFD, and 58% (n = 19/33) for GFD (P = .43)
- My take: All three diet approaches would be appropriate to reduce IBS symptoms, though the TDA is the easiest for patients.

3. Caregiving for Short Bowel Syndrome is a Full Time Job

C Belza et al. *J Pediatr* 2022; 250: 75-82. "Carrying the Burden: Informal Care Requirements by Caregivers of Children with Intestinal Failure Receiving Home Parenteral Nutrition" In this cross-sectional cohort study, Key findings:

- Caregivers reported a median of 29.2 hours per week (IQR, 20.8-45.7 hours per week) of direct medical care. 6.1 hours was spent on providing PN and care of the central venous catheter. 6.3 hours was spent on enteral nutrition and enteral tube care.

4. Kiwi is Good for Constipation and IBS-C

R Gearry et al. *AJG* 2022. DOI: 10.14309/ajg.0000000000002124 "Consumption of 2 Green Kiwifruits Daily Improves Constipation and Abdominal Comfort—Results of an International Multicenter Randomized Controlled Trial"

Participants included healthy controls (n = 63, mean age 35 years), patients with functional constipation (FC, n = 60), and patients with constipation-predominant irritable bowel syndrome (IBS-C, n = 61)

Key findings:

- Consumption of green kiwifruit was associated with a clinically relevant increase of \geq 1.5 CSBM (complete spontaneous bowel movement) per week (Functional constipation; 1.53, P < 0.0001, IBS-C; 1.73, P = 0.0003) and significantly improved measures of GI comfort (GI symptom rating scale total score) in constipated participants (FC, P < 0.0001; IBS-C, P < 0.0001)
- My take: Thought this study was completed in adults, it is likely to be an effective option for kids and likely more appealing than prunes for a majority

5. Webinar for Pediatric Formula Review.

This webinar, given by Diana Ricketts and hosted by Kipp Ellsworth/ Clinical Nutrition at Children's Healthcare of Atlanta, reviews the different formulas that are currently in use and their target population. "Pediatric Formula Basics."

Website: <https://tinyurl.com/formula-lecture> | Password: DqnXEmR8

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

Jay Hochman, MD

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



Everything I needed to know to be a pediatric emergency room doctor, I learned as a waitress



Sarah Lazarus, DO, FAAP

The training that prepared me best for my current career as a pediatric emergency room physician is far removed from the field of medicine: a waitress at a popular steakhouse chain. The patient experience skills that I bring to the ER daily were curated from a year in the service industry. Why do patient scores matter so much? Patient experience has been repeatedly proven to correlate with positive patient outcomes and safety [1]. In addition, when patients feel that they spend more time with the provider, they have fewer complaints and concerns and they are less likely to move forward with a lawsuit in the case of a bad outcome [2]. So, I utilized my long-lost waitressing skills and began to apply them to my daily job. The results curated from these ten tips: less burnout, better career satisfaction, and higher scores on my evaluations.

1) “Hi! Welcome to the ER. Would you like a chair or a bed?”

Smiling and making eye contact when you first meet a patient are effective ways to improve patient and family experience. The PatientSET “Satisfaction Every Time” communication training program focuses on these greetings in their 8 skills [3]. Similar to waitressing, I work to make the environment as comfortable as it can be (offering a blanket, water, or a popsicle).

2) “I’m so sorry for the wait. We have a table right over here.”

Acknowledging the patient’s wait time (even if it doesn’t seem like a long wait) immediately puts a positive spin on the encounter. This is another trick from the PatientSET training program [3].

3) Get to their eye level.

Numerous studies show that providers who sit down with their patients project the perception that they are spending more time with the patient [4-5], requirement at the steakhouse. Whether you knelt next to the table or squished your way into a booth with the customer, we were always told me to take their order while sitting down. In addition, touch is important, especially after the COVID pandemic. So, shaking a hand, asking a parent if you can give them a hug when they’re crying, and asking kiddos for a high-five are gestures that may increase your scores, decrease the cortisol levels of your families, and increase your own serotonin level [3,6].

4) “What can I get you today?”

Before jumping into “Does your child have any past medical history, allergies, or medications?”, ask instead, “What can I do for you today?” to establish a positive relationship. It also proves that you are open to listening, and not just rapid-firing questions about their past medical history. A study in 2019 stated that the median amount of time a physician listened to their patients prior to interrupting was 11 seconds [7]. Try to let parents talk without interruption.

5) “To summarize: you want a fried onion, sauce on the side, a steak, medium rare, light seasoning?”

Families come in with expectations of what they think they need. It may be a CT scan for a mild head injury or fluids for their well appearing 5-year-old who is drinking a soda in the waiting room. Verbalize your

exam findings, “Wow, I do see that big goose-egg on their head. That does look scary. But, there’s no blood behind the ears and, luckily, the forehead is the hardest part of the skull, so we worry a lot less about forehead injuries than if it’s the side or back of the head.” This wording explains my decision-making while simultaneously acknowledging their concerns.

6) Don’t forget a cocktail!

Treat pain and anxiety. Use your tools: lidocaine cream, child life and distraction for IV placements, midazolam for sutures. Unfortunately, a child’s pain is frequently under-treated [8]. Listening to a child’s cries of pain is probably one of the most stressful experiences a parent can have, so, by adequately treating their pain, you will give the child (and parent) a big sigh of relief.

7) “I’ll put that appetizer order in right away.”

Don’t batch your patients, orders, or notes. By seeing multiple patients in a row, you may feel more productive, but it slows down the ability to get a patient ibuprofen, fluids or an x-ray in a timely manner.

8) “That entrée is one of my favorites.”

Validating a parent is incredibly important. Many parents will ask at the end of their visit: “Should I have brought them to the ER?” I acknowledge that “parent gut.” Whether we view a parent’s choice as misguided or not, they are scared. By noticing that they are doing the best they can, you are helping them to be less fearful.

9) “I’ll get the manager.”

You will never make everyone happy, and sometimes, you can’t stop a situation from escalating. Despite apologies or explanations, you may need to back away from the room. Acknowledge that you can’t make the situation right: “I’m sorry. I hear your frustration, but I can’t with a reasonable conscience order that study.” If you cannot get them to de-escalate, find a nurse manager.

10) “Take care of yourself.”

One of the best ways to provide your patients optimal service is by making sure YOU are your best self. This goes both ways: a positive patient experience has proven to provide greater job satisfaction and less burnout [9]. Anxiety, depression, and burnout will steal the spirit of the best person and doctor you can be. Make yourself a priority by scheduling sleep, exercise, and meals. We put so much of ourselves and our lives into our jobs, but, if you are in a bad place, and enter your work in that place, your patients will feel it, and your interactions will suffer. You have to put your own oxygen mask on before anyone else.

Sarah Lazarus, DO, FAAP

**Emergency Physician
Children’s Healthcare of Atlanta
Atlanta**



Addressing Chronic Conditions to Level the Playing Field in Pediatrics



April Hartman, MD, FAAP

Healthy People 2030 (HP2030) focuses on improving health by helping people get timely, high-quality health care services. As pediatricians, championing these initiatives while facing inadequate reimbursement and the heavy weight of administrative burden is enough to have concerns about the viability of the primary care pediatric practice. One thing we know for sure is that as pediatricians, we are used to being advocates for children and we will overcome! The answer lies in what we are good at doing: providing a comprehensive, patient-centered medical home for those we serve.

Think back to all your training on patient-centered medical homes and serving as the source of information and care for your patients and their families. As you reflect on your patient panels, think about how you can leverage electronic health records to identify patients who need more time than your average appointment slot of ten to fifteen minutes. Identify these complex patients and use some of the tools we will discuss to improve their outcomes. What is the definition of a complex patient? It is the patient with at least one chronic condition, for instance, the patient dealing with a history of trauma, and patients who are identified as experiencing difficulties with any of the social determinants of health. These patients often need help navigating the health care system. So where do we start?

Social determinants of health are defined by HP 2030 as the conditions in the environments where people live and how they affect a person's overall quality-of-life outcomes and risks. With the recent crisis in mental health conditions added to what we already know about the increasing rate of autism, asthma, diabetes, hypertension and many other chronic conditions, the need for a way to track these patients has become critical. However, this takes time, and there are only 24 hours in a day. We feel pressured to see patients and all the additional requirements attached to visits has created a burden on practices who are trying to provide the best care they can. How can we do all that is required and still have time to take care of the patient who walks in with a fever? It starts with a registry. A list of patients who have at least one chronic condition that will last longer than 3 months and who need more time than the average visit.

Principle and Chronic care management services (PCM and CCM) are non-face-to-face contact with patients and their family to provide care coordination that will address patient needs, assisting with DME supplies, ordering special formulas, submitting PA's for referrals to specialists and many other tasks. Appropriate practice staff or the physician can document time spent on registry patients each month to permit reporting of this service and receive reimbursement.

Georgia Medicaid physician fee schedule includes the following principle and chronic care management codes to report physician

and clinical staff service time, medical decision making, and care plan adjustments for those individuals with chronic conditions:

- 99490 (\$36.31) - at least 20 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month.
- 99439 (\$31.76): each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month
- 99426 (\$51.79): first 30 minutes of PCM clinical staff time directed by a physician or other qualified health professional, per calendar month.
- 99427 (\$39.64): each additional 30 minutes of PCM clinical staff time directed by a physician or other qualified health professional, per calendar month.
- 99491 (\$71.25): CCM services provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month
- 99437 (\$50.08): each additional 30 minutes of CCM services by a physician or other qualified health care professional, per calendar month

These codes can be billed on the last day of the month for each patient who meets the criteria. It applies even if they come into the office for that fever of 101 degrees. The difference is that now, you only have to address the fever because you have already answered all their questions about their chronic condition and they feel confident that you know what is going on with them. So you can treat the acute illness with confidence in knowing the chronic condition (depression, for example) has been addressed and the patient and family will be less likely to ask you as you are on your way out the door, "hey doc, who should I talk to about the fact she has said she thinks it would be better if she wasn't here?"

We would like to hear your feedback on embarking on this effort. We hope you will consider joining our Medicaid Office Hours which will launch on June 1st or join the Medical Home Task Force call which takes place on the first Thursday of every month. Contact Fozia Khan Eskew at the Chapter office at feskew@gaaap.org for full details.

April Hartman, MD, FAAP

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PHIC to Offer REACH program to Pediatricians for Mental Health Training



Emily Anne Vall,
PhD



April Hartman,
MD, FAAP

Editor's Note: PHIC is a statewide network of Georgia's five children's hospital systems united to improve health outcomes for children and sustain quality pediatric care in Georgia. The hospitals include Children's Healthcare of Atlanta, Children's Hospital of Georgia in Augusta, University Health, Beverly Knight Olson Children's Hospital in Macon, the Children's Hospital at Piedmont Columbus Regional and the Dwaine & Cynthia Willett Children's Hospital of Savannah.

The Pediatric Healthcare Improvement Coalition (PHIC), Aetna and Resilient Georgia have partnered with The REACH (Resource for Advancing Children's Health) Institute to offer pediatric mental health training for pediatric providers across the state.

Resilient Georgia and PHIC started conversations in early 2022 about the spike in mental and behavioral healthcare needs that pediatric providers are seeing statewide as a result of the mental health crisis declared in October 2021. After many conversations, this team identified a strategy to support pediatricians while efforts are made to expand the mental and behavioral health workforce. The first step in this strategy was to assure pediatricians have the skills and tools needed to care for the mental health needs of the children they were seeing until they can be referred to specialized care if needed. Dr. April Hartman and Dr. Valera Hudson saw the huge value in offering REACH's Patient-Centered Mental Health in Pediatric Primary Care (PPP) training to providers statewide.

"As pediatricians see more patients with mental health concerns, it is critical that they have the skills and tools to care for these patients within the medical home. We are committed to offering this training to every pediatrician in the state," states Dr. Hartman.

The Patient-Centered Mental Health in Pediatric Primary Care ("PPP") training course offered by The REACH Institute has transformed the practices of 6,000+ primary care providers ("PCPs"), enabling them to deliver timely and effective primary care-based mental health services in the medical home. This interactive in-person course builds skills and confidence pediatricians need to care for these children and their families.

The training course is taught by a faculty team of three pediatricians and one child and adolescent psychiatrist. Throughout the three-day program, the faculty create a safe learning community in which providers learn how to integrate MH care in their primary care offices. The training is based on basic behavior change science, demonstrates the impact on PCP effectiveness, and illustrates practical ways to operationalize the program in everyday practice.

Upon completion of the three-day course, participants engage in a virtual case-based learning program in which small groups of providers meet on Zoom with a pediatric and psychiatric faculty to discuss challenging cases and apply the skills learned during the course. Participants can earn CME credits both through the three-day training and 6-month follow up programming.

Dr. Evan Brockman added, "The PPP training significantly improved my ability to counsel kids, parents and other caregivers about BH challenges. The 6-month consults connected me to a network of PCP's and other experts. I feel supported and confident that my patients receive the most up to date care. I highly recommend this program to anyone who provides healthcare to children and adolescents.

For more details visit: <https://www.resilientga.org/columbus-training>

This training significantly increased my confidence treating MH conditions in pediatric patients. I've seen them transform as they get the help they need, without having to wait months to see a psychiatrist. They each come back a different person. This program has been life changing for my practice.

– Dr. Priya Thomas

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Putting an Historic New Endowment to Work: Behavioral and Mental Health at Children's Healthcare of Atlanta



John Constantino, MD

The mental health of children and adolescents in Georgia is at a critical crossroads. Nationally, it is well-established that the burden of serious behavioral impairment is rising, against the backdrop of a fragmented system of mental health care that has for decades compromised the delivery of evidence-based intervention to children who can benefit from it most. High-quality care requires transdisciplinary coordination, early identification of risk or onset, attention to intergenerational factors (genetic and environmental) that influence serious mental health conditions, addressing social and/or traumatic determinants of behavioral health and development, and recognition that psychiatric syndromes tend to be chronic in nature and require ongoing support, surveillance, and “ownership” of the process of recovery. Poor access to such care defines the mental health parity problem for children, i.e., non-equal treatment of mental health conditions and physical health conditions. Parity has long been a standard mandated by federal law, but rarely enforced, and this is a key objective of Georgia's recently passed House Bill 1013, which will bring together insurers, health systems, and State governing bodies in new accountability practices to achieve mental health parity in our State.¹

An important first step in this agenda is to determine where to begin for children—what services to what populations at risk are likely to

have the highest impact on major indices of outcome, including death by suicide, chronic substance use disorder impairment, delinquency, school drop-out, or placement in the child welfare system? Since the clinical workforce and insurance reimbursement structure for these services are not yet sufficient in “care as usual” within health systems, the Board of Trustees of Children's Healthcare of Atlanta placed an initial \$600M endowment to establish, sustain, and study the impact of a coordinated set of evidence-based prevention, treatment, and crisis services to a large cohort of children and families, leveraging every possible partnership with the community. The goal is to sustainably supplement the existing service structure by filling or collaboratively improving the most critical gaps (Figure 1), with quality and equity for all children as first principles. The deployment of new clinical services will occur in venues in which the health system already has established access and the ability to identify children and families with serious unmet mental health needs: (i) affiliated primary care clinics including the Hughes-Spalding pediatric practice; (ii) schools throughout the State in which Children's has initiated clinical outreach; (iii) the new Children's Healthcare of Atlanta Zalik Center for Behavioral and Mental Health for professional referrals of children who can benefit from specialized outpatient mental health services;

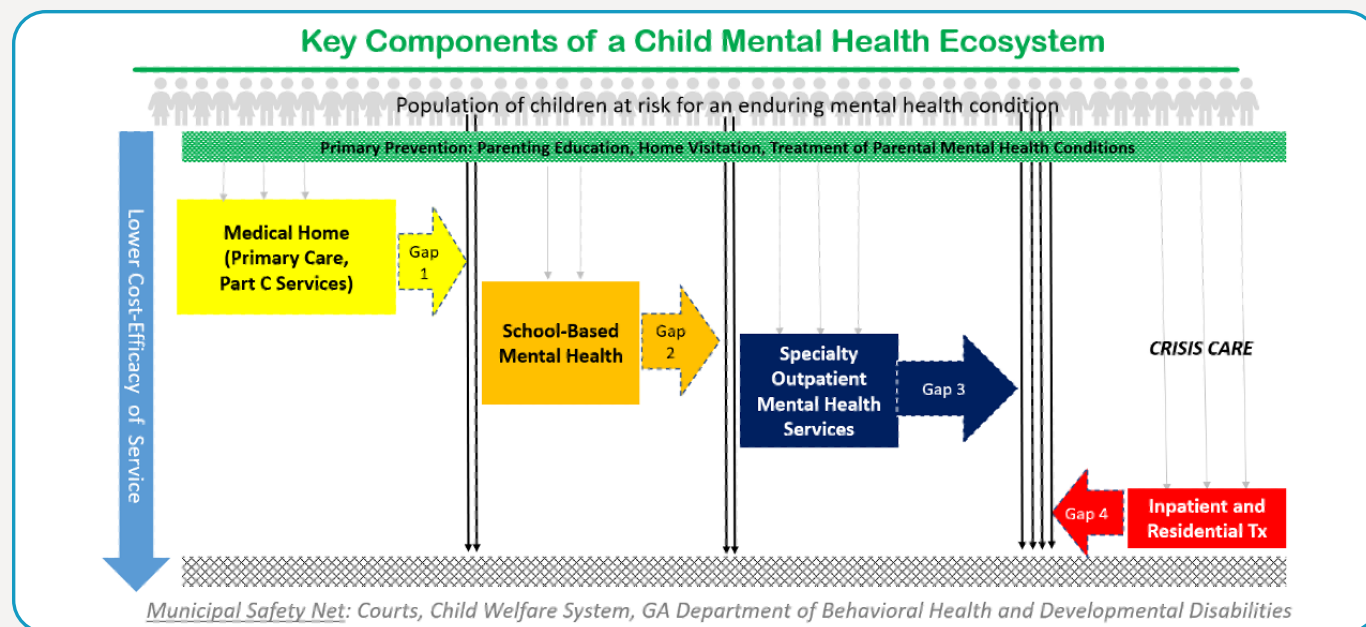


Figure 1. Key components of a child mental health ecosystem. Children at risk for enduring mental health conditions (gray) are ideally protected from major adverse outcomes (dark vertical arrows into the overburdened municipal safety net) by preventive intervention (green), early surveillance and treatment in primary care practices (yellow), school-based services (orange), evidence-based specialty outpatient mental health services (dark blue) and, when necessary, high-quality inpatient and residential services. In most communities across the U.S., interventions within each of these sectors are in short supply and of inadequate quality, a situation which creates major gaps that allow greater numbers of adverse outcomes. These gaps need to be filled in order to achieve standards of mental health care that are on a par with other medically necessary elements of pediatric practice. Children's Healthcare of Atlanta plans to rapidly increase clinical capacity in each of the service areas demarcated by gaps (horizontal block arrows) and to closely monitor the impact of these enhanced services on the children who receive them within our health system.

Behavioral and Mental Health...

Continued from previous page.

and (iv) state-of-the-art crisis recovery services for thousands of children who present to the emergency departments of Children's Healthcare of Atlanta each year for behavioral crises.

The array of services encompassed by this four-component expansion in clinical capacity will span the complete care continuum of evidence-based intervention for psychiatric syndromes of childhood, including two-generation (2GEN) preventive intervention, parent-child interactional therapies for preschoolers, psychopharmacology and neurostimulation, treatment of early addictions, trauma recovery services, and high-impact psychotherapies including cognitive-behavioral therapy, family therapy, multisystemic therapy, and dialectical behavioral therapy. The model of care will avert fragmentation of service and will emulate that of serious, chronic medical conditions of youth by adopting a standard of "ownership" of a child's mental health condition (or serious risk for one) until the condition is resolved or through the transition to adulthood, whichever comes first. In all cases, Children's Healthcare of Atlanta plans to leverage the capacity of community providers who are positioned to deliver necessary components of any intervention plan for any given child. When any necessary components of care are not available or accessible to a child on our Behavioral and Mental Health service, our goal is to provide it in order to ensure that the entire intervention plan is delivered in accordance with the evidence base of the field. The strategy for developing the necessary workforce for this increase in capacity has intentionally focused on providing early

career opportunities to new graduates in the disciplines of psychiatry, psychology, social work, counseling, and nursing, since recruitment of established community clinicians would only shift rather than increase total capacity for care.

The endowment ensures that the funds spent to enhance clinical capacity and cover its true costs can be sustained over time for large numbers of children within our health system. A distinct program monitoring infrastructure will qualify this endeavor as one of the nation's first learning health systems for child mental health. The lessons learned will be disseminated in real time so that knowledge of the true costs and benefits of comprehensive mental health care can inform decisions of insurers, health systems, and legislative bodies across Georgia and the nation toward achieving mental health parity for children.

Reference

1. Constantino, JN. Bridging the Divide Between Health and Mental Health: New Opportunity for Parity in Childhood. *J Am Acad Child Adolesc Psychiatry*, in press.

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Improving Identification of Autism Spectrum Disorder



Jennifer Zubler,
MD, FAAP

The Centers for Disease Control and Prevention (CDC) recently released new autism prevalence rates based on 2020 surveillance data from the Autism and Developmental Disabilities Monitoring Network which includes GA. It is now estimated that one in 36 (8-year-olds) have autism spectrum disorder (ASD).¹ Most of the increase in prevalence is attributed to increases in early identification and more equitable identification. The American Academy of Pediatrics (AAP) released its first clinical report recommending routine screening for autism at 18 and 24 months of age in 2007. Since then, significant effort has been made by pediatricians and other early childhood professionals to improve early identification of autism through developmental surveillance and autism screening. Autism is now referred to as autism spectrum disorder to reflect the diversity of strengths, challenges, and behaviors that children may display in the areas of social communication and repetitive restrictive behaviors. In 2020, the AAP published a comprehensive updated clinical report *The Identification, Evaluation, and Management of Autism Spectrum Disorder*² that is divided into user friendly sections including one regarding etiologic evaluations.

Longitudinal developmental surveillance at health supervision visits along with universal autism screening at 18 and 24 months of age and general developmental screening at 9, 18, and 30 months of age is recommended for early identification of ASD and other developmental delays and disabilities (DDs). Additional screening is recommended anytime a family, physicians, or early childhood professionals have a concern. There are limitations to surveillance and screening; not every child with ASD will be identified through these methods. In addition, the COVID-19 pandemic and the recent “Tripledemic” impacted access to screening, early identification, and developmental services for some children. If there are concerns about a child’s development, regardless of screening results, further evaluation for ASD should strongly be considered. Keep in mind if a family has developmental concerns they are typically substantiated.

While awaiting further evaluations, families should be referred to see if they qualify for early intervention services. For children under three years of age, refer children to the Babies Can’t Wait (BCW) program through GA’s Department of Public Health’s Children 1st program. Even if children are close to 3-years-old, it is still beneficial to refer them to BCW, so BCW can provide a “warm hand off” to the school district for special education pre-school services when the child turns three. If a child is already 3 years old, they should be referred to their school district’s special education department for evaluation for school-based services.

A diagnosis of ASD is not required to receive BCW or public pre-school services. Those services can be initiated along with other services a child may need for co-occurring conditions like speech or fine motor delays while awaiting an official ASD diagnosis. Consider additional services that may also support the child such as Home Visiting, Head Start, Early Head Start, and WIC. To receive adaptive behavioral services for ASD through GA’s Medicaid program, a documented autism diagnosis will be needed. Children in GA are typically diagnosed with autism by developmental and behavioral pediatricians, child psychologists, neurologists, and by some general pediatricians as spotlighted in the last issue of *The Georgia Pediatrician*.

To learn more, the GA-AAP has a Council on Children with Disabilities and supports educational content on developmental topics at the fall and spring conferences. Also consider joining the AAP’s Section on Developmental and Behavioral Pediatrics and the Council on Children with Disabilities that has an Autism Subcommittee.

The AAP and CDC have developed FREE resources for pediatricians to use with families to support early identification and linkage of families to services for developmental delays and disabilities, including autism.

AAP resource webpage for surveillance and screening:
www.aap.org/en/patient-care/developmental-surveillance-and-screening-patient-care/

- Family Friendly Referral Guide (English and Spanish) to guide families through complicated developmental referrals
- Facilitated Mini Training (15 minute) slides and case studies to support team-based care.
- Pedialink Trainings for developmental surveillance, screening, and ASD
- Strengths, Risks, and Protective Factors resource guide
- Coding Facts Sheets

Autism Spectrum

Continued from previous page.

CDC's Milestone Checklist:

Health Communication Tools for Developmental Surveillance



www.cdc.gov/ActEarly/Materials

The CDC's Revised Developmental Milestones to assist with developmental surveillance and support developmental screening. (Note these resources are not developmental screening tools if a child is missing milestones or there are other concerns about a child's development, screening is recommended)

www.cdc.gov/ncbddd/actearly/milestones/index.html

- Milestone Checklists – print and electronic versions
- Milestone Tracker app
- Milestones in Action – a photo and video library of the CDC's revised developmental milestones
- Tips and Activities within all CDC milestone resources so families can learn more about relational health, responsive feeding, sleep, and other ways to support their child's development.
- CDC's Autism-Specific Resources
www.cdc.gov/ncbddd/autism/index.html

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Dr. Jennifer Zubler is a general pediatrician who works to improve the early identification of children with developmental delays and disabilities in Georgia and nationally through physician training resources, messaging, quality improvement projects, and most recently the revision process for the CDC developmental milestones. Clinically, she works as a volunteer pediatrician where she also coordinates a developmental and behavioral clinic and assists families in navigating medical and educational systems of care. She is involved in the Georgia State University Leadership Education in Neurodevelopmental Disabilities (LEND) program and the advisory council for The Autism Plan of Georgia, the Georgia AAP, an executive committee member of the AAP's section on developmental and behavioral pediatrics' where she is co-chair of the advocacy committee and a member of the primary care committee.

Jennifer Zubler, MD, FAAP

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How Quality Initiatives Can Improve Pediatric Vaccination Rates



Iyabode Akinsanya-Beysolow,
MD, MPH, FAAP

The phrase “It’s time for another QI project” usually does not garner great enthusiasm. Quality Improvement (QI) methodology and tools, however, allow us to improve our processes, maximize efficiency, and achieve measurable goals. As we attempt to capture children who have missed well-child checks and routine vaccines since March 2020, performing a QI project can help.

What is QI, and how can it help us?

“A QI program involves systematic activities that are organized and implemented by an organization to monitor, assess, and improve its quality of health care. The activities are cyclical so that an organization continues to seek higher levels of performance to optimize its care for the patients it serves, while striving for continuous improvement².”

We can date the beginning of QI initiatives in health care to the 19th century with the obstetrician Ignaz Semmelweis, who championed the importance of hand washing in improving health outcomes.³ The QI movement has evolved from the manufacturing industry into healthcare. We are now focusing on preventing medication errors and other practices, including improving immunization rates. Studies^{14,15} show that QI initiatives do help to improve immunization rates.

One of the most used QI models in healthcare we can adopt in pediatrics is from the Institute for Healthcare Improvement (IHI)³. The Model for Improvement, developed by Associates in Process Improvement, is a tool for accelerating improvement and builds upon the well-known Plan-Do-Study-Act (PDSA) cycle model.

Our Scenario: Using the Model for Improvement, how can we make sustainable and measurable office process improvements in vaccination rates for children 19-35 months?

Utilizing the IHI’s Model for improvement, we divide every project into two parts, using the Plan-Do-Study-Act (PDSA) change model. Part 1 focuses on three objectives: setting the aim or organizational goal, establishing measures, and selecting changes. Part 2 (Plan-Do-Study-Act) focuses on testing these changes on small scales.

It is so easy to overestimate the importance of one defining moment and underestimate the value of making small improvements on a daily basis. Too often, we convince ourselves that massive success requires massive action.

– *Atomic Habits, Tiny Changes, Remarkable Results*
by James Clear.

Part 1. Planning: setting the aim or organizational goal. Establishing Measures. Selecting Changes.

The planning stage is vital to the ultimate success of your project. Spend as much time as needed here: Steps can be performed concurrently as staff and time permits.

- Build your Team. Include representatives from every department, preferably people strongly interested in improving care. Include front office, clinical, billing, and leadership. Obtain parent/patient perspectives. Identify an office champion to execute the team’s vision.
- Determine why a project is needed; what is your overall aim? Your aim should be measurable, time-specific and population defined.^{5,6}
- How will you know your change is an improvement? Establish and select measures^{5,7}. In our scenario, we can plot data over time. Obtain baseline immunization rates for your 19–35-month patient population and set up processes to assess changes in these rates monthly or quarterly.
- Selecting a Change: Gather barriers/problems unique to your setting. To help you see how your aim and the possible changes relate, utilize cause-and-effect tools.^{5,8} This may include a Fishbone Diagram⁹, where you collate all possible problems/barriers that can affect your aim. Remember the Pareto principle¹⁰, the 80/20 rule. 80% of your problem comes from 20% of your barriers.

Selecting a Change: Questions to consider

- Are we trying to improve our workflow so that vaccination opportunities are “seamless”?
- Are we trying to reduce missed opportunities to vaccinate?
- By changing the culture of the practice?
- By improving patient access (e.g., extending office hours)?
- “While all changes do not lead to improvement, all improvements require change, IHI”¹¹

Finally, develop a Key Driver diagram¹², a solution-based tool that shows the relationship between your overall aim and primary and secondary drivers. The diagram is fluid and may change as the project progresses.

Pediatric Vaccination Rates

Continued from previous page.

Part 2. Test your change on a small scale. (Plan, Do, Study and Act Cycle)

For steps on implementing a PDSA cycle, visit <https://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>

Tips for effectively testing changes:

- Keep the changes small.
- Study the results after each change. All changes are not improvements. Discontinue testing for changes that do not yield progress. Learn from them regardless. Consider other “changes.”
- If there is an improvement, expand the tests and gradually incorporate larger samples until you are confident that the changes should be adopted more widely.

In summary, the science of improvement is an applied science, with philosophical underpinnings, calling for action and learning from that action. It is not a specific intervention.¹³

For those interested in participating in QI initiatives led by the Georgia Chapter of the AAP, contact Noreen Dahill at ndahill@gaaap.org.

Ideas for PDSA Test Cycles

- Identify children in your practice ages 19-35 months who are missing vaccines utilizing your EHR or State Immunization Registry (IIR).
- Reduce missed opportunities to vaccinate.
- Perform ‘chart prep’ to ensure that the immunization record for every patient coming in the next day has been reviewed before the visit and assessed for missing vaccines.
- Screen all sick visits on one given date for their immunization status. Vaccinate that day if stable or schedule a vaccine appointment.
- Check the immunization status of the siblings of the patient.

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

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Looking Ahead: Join us for our upcoming events!

Webinar: Assessing Social Risk in Children with Autism Spectrum Disorders

May 30, 2023

Immunization Webinar Series Pediatric Vaccination Forum: A Discussion of the Past Present, and Future of Immunization in Your Practice

June 1, 2023

Webinar: Developmental Milestones and More for the Primary Care Pediatrician

June 8, 2023

Pediatrics by the Sea, Summer CME Meeting

The Ritz-Carlton, Amelia Island, FL
June 14-17, 2023
(Wed-Sat)

Pediatrics on the Perimeter Westin Atlanta Perimeter North, Atlanta October 6-8, 2023 (Fri-Sun)

Georgia Pediatric Nurses & Practice Managers Association Fall Meeting

Cobb Energy Center, Atlanta
November 17, 2023

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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.