Vision loss another potential consequence of delayed care due to COVID

by Daniel A. Greninger, M.D., FAAP

During the COVID-19 pandemic, a decrease in pediatric preventive care visits combined with a lack of in-person schooling have led to a significant drop in childhood vision screening. The result may be an increase in permanent visual impairment due to amblyopia.

Amblyopia is a disease of vision development affecting about 3% of children. Amblyopia is caused by uncorrected refractive error (need for glasses), strabismus (eye misalignment) or other conditions depriving the eye of normal images during the critical visual development period from birth to age 7. After age 7, amblyopia is more difficult to treat, and a patient diagnosed thereafter has a greater risk of permanent vision loss.

Vision screening is not just for detecting a need for glasses; it is essential for early detection of problems that can cause permanent visual impairment.

Amblyopia often goes undetected because young children can be asymptomatic. As such, vision screening and subsequent follow-up with eye care are essential to detect and treat the disease.

The AAP and other national organizations recommend all children be screened for amblyopia in primary care during early childhood when the disease is most treatable (https://bit.ly/3q2QgsB). The U.S. Preventive Services Task Force recommends vision screening for all children at least once between 3 and 5 years to detect amblyopia or its risk factors (JAMA. 2017;318:836-844).

Traditionally, screening has occurred as part of in-person well-child care visits. In-person vision screenings also take place in preschool and primary school settings.
Using cannabis during pregnancy may lead to having smaller babies


Women who used cannabis during pregnancy were more likely to have babies with low birthweight (LBW) or were small for gestational age than mothers who abstained, according to a retrospective study of 32,583 women. Furthermore, the odds for those adverse infant outcomes as well as prematurity were greater among women who used cannabis and smoked cigarettes than those who used neither or just one substance.

Findings from previous studies on prenatal cannabis use and birth outcomes have been inconsistent, and most were conducted decades ago. Since then, many states have legalized recreational and medical marijuana, and products have become more potent.

Researchers, therefore, sought to provide an update on whether prenatal cannabis use is associated with preterm birth (less than 37 weeks’ gestation), small for gestational age (less than the 10th percentile) and LBW (less than 2,500 grams). To do so, they used data from birth certificates and the 2017-’19 Pregnancy Risk Assessment Monitoring System, which collects information from state surveys of new mothers on behaviors and experiences during pregnancy.

Researchers analyzed data from 20 states and one territory that asked about cannabis use.

Nearly 5% of women used cannabis during pregnancy.

Adjusted models showed prenatal cannabis use was associated with increased risk for LBW and small for gestational age. Use of cigarettes was associated with increased risk for LBW, preterm birth and small for gestational age compared with not using either substance. Concomitant use of cigarettes and cannabis was associated with the greatest risk for all three adverse outcomes.

The authors noted that the American College of Obstetricians and Gynecologists recommends against using marijuana during pregnancy. However, many women still use products because they are legal, easy to get and have been touted as a treatment for nausea.

“Our findings are especially timely in the shifting landscape of the acceptance and perceived safety of cannabis,” they concluded.

Antibiotics may not benefit children with lower respiratory infection


Amoxicillin was no more effective than placebo in reducing symptom duration among children with uncomplicated lower respiratory tract infection (LRTI), a randomized, double-blind, placebo-controlled study found.

Antibiotics often are prescribed for children with uncomplicated LRTIs even though there is little evidence to show they are effective. Furthermore, antibiotic resistance has led to efforts to reduce prescribing.

The authors of this study sought to determine if amoxicillin would reduce the duration of moderately bad symptoms in children with uncomplicated LRTI. They randomized patients ages 6 months to 12 years with acute chest infections to receive a seven-day course of amoxicillin or a placebo.

For at least a week, parents rated symptoms, including cough, phlegm, shortness of breath, wheeze, runny nose, difficulty sleeping and fever on a scale from 0 to 6 (0=no problem, 3=moderately bad, 6=as bad as it could be).

The team, which received input from patients and the public, determined that treatment would be clinically important if there was a three-day difference between the groups in symptom resolution.

Results showed 156 children in the antibiotic group had moderately bad or worse symptoms for a median of five days compared to six days for 161 children in the placebo group. Analysis of five subgroups (patients with abnormal chest signs, fever, rated as unwell by physician, sputum and shortness of breath) also showed no differences in symptom duration.

Side effects were similar (38% of the treatment group vs. 34% of the placebo group). Complications were rare (2% in both groups).

Differences were seen in the percent of children who returned for new or worsening symptoms (38% in the placebo group vs. 30% in the treatment group).

“Our results suggest that antibiotics do not provide a clinically important benefit on average for symptom reduction nor symptom severity,” the authors concluded.

They recommended that clinicians forgo prescribing antibiotics for most children with chest infections unless pneumonia is suspected.

Weight loss surgery safe, effective for youths


A long-term follow-up study of children and adolescents who underwent laparoscopic sleeve gastrectomy (LSG) showed weight loss was maintained, comorbidities often resolved and patients’ growth was comparable to their peers.

Nearly 19% of U.S. youths have severe obesity, which can lead to poor physical and mental health. Previous studies have shown that metabolic and bariatric surgery is safe and effective for pediatric patients, and the AAP recommends considering surgery for youths with severe obesity and comorbid medical conditions. However, data are lacking on outcomes more than five years after surgery.

This study is part of an ongoing study of children and adolescents referred to a multidisciplinary obesity management program. Researchers looked at weight loss; resolution of type 2 diabetes, hypertension and dyslipidemia; growth velocity; and adverse events for up to 10 years in 2,504 pediatric patients who underwent LSG.

Patients were ages 5-21 at the time of surgery, 55% were female and all had severe obesity (body mass index at least 120% of the 95th percentile for age and sex).

Seven to 10 years after surgery, 632 patients maintained a 71% average loss of excess weight, and no significant changes were seen in growth velocity.

Twenty-seven patients were readmitted to the hospital in the first 90 days after the operation, but none had long-term sequelae. Before surgery, 10.5% had type 2 diabetes, 9.1% had dyslipidemia and 15.1% had hypertension. At follow-up more than seven years later, complete remission was seen in 71.5% of patients with diabetes, 57.3% with dyslipidemia and 58.1% of those with hypertension.

The authors noted that fewer than four per 10,000 eligible children and adolescents undergo weight loss operations.

“Our findings present clear evidence that should remove hesitance to perform bariatric surgical treatment in children and young adolescents who could benefit from the operation,” principal author Aayed R. Alqahtani, MD, FACS, FRCS, said in a news release. “We have a proven solution for severe obesity and its comorbidities.”
There are countless reasons why an issue gains traction on Capitol Hill. Sometimes, a sweeping crisis, like the COVID-19 pandemic, requires immediate attention and policy solutions. Other issues rise to the top due to the political landscape, shifting dynamics and the priorities of the party in power.

Another reason an issue captures lawmakers’ attention can best be described as a perfect storm. Numerous elements converge, making the issue impossible to ignore, even if it is no stranger to pediatrician advocacy.

That is how the momentum in Washington to protect children online and on their devices might be described. An existing, yet growing concern was compounded by a global pandemic that drove many aspects of life online and was elevated by recent news headlines spotlighting harmful practices.

As we close out this congressional session and look ahead to the new year, the Academy will be at the forefront of advocacy efforts to target these threats while amplifying the benefits of digital connection.

How we got here
Long before the pandemic, pediatricians were concerned about the impact of media use on children’s mental and physical health. A generation of children is growing up immersed in media, some even starting to interact with digital devices during their first few months of life. From a very early age, children can fall victim to online practices that compromise their data and privacy, and present them with harmful or inappropriate content. Yet, the Academy also recognizes that connectivity has benefits that should be maximized.

The pandemic accelerated the need for legislative action as children’s screen time increased and virtual learning went into high gear. Children and teenagers also experienced isolation and mental health challenges.

Recently, technology companies have come under growing scrutiny for the impact of their products on the health and development of young people. Lawmakers have raised these concerns on the national stage, especially the toll of social media on mental health.

Last year, the Academy published a policy statement on digital advertising to children (https://bit.ly/3bNqmk2), which examines the concerning practices used by technology companies to keep young people on their devices and market products to them. It also calls for major updates to federal laws protecting children and teens online.

In a pivotal advocacy moment, Nusheen Ameenuddin, M.D., M.P.H., M.P.A., FAAP, chair of the AAP Council on Communications and Media, testified earlier this year before a U.S. House of Representatives subcommittee about children’s safety in the digital age.

Opportunities for progress
The Academy’s advocacy in this arena falls into two major categories: privacy and data collection and manipulative marketing and design practices. Three AAP-endorsed bills in Congress would address these topics.

“One message I consistently try to share with policymakers is that families need help navigating the current media landscape that is designed to keep them connected 24/7,” Dr. Ameenuddin said. “It is no longer fair or feasible to place the entire burden of barriers that communities of color face when it comes to benefi ting from technology. For instance, access to broadband internet and devices is notably lower among students of color compared to White students.

The AAP is teaming up with partner organizations to work toward the goal of keeping children safe online. Of note, the Academy is part of a coalition led by Fairplay (formerly the Campaign for a Commercial-Free Childhood), which is working to enact protections for young people online.

“One message I consistently try to share with policymakers is that families need help navigating the current media landscape that is designed to keep them connected 24/7,” Dr. Ameenuddin said. “It is no longer fair or feasible to place the entire burden of responsibility on them to limit media use when these platforms and algorithms are designed to keep them clicking and generating revenue while also gathering information on children without explicit consent.”

Research is another area for growth. There is still much to learn about the evolving impact of digital technology and children’s mental and physical health. The AAP is urging increased federal funding to examine this relationship and understand how to maximize the benefits and minimize the harm of these platforms.

The promising news is that Congress is starting to pay attention, providing opportunities for progress. The Academy will ensure the child health perspective is prominent in these discussions and will continue to push for policies that are most protective for young people growing up in a digital world.
Answers to lingering questions about vaccinating 5- to 11-year-olds

by Carla Kemp • Senior Editor

Incredible. Heartening. Exciting. These are a few of the words pediatricians have used to describe approval of Pfizer-BioNTech’s COVID-19 vaccine for children ages 5-11.

“What an incredible week this has been,” AAP President Lee Savio Beers, M.D., FAAP, said at an AAP town hall after the director of the Centers for Disease Control and Prevention (CDC) signed off on using the vaccine in young children. “I think we’ve all been eagerly anticipating the availability of a COVID vaccine for our 5- to 11-year-olds, and it’s been so special and heartening to see all the messages and notes from all of you who are working hard to get your patients vaccinated.”

While the vaccine has been available to 5- to 11-year-olds since early November, pediatricians still have questions about how, when and to whom they can administer it. Following are answers to frequently asked questions based on the CDC’s interim clinical considerations for use of the vaccine that were current at press time.

Children should receive the age-appropriate vaccine formulation regardless of their size or weight.

Are young children at risk for myocarditis after vaccination?

No cases of myocarditis were reported in the 3,082 children ages 5-11 who participated in clinical trials with at least seven days of follow-up after dose 2. However, the study was not powered to assess the risk for myocarditis.

“It’s a rare enough event that you wouldn’t expect any cases in that size of a trial,” said Sean T. O’Leary, M.D., M.P.H., FAAP, vice chair of AAP Committee on Infectious Diseases. “And in fact, you couldn’t really design a trial large enough. It’s just not feasible to do a clinical trial of any medicine, vaccine or otherwise to detect a vaccine adverse event that is as rare as (myocarditis).”

Should a child who develops myocarditis or pericarditis after the first dose receive a second dose of vaccine?

Safety data are not available on administering a subsequent dose of COVID-19 vaccine to people who had myocarditis or pericarditis after a dose of an mRNA COVID-19 vaccine. Until safety data are available, they should not receive a subsequent dose of any COVID-19 vaccine.

However, administration of a subsequent dose can be considered in certain circumstances, including if people have underlying conditions or based on community transmission of COVID and personal risk of infection.

Should children who have been infected with COVID-19 be vaccinated?

Yes. Children with current SARS-CoV-2 infection should wait to be vaccinated at least until they have recovered from the acute illness (if symptomatic) AND they have met criteria to discontinue isolation (typically 10 days after positive test if asymptomatic or 10 days after symptom onset and after resolution of fever for at least 24 hours). Serologic testing to assess for prior infection is not recommended.

Should those with a history of multisystem inflammatory syndrome in children (MIS-C) receive the vaccine?

The benefits of COVID-19 vaccination for children with a history of MIS-C are likely to outweigh the theoretical risk of an MIS-like illness or the known risks of COVID-19 vaccination for people who meet all of the following criteria:

• Clinical recovery has been achieved, including return to normal cardiac function.
• It has been at least 90 days since MIS-C was diagnosed.
• They are in an area of high or substantial community transmission of SARS-CoV-2 or otherwise have an increased risk for SARS-CoV-2 exposure and transmission.
• Onset of MIS-C occurred before any COVID-19 vaccination.

What are the contraindications to receiving the COVID-19 vaccine?

Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine or known diagnosed allergy to a component of the COVID-19 vaccine.

Can COVID vaccine be co-administered with other vaccines?

Yes.

If more than two vaccines are injected in a single limb, the vastus lateralis muscle of the anterolateral thigh is the preferred site because of greater muscle mass.

What adverse events after vaccination should be reported and where?

The FDA requires vaccination providers to report vaccine administration errors, serious adverse events, cases of multisystem inflammatory syndrome and cases of COVID-19 that result in hospitalization or death to the Vaccine Adverse Event Reporting System (VAERS) at https://vaers.hhs.gov or by calling 800-822-7967.

In addition, the CDC developed a voluntary smartphone-based tool called v-safe that vaccine recipients/parents can use to report adverse events. Find details at https://bit.ly/3BOuLOm.
INTRODUCING
Another First & Only Innovation
From Similac®

Providing 360 Support for the Whole Baby

IMMUNE SUPPORT
Designed to strengthen the baby’s immune system

BRAIN DEVELOPMENT
Building blocks for the baby’s developing brain

DIGESTIVE HEALTH
Gentle and easy-to-digest formula supports a healthy digestive system

Talk to your Abbott sales representative to learn more about the new Similac® 360 Total Care® Products
Thank you for who you are, what you do, why you do it

As I sat down to write my last letter as your president, I took a moment to look back on the first letter I wrote at the beginning of the year. Reflecting on what the months ahead might bring, I felt hope, caution and gratitude — the same emotions I feel today.

Hope, because we increasingly have the knowledge and tools to end the pandemic and build a better future for our children. With a COVID-19 vaccine authorized and recommended for children ages 5-11, we are one step closer to being able to protect all children from the ill effects of SARS-CoV-2. While children have suffered greatly over the past two years, with many families more profoundly impacted than others, interest is increasing in building systems that will address the health and well-being of all children and the decades of inequities and systemic racism that manifest in disparate health outcomes. Notably, interest is intensifying in child and family mental health, which I think is a real opportunity for transformational change.

I also have hope because the pediatrician’s voice and expertise have been elevated in a way I have never seen before. Your passion, commitment and innovation have been clearly evident at the time when our nation’s children needed you most.

Despite the challenges, we must continue to break down those barriers, fight for the resources pediatricians need and look inward to advance equity within our own profession. If we don’t maintain focus on these things, we will not be able to make progress.

But, most importantly, I feel gratitude that as a pediatric community, we are walking together in hope and caution — supporting our communities, encouraging each other and working as hard as we can to take care of children and families. Over the past two years, I have seen countless examples of pediatricians displaying innovation and excellence in their work, always infused with the kindness and caring that exemplifies our profession.

Our member leaders and subject matter experts continue to step forward, contributing their wisdom and expertise to guide us. And, I am exceedingly grateful for the talented staff of the AAP. They work countless hours behind the scenes, often not recognized, in service to our organization’s mission to promote the health and well-being of children and adolescents.

I have truly never been prouder to be a pediatrician and deeply humbled to have had the opportunity to be your president during this challenging and tumultuous time. At our final Board of Directors meeting this year, I was able to sit with colleagues while we listened to the Advisory Committee on Immunization Practices vote to recommend the COVID-19 vaccine for 5- to 11-year-olds. It seemed fitting and symbolic that we were able to listen together while expert after expert spoke to the importance of child health.

I feel honored to be surrounded by colleagues who share that commitment and value, and work daily to improve the health and well-being of all children and families. I want to say thank you. Thank you for who you are, what you do and why you do it. I am forever grateful.

Lee Savio Beers, M.D., FAAP
President, American Academy of Pediatrics

Your passion, commitment and innovation have been clearly evident at the time when our nation’s children needed you most.

Lee Savio Beers, M.D., FAAP
President, American Academy of Pediatrics
a safety net to help ensure that amblyopia does not go undetected.

Data from Kaiser Permanente Northern California, which tracks vision screening within primary care for tens of thousands of children, suggest the rate of vision screening during well-care visits held steady from 2019–21. However, the opportunity to perform screenings in children ages 3–6 decreased by about 30% due to a reduction in in-person well-care visits. Rates of follow-up visits with optometry after failed screening decreased as well.

Data collected by the American Association of Certified Orthoptists also suggest that in Iowa and Oregon, two states with robust school and community screening programs, in-person vision screening of children in school and community settings decreased by 70% in 2020.

Many families also may be concerned about the effects of extended screen time on their children’s eyes due to the shift to online education during the pandemic.


Vision screening is important to help to identify myopia at an early age when behavioral modifications and treatments to slow progression, such as low-dose atropine eyedrops and specialty contact lenses, may be most effective.

As families and providers become more comfortable with telehealth for preventive care, there may be an opportunity for traditional vision screening to be supplemented by home-based screening. Systematic reviews of home-based visual acuity apps have been performed in adults (Samanta A, et al. J Telemed Telecare. https://bit.ly/3bI19Jo). While no app has been validated for home-based amblyopia screening, a systematic review is forthcoming (Sii S, et al. BMJ Open. 2021;11:e051830, https://bit.ly/3GTDPoI).

Vision screening is not just for detecting a need for glasses; it is essential for early detection of problems that can cause permanent visual impairment. Therefore, pediatricians should include vision screening on the list of catch-up items to address for patients who have delayed in-person care.

Dr. Greninger is a member of the AAP Section on Ophthalmology.

Tired of using Adult Dandruff Shampoos on Infants with Seborrheic Dermatitis?

Dr. Eddie’s Happy Cappy

- Created by a pediatrician to eliminate flakes, scaling, and redness on children’s scalps, eyebrows, behind the ears, in the axilla, and groin folds

- Contains FDA approved active ingredient, pyrithione zinc 0.95% which has been proven safe and effective for relief of seborrheic dermatitis and dandruff

- Contains the natural ingredient Licorice Root Extract to help soothe redness behind the ears, in the armpits, and neck folds

- Happy Cappy’s gentle, fragrance free, dermatologist tested, dye free, sulfate free, paraben free, phthalate free, alcohol free, BPA free, cruelty free, and vegan formula eliminates flaking while still leaving the skin and hair soft and smooth

Available at select:

For Walgreens Store Locator:
happycappyshampoo.com

RESOURCES


Certain sections of the text may be unanswerable due to the lack of clear questions or prompts.
Education, AAP Toolkits, AAP Pediatric Coding newsletter; and AAP Policy.

The unification of platforms is a byproduct of the AAP Digital Transformation Initiative (DTI), an ongoing commitment to improve AAP digital products that will result in enhanced experiences for members. The new platform aligns with DTI’s core principles of simplify, personalize and connect.

In addition to seamless searchability and a fresh design, products on the new platform have enhanced features:

- Policies: a dedicated page to search policy-related documents
- Journals: an intuitive table of contents and new landing pages
- AAP News: new home page, most read articles widget, email alerts
- AAP Books: preferred reading format, including split screen view
- Pediatric Care Online: streamlined Quick Reference, enhanced organization
- Red Book Online: streamlined vaccine status tables
- Pediatric Patient Education: improved search to find handouts
- AAP Toolkits: new quick links

In addition, the enterprise-wide navigation offers users options for filtering or expanding a search, while remaining in the AAP ecosystem. From the Publications site, members can move seamlessly between other key AAP sites, like AAP.org, HealthyChildren.org and ShopAAP. In addition, users can view abstracts and PDFs from the search results rather than having to click into an article.

“The American Academy of Pediatrics is the leader in pediatric publishing, providing critical guidance, research, news and health information to pediatricians, parents and many other audiences,” said Mark Grimes, vice president of publishing. “It is important that we are able to provide our publications in a way that is credible, current and seamless.”

The AAP partnered with Silverchair of Charlottesville, Va., to develop the unified platform.

---

**ENTERPRISE NAVIGATION**

- Pediatric Coding Newsletter: split screen, new resources section and streamlined table of contents
- In addition, the enterprise-wide navigation offers users options for filtering or expanding a search, while remaining in the AAP ecosystem. From the Publications site, members can move seamlessly between other key AAP sites, like AAP.org, HealthyChildren.org and ShopAAP. In addition, users can view abstracts and PDFs from the search results rather than having to click into an article.

“The American Academy of Pediatrics is the leader in pediatric publishing, providing critical guidance, research, news and health information to pediatricians, parents and many other audiences,” said Mark Grimes, vice president of publishing. “It is important that we are able to provide our publications in a way that is credible, current and seamless.”

The AAP partnered with Silverchair of Charlottesville, Va., to develop the unified platform.

---

**Be prepared to respond quickly and efficiently at every birth with NRP®.**

With the latest edition of NRP®, you’ll find:

- The latest resuscitation guidelines
- Useful course study materials
- Easy-to-use reference resources

Find the entire lineup of NRP materials at shop.aap.org/nrp

---

**TEXTBOOK OF NEONATAL RESUSCITATION**

New 8th edition materials must be in use by January 1, 2022

---

**Order at shop.aap.org/books.**

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
Board update: continued from front page


AAP President Lee Savio Beers, M.D., FAAP, remarked that after a week of conferences leading to the board meeting, it was fitting to observe the authorization and recommendation of the vaccine for younger children. Board members watched as the Advisory Committee on Immunization Practices voted on Nov. 2 to recommend the vaccine for 5- to 11-year-olds.

“It just speaks to the really important role that we have all played in this pandemic and in ending the pandemic,” Dr. Beers told the group.

“There are real moments of hope, and that feels good,” said AAP CEO/Executive Vice President Mark Del Monte, J.D. “Isn’t it great to think of a future that is different than the place that we’ve been living in for the last year and a half?”

It was the first hybrid board meeting; nearly all members gathered at AAP headquarters, and the proceedings were virtual.

Pandemic issues

More efforts will be required to maximize vaccination of young children, Dr. Beers said. An initial rush of parents seeking to get their children vaccinated could be followed by a decline and leveling-off period.

“The challenge ahead of us is really both in the handling of this initial surge but also to sustain that outreach …” Dr. Beers said. She offered the AAP’s continued support in promoting the safety and efficacy of the vaccine nationally, via chapters and through other local efforts.

In his report, Del Monte recounted the work of the last 22 months to assist members and others in the fight against COVID: critical updates including interim guidance on 27 topics updated every 30 days; 28 town halls viewed by more than 20,000 people; 6,000 email responses to member questions; countless articles and campaigns to reach members and parents; and numerous grants and awards to tackle pandemic issues.

A special call-out acknowledged AAP Research, whose work to track weekly COVID statistics in U.S. children became the standard for both federal government agencies and media reports.

There also has been an unprecedented volume of media coverage of the AAP.

In addition, the AAP partnered with nine states and submitted 14 briefs to defend state and local universal masking policies against lawsuits trying to overturn them.

From the beginning, the AAP lobbied the federal government that primary care needed to be the focus of the rollout of vaccines for children and that plans needed to be in place to protect kids.

“It is hard to overstate the impact of AAP advocacy on every element of this pandemic,” James Baumberger, senior director of federal advocacy, told the board.

Other priorities

Despite the urgency of the pandemic, work on the strategic plan and other child health priorities continues, Del Monte said.

A timeline revealed AAP EDI activities, including related policy statements, internal staff efforts, content offerings on racial justice, continuing education, the Words Matter guidance on inclusive language, the Equity Agenda plus ongoing work of task forces and committees.

The recent emergency declaration on the mental health crisis in children and adolescents also acknowledged the impacts of disparities.

Partnerships with organizations such as the National Medical Association and American Board of Pediatrics seek to broaden EDI activities and encourage leadership diversity.

“We’re really focusing on the pipeline support, mentorship and sponsorship to bring trainees and early career physicians along as leaders of the AAP,” said Wendy S. Davis, M.D., FAAP, chair of the board’s equity committee. “We’ve got a lot of momentum going.”

On the policy front, Dennis Cooley, M.D., FAAP, chair of the board’s policy committee, said efforts are progressing to improve communication, format changes, prioritization of focus areas and timeliness.

Martha C. Middlemist, M.D., FAAP, chair of the board’s strategic planning committee, reported the board continues to discuss implementation of goal #6: Continuously improve AAP member activities in education, advocacy and policy by strengthening the structure and function of committees, councils and sections.

The board is tasked with developing a new strategic plan that will take effect Jan. 1, 2023.
How to help reduce home medication errors that impact children: AAP policy

by Alyson Sulaski Wyckoff • Associate Editor

Errors in the home administration of pediatric medications occur for myriad reasons. Children with chronic conditions and special needs and those who take multiple medications are at greater risk.

Common mistakes involve errors in frequency, formulation, route of administration, preparation, storage and use of expired products. Certain physician prescribing and pharmacy dispensing practices also contribute to errors, especially when instructions are unclear.

A new AAP policy statement offers strategies to prevent such errors. The policy, Preventing Home Medication Errors, from the Council on Quality Improvement and Patient Safety and Committee on Drugs, is available at https://doi.org/10.1542/peds.2021-054666 and is published in the December issue of Pediatrics. It includes a supplement with resources to prevent errors.

Health care professional, pharmacist errors

Physicians and other health care providers contribute to the problem by providing unclear information, using unfamiliar abbreviations or confusing units of measurement, and relying on electronic medical record systems that don’t allow for precise or proper instructions. Problems can proliferate if clinicians don’t review medications at office visits and confirm that parents are giving medications correctly.

Studies show that when pharmacists change the units of measurement on prescriptions, it can confuse parents — especially if the units differ from what was discussed with the clinician. Problems also can occur when pharmacists use a different strength/concentration than one caregiver require multiple medications at different times of the day.

Health literacy

About 21 million U.S. parents are considered to have low health literacy. They may not understand prescription and over-the-counter (OTC) labels, how to use measuring devices, active ingredient information and weight-based dosing.

Parents with limited English proficiency — about 12% of U.S. adults — also are at risk of misunderstanding instructions and making errors. The risk is magnified when caregivers have both low health literacy and limited English.

Other concerns

More than 80% of pediatric home medication errors involve liquid formulations. Many caregivers are not aware that nonstandard kitchen spoons, which vary in size and shape, should not be used to measure doses. The AAP recommends using standard dosing tools to measure liquid medications.

With prescription and OTC products, the policy suggests using only the administration tool provided with the medication.

Another issue concerns units of measurement of liquid medicines. Terms like milliliter, teaspoon and tablespoon — and their abbreviations — can cause confusion.

Errors also can result when children with more than one caregiver require multiple medications at different times of the day.

Recommendations

The following suggested actions are among the guidance in the policy statement:

• Improve communication with parents and caregivers.
  o Simplify medication regimens as much as possible.
  o Use appropriate dosing units (e.g., use “mL” only and avoid spoon-based or nonmetric units).
  o Use only kilograms for child weight.
  o Learn and use health literacy-informed verbal counseling strategies (plain language, pictures/drawings, “teachback-showback” methods) in clinical and pharmacy settings.

• Use only the administration tool provided with the medication.

• Offer verbal counseling in the caregiver’s/patient’s preferred language, using a trained interpreter if necessary.

• Provide written patient education materials appropriate for the literacy level, as well as a printed after-visit summary.

• Confirm parent/patient understanding in cases of higher-risk regimens or for at-risk populations.

• Encourage use of a standardized dosing tool with all liquid medications.

• On all prescriptions, consider including patient weight and indications so pharmacists can double-check the dose.

• Continue to reconcile medications at all relevant patient encounters.

• Access educational modules and resources for safe prescribing practices.

• Promote safe disposal of unused medications.

More than 80% of pediatric home medication errors involve liquid formulations.
Legal environment for gender affirming care varies by state

by Ryan E. Alanzalon, M.D., FAAP

Within the past year, 22 state legislatures and Puerto Rico’s Legislative Assembly have introduced bills seeking to limit a physician’s ability to practice evidence-based medicine by limiting or denying access to gender affirming care for transgender and gender diverse youths (TGD).

Many of these bills share common characteristics, including exposing parents and health care providers of TGD patients to criminal and civil liability, as well as exposing physicians to sanction by their state medical boards. Some will explicitly prevent children from a right to privacy in regard to gender identity.

At press time, only Arkansas has passed a bill into law, which required a legislative override of Gov. Asa Hutchinson’s veto to be enacted.

The American Civil Liberties Union (ACLU) filed a lawsuit (Brandt et al v Rutledge et al) in late May challenging this law (https://bit.ly/3BDdbake), followed by a request for a preliminary injunction in June. The AAP submitted an amici brief (https://bit.ly/3pWkl7H) with 18 other national and state medical, mental health and educational organizations supporting the ACLU’s request for a preliminary injunction.

A federal judge granted a preliminary injunction (https://bit.ly/3GKmApV) on July 21, stopping the law from taking effect. The State of Arkansas has appealed the preliminary injunction, and the case has been referred to the U.S. 8th Circuit Court of Appeals.

Consent and privacy

Many pediatricians are familiar with their local statutes regarding confidentiality and ability to consent without caregiver knowledge or approval. These typically involve care associated with sexual, reproductive and mental health services.

However, many states do not explicitly confirm a minor’s right to consent or confidentiality to receive gender affirming care. This care falls under general medical care. Generally, at least one caregiver’s permission is required for treatment, but that may vary based on requirements of state law or as specified in a custody agreement.


Key points

- Gender affirming care goes beyond hormonal therapies and surgery.
- Minors generally cannot consent and cannot expect privacy when accessing all aspects of gender affirming care.
- Connect with your AAP chapter on state-level advocacy efforts to support TGD youths.
- Contact a local medical-legal partnership to see if legal resources are available.

As a practical example, use of contraception to prevent undesired pregnancy is held to a different standard than use for menstrual suppression secondary to gender dysphoria.

Gender affirming care encompasses an age and developmentally appropriate approach to gender identity involving discussions, determining the presence of gender dysphoria, and nonmedical and medical interventions.

Gender affirming care

It is estimated that at least 1%-2% of pediatric patients identify as TGD. Gender affirming care encompasses an age and developmentally appropriate approach to gender identity involving discussions, determining the presence of gender dysphoria and both nonmedical and medical interventions. Guidance and its evidence basis are clearly articulated in the AAP policy statement and technical report Ensuring Comprehensive Support for Transgender and Gender-Diverse Children and Adolescents. https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for

RESOURCES

- AAP policies and resources to enhance the care of gender diverse youths, https://www.aap.org/en/patient-care/lgbtq-health-and-wellness/
- As part of its Equity Agenda (https://bit.ly/AAPequityagenda), the AAP has identified goals of equipping members with knowledge and skills to address equity, diversity and inclusion.

This month in Pediatrics

The following are published in the December issue of Pediatrics:

**Tuberculosis Infection in Children and Adolescents: Testing and Treatment**

https://doi.org/10.1542/peds.2021-054665

— An AAP clinical report from the Committee on Infectious Diseases (see article on page 12)

**Promoting the Participation of Children and Adolescents With Disabilities in Sports, Recreation and Physical Activity**

https://doi.org/10.1542/peds.2021-054664

— An AAP clinical report from the Council on Children with Disabilities and the Council on Sports Medicine and Fitness (see article on page 13)

**Preventing Home Medication Administration Errors**

https://doi.org/10.1542/peds.2021-054666

— An AAP policy statement from the Council on Quality Improvement and Committee on Drugs (see article on page 10)

Coming in January

**Policy statement**

- COVID-19 Vaccines in Children and Adults

**Clinical report**

- Adolescents and Young Adults: The Pediatrician’s Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis
Report offers recommendations for diagnosis, treatment of tuberculosis infection

by Dawn Nolt, M.D., M.P.H., FAAP

A healthy 7-year-old who was adopted from a tuberculosis (TB)-endemic country has a routine well-child visit. The parents have no concerns about growth or development. The physical exam reveals a well-healed bacillus Calmette-Guérin (BCG) scar in the child’s right deltoid region. A screening tuberculin skin test (TST) shows induration at 8 millimeters (mm).

**Question:** What are the next steps in diagnostic interventions?

**Answer:** TB testing should not be performed in the absence of clinical concern or epidemiologic risks. This TST result likely represents cross-reaction to BCG vaccine. As a follow-up test, an interferon-gamma release assay (IGRA) is recommended, as there is little cross-reactivity with BCG.

A 16-year-old is a household contact of a person with TB disease. The induration of the TST is 20 mm. The physical exam and a two-view chest radiograph are normal.

**Question:** What therapeutic interventions are recommended?

**Answer:** This patient has tuberculosis infection (TBI, formerly called latent TB infection). The purpose of treating TBI is to decrease the risk of progression to disease. The medical practitioner should be aware of several well-tolerated and safe drug regimens for TBI.

TB remains an important problem in the pediatric population, and medical practitioners are faced with questions regarding interpretation of test results and what treatment regimens are safe and effective.

A new AAP clinical report provides updated recommendations for diagnosis and treatment of TBI in children and adolescents. *Tuberculosis Infection in Children and Adolescents: Testing and Treatment*, from the Committee on Infectious Diseases, is available at https://doi.org/10.1542/peds.2021-054663 and is published in the December issue of *Pediatrics*.

**Change in terminology**

A variety of outcomes may occur for an individual who encounters the tuberculosis bacilli. Infection may be followed by rapid progression to symptomatic disease or by immune control of the bacilli; the latter may be lost due to aging or immune-compromising conditions.

Under immune control, the bacilli are viable and not viewed as dormant or latent. Removal of the term “latent” better represents the pathogenesis of tuberculosis and will reduce confusion when discussing treatment goals with patients and families.

The clinical report uses the term tuberculosis infection (TBI) when describing individuals who are infected (as evidenced with a positive TST or IGRA), asymptomatic and have a chest radiograph without findings for active TB disease.

**Testing**

The first part of the report describes the available tests for TB and their interpretation. The TST has been used historically for diagnosis of TB infection and disease. Logistical problems (appropriate placement, interpretation, need for return visit) may make this test undesirable for medical staff, patients and families.

Data and experience in using IGRA’s are increasing, including in children as young as 2 years. Although more expensive than the TST, IGRA’s may be more cost-effective because of time savings and the elimination of many false-positive results. The report describes how medical practitioners can strategize their use in several scenarios, including close investigation of active TB cases, in immunocompromised individuals or in those with a history of BCG vaccination.

**Treatment regimens**

The second part of the report focuses on the rationale for TBI therapy and the available drug regimens. It outlines the factors to consider in treatment selection for a child or adolescent with TBI. Principles of treatment include efficacy against progression to TB disease, safety and completion of the regimen.

The traditional six- to nine-month course of isoniazid (INH) monotherapy has poor real-world adherence given the prolonged length. Rifamycin-containing regimens (e.g., three months of INH and rifapentine, four months of rifampin alone or three months of INH and rifampin) are appealing given their shorter duration and safety and efficacy profiles comparable to INH monotherapy. Rifamycin-containing regimens are preferred for treatment of TBI.

**RESOURCES**

- Tables and a photograph in the clinical report at https://doi.org/10.1542/peds.2021-054663 offer resources on testing and treatment regimens.

**Dr. Nolt is a lead author of the clinical report and a member of the Committee on Infectious Diseases.**

*Scanning electron micrograph of Mycobacterium tuberculosis.*

*Courtesy of the National Institute of Allergy and Infectious Diseases*
Pediatricians can break down barriers to physical activity for children with disabilities

by Paul S. Carbone, M.D., FAAP

Children with disabilities benefit from participation in sports, recreation and physical activity, yet have reduced participation rates, lower fitness levels and a higher prevalence of overweight and obesity compared with typically developing peers. Pediatricians and caregivers may overestimate the risks or overlook the benefits of physical activity, which limits participation.

To address this, an updated AAP clinical report reviews the importance of sports, recreation and physical activity for these children and offers pediatricians suggestions to facilitate participation.


Benefits, barriers to participation

Exercise intervention research on children with disabilities points to benefits such as improvements in aerobic capacity, muscular strength, physical and cognitive function, body weight and composition, social skills, relationships and psychological well-being. Despite these benefits, physical activity often is prioritized below other interventions in treatment planning.

Frequently identified barriers to participation in sports and physical activity are the child’s functional limitations, negative self-perceptions, high cost, lack of nearby or accessible facilities and programs, and lack of providers with adaptive recreation expertise. Additionally, children with disabilities are still, to a large extent, socially segregated and experience negative societal stereotypes and low performance expectations, which limit opportunities for participation in group-based physical activities.

Some children are discouraged from participating by an implicit societal bias that favors competitiveness and winning over participation for the sake of fun, enjoyment and inclusion. When children with disabilities do try to take part in sports, they also are more likely to be bullied by their peers. Pediatricians, other professionals and parents also may overestimate the risk of injury during physical activity, although sports involvement has been shown to be reasonably safe for this population.

What facilitates participation?

To start the conversation about physical activity, pediatricians can ask about activity levels and use tools such as a physical activity vital sign in the electronic health record. Then, they can create “physical activity prescriptions” with goals for participation and referrals to programs or resources based on baseline physical activity, preferred activities and functional limitations.

Children with disabilities can be empowered to take part with a can-do attitude, enjoying the dignity of taking acceptable risk during participation just as individuals without disabilities are allowed to do.

Providers can make referrals to specialized adaptive programs staffed by recreational, physical or occupational therapists that create a safe and fun recreational environment while coordinating with the primary care provider if medical concerns occur.

Providers should be aware of local adaptive recreational programs that address barriers to participation (time, cost, transportation) and share this information with families.

To facilitate physical activity at school, pediatric providers and parents can partner with the educational team to include physical activity goals and progress metrics in a child’s individualized education program (IEP).

Preparticipation evaluation: special concerns

The preparticipation evaluation allows opportunities for families and providers to discuss medical and psychosocial issues relevant for participation in physical activity. Important considerations include the child’s health status and functional ability, demands of the sport, and whether the sport can be modified with protective or adaptive equipment to allow for safer participation. Given the complexity of the preparticipation evaluation, it can occur over several visits, with the primary care medical home obtaining input from the child’s multidisciplinary team.

The goal of the preparticipation evaluation is to review the desired activities of the child and family and disability-specific and co-occurring conditions to provide an appropriate menu of activities and potential accommodations that promote safe participation. The clinical report covers important elements of the history and physical examination during the preparticipation evaluation.

Recommendations

Pediatricians can promote participation of children and adolescents with disabilities in sports, recreation and physical activity in the following ways:

- Assess physical activity levels at all health supervision visits.
- Communicate the physical, behavioral, cognitive and social-emotional benefits of participation in sports, recreation and physical activity to children and their caregivers. Address barriers to participation.
- Encourage parents to be physically active and include their children in family recreational activities.
- Discuss physical activity goals with children and their families. Partner with interdisciplinary team members to develop physical activity prescriptions that can be incorporated in an after-visit summary within the electronic medical record.
- Perform preparticipation evaluations in collaboration with the child, family, pediatric specialists and therapists, leading to opportunities to participate in sports and recreational activities with appropriate adaptation to minimize injury risk.
- Partner with children, parents and educational teams to include physical activity goals and modifications in a student’s IEP and advocate for school-based physical activity programs.
- Be aware of and refer to local school and community-based organizations that offer appropriate physical activity programs and sports.
- Advocate for policies that promote inclusion in sports, recreation and physical activity and for surveillance systems that include children with disabilities to track participation and access.

Dr. Carbone is a lead author of the clinical report. He is a former member of the Council on Children with Disabilities.
Recent findings suggest mild, isolated neutropenia may be transient in asymptomatic children

by Lewis L. Hsu, M.D., Ph.D., FAAP, and Sri Lakshmi Jamalapur, M.D., FAAP

Isolated neutropenia is a laboratory finding in an otherwise healthy child that may raise concern in both general pediatric practice and subspecialty care.

Although there is no clear biologic basis for an absolute neutrophil count (ANC) at or above 1,500 cells/microliter (μL) to be considered normal, counts below this level are labeled “neutropenia” and regarded as a clinically insufficient number of neutrophils for children older than 1 year.

Neutropenia can trigger an extensive clinical evaluation and parental anxiety. Following is a review of recent findings that suggest mild, isolated neutropenia in an otherwise healthy child may be transient and without clinical repercussions.

ANC is calculated as $10 \times (\text{total number of white blood cells}) \times (\% \text{neutrophils} + \% \text{bands})$.

Neutropenia is defined as:

<table>
<thead>
<tr>
<th>Neutropenia</th>
<th>ANC range (cells/μL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>1,000 to &lt;1,500</td>
</tr>
<tr>
<td>Moderate</td>
<td>500 to &lt;1,000</td>
</tr>
<tr>
<td>Severe</td>
<td>200 to &lt;500</td>
</tr>
<tr>
<td>Very Severe</td>
<td>&lt;200</td>
</tr>
</tbody>
</table>

The etiology of neutropenia can be subdivided into congenital and acquired. A number of bone marrow failures encompass congenital neutropenias and often involve severe and very severe levels of neutropenia. These usually are seen in conjunction with other cytopenias or systemic illnesses.

Acquired neutropenia can be secondary to a multitude of etiologies, including infectious, rheumatologic, medication induced, immune deficiencies, malnutrition, acquired marrow failure or malignancies.

A retrospective chart review of 155 children referred to an academic pediatric hematology and oncology clinic for isolated neutropenia found that after one year of follow-up and workup, a specific diagnosis was not identified in 54% of children (Nagalapuram V, et al. Pediatrics. 2020;146:e20193637). The most common etiologies were viral suppression (16%), autoimmune neutropenia (14%) and drug-induced neutropenia (8%). The authors concluded, “Most children referred for isolated neutropenia do not progress in severity and do not require subspecialty interventions or hospitalizations.”

However, neutropenia in the setting of bi- or pancytopenia with systemic illness requires prompt referral to pediatric hematology/oncology as this can have significant clinical implication.

The study further revealed that Black children had 3.5-fold higher odds of having mild, isolated neutropenia lasting more than one year compared to non-Black children. Black children were found to have no illness-related etiology, and the authors attributed their mild, isolated neutropenia to population-based variations.

In light of greater global awareness of racial disparities in medical care, health care providers are encouraged to provide thorough yet appropriate evaluation and care for healthy children with isolated neutropenia in the context of diversity.

In an opinion piece, Lauren E. Merz, M.D. and Maureen M. Achebe, M.D., noted there is a genotype-phenotype correlation between mild, isolated neutropenia and the null phenotype for the red blood cell surface molecule Duffy [Fy(a-b-)] (Merz LE, Achebe M. Blood. 2021;137:13-15). The Duffy null phenotype has been associated with a more attenuated course of malaria and is found in 80% to 100% of individuals with sub-Saharan African ancestry, 50%-70% with Arabic ancestry and less than 1% with European or Asian descent.

Since the function of the neutrophil is no different in people who have Duffy null phenotype compared to others, mild, isolated neutropenia may be considered non-illness-related or a constitutional neutropenia.

**What does this mean?**

These two articles highlight new perspectives on ANC below 1,500 cells/μL and how isolated, mild, asymptomatic neutropenia can be a normal baseline in many children. The terminology of benign ethnic neutropenia, defined as ANC greater than 1,000 cells/μL but less than 1,500 cells/μL in the absence of secondary causes in individuals of African or other descent, as noted above, can be questioned in the context of current discussions about race-based medicine and consider rephrasing as constitutional neutropenia or as normal.

General and subspecialty pediatricians can have a deeper understanding about the definition and clinical relevance of isolated, mild neutropenia in otherwise healthy children regardless of ethnicity. However, it is likely more research is needed to explore the definition, causes and impact of neutropenia.

Pediatricians can draw the following take-home messages from these articles:

- Population-based variations can account for mild, isolated neutropenia in otherwise asymptomatic children. Clinicians must elicit comprehensive histories and clinical exams to evaluate whether patients have any degree of neutropenia that warrants medical observation or intervention.
- Prompt referral to a pediatric hematologist is strongly recommended in a patient with neutropenia in the setting of other cytopenias or systemic illness or with sudden severe or very severe neutropenia.
- Longitudinal comparisons of neutrophil counts for an asymptomatic individual that reveals a baseline ANC of greater than 1,000 cells/μL may be suggestive of constitutional neutropenia when testing for Duffy null genotype or phenotype (Fy a/b) is not feasible.
- Population-based variations suggest a re-evaluation for a more accurate definition of neutropenia than the current neutrophil count thresholds.
Track down SARS-CoV-2 and 18 other bad bugs.


Right now, SARS-CoV-2 is everyone’s top suspect, but many other respiratory bugs can cause similar, overlapping symptoms. Testing for just SARS-CoV-2 or influenza could mean running the risk of missing the real culprit, leading to missed infections, or even coinfections. Additionally, many rapid diagnostic tests sacrifice accuracy for speed, with sensitivities oftentimes ranging from 50–70%.

Now you can test for SARS-CoV-2 in patients suspected of COVID-19, along with 18 common respiratory pathogens with syndromic testing from the BioFire RP2.1-EZ Panel—now available under an FDA Emergency Use Authorization (EUA). Syndromic testing means all it takes is one test and about 45 minutes to round up SARS-CoV-2—and all the other usual respiratory suspects. What’s your frontline solution for respiratory season and beyond?

To learn more, visit biofiredx.com

1. This test has not been FDA cleared or approved. This test has been authorized by FDA under an EUA for use by authorized laboratories. This test has been authorized only for the detection and differentiation of nucleic acid of SARS-CoV-2 from multiple respiratory viral and bacterial organisms. This test is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of in vitro diagnostics for detection and/or diagnosis of COVID-19 under Section 564(b)(1) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 360bbb-3(b)(1), unless the authorization is terminated or revoked sooner. 2. http://www.cdc.gov/flu/professionals/diagnosis/rapidlab.htm 3. For use with the CLIA-waived BioFire® FilmArray® 2.0 EZ configuration. 4. Based on the prospective portion of the clinical study for the BioFire® FilmArray® Respiratory 2 (RP2) Panel. 5. Based on the archived specimen study in the BioFire Respiratory 2.1 (RP2.1) Panel EUA submission. 6. Based on the contrived specimen study in the BioFire Respiratory 2.1 (RP2.1) Panel EUA submission.
AAP study: Most early career pediatricians would choose same subspecialty

Interest in specific diseases along with patient acuity and complexity are the top factors influencing the subspecialty choice of pediatricians in fellowship training, according to findings from the AAP Pediatrician Life and Career Experience Study (PLACES).

Among pediatricians who graduated residency between 2016 and 2018, one-third were in fellowship training in 2019. Within the cohort, pediatricians who identified as being female, having a partner or spouse and being a parent were less likely to be in training. The majority of pediatricians were in fellowships in one of five specialties: neonatology, emergency medicine, hematology/oncology, critical care or endocrinology.

The factors most likely to influence their choice of subspecialty were interest in specific diseases or systems (86%) and patient acuity and complexity (78%) (see figure). Two-thirds of pediatricians reported work-life balance, teaching opportunities, future job opportunities and experiences during residency, such as subspecialty exposure and mentors, were essential or very important in their decisions. The factor least likely to influence their choice was future income expectations.

Men and women prioritized the factors in a similar way. Fellowship trainees with children were more likely than those without children to report work-life balance (77% vs. 65%) and family considerations (70% vs. 39%) as essential or very important.

Ninety percent reported they would choose the same subspecialty if they could start again; 6% reported they would not choose to specialize; and 4% would choose a different subspecialty. Women were less likely than men to report they would choose the same subspecialty (87% and 95%, respectively).

PLACES is an AAP cohort study that tracks the career and life choices and experiences of pediatricians across their careers. Cohorts include pediatricians who graduated residency in 2016–18, 2009–11 and 2002–04. Each cohort has about 900 participants. The Academy is conducting its 10th annual survey of the 2009–11 and 2002–04 cohorts this year. The commitment among pediatricians participating in PLACES has been strong, with eight in 10 completing the survey each year.

AAP holds summit on youth access to sexual, reproductive health services

A virtual summit hosted by the AAP examined barriers youths face in accessing comprehensive sexual and reproductive health services, especially in under-resourced and medically underserved communities. It also explored how pediatricians can support and expand access to comprehensive sex education, contraception and abortion.

More than 50 stakeholders representing youths, pediatricians, obstetricians and gynecologists, public health professionals, reproductive rights advocates and community organizations attended the three-day summit. Stakeholders included those who could speak to inequities and disparities in access to sexual and reproductive health services and strategies to promote health equity.

Following are key findings from an early analysis of the summit:

• Access to sexual and reproductive health services is a critical component of adolescent health. These services should be medically accurate and culturally appropriate; provided to all youths without discrimination; and accessible without physical, geographic or economic barriers.

• Health equity is a critical component of supporting and expanding youth access to sexual and reproductive health services.

• Bans and limitations on access to comprehensive sex education, contraception and legal abortion impact adolescent health, well-being and resilience. These bans also impact children, families and health care providers.

• Strategies to support and expand access to sexual and reproductive health services should include resources and clinician education.

• Access to sexual and reproductive health care is a complex issue that requires collaboration among medical experts, community leaders and youths.

• The AAP is a critical leader on this issue, with the support of its 67,000 members.

Summit proceedings continue to be examined. Findings will be used to develop a resource that will include strategies to engage key stakeholders in protecting equitable access to reproductive care and steps to support access to care in clinical and community settings. The resource will include a focus on communities that face additional barriers when accessing this care.
Keep babies safe while in carriers, slings

Many parents use slings, wraps and carriers to keep their babies close and calm while doing chores or running errands. Moms and dads should make sure the wearable device fits well and their baby is safe.

A recent study estimated that 14,000 young children went to the emergency room from 2011-20 after they were injured when they fell out of carriers or a caregiver fell while wearing one. Most of the babies had head injuries. Some had broken bones or cuts. About 15% were admitted to the hospital.

Following are guidelines from the American Academy of Pediatrics to keep you and your baby safe and comfortable while using carriers.

- Do not put infants who were born prematurely or with respiratory problems in backpacks or other upright positioning devices because it may be hard for them to breathe.
- When using a sling, make sure the baby’s body does not curl into a C shape, which may cause breathing problems. Instead, the baby’s neck should be straight and the head above the fabric.
- Check frequently to make sure you can see your baby’s face and fabric is not blocking the baby’s mouth or nose.
- Make sure the carrier is the right size for your child and is made of sturdy material. It should support the back, and the baby should not be able to slip through the leg holes.
- Aluminum frames on backpacks should be padded so babies won’t be hurt if they bump against the frame.
- Check carriers and backpacks often to make sure seams and fasteners are not ripped.
- Bend at your knees if you need to pick something up while wearing a carrier. If you bend at the waist, the baby could fall out of the carrier, and you could hurt your back.
- Use the device’s restraining straps so your child doesn’t fall out, and make sure the baby is seated before you walk.

— Carla Kemp

Take awkward off the table

Not every patient feels comfortable disclosing their sexual activity. An opt-out approach makes the conversation easier.

As providers, you know that STIs are on the rise and can happen to anyone. Not everyone is as aware of the risks, and up to 84% of chlamydia and gonorrhea infections are asymptomatic. The CDC now recommends considering an opt-out approach for young women under 25. Universal screening is an inclusive solution that is proven to decrease STI prevalence, infertility issues and cost. Let’s help protect her reproductive health today, and tomorrow.

Learn more at


ABS-03385-201 Rev 001 © 2021 Hologic, Inc. All rights reserved. Hologic and associated logos are trademarks and/or registered trademarks of Hologic, Inc. and its subsidiaries in the United States and/or other countries.

Get Social:
Follow AAP News on
Facebook  facebook.com/aapnews
Twitter  twitter.com/aapnews

Aptima Combo 2®
Assay for CT/NG
Lower blood lead reference level doesn’t change clinical management

by Jennifer A. Sample, M.D., FAAP, and Lauren Zajac, M.D., M.P.H., FAAP

The Centers for Disease Control and Prevention (CDC) announced that it is lowering the blood lead reference level from 5 micrograms/deciliter (mcg/dL) to 3.5 mcg/dL. However, the new reference level does not significantly change clinical management.

Since 2012, the term “reference level” has been used to describe the level that represents the 97.5th percentile for blood lead concentrations in preschool children based on National Health and Nutrition Examination Survey (NHANES) data. A confirmed lead level at or above 3.5 mcg/dL is found in 2.5% of children ages 1-5 years.

The reference level is a statistical definition that is helpful for surveillance purposes and to prioritize public health interventions. However, it is not intended to stratify risk or present a level at which any specific intervention is required. In fact, many laboratories and point-of-care tests may not be able to accurately provide a result below 5 mcg/dL.

Therefore, the message is still the same: No level of lead exposure or blood lead level (BLL) is safe, and even low levels can impact neurodevelopment.

The AAP offers the following interpretation of the effect of lowering the reference level.

<3.5 mcg/dL

A blood lead below this reference level is found in 97.5% of children ages 1-5 years, according to NHANES data. However, no level of lead should be considered acceptable. The clinician may need to reassess the child’s environment in the future. The child may need to be retested depending on age or other factors.

≥3.5-5 mcg/dL

This result may be within the variability of the test and presents uncertainty as to the accuracy of the result. Clinicians should retest to establish a trend.

Clinicians also should discuss possible sources of lead exposure, consider an assessment of the child’s environment through local lead programs and/or public health departments, and follow state and local health department guidelines for public health intervention.

≥5 mcg/dL

The clinician should discuss possible sources of lead exposure, consider an assessment of the child’s environment and retest to establish a trend. Clinical management for these children is not changed by the lowered blood lead reference level.

Disparities in BLLs

The updated reference level indicates that we are doing a better job at removing lead from the environment and keeping children safe. However, low-income and minority communities experience a prevalence of elevated BLL in children at rates higher than the national average.

Black children are two times more likely to have elevated BLLs as White children (https://www.cdc.gov/mmwr/volumes/65/wr/mm6539a9.htm), which is partly attributed to racist housing policies. This reinforces the need for pediatricians to continue discussing with high-risk families the dangers of lead and where it may lie as well as address structural drivers of health disparities.

Guidance for pediatricians

The AAP Council on Environmental Health and Climate Change offers the following guidance for pediatric practitioners to protect all children from the adverse effects of lead:

• Cooperate with state and local health departments’ suggestions regarding which children require blood lead testing (some statutes may use the terminology “screening”), at what ages such testing should occur, which initial BLLs should be confirmed and within what time span confirmation should occur.
• Comply with Medicaid and CDC policies on lead testing.
• Encourage families who have a child with an elevated BLL to provide a diet rich in calcium and iron as well as an enriched environment in which to learn. While it is theorized that all levels of lead cause neurodevelopmental problems, not every child with an elevated BLL will have neurodevelopmental delay.
• Consult your local Pediatric Environmental Health Specialty Unit for additional guidance when needed (https://www.pehsu.net/Lead_Expose.html).

Finally, the AAP urges commercial and state laboratories to assess and improve precision in all technical aspects of testing blood for lead concentration. This not only provides better surveillance at the community, state and national levels, but also helps clinicians better care for their patients with lead exposures.

Dr. Sample Dr. Zajac

is immediate past chair and Dr. Zajac is a member of the AAP Council on Environmental Health and Climate Change Executive Committee.

RESOURCES

• Information on management of childhood lead exposure from Pediatric Environmental Health Specialty Units, https://www.pehsu.net/Lead_Exposure.html
A NUTRITION SUPPORT WEB PORTAL, DESIGNED EXCLUSIVELY FOR HEALTHCARE PROFESSIONALS, WITH CONTENT TAILORED TO YOUR PRACTICE

- **Science-based nutrition** resources and clinical research
- **Detailed nutrient profiles** and real-time product information
- **Easy access** to patient education and valuable resources
- **Send samples** directly to your patients with ease

NEW! PediatricPROCONNECT.com

Scan QR code to register

Visit PediatricPROCONNECT.com
New ICD-10-CM codes support resource utilization for newborns with concerns

from the AAP Division of Health Care Finance

Among the new International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes released in October are several that can be used to report newborn concerns. The new codes support additional services provided to babies whose mother has a condition or when newborn screening results are abnormal, even if the baby has no signs or symptoms. The codes also allow support of resource utilization and long-term tracking.

Vignette: Newborn affected by positive maternal group B strep

A pediatrician provides initial care to a baby who was born vaginally at 38 weeks' gestation. The mother tested positive for group B streptococcus with rupture of membranes for 12 hours. The highest laboring temperature was 100.3 degrees Fahrenheit. The mother received one dose of penicillin G intrapartum prophylaxis less than two hours prior to delivery. The baby is asymptomatic at birth and has normal vital signs. The pediatrician orders a blood culture but otherwise anticipates routine newborn care with an inpatient stay of 48 hours.

The ICD-10-CM codes reported for the baby are Z38.00, Single liveborn infant, delivered vaginally and P00.82, Newborn affected by (positive) maternal group B streptococcus (GBS) colonization.

**Abnormal findings on neonatal screening vignettes**

- Due to an abnormal phenylketonuria (PKU) screening result as part of the state panel, confirmatory plasma amino acids are obtained to evaluate for PKU. The patient is asymptomatic, and the results are normal. Report code P09.1 Abnormal findings on neonatal screening for inborn errors of metabolism.
- After an abnormal newborn screen suggests congenital adrenal hyperplasia, a 2-day-old baby is referred for follow-up testing of 17-OH progesterone. The test is normal. Report code P09.2 Abnormal findings on neonatal screening for congenital endocrine disease.
- A newborn with a family history of sickle cell disease has a positive screen. The baby is referred for further diagnostic hemoglobin electrophoresis. All tests are normal. Report code P09.3 Abnormal findings on neonatal screening for congenital hematologic disorders. You also could add code Z83.2 Family history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism.
- A newborn's state screening test comes back abnormal for cystic fibrosis. The baby is referred for a diagnostic sweat test, which is normal. Report code P09.4 Abnormal findings on neonatal screening for cystic fibrosis.
- An asymptomatic newborn fails the pulse oximetry screening for congenital cardiac disease. This baby is referred for an echocardiography. The results are normal. Report code P09.5 Abnormal findings on neonatal screening for critical congenital heart disease.
- A newborn failed two auditory brainstem evoked response screening tests in the hospital. After discharge, the patient is sent for further diagnostic testing to determine if there is hearing loss. Report code P09.6 Abnormal findings on neonatal screening for neonatal hearing loss. Do not report Z01.110 Encounter for hearing examination following failed hearing screening.
- If any of the above newborns were symptomatic and also had an abnormal screen, the abnormal symptom would be reported first followed by the abnormal screen.
Listen to the science behind child health

Subscribe to the podcast today!

Tune in weekly to Drs Joanna Parga-Belinkie and David Hill discussing hot topics with the leading experts in pediatric medicine.

For more information, visit aap.org/podcast
Refill your ‘well’ so you can continue caring for others

by Fan Tait, M.D., FAAP

“People can do the most amazing things under the most challenging conditions as long as we have the right reasons.”

— Valerie Davidson, president, Alaska Native Tribal Health Consortium

Few events have epitomized this perspective more than the COVID-19 pandemic. Since March 2020, pediatricians everywhere have “leaned in” more than ever to care for families, advocate for children and combat health misinformation. Many pediatricians are exhausted from the politicization of medical expertise and scientific information, some even experiencing threats to their own health and safety. But these challenges also have demonstrated our strength as a pillar for children and their families.

“Pediatricians are there because they want to take the best possible care of kids and families they serve. When societal divisiveness starts to interfere with that, it makes it hard.”

— AAP President Lee Savio Beers, M.D., FAAP

More than ever, I can see the meaning and joy in the practice of pediatrics. Our collective passion and commitment are what support children and families and, in many ways, move this country. I have never been prouder to be a pediatrician nor have I never been more of an advocate for pediatricians caring for themselves and our colleagues.

“Self-care is not selfish. It is actually one of the greatest gifts we give ourselves and others because we cannot give from an empty well.”

— Michelle Maldonado, founder and CEO of Lucencia

Pediatricians care for children, families and communities but often not themselves. It is time we give ourselves and each other permission to fill our “well.” The more we search for and demand well-being in our professional and personal lives, the more we will find it.

The Institute for Healthcare Improvement (IHI) offers ideas for small changes individuals and leaders can make through its “Psychological PPE”. Promote Health Care Workforce Mental Health and Well-Being white paper.

As individuals:
• Create space between work and home.

Long hours without time off can contribute to job dissatisfaction, distress, fatigue and burnout. Consider strategies to create space between your work and home such as a mindfulness exercise at the end of each shift. Acknowledge what went well that day and decide what you want to let go.
• Avoid publicity and media. Several studies have demonstrated that watching negative media coverage of events can cause stress and anxiety. It can be helpful to turn off our phones, TVs and other media outlets to give ourselves a break.
• Seek mental health support. Almost everyone will struggle with emotional health, including burnout, exhaustion, compassion fatigue and/or depression during their lives. One of the most important changes we can make as physicians is to change the culture of medicine to destigmatize mental well-being. The Physician Support Line (https://www.physiciansupportline.com/) offers support to physicians struggling with physical or mental illness.
• Facilitate opportunities to show gratitude.
• Reframe negative experiences as positive.
Positive Psychology offers worksheets and tips to change our automatic negative thoughts, https://bit.ly/3CTx83K.

As leaders:
• Limit staff time on site/shift. A variety of strategies exist to limit staff time and create supports during clinical hours. Examples such as flexible scheduling, cross training staff and building float teams can help ease the workload. The American Medical Association (AMA) offers a resource on workload distribution, https://bit.ly/3wriIpe.
• Design clear roles and leadership.
• Train others to be aware of risk factors and signs of distress. The National Alliance on Mental Illness offers resources on identifying common signs of mental distress, https://bit.ly/3BP4Vdd.
• Pair workers to serve as peer support in a buddy system. Support for each other is a key component of pediatrician well-being. The AMA offers resources on building peer support programs, https://bit.ly/2PSM6TS. I also encourage you to utilize AAP networks through committee, section and/or council email lists. We must continue to build hope in ourselves and one another in this time of uncertainty. I hope pediatricians seek opportunities to thrive in medicine, opportunities that allow us to care for ourselves. I hope we all learn that needing and accepting help are not signs of weakness. I hope we reach out to each other offering support. I hope we maintain our strength as a pillar for children and their families.

I have seen pediatricians do the most amazing things under these challenging conditions because you have the right reasons. Providing ourselves the quality of care we demand for our patients is one of the right reasons.

RESOURCES

• “Psychological PPE”: Promote Health Care Workforce Mental Health and Well-Being white paper from the IHI, https://bit.ly/3G75UMW
• 12-minute guided meditation by Michelle Maldonado, https://bit.ly/3ErZt9hB
• Resources on health professional well-being from the Federation of State Physician Health Programs, https://bit.ly/3qaQrBV
• Physician Support Line: 888-409-0141

Dr. Tait is AAP chief medical officer.
AAP Publications—
the new home for Journals,
News, Point-of-Care Solutions,
and Books—offers unparalleled
innovation and streamlined
access to essential pediatric titles.

Tour and bookmark the
new AAP Publications site
at publications.aap.org.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
Equity, diversity and inclusion (EDI) is one of the top chapter activities this year, according to an AAP survey of chapter presidents and executive directors.

Every three years, the AAP conducts a needs assessment of all 66 chapters to identify trends in chapter activities and operations, evaluate services provided by the national office and demonstrate alignment between national and chapter priorities. The needs assessment also asks chapters to identify their top 10 activities. The AAP uses the information in strategic planning and to develop educational programming.

The 2021 needs assessment was the ninth survey conducted by the AAP. Advocacy for children, continuing medical education, public health initiatives and advocacy for pediatrics were the top four activities this year as well as in 2018 (see chart). For the first time, EDI made the list of top chapter activities.

The New Jersey Chapter’s EDI efforts exemplify innovative work being done by chapters. The chapter’s Board of Trustees created a Diversity, Equity and Inclusion (DEI) Committee last year. The committee recommended surveying the membership to explore opportunities to be more intentional about diversity, equity and inclusion in chapter policies, programs and events.

The results revealed a need to take a holistic approach to integrating DEI principles throughout the organization. In response, the committee recommended creating a board position with voting rights that would serve on the Executive Committee, lead efforts and infuse diversity, equity and inclusion throughout all chapter operations. The creation of the new position required a change to the chapter bylaws, which was approved overwhelmingly by the board and membership.

Tiffany T. Tucker, M.D., M.H.S., FAAP, is the chapter’s diversity, equity and inclusion officer. In addition to serving on the Executive Committee, she is chair of the DEI Committee, a member of the Nominating Committee and a member of the Pediatric Council on Research and Education Executive Advisory Council.

Transgender teens share perspectives on health care needs during listening session

The Food and Drug Administration (FDA) recently held a listening session with transgender adolescents to learn about their health care challenges and unmet medical needs.

The small, nonpublic meeting was part of the FDA’s Patient Listening Session program, which allows the agency to hear patient and caregiver perspectives on living with diseases and conditions, perceptions of risk tolerance and unmet medical needs, and preferences related to clinical trial participation.

The adolescents also discussed their experiences with mental health concerns, gender dysphoria, challenges accessing gender-affirming medical care, the need for age-appropriate educational resources for gender-affirming care and barriers to accessing health care due to state laws and discrimination.

The listening sessions are among the ways the FDA includes the voices of patient communities in medical product development and the regulatory process, particularly communities that have been historically underrepresented.

Adolescents’ perspectives on transgender health are important, as many transgender teens begin hormone therapies and hormone-blocking therapies around puberty.

During the listening session, adolescents ages 13 to 17 years said the most important outcome is for their body (gender presentation) to match their internal identity. In discussing benefit-risk tradeoffs related to medical transition, adolescents described a willingness to accept risks associated with surgeries and treatments to achieve their goals related to gender transition and presentation.

The adolescents also discussed their experiences with mental health concerns, gender dysphoria, challenges accessing gender-affirming medical care, the need for age-appropriate educational resources for gender-affirming care and barriers to accessing health care due to state laws and discrimination.

This was the first listening session that included only adolescent participants. Therefore, the FDA addressed privacy concerns by seeking parental consent for minor participation. It also took care to use gender-affirming language and age-appropriate communications.

The Patient Listening Session program is managed by the Office of Patient Affairs in the Office of the Commissioner. The Office of Patient Affairs hopes to continue to bring patient voices to the FDA, including those of youths in underrepresented populations.

The FDA’s Office of Pediatric Therapeutics (OPT), Office of Patient Affairs (OPA), Division of Pediatric and Maternal Health (DPMH) and Division of Urology, Obstetrics and Gynecology (DUOG) contributed to this article. OPT and OPA reside in the Office of Clinical Policy and Programs in the Office of the Commissioner. DPMH and DUOG reside in the Office of Rare Diseases, Pediatrics, Urologic and Reproductive Medicine within the Office of New Drugs in the Center for Drug Evaluation and Research.
Does your child have a cold or respiratory syncytial virus infection?

Many children catch colds or get the flu during the fall and winter. Another illness that is common from late fall through early spring is respiratory syncytial virus infection or RSV.

The virus can spread from one person to another, and you can get it by touching unclean surfaces. Almost all children get RSV by their second birthday.

Most children with RSV have symptoms similar to a cold such as fever, cough, congestion, sneezing, runny nose, fussiness and poor feeding. They usually get better in a week or two.

Other infants and young children get very sick. About 100 to 500 U.S. children under 5 years old die each year because of RSV, according to the Centers for Disease Control and Prevention. About 58,000 children with RSV go to the hospital because they are having trouble breathing or are dehydrated.

How do you know if your child is having trouble breathing? Watch the child’s rib cage as he or she breathes in. If the rib cage caves in and forms an upside-down “V” shape under the neck, then the child is working too hard to breathe.

Call your doctor right away if your child is having trouble breathing or has any of the following symptoms:

- fast breathing,
- flaring of the nostrils,
- head bobbing with breathing,
- rhythmic grunting during breathing,
- wheezing (a high-pitched purring or whistling sound),
- dehydration (fewer than one wet diaper every eight hours),
- gray or blue tongue, lips or skin, or decreased activity and alertness.

There are no medicines to treat RSV, but here are some things you can do to help your child feel better:

- Use nasal saline with gentle suctioning and a cool-mist humidifier to help your child breathe.
- Make sure your child gets enough fluids and eats frequently. Breastfed babies do not need formula or water. If your child is older than 6 months, you can give acetaminophen or ibuprofen to reduce low-grade fever. Do not give aspirin or cough and cold medications.
- There is a medication called palivizumab that can help prevent severe illness in some infants, including those who were born prematurely and those with heart defects or weak immune systems. Your pediatrician will let you know if your baby can get the medication.

For more information on RSV, visit https://bit.ly/3k1X3iv.

— Carla Kemp

NOWS the time to access the care and resources of the American Academy of Pediatrics. And more than ever, your role as a thoughtful, understanding health expert supporting a family through recovery is essential for the development of the infant. Visit aap.org/nows
A look back at how the AAP helped jump-start early polio vaccination efforts

by Alyson Sulaski Wyckoff • Associate Editor

Did you know?

During the polio vaccination effort in 1953–65, the AAP played a major role in helping to ensure the nation’s children and their parents became vaccinated against the deadly disease.

As with the COVID-19 vaccine today, the Academy faced hesitancy and inertia on the part of the public. Education, organization and persistence helped overcome the main challenges.

Over time, AAP experts, including members of the then-Committee on Control of Infectious Diseases, were called to fill various roles. They weighed in on vaccine recommendations, findings and distribution.

When immunization progress slowed around 1958, AAP leaders turned to members and local leaders for help. “The Central Office will offer every assistance, but you locally are the only ones who can get the job done,” said then-AAP President Stewart H. Clifford, M.D., FAAP.

He said the Academy “is dedicated to promote the welfare of all children, not just the fortunate ones who are the patients of its members. In all probability … nearly half of the vulnerable children in your community are not being protected.”

The AAP News-Letter, predecessor to AAP News, provided members with guidance, encouragement and the latest news on the vaccine.

Vaccine development

AAP leaders offered members’ support and assistance to the National Foundation for Infantile Paralysis (NFID), later renamed the March of Dimes. In the late 1940s, the NFIP helped fund development of the polio vaccine by Jonas Salk, M.D. (hon. FAAP).

In 1953, the AAP invited Dr. Salk to speak at the annual meeting about development of the vaccine.

In 1958, about 20,000 physicians took part in field trials, according to the AAP News-Letter. In April of the following year, Thomas Francis Jr., M.D., director of the Poliomyelitis Vaccine Center in Ann Arbor, Mich., declared that Dr. Salk’s trivalent vaccine was 60%-90% effective in preventing paralytic poliomyelitis in the 6- to 9-year-olds being tested. That age range was considered most susceptible.

Supply, distribution challenges

In April 1955, NFIP funding allowed the vaccine to be distributed at no cost to first and second graders.

Soon after, however, the vaccine program was stopped temporarily when it was discovered that some lots of the vaccine unintentionally included live virus, resulting in 40,000 cases of polio. Two hundred children had varying degrees of paralysis and 10 died. The “Cutter incident” was named after the Cutter Lab where this occurred.

After vaccination resumed, supply and distribution problems surfaced.

The NFIP initially bought 99% of the vaccine supply to provide free vaccination for school-age children, distributing vaccines to state health departments. Some pediatricians complained about their states’ distribution of the vaccine.

When the supply was gone, the NFIP considered its program to be completed.

Appeal to improve vaccination rates

Vaccination clinics were held in school buildings with the help of volunteers, including physicians, nurses and public health workers. By 1957, the American Medical Association headed an advisory committee that included AAP members and resolved to have physicians administer the vaccines.

In his April 1958 report to the executive board, Dr. Clifford appealed to fellow leaders to improve the polio vaccination rate. He lamented that up to 40% of the 20 million preschoolers still were not immunized.

“… Here is an age group that is highly vulnerable and won’t be immunized until they get to school,” he wrote. “What can we as the Academy do to stimulate immunization in this particular age group? I don’t know the answer, but I know we have a responsibility.”

In response, the AAP Committee on Polio Vaccine for Pre-School Children and Toddlers was created. It recommended that President Clifford release an appeal to members, which appeared on page 1 of the AAP News-Letter. The headline of the May 1958 publication read: “Urgent Message From the President — Polio Immunization of Pre-School Children.” He called on AAP district and state leaders to alert county medical societies and local groups to spread the word, in their own way, and with “the ingenuity of the Academy Fellow or Fellows in their hometown.”

Rise in vaccine campaigns

Chapters and individual pediatricians launched local campaigns. Signs were placed in hospital clinics. Newspaper ads offered free vaccinations at local fire stations. There were radio and television campaigns. The AAP Florida and Delaware chapters were championed as having especially effective campaigns.

In 1960, records showed that polio was more prevalent in “unvaccinated islands.” The disease was concentrated in low-income urban and rural areas but also existed in pockets of well-vaccinated communities. There was concern that the threat of polio epidemics remained. It was decided that the vaccine would be taken to these areas instead of expecting families to travel for vaccination.

The surgeon general’s office started a vaccine campaign for “babies and breadwinners.” In 1965, 10 years after the introduction of polio vaccines, the infectious diseases committee released a statement touting a 99.75% reduction in paralytic disease.

In 1969 and ‘70, the AAP launched public service announcements on radio and television. The messages ended with: “This announcement is brought to you as a public service by the American Academy of Pediatrics.”

AAP archivist Allison Seagram, M.L.I.S., C.A., contributed the research for this article.
New MIS-C materials from CDC

The Centers for Disease Control and Prevention has new materials on multisystem inflammatory syndrome in children (MIS-C) that health care professionals can share with parents and caregivers.

MIS-C is a rare, delayed immune response related to COVID-19. Symptoms are likely to appear within six weeks after a SARS-CoV-2 infection and include ongoing fever, abdominal pain, vomiting, diarrhea, skin rash, bloodshot eyes and dizziness.

Materials include How to Recognize MIS-C, What Parents Need to Know about MIS-C and What Parents Need to Know After Diagnosis of MIS-C. They are free to download and can be posted in offices or given to families.


Developmental surveillance resources

A new AAP resource can help pediatricians when conducting developmental surveillance.

Recent interviews with pediatricians showed they have challenges conducting risk, strength and protective factors assessments, which should occur at every health supervision visit as outlined in the AAP clinical report Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening. Identifying Strengths, Risks, and Protective Factors Resource Guide offers supports and strategies as well as questions pediatricians can ask during health supervision visits. It is available at https://bit.ly/3aDb0ya.

Also available is the Family Friendly Referral Guide to support families and caregivers whose child has a developmental concern. Pediatric practices can customize the guide with local referral resources. The guide also illustrates the importance of following through with developmental referrals. Visit https://bit.ly/3BNmACP.

CATCH call for proposals

The Community Access To Child Health (CATCH) program is accepting grant proposals from pediatricians and pediatric residents who have innovative ideas to plan or implement initiatives that address critical child health issues in their communities.

Pediatricians and residents in U.S., Puerto Rico and Canadian AAP chapters can apply for grants up to $10,000 and $2,000, respectively.

CATCH resident grant guidelines include targeted funding opportunities on more than 10 topics, including oral health, community pediatrics, environmental health, developmental and behavioral pediatrics, emergency medicine, school health, obesity prevention and child abuse/neglect. Find details at https://downloads.aap.org/AAP/PDF/catchresidentcall.pdf.

Find details on CATCH planning and implementation grants for pediatrics at https://downloads.aap.org/AAP/PDF/catchplanningcall.pdf.

The deadline to apply is Jan. 24, 2022. Applicants will receive email notice of funding decisions by April 15, 2022. Grantees start their 12-month projects on June 1, 2022.

For assistance, contact your chapter CATCH facilitator (https://bit.ly/3s896xM), district resident CATCH liaison (https://bit.ly/3JB9YI6) or email catch@aap.org. For more information on the CATCH program, visit https://www.aap.org/CATCH.

Vaccine video series

The AAP is launching a video series that will answer common questions parents ask pediatricians about their children’s immunizations.

The series will include more than 30 videos featuring straightforward, friendly advice from practicing pediatricians who talk with parents every day about childhood and adolescent immunizations. Some of the questions they will address are why vaccines are recommended at certain ages, what side effects to anticipate and how to reduce the pain of shots.

The AAP recently conducted research in partnership with the FrameWorks Institute into how to improve public understanding and acceptance of vaccines, and used this research to inform its approach to the video series.

The videos will be part of a library of content for parents on child and adolescent health offered on social media platforms like YouTube, in print publications and on HealthyChildren.org.


Early career physician leadership projects

Posters presented by 22 graduates of the Young Physicians Leadership Alliance (YPLA) are available for viewing at https://collaborate.aap.org/ECLP/Pages/default.aspx (login required). Topics include family-centered rounds, advocacy, immigrant health, adverse childhood experiences, COVID-19 and more.

YPLA, a two-year training program presented by the AAP Section on Early Career Physicians, aims to develop leadership skills and a network of early career pediatric leaders. YPLA participants complete an independent leadership project that allows them to put their skills into practice. They presented posters on their projects at the 8th annual YPLA poster symposium.
AAP Chief Medical Officer Dr. Tait announces retirement

After 16 years at the Academy, Chief Medical Officer/Senior Vice President V. Fan Tait, M.D., FAAP, will retire Dec. 31.

A national child health expert and pediatric neurologist, Dr. Tait has made her mark on a range of AAP initiatives, including many strategic priorities.

She has overseen activities related to the medical home, early brain and child development, disaster preparedness, children with special needs, toxic stress and resilience, injury prevention and healthy childhood weight. More recent efforts have focused on physician wellness and equity, diversity and inclusion.

Dr. Tait, who has won awards for mentorship, also has served on numerous national and state advisory committees and groups.

She worked with the Maternal and Child Health Bureau on programs such as Bright Futures, the National Center for Medical Home Implementation, the National Center for Early Childhood Health and Wellness and the National Coordinating Center on Epilepsy.

Dr. Tait is widely known for her friendly, collegial manner and passion for child health. She joined the AAP in 2005 to head what was then the Department of Community and Specialty Pediatrics and later, the Department of Child Health and Wellness. She also has served as associate executive director.

Earlier roles included director of the Bureau of Children with Special Health Care Needs at the Utah Department of Health, president of the AAP Utah Chapter and clinical associate professor of pediatrics at the University of Utah Health Sciences Center.

“Fan has been one of our greatest advocates, changemakers and vision keepers,” said AAP CEO/Executive Vice President Mark Del Monte, J.D.

“The impact she has made on the AAP is vast … and her legacy will be enduring.”

Shari L. Barkin, M.D., M.S.H.S., FAAP, of Brentwood, Tenn., is among new members elected to the National Academy of Medicine.

Dr. Barkin was selected for “pioneering pragmatic and randomized controlled trials in community settings, undertaken in collaboration with parents and community partners, and addressing health disparities in pediatric obesity.”

She is the William K. Warren Endowed Chair and professor of pediatrics at Vanderbilt University Medical Center, where she also is chief of the Division of General Pediatrics.

Susan B. Bostwick, M.D., M.B.A., FAAP, of New York, is serving in the new role of associate dean of affiliations at Weill Cornell Medicine. She is a liaison between Weill Cornell and its affiliated network of health care systems and academic medical centers across the country.

A professor of clinical medicine, Dr. Bostwick is division chief of general academic pediatrics.

Mary L. Brandt, M.D., M.Div., FACS, FAAP, of New Orleans, received the 2021 Olga Jonasson Distinguished Member Award from the Association of Women Surgeons Foundation. The award recognizes a member who enables and encourages female surgeons to realize their personal and professional goals.

Dr. Brandt is professor of surgery and pediatrics at Tulane University School of Medicine.

Kristina H. Deeter, M.D., M.B.A., FAAP, of Reno, Nev., is the new vice chair of pediatrics at University of Nevada, Reno School of Medicine and associate physician-in-chief of Renown Children’s Hospital.

Dr. Deeter was head of the hospital’s pediatric critical care department.

Sidney M. Gospe Jr., M.D., Ph.D., FAAP, of Durham, N.C., received the 2021 Roger and Mary Brumback Lifetime Achievement Award from the Child Neurology Society. He was recognized for commitment to child neurology, patient care and humanism in medicine.

Dr. Gospe is professor emeritus of neurology and pediatrics at the University of Washington and adjunct professor of pediatrics at Duke University.

Elizabeth B. Lange, M.D., FAAP, of Exeter, R.I., is the new president of the Rhode Island Medical Society.

She is a member of the board and former president of the AAP Rhode Island Chapter.

Joseph Lopreiato, M.D., M.P.H., FAAP, of Potomac, Md., was named a fellow of the Society for Simulation in Healthcare in recognition of his contributions to the field of health care simulation.

A retired Navy captain, he is associate dean for simulation education at the Uniformed Services University of the Health Sciences in Bethesda, Md.

Julie Morita, M.D., FAAP, of Princeton, N.J., is among newly appointed experts on the re-established Advisory Committee to the Director (ACD) of the Centers for Disease Control and Prevention (CDC). The ACD advises the CDC director and the assistant secretary for health on policy and strategies. Formed in 1962, the committee was discontinued in 2019.

Dr. Morita is executive vice president of the Robert Wood Johnson Foundation.

Richard J. Whitley, M.D., FAAP, of Birmingham, Ala., will receive the 2022 John Howland Award from the American Pediatric Society during the 2022 Pediatric Academic Societies meeting April 21-25 in Denver.

The award, the group’s highest honor, recognizes Dr. Whitley for his significant contributions to advancing child health and the profession of pediatrics.

An expert on antiviral therapies, Dr. Whitley is professor of pediatrics, vice chair of the pediatrics department and co-division director of pediatric infectious diseases at the University of Alabama at Birmingham School of Medicine. He also is Loeb Eminent Scholar Chair in Pediatrics; professor of microbiology, medicine and neurosurgery; senior scientist in the gene therapy department; and co-founder and co-director, Alabama Drug Discovery Alliance.

Mary Lynn Zupanc, M.D., FAAP, of Orange, Calif., received the Arnold P. Gold Foundation Humanism in Medicine Award from the Child Neurology Society. Dr. Zupanc is co-medical director of Children’s Health of Orange County Neuroscience Institute and professor of pediatrics and neurology at University of California, Irvine. She is board certified in pediatrics, neurology, neurophysiology and epilepsy.
Section on Pediatric Trainees issues new awards

The AAP Section on Pediatric Trainees announced the following inaugural 2021 awards:

**Advancement in Research Award:** Shannon Baumer-Mouradian, M.D., FAAP

**Excellence in Education Award:** Elizabeth Donner, M.D., FAAP, and Shakun Gupta, M.D., FAAP

**Leadership in Advocacy Award:** Y-HEALAR (Yale Health and Literacy for Asylees and Refugees) at Yale School of Medicine

To make a gift in memory of a colleague, visit donate.aap.org or email the AAP Development Office at development@aap.org.

In Memoriam

- **Eric M. Dreyfuss, M.D., FAAP,** of Miami, died June 23 at age 90.
- **John W. Gallup, M.D., FAAP,** of Salisbury, Conn., died Sept. 20 at age 91.
- **William G. Gottfried, M.D.,** of Orinda, Calif., died Sept. 29 at age 85.
- **George J. Peckham, M.D., M.S.,** of Villanova, Pa., died Oct. 7 at age 82. He was a pioneer in the establishment of the Neonatal Resuscitation Program (https://bit.ly/3bAmItW), serving as chair of the original AAP Task Force on Neonatal Resuscitation Education in the 1980s. A neonatologist and cardiologist, Dr. Peckham chaired the Section on Perinatal Pediatrics in 1981. He also was a leader in international health and health care partnerships.
- **Ann Robbins Poindexter, M.D., FAAP,** of Conway, Ark., died Sept. 30 at age 87.
- **Beverly P. Wood, M.D., M.S.Ed., Ph.D.,** of San Diego, died Sept. 24 at age 82. A pediatric radiologist, she was a former chair of the AAP Committee on Pediatric Education and consultant to the Committee on Continuing Medical Education.

Dr. Levine begins commission as four-star admiral

**Rachel L. Levine, M.D., FAAP,** was sworn in Oct. 19 as a four-star admiral of the U.S. Public Health Service (USPHS) Commissioned Corps.

She is the first openly transgender four-star officer across any of the eight uniformed services and the first female four-star officer of the USPHS Commissioned Corps.

Dr. Levine is assistant secretary for health in the Department of Health and Human Services. Former health secretary for Pennsylvania, she received the AAP Child Health Advocate Award from the Committee on State Government Affairs in 2020.

Fewer than 10% of all emergency medical services (EMS) calls are pediatric emergencies.

Be ready with NEW Virtual Reality Simulation Trainings from Health Scholars and the AAP!

Don’t miss out on these additional emergency resources from the AAP!


*Editors: Susan Fuchs, MD, FAAP, FACEP, and Mike McEvoy, PhD, NRP, RN, CCRN*

**The Field Guide for Air and Ground Transport of Neonatal and Pediatric Patients**

*AAP Section on Transport Medicine*

*Editors: Keith Meyer, MD, FAAP; Caraciolo J. Fernandes, MD, FAAP; and Hamilton P. Schwartz, MD, MEd, FAAP, FACEP*

Order at shop.aap.org/books

To make a gift in memory of a colleague, visit donate.aap.org or email the AAP Development Office at development@aap.org.
Bacteria in room spray linked to 2 deaths

Walmart is recalling about 3,900 bottles of Better Homes and Gardens Essential Oil Infused Aromatherapy Room Spray with Gemstones in six scents because it may contain dangerous bacteria that can cause death. The Centers for Disease Control and Prevention (CDC) found bacteria in the room spray was the same as the bacteria identified in four patients with an infectious disease called melioidosis. Two of the four people have died, including a child.

The room spray was sold from February through October 2021. The CDC recommends that consumers who have the recalled aromatherapy spray in their home do the following:

- Stop using this product immediately. Do not open the bottle. Do not throw away or dispose of the bottle in the regular trash.
- Double bag the bottle in clean, clear zip-top bags and place in a small cardboard box. Return the bagged and boxed product to a Walmart store.
- Wash sheets or linens that the product may have been sprayed on using normal laundry detergent and dry completely in a hot dryer; bleach can be used if desired.
- Wipe down counters and surfaces that might have the spray on them with undiluted Pine-Sol or similar disinfectant.
- Limit how much you handle the spray bottle and wash hands thoroughly after touching the bottle or linens. If you used gloves while handling the bottle or cleaning, wash hands afterward.
- If you have used the product within the past 21 days and have melioidosis symptoms such as fever, abscess, cough, chest pain, headache, disorientation or weight loss, seek medical care and tell your doctor you were exposed to the spray. If you do not have symptoms but were exposed to the product in the last seven days, your doctor may recommend that you get antibiotics to prevent infection.


5-drawer chests

Magnussen Home is recalling Nova Series five-drawer chests because they are unstable if they are not anchored to the wall. They can tip over and cause death or serious injuries to children. The chests were sold from August 2009 through August 2015. Call 833-748-0210, email recall@magnussen.com or visit https://www.magnussen.com/Recall.

Jogging strollers

Joovy Holding Co. is recalling Zoom 360 Ultralight jogging strollers because the strollers’ front wheel bearing can fail or detach, posing a fall and injury hazard. The strollers were sold from May through December 2020. Call 800-495-8718, email zoom360@joovy.com or visit https://joovy.com/zoom360-recall/.

Power banks

MyCharge is recalling power banks because the lithium-ion battery can overheat and ignite, posing fire and burn hazards. The power banks were sold from August 2018 through December 2019. Call 888-251-2026, email compliance@mycharge.com or visit https://mycharge.com/pages/productsafety.

Bicycles

Specialized Bicycle Components is recalling Tarmac SL7 bicycles and framesets because the bikes’ fork steerer tube can crack or break after impact such as hitting a deep pothole. Riders then can fall and suffer injuries. The bikes were sold from July 2020 through August 2021. Call 877-808-8154, email ridercare@specialized.com or visit https://www.specialized.com/us/en/safety-notices.

Stand-up bikes

ElliptiGO Inc. is recalling Arc model stand-up bicycles because the frame can break while riding, and users can fall and suffer injuries. The bikes were sold from November 2015 through December 2020. Call 888-551-0117, email info@elliptigo.com or visit https://www.elliptigo.com/arcs/.

Furniture

Design Within Reach is recalling Arc Collection furniture, including chairs, barstools and tables. Paint on the furniture contains lead, which is toxic if ingested by young children. The furniture was sold from April through July 2021. Call 800-338-2107, email recall_info@hermanmiller.com or visit https://www.elliptigo.com/arcs/.

To see more recalls, or to share this information, go to https://bit.ly/AAPNewsHealthAlerts
A LOOK AHEAD AT THE AAP CME SCHEDULE
The Best Pediatric CME/CPD for the Best Pediatric Care

For the latest information on upcoming AAP CME activities or to register,
🌟 Visit shop.aap.org/live-activities
📞 Call toll-free 866/843-2271

**Practical Pediatrics CME Courses**
Designed for pediatricians, family physicians, and advanced care professionals caring for children, these courses feature nationally prominent faculty presenting topics that highlight current issues in pediatrics.

**Williamsburg, VA**
- **IN PERSON**
- December 10-12, 2021

**Rio Grande, Puerto Rico**
- **IN PERSON**
- January 28-30, 2022

**Orlando, FL (Disney)**
- **IN PERSON**
- March 25-27, 2022

**Santa Ana Pueblo, NM**
- **IN PERSON**
- April 22-24, 2022

**Hilton Head Island, SC**
- **IN PERSON**
- May 27-29, 2022
  (Memorial Day Weekend)

**Seattle, WA**
- **IN PERSON**
- May 27-29, 2022
  (Memorial Day Weekend)

**Baltimore, MD**
- **IN PERSON**
- June 10-12, 2022

**Board Preparation Cram Courses**
An intensive review and preparation for the American Board of Pediatrics (ABP) initial certification examination in general pediatrics or pediatric subspecialties. Course content is guided by the ABP Specifications Outline.

**NeoCram**
- **VIRTUAL ONLY**
- February 26-27, 2022

**Subspecialty/Section CME Courses**
Appropriate for the pediatric subspecialist or the general pediatrician with an interest in the topic.

**NeoPREP®**
- **VIRTUAL ONLY**
- January 22-24, 2022

**Celebration of Pediatric Pulmonology and Sleep**
- **IN PERSON**
- February 18-20, 2022
  Scottsdale, AZ

**Workshop on Neonatal-Perinatal Practice Strategies**
- **IN PERSON**
- March 25-27, 2022
  Scottsdale, AZ

**Diagnosis and Treatment of Common Pediatric Mental Health Disorders Course**
- **VIRTUAL**
- April 8-10, 2022
  Rosemont, IL

**Safety precautions due to COVID-19:** As we approach in-person meetings, the AAP will seek guidance from local and national public health experts on implementing the necessary safety precautions to ensure the health and safety of all attendees, staff and local community. Please continue to visit [shop.aap.org/live-activities](http://shop.aap.org/live-activities) and click on the activity of interest to you for updates.
Welcome New Fellows

Congratulations on passing the pediatric board exam! As a member and Fellow of the AAP (FAAP), you are part of an exceptional pediatric community. You have access to unmatched opportunities for leadership and quality improvement that will positively impact your care of children and take your career to the next level.

UNDISTRICTED
Corresponding Fellow
Mariam Ayed, M.D., FRCP, FAAP
Surra, Al Asimah (Al Kuwait)
Kuwait

Aseel AbuDayya, M.D., FAAP
Dubai, Dubai United Arab Emirates

DISTRICT I
NORTHEAST
Connecticut
Julie Flom, M.D., FAAP
Weston, CT

Lacey Whitmire, M.D., M.P.H., FAAP
New Haven, CT

Christopher Woll, M.D., FAAP
New Haven, CT

Maine
Kirsten Orloff, M.D., FAAP
Scarborough, ME

Child Neurology Specialty Fellow
Thomas Reynolds, D.O., FAAP
Cape Elizabeth, ME

Massachusetts
Kristyn Beanz, M.D., FAAP
Waltham, MA

Laura Chiel, M.D., FAAP
Boston, MA

Pediatric Urology Specialty Fellow
Beth Drzewiecki, M.D., FAAP
Newton Highlands, MA

New Hampshire
Natalie Frassica, M.D., FAAP
New Hampshire

Uniformed Services East
Brian Brennan, M.D., FAAP
Poolesville, MD

Quebec
Mario Dumas, M.D., FAAP
Sherbrooke, QC Canada

DISTRICT II
NEW YORK STATE
New York
Gladys Banegas Girimonti, M.D., FAAP
Bronxville, NY

Monika Gajdek, M.D., FAAP
Webster, NY

William McCarran, M.D., FAAP
Sewickley, PA

Elizabeth Hall, D.O., FAAP
Grosse Pointe Woods, MI

Emily Rudloff, M.D., FAAP
Saint Louis, MO

Keisha White, M.D., FAAP
Saint Louis, MO

Nebraska
Gordon Still, M.D., FAAP
Omaha, NE

Wisconsin
Christina Bryndzia, D.O., FAAP
Madison, WI

Dermatology Specialty Fellow
Leah Lator, M.D., FAAP
Shorewood, WI

Megan Peters, M.D., FAAP
McFarland, WI

Pediatric Anesthesiology Specialty Fellow
Stacy Peterson, M.D., FAAP
Brookfield, WI

Ashley Przybilla, M.D., FAAP
Verona, WI

DISTRICT IV
SOUTH APPALACHIAN
Kentucky
Anna Iddings, M.D., FAAP
Lexington, KY

Michelle Grace MacDavid, M.D., FAAP
Louisville, KY

North Carolina
Nathaniel Bales, M.D., FAAP
Charlotte, NC

Marc Chester, M.D., FAAP
Charlotte, NC

Daniel Kelly, M.D., FAAP
Charlotte, NC

Steven Wasserman, M.D., FAAP
Chapel Hill, NC

South Carolina
Anthony Johnson, M.D., FAAP
Greenwood, SC

Tennessee
Stephanie Patterson, M.D., FAAP
Nashville, TN

Kaya Wienickowski, M.D., FAAP
Lebanon, TN

Virginia
Olivia Carey, M.D., FAAP
Norfolk, VA

Hannah Kim, M.D., FAAP
Vienna, VA

Allie Ojegbeli, M.D., FAAP
Midlothian, VA

DISTRICT V
GREAT LAKES
Indiana
Jonathan Merrell, M.D., FAAP
Indianapolis, IN

Elizabeth Partain, M.D., FAAP
Carmel, IN

Allie Sadowitz, M.D., FAAP
Whitestown, IN

Michigan
Adolubimi Adelakun, M.D., FAAP
Redford, MI

Tyler Murthaugh, M.D., FAAP
Kansas City, MO

DISTRICT VI
NORTH CENTRAL
Illinois
Haroon Ali, M.D., FAAP
Peoria, IL

Madeleine Genereux, M.D., FAAP
Chicago, IL

Eric Jackson, M.D., FAAP
Chicago, IL

Mary McCauley, M.D., FAAP
Winfield, IL

Iowa
Kaitlyn Voss, M.D., FAAP
Dubuque, IA

Kansas
Nisha Agasthya, M.D., FAAP
Wichita, KS

Mohammed Ali, M.B.B.S., FAAP
Andover, KS

Minnesota
Jeffrey Oseid, M.D., FAAP
Minneapolis, MN

Jenna Still, M.D., FAAP
Rochester, MN

Missouri
Julie Dorfman, M.D., FAAP
Saint Louis, MO

Sarah Greenberg, M.D., FAAP
Houston, TX

Maha Haroon, M.D., FAAP
Collegeville, TX
Neurological Surgery
Specialty Fellow
Sze Chun Winson Ho, M.D., FAAP
Austin, TX

Erich Hoyos Martinez, M.D., FAAP
Houston, TX

Surgery Specialty Fellow
Danielle Hsu, M.D., FAAP
Houston, TX

Beverly Lee, M.D., FAAP
Houston, TX

Morganne Mathew, M.D., FAAP
The Woodlands, TX

Punya Narain, M.D., FAAP
Houston, TX

Stephanie Novak, M.D., FAAP
Belton, TX

Cynthia Oyubu, M.D., FAAP
El Paso, TX

Jacklin Roufail, M.D., FAAP
Corpus Christi, TX

Katherine Saliccioli, M.D., FAAP
Houston, TX

Alyson Zulfer, D.O., FAAP
Mineral Wells, TX

DISTRICT VIII
WEST
Alaska
Justin Willis, M.D., FAAP
Bethel, AK

Arizona
Harriet Banda, M.D., FAAP
Scottsdale, AZ

Anita Bharath, M.D., FAAP
Phoenix, AZ

Devika Malhotra, M.D., FAAP
Yuma, AZ

Colorado
Kimberly Mickey, M.D., FAAP
Denver, CO

Adam Ploegman, D.O., FAAP
Fort Collins, CO

Allen Ruan, M.D., FAAP
Boulder, CO

Lisa Umpfrey, M.D., FAAP
Denver, CO

DISTRICT IX
CALIFORNIA
California
Lakshmi Ganesan, M.D., FAAP
Redlands, CA

Sarah Henshaw, D.O., FAAP
Roseville, CA

Alyson Zulfer, D.O., FAAP
Mineral Wells, TX

DISTRICT V
WEST
New Fellows

Hawaii
Christopher Gibu, M.D., FAAP
Kailua, HI

Jordan Kono, M.D., FAAP
Honolulu, HI

New Mexico
Tommie Begay, M.D., FAAP
Shiprock, NM

James Goldsmith, M.D., FAAP
Albuquerque, NM

Uniformed Services West
Brittany Wake, D.O., FAAP
Kaneohe, HI

Washington
Joan Lee, M.D., FAAP
Seattle, WA

Dean Lorimer, Jr., M.D., FAAP
Spokane, WA

Kashmir Metha, M.B.B.S., FAAP
Richland, WA

Fabiola Movius, M.D., M.P.H., FAAP
Seattle, WA

Hannibal Person, M.D., FAAP
Seattle, WA

Alberta
Jennifer Thull-Freedman, M.D., M.Sc., FAAP
Calgary, AB Canada

DISTRICT X
SOUTHEAST
Alabama
Cary Cavender, M.D., FAAP
Hoover, AL

Luz Gutierrez, M.D., FAAP
Birmingham, AL

Rachel Kassel, M.D., Ph.D., FAAP
Birmingham, AL

Giannina Lamaletto, M.D., FAAP
Florence, AL

Jeanine Maclin, M.D., FAAP
Hoover, AL

Leena Shabbaz, M.D., FAAP
Fairfield, CA

Deborah Shamsian, M.D., FAAP
Santa Monica, CA

Livpreet Singh, D.O., FAAP
San Diego, CA

Lee Trope, M.D., FAAP
San Francisco, CA

Eric Tsay, M.D., FAAP
Chino Hills, CA

Vanessa Wong, M.D., FAAP
Oakland, CA

Diana Yan, M.D., FAAP
Los Angeles, CA

Jeff Yu, M.D., FAAP
Los Alamitos, CA

DISTRICT XI
SOUTHEAST
Florida
Noelia Aviles-Otero, M.D., FAAP
Fort Myers, FL

Porsa Butler, M.D., FAAP
Rockledge, FL

Sean Curtis, M.B.B.S., FAAP
Naples, FL

Lisa Dinh, M.D., FAAP
Lakeland, FL

Michael Dressing, M.D., FAAP
Boca Raton, FL

Gabrielle Fisher, M.D., FAAP
Miami, FL

Matthew Henderson, D.O., FAAP
Winter Springs, FL

Farhan Malik, D.O., FAAP
Saint Petersburg, FL

Brittany Marlin, M.D., FAAP
Birmingham, AL

Jose R. Mestre, M.D., FAAP
Birmingham, AL

Henry Herchung Shiau, M.D., FAAP
Birmingham, AL

Thanh Summerlin, M.D., FAAP
Gardendale, AL

Preventive Medicine
Specialty Fellow
Cynthia Wozow, D.O., FAAP
Hoover, AL

Georgia
Saji Azerf, M.D., FAAP
Roswell, GA

Jonathan Beus, M.D., M.S., FAAP
Decatur, GA

Merritt Dammeyer, M.D., FAAP
Athens, GA

Jocelyn Grunwell, M.D., FAAP
Suwanee, GA

Amy Thompson, M.D., FAAP
Augusta, GA

Beatriz Marin Ruiz, M.D., FAAP
Saint Petersburg, FL

Diana Montoya Melo, M.D., FAAP
Miami, FL

Reema Patel, M.D., FAAP
Clearwater, FL

Imran S. Sajan, M.D., FAAP
Saint Petersburg, FL

Shannon Shea, M.D., FAAP
Jacksonville, FL

Andrew Smith, M.D., FAAP
Tampa, FL

Christopher Talluto, M.D., FAAP
Saint Peters burg, FL

Kathleen Vazzana, D.O., FAAP
Orlando, FL

Hawaii
Christopher Gibu, M.D., FAAP
Kailua, HI

New Fellows

Leena Shabbaz, M.D., FAAP
Fairfield, CA

Deborah Shamsian, M.D., FAAP
Santa Monica, CA

Livpreet Singh, D.O., FAAP
San Diego, CA

Lee Trope, M.D., FAAP
San Francisco, CA

Eric Tsay, M.D., FAAP
Chino Hills, CA

Vanessa Wong, M.D., FAAP
Oakland, CA

Diana Yan, M.D., FAAP
Los Angeles, CA

Jeff Yu, M.D., FAAP
Los Alamitos, CA

DISTRICT X
SOUTHEAST
Florida
Noelia Aviles-Otero, M.D., FAAP
Fort Myers, FL

Porsa Butler, M.D., FAAP
Rockledge, FL

Sean Curtis, M.B.B.S., FAAP
Naples, FL

Lisa Dinh, M.D., FAAP
Lakeland, FL

Michael Dressing, M.D., FAAP
Boca Raton, FL

Gabrielle Fisher, M.D., FAAP
Miami, FL

Matthew Henderson, D.O., FAAP
Winter Springs, FL

Farhan Malik, D.O., FAAP
Saint Petersburg, FL

Brittany Marlin, M.D., FAAP
Birmingham, AL

Jose R. Mestre, M.D., FAAP
Birmingham, AL

Henry Herchung Shiau, M.D., FAAP
Birmingham, AL

Thanh Summerlin, M.D., FAAP
Gardendale, AL

Preventive Medicine
Specialty Fellow
Cynthia Wozow, D.O., FAAP
Hoover, AL

Georgia
Saji Azerf, M.D., FAAP
Roswell, GA

Jonathan Beus, M.D., M.S., FAAP
Decatur, GA

Merritt Dammeyer, M.D., FAAP
Athens, GA

Jocelyn Grunwell, M.D., FAAP
Suwanee, GA

Amy Thompson, M.D., FAAP
Augusta, GA
NORTHEAST

Largest Concierge Pediatric Practice in the Country

We are a well-established, rapidly growing CONCIERGE PEDIATRIC outpatient office searching for a third full-time pediatrician to join our family. We offer an opportunity to practice Pediatrics that can’t be found in a typical practice. Concierge care means spending a full hour with your patients during physicals; home visits as well as in-office visits; never having patients wait in the waiting room; and staying ahead of the curve with five Covid PCR machines in the office. We value lifestyle: work four days per week; frequently finish before 5 p.m.; no hospital or delivery call; and extremely flexible call schedule so you never miss a family event. Unique Opportunities: final partnership comes with a salary well above average for life; we value your input on further growth of the practice; and a work atmosphere that emphasizes making each day fun! Check out our website at www.ngpeds.com. Please send all inquiries to NGPedsJob@gmail.com.

Pediatric Gastroenterologist

Excellent opportunity for a BC/BE pediatric gastroenterologist to join a well-established three practitioner pediatric gastroenterology practice. We provide tertiary pediatric care for the region, offering a full spectrum of pediatric subspecialties and inpatient care including neonatal intensive care, pediatric critical care, pediatric surgery, and a mature pediatric sedation service. There is a strong working relationship with the pediatric sedation service for procedural sedation. Northern Light Eastern Maine Medical Center is a 411-bed regional tertiary care center and an ACS-verified level II trauma center with academic affiliations, serving a population of 500,000 living in the northern 2/3 of the state. We offer dedicated neonatal and pediatric transport and are a base hospital for LifeFlight of Maine, a critical care air transport service flying nearly 900 missions per year. Patient care responsibilities include an active outpatient clinic and inpatient consultation services. Desire to teach family practice residents and medical students is also highly valued and encouraged. Bangor is an award-winning small city offering easy access to ocean and mountains. Bangor serves as the regional hub for medicine, the arts, and commerce. Contact: Amanda Klausing, CRRP at ProviderJobs@northernlight.org or 207-973-5385.

MID-ATLANTIC

General Pediatrician in Private Practice

Located in Montgomery County, Maryland, just outside Washington, D.C. The county has a terrific school system, great access to culture/sports, and beautiful outdoor spaces. Our group practice has been physician owned and operated for more than 50 years. The practice has a full-time pediatric dietitian and a lactation consultant. Seeking BC/BE pediatrician to join the group. Call is currently one in eleven and split equity. Extensive benefits package. Contact Paula Kress at Paula.kress@pediatric-associates.org, via fax at 301-933-5923, or by phone at 240-514-1912.

General Pediatrician

Full-time BC/BE Pediatrician to join an office based pediatric practice in Western Morris County, N.J. No hospital rounds. Four days per week. Every third Saturday, 30 miles from N.Y.C. Wonderful place to make home. Excellent school systems. Partnership track available. Please email cover-letter and CV to Dr. Michael Peters: mapeters@advacaredoctors.com.

Mid-Atlantic Pediatrician Needed in a Charming Historic Community

Mercy Health-Lourdes Hospital is currently seeking a BE/BC Pediatrician to join the regional leader in primary care in a charming historic community. Paducah, Kentucky is an ideal combination of southern charm and big city conveniences. Paducah is the perfect place to build a career, raise a family and lead a fulfilling, active life. This candidate will enjoy an existing patient panel in a busy practice. The candidate will see 25-30 patients a day. Only covering one hospital. Call is 1:3. EMR is Epic. Mercy Health Physicians-KY is the largest multi-specialty group in Western Kentucky with close to 150 providers. We offer a competitive Compensation Package Including: two-year income guarantee with excellent income potential; enhanced benefit package; significant student loan forgiveness program; stipend program; paid CME and relocation assistance; sign-on bonus; health, dental, vision, disability, and medical malpractice insurance and tail coverage. Please email CV to eswlison@mercy.com.

Award-winning Pediatric Office in Metro Atlanta Seeks BC/BE Pediatrician

Award-winning, established pediatric practice in metro Atlanta is seeking qualified pediatrician. The practice employs state of the art technology while maintaining good patient relationships. Call is 1:4 or better. No C/O responsibility. We enjoy great tertiary specialty support including NICU and Pediatric Urgent Care facilities. Our practice includes a dedicated Newborn Center, Teen Center, Lactation Clinic, and more. Robust in-house labo-

Positions Wanted

NORTHEAST

Children’s Hospital of Philadelphia Position

Children’s Hospital of Philadelphia is searching for a full-time pediatrician to join the team at TidalHealth Peninsula Regional in Salisbury, Maryland. The job description includes inpatient pediatric care and well-baby nursery. Candidates must be pediatric board certified or eligible. If interested, please contact Lauren McGovern at lmcover@childrensnational.org.

SOUTHEAST

Multiple Career Opportunities

(Louisville, Kentucky)

NORTON CHILDREN’S MEDICAL GROUP, AFFILIATED WITH THE UOFLO SCHOLL OF MEDICINE, is seeking candidates across a variety of pediatric specialties. The selected candidates will join a dynamic, physician-led medical group dedicated to meeting the needs of children through clinical care, medical education, research and advocacy. Providers cover Norton Children’s Hospital, a Level I Pediatric Trauma Center that includes a 101 bed, Level IV neonatal intensive care unit, dedicated Jennifer Lawrence Cardiac Intensive Care Unit and comprehensive suite of pediatric care services. Providers in each of these positions have access to the University of Louisville’s School of Medicine including clinical research and teaching opportunities. Salary and academic rank commensurate with experience. Submit your CV at BeaNortonDoctor.com. To discuss this opportunity, contact Tracy Shaughnessy, senior recruiter, physicians, Norton Medical Group, at 502-609-3672 or tracy.shaughnessy@nortonhealthcare.org.

General Pediatrician

We are seeking a Board Certified compassionate and energetic Pediatrician to join our warm, supportive and friendly practice. We are a private practice located about 25 minutes from downtown Atlanta. We are now seeking an additional full-time or part-time physician. We offer a very competitive compensation package. Please email CV to Careers@pcpwellness.com.

Pediatrician

Well-established and growing private pediatric office in Kennesaw, GA is looking for a BC/BE pediatrician. Outpatient only pediatricians, no hospital visits. Excellent place to live, competitive benefit package including Health insurance, CME, 401(k). Base salary of $185,000 plus negotiated productivity bonus. Relocation expense and sign on bonus offered. Please email CV to contacts@spectrumpedds.com.

SOUTHEAST

Children’s National Hospital Pediatric Hospitalist Position

Children’s National Hospital is seeking a full-time pediatric hospitalist to join the team at TidalHealth Peninsula Regional in Salisbury, Maryland. The job description includes inpatient pediatric care and well-baby nursery. Candidates must be pediatric board certified or eligible. If interested, please contact Lauren McGovern at lmcover@childrensnational.org.

MIDWEST

Pediatric Opportunities

Children’s Hospital & Medical Center in affiliation with the University of Nebraska College of Medicine, is recruiting for multiple pediatric positions due to our significant growth. This affiliation aligns the two organizations in a way that allows a shared vision for the future of pediatric health care and ensures children have access to world-class clinical care, treatments influenced by cutting-edge research and a future generation of well-educated and highly trained medical professionals. Children’s is the only full-service, pediatric health care center in Nebraska, providing expertise in more than 50 pediatric specialties to children across a five-state region and beyond. Children’s is home to Nebraska’s only Level IV regional NICU and the state’s only Level II Pediatric Trauma Center. A regional heart center, it also offers expertise in pediatric heart transplantation. Children’s is focused on extraordinary clinical care, education, basic science and translational research and advocacy and is embarking on transformational programmatic and physical growth. The newly opened Hubbard Center for Children is home to an additional 100 patient beds, an expanded NICU, a dedicated Cardiac Care Unit, a new Cancer & Blood Disorders Unit, expanded surgical space, an expanded Radiology and Emergency Department and more. The Child Health Research Institute was established in 2017 and aims to assist investigators with start-up funding and infrastructure for clinical, basic science or translational research. We are looking for YOU! We are committed to increasing diversity in our organizations to reflect the population that we serve and encourage applications from all candidates who will contribute to the diversity and excellence of the institution. Please explore our current pediatric opportunities and contact us to discuss. Interest and/or CVs should be directed to facultycareer@childrensomaha.org.

Pediatric Career Opportunities in Michigan

McLaren pediatric departments provide care that is individualized and age-specific to each patient we treat in both the outpatient primary care and inpatient settings. The family is included as an integral component of any treatment program. Working together, we can maximize the individual’s health and potential for optimum recovery from illness or injury. Please reach out to our recruitment team at 810-342-1575 to find out more about Peds openings with McLaren!

CoxHealth Is Seeking Physicians

CoxHealth is seeking physicians for opportunities in Pediatric Endocrinology, Pediatric Pulmonology, and General Pediatrics. Join our well-established practices in Springfield, Missouri and surrounding areas. CoxHealth is a physician-led, not-for-profit health system with 6 hospitals and 80+ clinics, serving a 1.2 million patient region in southern Missouri. Our health system includes a wide variety of Pediatric primary and specialty care services. Springfield is a vibrant mid-size city with a metro area population of nearly 500,000. Springfield offers numerous amenities- restaurants, shopping, cultural activities, sporting events, and abundant outdoor activities. Residents of the area enjoy a low cost-of-living, quick commutes, and top-rated schools. For more information, please visit our careers page at www.coxhealth.com/careers, or contact Michelle Freeman, CoxHealth Pediatric Recruiter, at michelle.freeman@coxhealth.com, or by phone at 417-619-3139.

SOUTHWEST

General Pediatrics & Subspecialties

Banner Health is one of the largest non-profit health care systems in the country with twenty-eight hospitals, six long-term care centers, and an array of other integrated services, including multi-specialty clinics, and home care services. Through our partnership with the University of Arizona, our academic medicine teams are paving the way in the future of medicine.

Northern Virginia Pediatrician Needed

Located in Montgomery County, Maryland, just outside Washington, D.C. The county has a terrific school system, great access to culture/sports, and beautiful outdoor spaces. Our group practice has been physician owned and operated for more than 50 years. The practice has a full-time pediatric dietitian and a lactation consultant. Seeking BC/BE pediatrician to join the group. Call is currently one in eleven and split equity. Extensive benefits package. Contact Paula Kress at Paula.kress@pediatric-associates.org, via fax at 301-933-5923, or by phone at 240-514-1912.

General Pediatrician

Full-time BC/BE Pediatrician to join an office based pediatric practice in Western Morris County, N.J. No hospital rounds. Four days per week. Every third Saturday, 30 miles from N.Y.C. Wonderful place to make home. Excellent school systems. Partnership track available. Please email cover-letter and CV to Dr. Michael Peters: mapeters@advacaredoctors.com.

General Pediatrician Position

Excellent opportunity for BC/BE General Pediatrician looking for FT/PT employment in beautiful Philadelphia suburbs, 30 minutes from Philadelphia. Thriving provider practice. Competitive salary, great benefits package includes health, dental, four weeks paid leave, malpractice insurance, pension plan and more. 1:4 Call. Must possess medical degree, have completed approved pediatric residency training program, and board-certified/eligible. Fax CV to 215-865-6795 or send to info.pcgkids@gmail.com.

Award-winning Pediatric Office in Metro Atlanta Seeks BC/BE Pediatrician

Award-winning, established pediatric practice in metro Atlanta is seeking qualified pediatrician. The practice employs state of the art technology while maintaining good patient relationships. Call is 1:4 or better. No C/O responsibility. We enjoy great tertiary specialty support including NICU and Pediatric Urgent Care facilities. Our practice includes a dedicated Newborn Center, Teen Center, Lactation Clinic, and more. Robust in-house labo-
Classifieds

through collaborative partnerships, innovative research, and teaching. With a disciplined focus on the transformation of healthcare, we are obsessed with our customer’s experience as they make healthcare choices every day. Banner Health values a culture of innovation and improvement, trust and accountability, diversity, and inclusion. The result is excellent patient care and employees who are passionate about practicing medicine. For more information or to formally apply, please provide a CV and cover letter to Doctors@BannerHealth.com.

Pediatrician

Reports To: Chief Executive Officer. Job Summary: Provides and manages a high standard of health care for pediatric patients. Central Coast Pediatrics is seeking an enthusiastic and compassionate Board Eligible/Certified Pediatrician to join our team of eight providers. We are a single specialty and privately owned practice with two offices located on the California Central Coast, specifically San Luis Obispo and Templeton. This is a full-time position which consists of four clinic days per week. The on-call responsibilities are rotated with our five staff Pediatricians. Our doctors provide normal newborn care at all three of our local hospitals. CCP is a busy practice that will provide many opportunities for growth. New graduates are strongly encouraged to apply. Where you’ll work: Nestled on the Central Coast, halfway between San Francisco and Los Angeles, San Luis Obispo and Templeton are both amazing communities in which to live and work. San Luis Obispo county offers small-town charm and friendliness combined with world-class wineries, a thriving university, unparalleled hiking trails, scenic beauty, and a wide variety of elementary and secondary school options. Central Coast Pediatrics is committed to diversity and inclusion in the workplace, and we are proud to be an equal opportunity employer. We are also committed to building a culturally diverse workplace. All qualified applicants will receive consideration until a candidate has been selected and hired. Essential Job Duties and Responsibilities: The job duties and responsibilities listed below are representative of the knowledge, skill, and/or ability required. Other duties that fall within the broad scope of this classification may be assigned. Provides and manages direct patient care, including physical examinations, evaluations, assessments, diagnostic evaluations of labs and imaging or other diagnostic procedures, and treatment for patients within scope of practice. Refers patients to specialists and to relevant patient care components as appropriate. Directs and coordinates the patient care activities of nursing, care coordinators, and support staff. Ensures completion of tasks, patient labs, imaging, and reports, as well as required paperwork in a timely and efficient manner. Maintains patient charts using electronic medical records. Also provides accurate billing data in a timely manner. Assists in facilitating and providing training and mentorship to improve and advance professional skills and competence of Nurse Practitioners, and other pediatric-related providers and staff. About you: Should possess an empathy-first approach to working with your patients’ parents and caregivers. Thrives in a team-centered environment. Willingness to ask for help from your team members when you need it. Driven in your pursuit of professional growth and life-long learning. Willingness to go above and beyond for the needs of our patients/families and the organization as a whole. Please email your cover letter and resume to Anna Sosa, COO at asosa@centralcoastpeds.com. We look forward to meeting you.

Full-Time General Pediatrician

Pediatric practice in far north Phoenix, Arizona, is seeking to add a Board-Certified/Board-Eligible Pediatrician to work full-time at the practice. This is solely an outpatient practice. There are no hospital and no nursery responsibilities. All weekends are off, with the exception of 1-2 weekends per year. Call is, on average, one week out of every three weeks, and consists of answering questions for a pediatric nurse triage service, which handles the majority of the after-hours phone calls. Benefits include health plan, dental plan, retirement plan (participation in this plan begins after one year of employment), malpractice insurance, CME allowance, paid time off and paid holidays. Seeking someone who is hard-working, diligent, personable, and willing to go above and beyond to provide healthcare to the children of this community. Please send your CV by email to: angelepeds2017@gmail.com.

NATIONWIDE

Your dream job awaits.

Let us help you find it.

Thinking of making a change? Or just starting your search for a new practice setting? Pediatric Search Partners is a specialized boutique search firm with over 30 years of experience. Our sole focus is serving the pediatricians, pediatric subspecialists, healthcare executives and physician leaders dedicated to providing children’s healthcare. Since 2009, we’ve successfully filled more than 500 searches within leading children’s hospitals and healthcare organizations across the nation, each of them with a highly personalized approach. Our passion is matching the physicians and executives who care for children with opportunities they truly care about.

For complete details and consideration, please contact: Glenda Smith, Principal, Pediatric Search Partners, Phone 877-440-3832; Cell: 214-850-3094 or email glenda@pediatricsearchpartners.com.

AAP News

CLASIFIED ADVERTISEMENTS & ANNOUNCEMENTS

Classified Advertisements

Advertisements in the Classified Advertising section of AAP News reach more than 67,000 child health-care professionals and clinicians monthly. AAP News circulation encompasses 85% or all board certified pediatricians, more than 90% of certified pediatric allergists, cardiologists, and surgeons, and more than 9,000 pediatric residents

LINE ADS

Line ads: A line ad is a text ad with no logos, and no paragraph formatting. Cost is calculated by word count. To calculate words, either open Microsoft Word and use the word count function, or count each word as one. Web addresses, e-mail addresses, phone numbers, or fax numbers are all calculated as one word. BS/BA is calculated as one word, but Board Certified/Board Eligible is calculated as four. All line ads are packaged with a job posting at www.pedjobs.org. There is no print advertising only. There is online advertising only. When placing your ad, the online compatibility allows you to search the job bank of hundreds of CVs.

If you would like information about placing your ad, please call 443.512.8899, ext. 106.

CLASSIFIED DISPLAY

Classified advertising on a set-size basis (1/2 page, 1/4 page, etc.) also is available an AAP News. All display ads are packaged with a job posting at www.pedjobs.org. There is no print advertising alone. Rate sheets are furnished upon request. Please call 443.512.8899, ext. 106, between the hours of 8:30 am and 5:00 pm Eastern Standard Time for more information.

PLACING AN AD

To confirm an insertion order, send classified ad copy with payment to American Academy of Pediatrics
2225 Old Emmorton Road, Suite 201
Bel Air, MD 21015
E-mail ad copy to: rhonda.beamer@ttw-group.com
Ad copy may be sent via e-mail in a Word-friendly format or by typewriter. No handwritten or telephone (verbal) orders will be accepted.

DEADLINE

The deadline for placing a classified ad in AAP News is the 1st of the month preceding month of issue. Example: January 1st for the February issue.

TERMS

Please note, payment must accompany order. No ads will be placed without prior payment. Make checks payable to: American Academy of Pediatrics, Visa, Master-Card, American Express, and Discover are accepted. Ads will not be placed until payment is collected. An advertiser may cancel an ad without refund.

REPLYING TO A CONFIDENTIAL BOX AD

To reply to an ad with a confidential box number (box #000), please use the following address: Pediatrics Classified Ads. 2225 Old Emmorton Road, Suite 201, Bel Air, MD 21015

CLASSIFIED ADVERTISING POLICY

Although the American Academy of Pediatrics believes classified advertisements published in AAP News are from reputable sources, the Academy reserves the right to revise or reject advertising copy that is inconsistent with the publication’s standards. All advertising is subject to approval.

Ads in AAP News must be relevant to the practice of medicine. The Academy does not investigate offers made in classified ads and assumes no responsibility concerning them. In consideration for acceptance of an advertisement for publication, the agency and advertiser agree to indemnify and hold the American Academy of Pediatrics harmless against any losses or expenses arising out of publication of such advertisements, including and without limitation, those resulting from claims based on the contents, claims, or subject matter of such advertisements. Every effort is made to avoid mistakes, but the Academy cannot accept responsibility for printing or clerical errors.

Without limiting the American Academy of Pediatrics’ terms, conditions, and policies, the American Academy of Pediatrics, in accordance with Department of Justice guidelines:

• Prohibits any job posting that requires U.S. citizenship or lawful permanent residence in the U.S. as a condition of employment, unless otherwise required in order to comply with law, regulation, executive order, or government contract.

• Prohibits any job requirement or criterion in connection with a job posting that discriminates on the basis or citizenship status or national origin.

For complete EEO guidelines please refer to the following resource: http://www.justice.gov/crt/osc/

CONTACT INFORMATION

The Walchli Tauber Group, Inc
Attn: Rhonda Beamer
2225 Old Emmorton Road
Suite 201
Bel Air, Md. 21015
Phone: 443.512.8899, ext 106
Fax: 443.512.8899
Combating physician burnout through innovative, physician-led approaches

Physician burnout has long been recognized as a cause of physician distress that results in suboptimal patient care. The Children’s Hospital at Montefiore (CHAM) is leading the battle against physician burnout by training and supporting physician “wellbeing” officers. We empower physician experts to analyze and understand the root causes of burnout in individual departments. Our wellbeing officers collaborate with hospital administrators and are able to implement customized solutions to improve wellness throughout our institution. Our physician leaders are nationally recognized for their work in physician burnout and even teach courses on fighting burnout to other doctors.

Our Expertise
• Regular burnout assessment
• Root cause analysis of potential burnout triggers
• Collaborative relationships between wellbeing officers and hospital administration

www.cham.org/urology
Contact us at 718-920-7479 or anorth@montefiore.org.