Making a Healthier Minnesota Starts Now

By Eric Dick, MNAAP Lobbyist

While the summer and fall of a non-election year are generally a quiet time for state legislators and advocates alike, it’s a perfect time to make or reinforce relationships with your legislators. Though the start of the 2020 Minnesota legislative session is many months away, the work of being an advocate for healthier kids, adolescents, and families does not take a vacation.

State legislators are back in their districts for the autumn and will be into the winter. Many legislators are hosting town hall meetings with constituents, and knocking on doors to build support in anticipation of close races once the November 2020 election arrives. These are terrific opportunities to remind legislators to invest in child and adolescent health and safety.

The fall is also a terrific time to invite your legislator to your clinic or a neighborhood coffee shop to urge them to support the issues that matter to pediatricians and their young patients. I am always eager to assist with scheduling a visit or to offer background, talking points, or tips on being an effective advocate.

MNAAP leadership has been busy this summer advocating for stronger immunization laws. While the most recent and dangerous national measles outbreak lingered, MNAAP leaders have been meeting with key legislators and advocating within their clinics and health systems to support fixing Minnesota’s weak immunization requirement. MNAAP staff has been similarly busy meeting with potential allies, health care professional associations, patient advocates, and other immunization advocacy leaders. We face an uphill climb to fix the law, but the chapter has received an encouraging level of support.

Several MNAAP leaders held a conference call with California State Senator Richard Pan, a pediatrician and the author of legislation to repeal California’s personal belief exception (PBE). Dr. Pan shared with the group his experience, encouraging the MNAAP to build a broad coalition of advocates and allies. Read Dr. Lori DeFrance’s “Word from the President” (page 3) for specific takeaways from our conversation.

To make a healthier Minnesota, we must start now. As autumn arrives and winter looms, take the time to make or build a connection with your legislator. It’s as simple as an email, a phone call, or a cup of coffee and it matters.

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September 19-20, 2019
1st Annual Twin Cities Pediatrics Update
Hosted by Children’s Minnesota and the University of Minnesota

September 26-28, 2019
National Pediatric Hypnosis Training Institute
10th Anniversary Pediatric Clinical Hypnosis Skill Development Workshops
Crowne Plaza Hotel & Conference Center, Plymouth
Sponsored by: Minnesota Medical Association, Department of Pediatrics-University of Minnesota, Children’s Minnesota-Minneapolis

September 27, 2019
Caring for the Littlest Patients: What’s New in Pediatric Medicine
Essentia Health Fall Conference
Duluth Entertainment Convention Center, Duluth, MN

October 4, 2019
Advanced Therapies for Pediatric Obesity
University of Minnesota Masonic Children’s Hospital
Presented by the Center for Pediatric Obesity Medicine

October 7-8, 2019
Pediatric Days
Hosted by Mayo Clinic School of Continuous Professional Development

October 9, 2019
Supporting the Nutrition Needs of Children with Complex Medical Conditions: A Focus on Nutrition Support
Hosted by Gillette Children’s Speciality Healthcare

October 24-25, 2019
Children’s Orthopaedic Trauma Summit
Hosted by University of Minnesota, Department of Orthopaedic Surgery; Regions Hospital, Department of Orthopaedic Surgery; University of Minnesota Medical School, Interprofessional Continuing Education of Minnesota

October 25-26, 2019
Equity and Inclusion in Healthcare Conference 2019
Hosted by Mayo Clinic School of Continuous Professional Development

November 8, 2019
Minnesota Memorial Pediatric Orthopaedic Symposium
Hosted by Mayo Clinic School of Continuous Professional Development in collaboration with Gillette Children’s Specialty Healthcare and Shriners Hospitals for Children

November 13, 2019
Partners in Care: Seizure Recognition and First Aid/Management
Hosted by Gillette Children’s Specialty Healthcare
I am grateful to have a cabin on Ojibway Lake just outside of Ely, Minnesota. It is a very quiet lake with a Boundary Waters-like landscape where I can truly relax and recharge. I hope that all of you have had the opportunity to do the same over the summer.

At the 2019 American Academy of Pediatrics (AAP) Annual Leadership Forum, elimination of non-medical exemptions to vaccination was voted as the number one priority. AAP President Dr. Kyle Yasuda has stated, “Given the measles outbreaks, prioritizing the elimination of non-medical exemptions is a timely undertaking.”

The leaders of our chapter, along with our lobbyist, Eric Dick, and Immunization Work Group Chair Dr. Dawn Martin, kept the wheels turning this summer as we pursued a timeline for eliminating non-medical exemptions for vaccines in the state of Minnesota. This was identified as a chapter priority last year and will likely be a marathon undertaking. We have good news in that we have identified Minnesota legislators who are willing to co-author a bill. This will require no small measure of diligence and courage on their behalf as we move forward. A highlight in our advocacy path was a telephone conference in July with Senator Richard Pan, who is a pediatrician and state senator in California. Three years ago, he co-authored a bill that prohibited “any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home or development center” from admitting children who have not been fully immunized against several diseases. His words to us during the phone call were a treasure trove of information on how to proceed.

Here are some pearls from the conversation with Senator Pan:

1) **Science is important, but it isn’t always effective in winning the hearts or votes of legislators.** The face of the bill should be families and children in our communities who are vulnerable to vaccine-preventable infectious diseases and who are fierce advocates of vaccinations.

2) **He used the phrase “community immunity” rather than herd immunity.** We like this catchy version!

3) **Public health comes first and foremost.** When anti-vaxxers start to talk about personal freedom, remember that state and federal law rightly allows the government to protect the health of the community.

4) **Building a coalition of like-minded organizations, including those in health care, schools and business will be important in strengthening this mission.**

**We must remain steadfast in protecting children from infectious diseases that may result in harm and death.**

The headlines regarding the measles outbreak of 2019 are winding down as I write this letter. But one thing we know for sure is that another measles outbreak in Minnesota is only a matter of time. Other vaccine-preventable diseases are always on our radar, too. We must remain steadfast in protecting children from infectious diseases that may result in harm and death. I invite you to be a part of this chapter initiative. Please contact me or any of our board of directors members if you have families that would like to step forward and participate. Consider signing up for the MNAAP Immunization Work Group. Email your legislators to support this bill when it is introduced. Be available for testimony to the legislature. Become a MNAAP board of directors member!

All of your efforts have an indelible impact on the families and children that we serve.

Thank you,

Lori DeFrance, MD, FAAP
MNAAP President
lori.defrance@essentiahealth.org
Gender Health Program Offers Sensitive, Affirming Care

While nearly 3 percent of Minnesota high school students identify as gender diverse, many of them do not know where to turn when it comes to finding culturally sensitive, gender-affirming care. And despite recent advances in health care, transgender and gender-diverse youth continue to face significant health disparities, including higher rates of harassment, discrimination, homelessness, and suicidality.

As part of Children’s Minnesota’s commitment to provide equitable and inclusive care to all children, we launched the Gender Health Program in April. This personalized and comprehensive pediatric multispecialty clinic provides transgender and gender-diverse children and their families with medical care and support from pediatric experts they can trust, including experts in pediatric gender health, endocrinology, and gynecology.

About the program

Each family that comes to the Gender Health Program will start with a gender consultation with one of our physicians. During this initial consultation, children and their families meet with a gender health expert to discuss developmental questions or concerns about gender identity and develop a personal care plan. Each family comes to the program at a different place and with a different path, so this consultation helps to answer questions, discuss goals, and think about next steps. Often youth—especially teenagers—and their families come to this initial consultation with different questions and goals. Our team is committed to helping understand what each child, parent, and family needs before moving forward. We can often help youth and families understand each other and learn to speak a common language as they navigate future steps on their journey.

One key component for most families is appropriate mental health assessment and referrals as needed. Our program includes a social worker/care navigator who participates in the initial intake assessment for each family to help determine what resources are needed. We can connect parents with resources and support for their questions, and can connect youth with individualized support systems. Our goal is to optimize care and outcomes for each patient, by supporting the mental and physical well-being of the whole child and the whole family.

The onset of puberty can be difficult for many transgender and gender-diverse adolescents, and Children’s offers both pubertal and menstrual suppression. These reversible interventions pause puberty and/or menstruation for patients as necessary. Patients may also meet with a pediatric gynecologist for a consultation to discuss options to preserve fertility prior to beginning pubertal suppression and/or gender-affirming treatment.

For patients who are in middle-to-late adolescence, gender-affirming hormone treatment may be appropriate. This hormone treatment creates changes in the body to align with the patient’s gender identity. The decision to move forward with such treatment is made with one of our gender health experts, along with a readiness assessment by a mental health professional to optimize outcomes—and to gauge the support and obtain the consent of parents.

Gender-affirming surgeries are most often performed for patients who are over the age of 18 and are not done at Children’s Minnesota. While Children’s Gender Health Program does not perform these surgeries, we can refer patients to plastic surgeons in the community as needed.

Tips for primary care physicians

While transgender and gender-diverse children and adolescents may come to the Children’s Gender Health Program for specialized and expert care related to their gender identities, they will continue to receive their primary care (including well-child exams, immunizations, and ill-child visits) through their primary care offices. Primary care clinicians often have questions about how to best provide supportive and affirming care to transgender patients and their families.

Ask each child the name they would like to be called, and the pronoun they use, and be sure to use this name and pronoun at each visit. (Continued on page 13)

About the Author

Angela Kade Goepferd, MD, FAAP, is the medical director of Children’s Minnesota’s Gender Health Program, the director of Medical Education and vice chief of staff for Children’s Minnesota, and a general pediatrician in the Children’s Minneapolis Primary Care clinic. An advocate for advancing equitable health care for all children, Dr. Goepferd works to ensure a positive human experience for patients, families, and professional staff, and has been an engaged member and leader on several committees, strategic planning teams, and other initiatives across the organization.
Food Insecurity Screening in Two Settings

The American Association of Pediatrics has called upon pediatricians to take an active role in screening for food insecurity in clinical settings and connecting families to food resources. Implementation of screening for food insecurity has accelerated rapidly over the past few years, but many questions remain, including where and how to screen, and what to do once a family screens positive. Jonathan KenKnight, MD, FAAP, and Gretchen Gretchen J. Cutler, PhD, MPH, share screening practices from two different settings.

In the clinic | Dr. Jonathan KenKnight

As pediatricians, we are all acutely aware of the stress and burden food insecurity places on our patients and families, and we need to be screening for problems. Bright Futures recommends routine screening for food scarcity along with other socioeconomic factors at our well visits. The Minnesota Department of Health also added this to its Child and Teen Checkup requirements in 2017.

At Essentia Health, where I practice in Duluth, we have developed an automated screening questionnaire that is given to families prior to well visits. These are completed in privacy after the patient is roomed. Depending on responses, these are flagged for follow-up with our community health worker, who then reaches out to families to assist in finding resources.

Fortunately in Duluth, we have several food banks locally and many organizations built to help families address this increasingly common problem. However, given that we take care of a large area ranging from Northeastern Minnesota, Northern Wisconsin, and the upper peninsula of Michigan, sometimes finding local resources is challenging. Fortunately, we have a social worker present in our office space. She is available to speak with families and connect them with resources in person during the visit and can follow up as needed to ensure our children and families have access to food and any other social needs - housing, safety, etc. We also have pamphlets present in our exam rooms with lists of local resources that are freely available to take.

Jonathan KenKnight, MD, FAAP, is a pediatrician with Essentia Health in Duluth, MN.

In the emergency department | Gretchen Cutler, PhD, MPH

I’ve had the unique opportunity to co-lead a research project with Caitlin Gaspi, ScD, from the University of Minnesota Department of Family Medicine and Community Health that has tried to tackle questions regarding food insecurity screening with a research team including investigators from Children’s Minnesota (Anupam Kharbanda, MD, MSc), the University of Minnesota (Marissa Hendrickson, MD), and HCMC (Diana Cutts, MD). This study was supported by a research grant from the University of Minnesota’s Clinical and Translational Science Institute, Child Health Collaborative Grant Program, a partnership between the University of Minnesota and Children’s Minnesota.

In February 2017, Children’s Minnesota started screening for food insecurity in our Minneapolis and St. Paul emergency departments (EDs) with the aim of examining a universal electronic medical record (EMR) based screening process along with a text message system for providing follow-up community food resource information.

The validated 2-item Hunger Vital Sign was embedded in the EMR along with other rooming assessment questions. After an 8-month period of verbal screening by nursing staff, only 4 percent of caregivers were screening positive, which was surprising as other studies have found food insecurity rates as high as 40 percent in urban pediatric EDs. Screening was also only being completed in a little over half of patient visits, and nursing staff was raising concerns about difficulties with asking questions directly as written and patient discomfort. We had chosen an EMR-based screening method in order to screen as many families as possible, but this method was not reaching all patients, and was not accurately identifying all families experiencing food insecurity. With a few months of study funding left, we decided to test whether the number of positive screens would go up if we switched to a private, electronic tablet-based method. Over a five-month period this new process resulted in a four-fold increase in the percentage of positive screens, increasing from 4 percent to 16 percent.

During the two-year study, we identified 2,272 families as food insecure and provided each with a food resource handout. A subset of 265 caregivers completed a more comprehensive screen, which showed that over half of these families were classified in the most severe category of food insecurity. These caregivers were also randomized to receive a food resource handout or a handout plus a series of text messages with community food resource information. (Continued on page 13)
Minnesota has recently seen a cluster of severe pertussis cases in young children, primarily infants younger than 3 months old. Since mid-April, the Minnesota Department of Health (MDH) has received reports of six Minnesota infants and a non-Minnesota toddler hospitalized with pertussis. Three of these cases required extracorporeal membrane oxygenation (ECMO), and initial reports suggest that not all mothers were offered the Tdap vaccine during their pregnancies.

Parents and older siblings are often the source of infection for infants; however, diagnosis in adolescents and adults can be complicated by atypical presentation, leading to misdiagnosis and lack of intervention. Especially if vaccinated, patients may present with a persistent cough otherwise lacking pertussis-like symptoms. This can lead to a misdiagnosis of acute bronchitis or nonspecific viral syndrome.

To help prevent pertussis and reduce morbidity in infants, MDH asks physicians to remember to think, test, and treat to stop pertussis transmission:

- Think about pertussis as a differential diagnosis when assessing patients with persistent cough of unknown etiology lasting more than 7 days, even if pertussis-like symptoms are not present.
- Test for pertussis if patients have symptoms.
- Treat and report suspected and confirmed cases of pertussis to help stop transmission.

Pediatricians can also make sure their patients are up to date on their pertussis-containing vaccines at each visit. If you encounter pregnant women in your practice, remind them that Tdap vaccine is recommended during each pregnancy to help protect their baby.

For more information on pertussis, please visit the MDH website at [https://www.health.state.mn.us/pertussis](https://www.health.state.mn.us/pertussis) or call MDH at 1-877-676-5414.

Information provided by the Minnesota Department of Health.
From Consultation to Special Connection

MNAAP President-Elect Sheldon Berkowitz, MD, FAAP, attended the May 2019 signing ceremony of the bill which formed the Rare Disease Advisory Council. His attendance was at the request of the family who advocated for its creation, and he shares these thoughts with Minnesota Pediatrician.

“I’m not sure if you remember me, but I am Chloe Barnes’ mother.” This was the beginning of an email I received in March 2019. To be honest, I vaguely remembered the name but once I looked up her medical record, it all came back. This family came to see me for a second opinion nine years earlier with concerns about their daughter’s lack of walking ability and muscle strength. I examined her and agreed with her parents that yes, her gross development was delayed and she had some hypotonia. I thought further testing was indicated. We talked about whether the parents wanted to have this done with their primary care physician (to whom I would send a copy of my notes) or have me start it, and they requested I order the tests. A neurology referral, brain MRI and subsequent workup showed that she had a severe neurologic disorder. She eventually underwent a bone marrow transplant, but succumbed to her disease a few months later. Other than the initial clinic visit and a preoperative exam for her MRI, along with a few other phone calls along the way, my involvement in her care was very limited.

Fast forward nine years to the email I received from her mom that ended with, “Thank you for your dedication to these little ones.” There were other emails we traded over the next two months, including one where this mom wrote me that “your clinical judgment gave Chloe a chance” and others where we discussed the bill she had been working on to get additional resources and funding for a Rare Disease Advisory Council from the Minnesota Legislature. We talked about how the Minnesota Chapter of the American Academy of Pediatrics had already signed a letter of support for the bill. Finally, I received an email inviting me to join the family and others for the signing of this bill by the governor. Next thing I knew, I found myself in the Minnesota Capitol Rotunda greeting Chloe’s mom with a big hug.

What I heard from her that day, as well as from Chloe’s father when I reintroduced myself to him at the actual signing, was how significant my involvement had been for this family. They talked about how important my listening to their concerns and taking them seriously and then acting on them had been.

In addition, they talked about how even though their child eventually died from her disease, my assistance in getting a diagnosis made and treatment provided, gave them extra time with her and allowed them to feel that they did everything they could for her.

We can never know what impact our involvement in a child or young patient or their family’s life will be.

I write this not to pat myself on the back as I really don’t think I did anything that remarkable. But to this family I did, and that is a very humbling feeling. As pediatricians, we are allowed into family’s lives and learn intimate details about both their children and often the parents. We are expected to guard that information carefully and to act on it for the best interests of the child we are caring for. Sometimes, that relationship develops over years or decades, while other times it may be a single or a few visits and phone calls. We can never know what impact our involvement in a child or young patient or their family’s life will be. But we should always be aware that it may end up being an incredible experience for everyone involved and make sure we do everything we can to make that happen.

About the Author

Sheldon Berkowitz, MD, FAAP, is the president-elect of the MNAAP. Dr. Berkowitz is a pediatrician in the General Pediatrics Clinic in Minneapolis and also the Medical Director for Case Management, Utilization Management and Clinical Documentation Improvement for Children’s Minnesota.
Cars and Kids: Communicating Passenger Safety

Children have many points of interaction with motor vehicles long before they themselves become licensed drivers, and as pediatricians we can help reinforce to their caregivers the many opportunities that exist to keep children safe. According to the Minnesota Department of Public Safety (DPS), 27 children and teens between the ages of 0 and 18 were killed in motor vehicle accidents in 2017, and more than 4,400 were injured.

Car Seat Safety

Perhaps the most obvious safety issue for children in a motor vehicle is how they ride in that car. The American Academy of Pediatrics (AAP) recommends that all infants and toddlers should ride in a Rear-Facing Car Safety Seat until they are two years old or until they reach the highest weight or height allowed by their car safety seat's manufacturer.

Often, parents or caregivers will ask about booster seats for older children. A child who is both under age 8 and shorter than 4 feet 9 inches is required to be fastened in a child safety seat that meets federal safety standards. Under this law, a child cannot use a seat belt alone until they are age 8, or 4 feet 9 inches tall. It is recommended to keep a child in a booster based on their height rather than their age. Check the instruction book or label of the child safety seat to be sure it is the right seat for a child’s weight and height.

Minnesota does not have a law prohibiting children from riding in the front seat. However, according to the Office of Traffic Safety, it is considered safest and the best practice to keep children in the back seat until they reach age 13.

You can recommend parents or caregivers visit CarSeatsMadeSimple.org for easy to find information. This website is maintained by the Minnesota Safety Council. The Minnesota Office of Traffic Safety also keeps a calendar of free car seat check opportunities under its “Child Passenger Safety” section of its website.

Unattended Minors in Motor Vehicles

Minnesota does not have specific laws that address the age at which a child may be left unattended in a motor vehicle. However, accidents can happen quickly, and young children lack the impulse control or decision making skills to keep themselves as safe as an adult caregiver can.

In addition to accidents, weather can affect the internal temperature of a motor vehicle quickly, and a child left unattended in a car may not be able to escape a vehicle that becomes too hot or too cold. The National Safety Council has recorded 6 child heatstroke deaths in vehicles in Minnesota since 1998, but any number is too great.

Remind parents and caregivers that leaving children unattended in motor vehicles is a decision that must be weighed carefully based on the child’s age, ability, and maturity, but that the best course of action is to not leave children unattended in a car.

Technology and Driving

Minnesota recently enacted a hands-free law on Aug. 1, which requires drivers to put down their phones and go hands-free while driving. This is excellent news for child passenger safety, because children involved in a distracted driving traffic accident are the unintended victim to an avoidable situation.

The new law allows drivers over 18 to use their cell phones to make calls, text, listen to music or podcasts and get directions, but only by voice commands or single touch activation without holding the phone.

When talking with teen patients, remind them that the new hands-free law does not change anything for teens under 18 with a driver’s permit or provisional driver’s license: they cannot make or answer calls while driving (hand-held or hands-free).

The DPS has prepared several resources to help in educating patients and their caregivers about the new law, and these can be viewed on its website at HandsFreeMN.org.

Driver Impairment

No driver should ever sit behind the wheel of a car while under the influence of drugs or alcohol, and children should not be in the car with a driver who is impaired. In 2017, the DPS reported two Minnesota children between the ages of 0 and 18 were killed in alcohol-related car crashes, and 231 were injured in alcohol-related motor vehicle accidents.

For additional resources, visit: http://www.mnaap.org/work-groups/child-safety/ and click on free safety resources.

About the Author

Vijay Chawla, MD, FAAP, is a member of the MNAAP Child Safety Work Group. Dr. Chawla retired after practicing for 20 years at the Mayo Clinic Health System in Albert Lea.
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<thead>
<tr>
<th>Age Group</th>
<th>Type of Seat</th>
<th>General Guidelines</th>
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<tbody>
<tr>
<td>Infants and Toddlers</td>
<td>Rear-facing-only</td>
<td>All infants and toddlers should ride in a rear-facing seat until they reach the highest weight or height allowed by their car seat manufacturer. Most convertible seats have limits that will allow children to ride rear facing for 2 years or more.</td>
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<td></td>
<td>Rear-facing-convertible</td>
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<tr>
<td>Toddlers and Preschoolers</td>
<td>Forward-facing convertible</td>
<td>Children who have outgrown the rear-facing weight or height limit for their convertible seat should use a forward-facing seat with a harness for as long as possible, up to the highest weight or height allowed by their car seat manufacturer. Many seats can accommodate children up to 65 pounds or more.</td>
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<td></td>
<td>Forward-facing with harness</td>
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<tr>
<td>School-aged children</td>
<td>Booster</td>
<td>All children whose weight or height exceeds the forward-facing limit for their car safety seat should use a belt-positioning booster seat until the vehicle seat belt fits properly, typically when they have reached 4 feet 9 inches in height and are 8 through 12 years of age. All children younger than 13 years should ride in the back seat.</td>
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<tr>
<td>Older Children</td>
<td>Seat belts</td>
<td>When children are old enough and large enough for the vehicle seat belt to fit them correctly, they should always use lap and shoulder seat belts for the best protection. All children younger than 13 years should ride in the back seat.</td>
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*Information from HealthyChildren.org; “Car Seats: Information for Families”*
Time to Cast Your National Ballot!

CAST YOUR VOTE
AAP NATIONAL ELECTION
voting closes September 21
AAP.org/vote

As a national AAP member, you have the opportunity to vote in the national election Sept. 7-21, 2019 for president-elect and at-large positions.

Last year our chapter had 13.39% of members voting, let’s increase that this year!

www.aap.org/vote

Meet the candidates for AAP President-Elect:

Dr. Lee Savio Beers is a community pediatrician, Associate Professor of Pediatrics and Medical Director for Municipal and Regional Affairs at Children’s National in Washington DC. She earned her medical degree from Emory University and completed her pediatric residency at Naval Medical Center Portsmouth. Previously, she was a pediatrician at Naval Hospital Guantanamo Bay and National Naval Medical Center.

Dr. Beers has held numerous leadership positions in the American Academy of Pediatrics, and is currently Associate Editor-Mental Health for Pediatric Care Online, DC’s Early Childhood Chapter Champion and a member of the Think Babies Campaign Steering Committee. Previous AAP leadership roles include District I Coordinator-Section on Residents, Vice President-Unified Services East Chapter, Nominations Committee Chairperson-Section on Young Physicians, Chairperson-Committee on Residency Scholarships, President- District of Columbia Chapter, District III Chapter Forum Management Committee Representative and member of the CEO Search Committee.

For full candidate bios, videos, and information about open at-large positions, visit www.AAP.org/elections.

Dr. Pam Shaw is a Professor of Pediatrics at the University of Kansas Medical Center. For the university, she is the Assistant Dean for Clinical Sciences and the Associate Vice Chancellor for Student Services. She has served as president of the Kansas Chapter of the AAP and recently completed 6 years as the District Chair and board member for District VI for the American Academy of Pediatrics (AAP).

She has been involved in training for the chapter to help private practice physicians offer evidence based and quality care to children including developmental screening, mental health screening, detection and treatment of obesity and oral health services and immunizations. Part of her new job is providing student services to students from the medical school, nursing school and health professions.

Her undergraduate degree was in Human Biology at the University of Kansas. She attended medical school and did her pediatric residency at the University of Kansas.
Many of us are members of the Minnesota Chapter of the American Academy of Pediatrics (MNAAP) as well as National American Academy of Pediatrics (AAP). However, until I started attending national AAP meetings on behalf of our chapter in my role as president-elect (VP) of the Minnesota Chapter, I really had no idea how the two were connected. Here is what I have learned:

1. The Minnesota Chapter of the AAP is a “stand-alone” not-for-profit organization in the state of Minnesota, and is the leading voice on children’s health and wellbeing in Minnesota, representing over 1,000 pediatricians practicing or residing in the state.

2. There are 10 districts in the AAP, representing all 50 states and six Canadian provinces.

3. Our chapter is part of District VI of the AAP – including eight other Midwest states and two Canadian provinces.

4. The District Chairpersons are each members of the National AAP Board of Directors. As a result, MNAAP has direct access to AAP leadership.

5. In addition to monthly District VI conference calls, there are two annual meetings that our chapter president, president-elect and executive director attend in Itasca, IL (west of Chicago) where the National AAP Headquarters is located:
   - The Annual Leadership Forum (ALF) in the spring, where all state, district, section, council and committee Leadership are present at this meeting. We meet with the other chapters in our district, hear presentations from national leadership and the AAP presidential candidates and discuss and vote on all the resolutions that are put forth by AAP members/chapters around the country.
   - The District VI meeting in August where all district chapter leadership and district leadership, as well as some national leadership attend. This meeting is smaller than the ALF and allows for more discussion time with chapters in your own district and one other district that is also in attendance. We also get to hear presentations from our national leadership, other speakers and again, the AAP presidential candidates.

MNAAP communicates and works closely with AAP on a number of issues involving education, advocacy and membership. With more than 500 employees, AAP is an incredible resource for chapter staff, volunteers and leaders. Currently our chapter has four paid consultants – all of whom are part-time – including our executive director, foundation executive director (who handles state and community grant projects), communications manager and lobbyist. Everyone else, including our board and officers are volunteers.

There are three officers in our chapter: president, president-elect (vice president) and treasurer. These three officers, along with our executive director, past president, and two at-large members make up the executive committee of the board. Our board is made up of 25 elected pediatricians from around the state. There are also a number of chapter work groups and champions for various issues (e.g. Dental Champion, Early Childhood Education).

- The chapter has 10 work group co-chairs overseeing the chapter’s priorities: policy, immunizations, child safety, poverty and disparities, and behavioral health.
- The chapter has 11 chapter champions or liaisons to AAP on a number of issues, ranging from early childhood to breastfeeding to disaster preparedness.
- The chapter has 22 members who serve in leadership roles on AAP committees, sections and councils.
- Both our local chapter and the national AAP are dedicated to education and advocacy at the state and federal levels to improve the health and wellbeing of children.

If you want to know more, or are interested in becoming more involved with AAP at the chapter or national level, please reach out to either our president, Dr. Lori DeFrance or myself.

Sheldon Berkowitz, MD, FAAP
MNAAP President-Elect
sheldon.berkowitz@childrensmn.org
No Missed Opportunities: 
Long-Acting Reversible Contraceptives for Adolescents

Seventy-five percent of pregnancies among adolescents are unplanned and every day in the state of Minnesota, approximately eight adolescents become pregnant and six give birth. Long-acting reversible contraceptives (LARCs), including intrauterine devices (IUDs) and etonogestrel implants (Nexplanon), are the first-line contraceptive method for adolescents, yet fewer than 5 percent of adolescents ages 15-19 use these methods. In 2014, the American Academy of Pediatrics (AAP) joined the Institute of Medicine, the American College of Obstetricians and Gynecologists, and the American Academy of Family Medicine in recommending LARCs as first-line contraception for adolescents. Although pediatricians are well-positioned to increase adolescent LARC use, provider knowledge, attitudes and experience remains a barrier, resulting in missed opportunities to prevent teen pregnancy.

A multidisciplinary, trainee-led team from the University of Minnesota conducted a needs assessment among pediatric community clinicians and trainees. It revealed two key findings: (1) few pediatric providers in our community were providing LARCs, and (2) the vast majority (88 percent) of pediatric trainees desired LARC training, yet opportunities were limited. To address this gap, in July 2018, the trainee-led team launched monthly LARC workshops for pediatric community clinicians and trainees. This free 3.5-hour workshop includes an interactive educational session on LARC methods, followed by hands-on etonogestrel implant (Nexplanon) training and certification.

To date, a total of 147 clinicians have participated in the LARC workshop - 52 medical residents and fellows (35 percent), 58 advanced practice providers (39 percent), and 19 attending physicians (13 percent). Clinicians who have attended the workshop report increased knowledge and comfort with LARC methods and are more likely to recommend and provide LARCs in their clinics. We are all too familiar with the missed opportunities to prevent unplanned teen pregnancy and as pediatricians; we are uniquely positioned to make a difference.

We hope to see you at one of the upcoming trainings!

For more information and to sign up, please contact Alex Prince by email princ092@umn.edu.

Quick Facts: Long Acting Reversible Contraceptives (LARCs)

• They are the most effective form of reversible contraception.
• There are very few contraindications.
• They are safe and well-tolerated among adolescents.
• Adolescents prefer LARCs compared to other contraceptive methods.

About the Authors

Taylor A. Argo, MD; Janna R. Gewirtz O’Brien MD, FAAP; Kathleen K. Miller, MD, FAAP; Emily Borman-Shoap MD, FAAP authored the content for this article.

Alexandra Prince, Tori Bahr, MD, Christy Boraas, MD, MPH, Nicole Chaisson, MD, MPH, collaborated on this project.

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(Gender Health Program, continued from page 4)

Educate staff about how to ask each patient what name they would like to be called and what pronoun they use, so that they can do the same; this is especially important for those answering phones, checking in, and rooming patients. It’s also important to remember that we all make mistakes, even when we are trying to do our best. When mistakes happen, we should acknowledge them, apologize, and commit to continuing to get it right in the future.

Often, mistakes in calling a patient the correct name or using the correct pronoun are made due to limitations and barriers of the electronic medical record (EMR). Primary care providers should find out the best way to optimize their EMR system to visibly display the preferred or declared name of each child, as well as the pronoun they use. Being misgendered when seeking medical care is a common fear of transgender and gender-diverse patients and their parents, and anything we can do to ensure a smooth and affirming patient care experience will allow children and families to relax and focus on the medical reason for their visit.

Parents often struggle to know how to best support their kids on top of dealing with their own feelings of grief, anger, disappointment, or fear. Primary care clinicians can affirm to parents that asking questions is OK, and seeking supportive resources is encouraged. Parents often need just as much, if not more, room to ask questions and seek support as they learn more about their child’s identity. Parental rejection is a significant risk factor for poor physical and mental health outcomes for transgender youth, including a significantly increased risk of suicide, so clinicians should always encourage parents to consistently reassure their children that they love them, even when they are struggling to understand their expressed identities. Unconditional parental love is the single biggest protective factor to keep transgender and gender-diverse kids healthy and safe.

Although positive steps have been taken in recent years, transgender and gender-diverse youth are still a medically underserved population, experiencing a variety of health disparities. The Children’s Gender Health Program offers transgender and gender-diverse children and their families a place to go for exclusively pediatric, comprehensive, compassionate medical care when they have questions about their gender. With this program, Children’s continues to strive to be every family’s essential partner, and to ensure that transgender and gender-diverse children can grow up happy, healthy, safe, and strong.

(Food Insecurity Screening, continued from page 5)

Food insecurity status was slightly improved in families at a three-month follow-up, but this did not differ by delivery method of food resource information.

The increase in screening for food insecurity in health care settings is a crucial step towards treating all factors that influence a child’s health, and our finding highlight the importance of choosing the correct screening method. Food insecurity is a stigmatizing condition, which can make verbal disclosure difficult, especially when children are present or in an ED setting when there is rarely an established relationship with a family. To accurately identify all families in need screening methods should be consistently monitored, adjusted when needed, and should incorporate feedback from impacted families.

Gretchen J. Cutler, PhD, MPH is a Scientific Investigator with the Children’s Minnesota Research Institute and an Affiliate Assistant Professor with the Division of Epidemiology, University of Minnesota.

Join a MNAAP Work Group!

MNAAP has work groups that meet on a monthly or bi-monthly basis by conference call to share best practices, identify helpful resources and consider advocacy efforts in the following areas:

- Mental health
- Immunizations
- Safety and injury prevention
- Poverty and health disparities

Email debilzan@mnaap.org for more information, or visit www.mnaap.org/take-action for more ways you can get involved with MNAAP.
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Nathan Chomilo, MD, FAAP, was interviewed by MPR News about the importance of unstructured play in child development. Dr. Chomilo also spoke to KARE 11 about childhood imaginary friends after a UK report suggested there was a decrease in their presence in childhood.

Nusheen Ameenuddin, MD, MPH, FAAP; Robert Jacobson, MD, FAAP; and Angela Mattke, MD, FAAP, met with Surgeon General of the United State Jerome Adams during his visit to the Mayo Clinic on Aug. 27. The MNAAP members discussed immunization efforts with the surgeon general in a meeting organized and hosted by the Zumbro Valley Medical Society.

Katy Miller, MD, FAAP, and Calla Brown, MD, FAAP, along with their team members Maura Shramko PhD and Maria Veronica Svetaz, MD (principal investigator), were recently awarded the Joanna Simer Research Fellowship Grant.

Marjorie Hogan, MD, FAAP, co-wrote the book “Terrific Toddlers! Simple Solutions, Practical Parenting.” The book is a resource for parents navigating the toddler years.

Emily Chapman, MD, FAAP, chief medical officer at Children’s Minnesota, and Ruth Lynfield, MD, FAAP, state epidemiologist, were recently quoted in a Star Tribune article, “Teen lung diseases linked to vaping, Minnesota Health Department reports.”

Jeff Schiff, MD, FAAP, penned an open letter to Governor Tim Walz and state lawmakers calling for the creation of an independent board to oversee the Medicaid program and its policies. Dr. Schiff previously served as the medical director of Minnesota’s Medicaid program.

Janna Gewirtz-O’Brien, MD, FAAP, was quoted in a Star Tribune article that identified short-sighted decisions about Minnesota’s Medicaid program that are harming patients in the process.

Krishnan Subrahmanian, MD, FAAP, spoke with WCCO-TV about the importance of sports physicals as part of the station’s “Good Question” segment.

Nusheen Ameenuddin, MD, MPH, FAAP, was promoted to chair of the Council on Communications and Media at American Academy of Pediatrics.

Brian Lynch, MD, FAAP, was interviewed by Minnesota Public Radio as part of the “Call to Mind” mental health exhibit. Dr. Lynch spoke about adverse childhood experiences and how early trauma can affect kids, adults, and public health.

Angela Mattke, MD, FAAP, was interviewed by WGN – Chicago about her new book “Mayo Clinic Guide to Raising a Healthy Child.”

Kathleen Miller, MD, FAAP, authored a counterpoint opinion article that was published in the Star Tribune, providing insight into the value of gender affirming care after the Children’s Minnesota’s gender health program was called risky and unnecessary by a previous letter to the editor.

After reading a Pioneer Press article about an 8-year-old girl who found her mom’s gun in her backpack, MNAAP President-elect Sheldon Berkowitz, MD, FAAP, wrote a letter to the editor to make sure everyone knows the “4 simple steps to keep guns out of kids’ hands.”

Tom Scott, MD, FAAP, has been invited by the Children’s Defense Fund to serve on the 2019 Minnesota KIDS COUNT advisory group.

Submit MNAAP member news and announcements!

If you or someone you know started a new position, received a promotion or recently retired, let us know! If you have received special recognition, been quoted in the media, or are quietly working on clinic or community initiatives to improve children’s health, reach out! Email venable@mnaap.org for all member news and announcements.
If you are a member, you should be receiving:
- Weekly emails from MNAAP President Dr. Lori DeFrance -
- Bi-weekly legislative updates during the legislative session -
- Quarterly newsletters from the chapter -

Additionally, you can follow MNAAP on:

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