The safety and health of children is a pediatrician’s first concern, and has never been more so than now. I know many of you, like me, watched recent explosive events unfold knowing that they will shape the children of today and the adults of tomorrow. As pediatricians, we recognize that racism is a social determinant of health which impacts the long-term outcomes of health, education and economic stability of our communities of color. And in the days following the tragic death of George Floyd, we have seen the immediate outcomes of the effects of racism, accelerated and brought in to sharp focus. Children across Minnesota are being affected by violence and upheaval. Families that already live in precarious situations were left without reliable access to food or formula, medicine or first aid. Children and adolescents are traumatized from the sights and sounds in their worlds, whether it be the sirens and fires in their communities, or the video images of a man’s agonizing last moments as he pleads for help.

Our children were already experiencing an imbalance in their sense of physical safety as a global pandemic uprooted their lives, and this trauma has been compounded by the abhorrent act of racism that resulted in the death of Mr. Floyd and the subsequent violence that has erupted. The disparate consequences of racism are laid bare for all to see during this outcry in our communities and we need to reassure families that pediatricians are here to support all children and help create safe environments for all families.

In times of crisis and uncertainty, children and adolescents look to their grown-ups for a road map on how to travel through the experience. We need to encourage parents across our state and nation to see their child’s doctor as an ally in addressing the systemic disease of racism.

(Continued on page 2)
Having an age-appropriate conversation with children or adolescents about racism is a crucial part to preventing a future generation that enables inequity and human suffering. It can feel like a daunting task, but it is imperative. MNAAP has collected resources and guides that can be helpful in approaching and facilitating these conversations. You can find them at www.mnaap.org/racism-and-violence-undermine-childrens-safety/.

The members of the Minnesota Chapter of the American Academy of Pediatrics stand firm in our collective mission to recognize the challenges that our children are facing, identify implicit bias and advocate for equity in all areas of our social structure that will allow them to grow up to be healthy and strong.

Take care,

Lori DeFrance, MD, FAAP
MNAAP President

“Alone we can do so little; together we can do so much.”
– Helen Keller
All legislative sessions have their own ‘feel’ for the legislators, lobbyists, and advocates who live in the Capitol during each legislative session. Some sessions are dominated by partisan sniping and fighting, while others see more bipartisan cooperation. A few years ago, was unusual in that the Capitol was closed for major renovations, and another recent session saw a Republican member of the Senate elevated to serve as the lieutenant governor under a DFL governor. But nothing compares to the 2020 session.

Legislative leaders entered the session in early January with a projected surplus of over a $1 billion, with the House DFL intent on investing in early education, while the Senate GOP hoped to pass tax relief. Governor Tim Walz, as well as both the House and Senate, spoke of passing a robust bonding bill. The best laid plans were quickly scrambled in early March as the COVID-19 pandemic arrived in Minnesota. It quickly become clear that ‘business as usual’ wasn’t going to work in 2020.

With several staff members diagnosed with COVID-19 in early March, legislative leaders quickly extended the Easter/Passover break by a week to clear the Capitol as they discussed plans on how to continue or even end the session. Ultimately, the House and Senate returned to the Capitol, albeit in a very different setting. All committee hearings were conducted remotely, and both the House and Senate strictly followed the social distancing guidelines from the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). Some legislators voted remotely, while others were spread throughout the Capitol and would come to the floor in shifts to register their vote. Routine roll call votes that normally take mere minutes took 15 minutes or longer. Much of the debate focused upon legislation to address the pandemic’s impact.

Unfortunately, the pandemic did affect the MNAAP’s legislative priority agenda at the Capitol. While we always knew we faced an uphill battle to pass meaningful measures to reduce firearm death and injury and strengthen Minnesota’s weak vaccine laws, it was our goal to educate legislators and prepare to move these important issues forward in 2021. Most notably, our annual Pediatricians’ Day at the Capitol had to be cancelled. With a dramatically smaller field of issues being considered as the pandemic changed the dynamics at the Capitol, pursuing these controversial issues become impossible. Our legislative allies simply didn’t have the bandwidth to raise these issues given the enormity of the pandemic.

The MNAAP did have a big, important win. Our third legislative priority for the session – increasing the age to purchase tobacco from 18 to 21 – is now law. While the federal government increased the age late last winter, the MNAAP and other tobacco control advocates sought passage of a state law to ensure effective enforcement and compliance. This was an important win for the chapter.

The MNAAP saw another big win in the passage of prior authorization (PA) reform. Under the bill, health plans will be required to more quickly respond to PA requests, timelines for appeals are accelerated, “peer to peer” reviews must involve a Minnesota-licensed physicians in the same or similar specialty, and plans must post written clinical criteria for the PA policies. Other provisions protect patients when they change health plans or when their health plan changes PA criteria in the middle of the individual’s contract year. MNAAP President-elect Sheldon Berkowitz, MD, FAAP, offered testimony in support of the legislation in the House.

(Continued on page 12)
When pediatric residents from the University of Minnesota came to Brainerd to participate in my rural preceptorship, I would always make sure we took a field trip to the Brainerd Head Start Classroom for two reasons. First, because I was on the Head Start Advisory Board and could easily make the arrangements and second, because I wanted young pediatricians to observe the human fabric of these radiant, busy children’s faces woven by many threads but the single most common thread: poverty.

Poverty predicts that you are unlikely to leave the county you were born in, it predicts you are more likely to suffer from childhood obesity, heart disease, diabetes and mental health disorders, become a high school dropout or experience teen pregnancy.

Minnesota Head Start exists to help change these outcomes. Head Start oversees a program of services for pregnant women and children from birth to age 5 across 87 counties and 8 tribal nations. It assures the enrolled children will have a well child exam and perhaps find a medical home. It assures immunizations are current, that hearing and vision are normal or appropriately referred, and dental health evaluation is completed.

Head Start is a successful program and insists high-quality education and care must be available to every one of the more than 50,000 Minnesota children under the age of 5 who live in poverty.

In 2017–2018, there were 69,310 children in poverty under age 5 in Minnesota. Of those, only 46 percent of three and four-year-olds had access to Head Start. And only 9 percent of children under 3 had access to Early Head Start (EHS). EHS programs are available to families prenatally until a child turns 3 years old and is ready to transition into Head Start or another pre-K program. Most early childhood initiatives focus on preschool-age children (3-5-year-olds). Younger children (birth-3 years) who are defined as at-risk can also clearly benefit, but for many of them, Head Start at age 4 is too late. Current Minnesota funding for Early Head Start is for only 1,400 children.

For a student, Head Start could likely be the place she learns she has a last name, an address, and phone number. It could be the place one learns the pleasure of sliced apple, banana or grapes or an orange segment. Head Start is the place that improves the use of please and thank yous and sharing and perhaps how to tie your shoes.

(Continued on page 12)
Telehealth in the Time of COVID-19

For some pediatricians, the prospect of regularly using telehealth to connect virtually with patients was a distant thought prior to the COVID-19 pandemic. However, the public health emergency created by the novel coronavirus meant an accelerated introduction to the technology that would provide a link to patients and families when social distancing demanded fewer in-person visits.

Minnesota Pediatrician asked for reflections from members around the state about their experiences with telehealth in the time of COVID-19. Here’s what we heard:

Katie Smentek, MD, FAAP; Mankato Clinic
Within 12 hours of investigating telehealth options at the Mankato Clinic, we had our first provider up and running. Within one week, every provider was trained and using the new platform. Telehealth visits were critical to our clinic in April, when 45 percent of our visits were via telemedicine. Our families are so thankful to have an additional way to see their pediatrician during this time.

Janna Gewirtz O’Brien, MD, FAAP; Adolescent Medicine Fellow, Leadership Education in Adolescent Health Fellowship, University of Minnesota
I’m particularly excited about the use of telemedicine with adolescents. I’ve heard from them that they love being able to access their healthcare virtually from the comfort of their own homes. I’ve also had the opportunity to connect via telemedicine with youth facing homelessness in shelter and they are grateful to have the opportunity to receive healthcare without having to leave the relative safety of the shelter. While we as providers may find integrating the technology to be a challenge, we can learn from young people who are savvy with technology and have adapted to this new world, even in the face of significant adversity. Even though many of us have launched telehealth as a rapid response to COVID-19, I think there is great potential to continue to use virtual care in the future as one way of expanding healthcare access for teens.

Gretchen Karstens, MD, FAAP; St. Luke’s
Telemedicine worked well to help get us started back up seeing our kids. We worked with Doxy.me and it seemed to generally go well. It was so good to see my families, reassure them, and be reassured that they were okay. Going forward, it seemed like telemedicine might work well for some of the behavioral health visits especially with teens as they seemed very comfortable with working in this medium.

The American Academy of Pediatrics continues to offer members guidance about the increased use of telehealth during the pandemic. Most recently, Dr. Richard Oken, a member of the AAP Committee on Medical Liability and Risk Management, authored the article, “How to provide good care using telehealth and reduce medical liability risks” through AAP News.
You can find the article at https://www.aappublications.org/news/2020/05/21/law052120.
A study conducted through a collaboration between MNAAP Early Hearing Detection and Intervention (EHDI) Chapter Champion Abby Meyer, MD, MD, MPH, and Minnesota Department of Health (MDH) EHDI personnel was published in the March 20, 2020 edition of the CDC publication Morbidity and Mortality Weekly Report. The study looked at disparities with regard to timing of identification of hearing loss among 729 infants born in Minnesota from 2012-2016 who were identified as deaf or hard of hearing (DHH). Based on the Joint Committee on Infant Hearing benchmark of identification of hearing loss by 3 months of age, 30.4 percent of DHH infants had delayed identification of hearing loss. Infants were more likely to have delayed identification of hearing loss if they had 1) low birthweight, 2) public insurance, 3) a residence outside the metropolitan area, 4) a mother with a lower level of education, 5) a mother aged <25 years, or 6) a mother who was Hmong.

Disparities in timely identification of hearing loss exist among infants who are DHH in Minnesota. Delayed identification might lead to delay in initiation of Early Intervention services, which has been shown to result in poorer language outcomes in children identified as DHH. More work is needed to understand the barriers to audiologic follow-up in these identified at-risk populations. Pediatricians are in an optimal position to enhance messaging about the need for follow-up after newborn hearing screening and are in a position to encourage or even facilitate scheduling of follow-up appointments for diagnostic hearing testing.
Fund Provides Trainees Safety Net During Residency

Heidi Hubbard, MD, FAAP

Many of us remember residency as the best, and most stressful, time on the path to becoming practicing physicians. It marks the period in training when a person is most likely to get derailed because very little margin exists to allow for balancing work and life. Trainees are especially vulnerable, considering their long hours, increasing responsibility, financial stress and limited time for personal health and wellness. A recent review of three years of national data about burnout in pediatric residency published in *Pediatrics* showed that a majority of residents met burnout criteria. But for anyone who has lived through residency, this information is not new.

In 2007, I established a fund at the University of Minnesota Medical School – where I completed my residency training – to provide an emotional and financial safety net for unforeseen life events as young doctors moved through residency. One of the most critical areas of need is financial stability. The Pediatric Resident Wellness Fund provides hardship grants for immediate support for residents who experience significant and unexpected financial burdens. Residents access the grants to relieve the stress associated with costs of travel for a family emergency or funeral, medical expenses, mental health resources, car repairs, child care and other critical needs. Ensuring residents can focus on their personal life demonstrates our commitment to their overall wellbeing.

Enhancements to the pediatric resident lounge at M Health Fairview University of Minnesota Masonic Children’s Hospital allowed for a dedicated space for residents to connect, socialize and relax with one another. The fund also created social and networking opportunities for residents, promoting community building, camaraderie and volunteerism. In 2017, the program sought to expand its mission by supporting an annual wellness retreat to connect residents with one another, reflect on their experiences and renew their purpose. Throughout the year, residents have opportunities to engage in wellness activities including meditation and yoga classes, participate in a wellness leadership series, enjoy healthy meals, and take part in other programs dedicated to promoting residents’ wellbeing during a demanding time.

Creating meaningful opportunities for residents to promote compassion and resilience has brought me great joy. I encourage you to consider ways you can support the next generation of pediatricians, whether through mentorship or programs like the Pediatric Resident Wellness Fund at the University of Minnesota. If you are interested in learning more, contact Jonna Schnettler, director of development with the University of Minnesota Foundation, at jschnett@umn.edu.

According to “Burnout in Pediatric Residents: Three Years of National Survey Data”:

Four factors were associated with an increased risk of burnout:
- stress
- sleepiness
- dissatisfaction with work-life balance
- recent medical error

Four factors were associated with a lower risk of burnout:
- empathy
- self-compassion
- quality of life
- confidence in providing compassionate care

Report published in January 2020 *Pediatrics*
Member Spotlight:
Nusheen Ameenuddin, MD, MPH, FAAP

What drew you to pediatrics?
I knew early on that I was interested in primary care because I really enjoyed getting to know patients in the clinic as a medical student, but I was torn between wanting to work with children and the elderly. When I look back, I see that I kept choosing projects that focused on children, which I think subconsciously kept bringing me back to pediatrics. Then there was that gut feeling doing peds as my final third-year rotation that cemented my passion for working with and for children.

What is a typical day like for you?
I work exclusively in outpatient primary care pediatrics within a large academic institution, so most days I am doing some combination of seeing patients and teaching. Often that means having a medical student with me in the morning or supervising our resident pediatric clinic in the afternoon. I also serve as director of the resident continuity clinic which has given me the opportunity to create and implement a curriculum over the last several years. It has also taught me that the one constant I can count on in medical education is change!

You are involved with the AAP Council on Communications and Media (COCM) as the chairperson. Can you tell me about your work with the council?
I joined the council a little over a decade ago as the council itself had recently been formed as a combination of two committees, one that examined the effects of media on children and the other which served to prepare pediatricians to work with the media to accurately translate important science about children’s health to the public. I’ve been interested in children’s media exposure and its effects since residency. That interest hit me right in the face during my first year of practice when a four-year-old patient, after seeing a television commercial, told his dad that he was supposed to ask his doctor (me!) about Levitra.

Now, I feel that I have a foot in both worlds as we talk to parents about how to manage media when so many people are on lockdown due to the novel coronavirus, but I also use social media to inform, amplify, and advocate. As part of COCM’s Executive Board, I was the lead author and editor of Pedialink’s first-ever online CME media education module, which was also approved for MOC Part 2 credit. Before I became chair of COCM, I served as both Program and Education chairs, which involved creating programming for the AAP National Conference and Exhibition every year. I also chaired the 2016 Peds 21 pre-conference that focused on media. I’m also thrilled to be part of the 2020 Peds 21 program committee which will focus on racism, bias and health inequities for children of color.
MNAAP Member News

Gigi Chawla, MD, FAAP, spoke with the Star Tribune about the ways in which Children’s Minnesota is adapting patient visits at its clinic locations in order to provide care to children during the pandemic.

Abe Jacob, MD, FAAP, M Health Fairview chief quality officer, spoke with KARE11 about the importance of mask compliance.

Ruth Lynfield, MD, FAAP, participated in a webinar hosted by Children’s Health Network exploring epidemiological and policy considerations of COVID-19.

Malini DeSilva, MD, FAAP, spoke with the Star Tribune, St. Paul Pioneer Press, and MinnPost about the Morbidity and Mortality Weekly Report (MMWR) that indicated a drop in childhood vaccinations during the COVID-19 pandemic, which Dr. DeSilva co-authored.

Madeleine Gagnon, MD, FAAP, spoke with Fox9 about the rare inflammatory condition being seen in children with COVID-19.

Dawn Martin, MD, FAAP, spoke to the Star Tribune about the importance of childhood vaccinations and well child visits during the pandemic.

Andrew Olson, MD, FAAP, FACP, was quoted in a Star Tribune in an article about COVID-19 preparations and hospital discharges.

Mark Schleiss, MD, FAAP, spoke with KCBS Radio about a rare inflammatory condition being seen in children who test positive for COVID-19.

Krishnan Subrahmanian, MD, FAAP, spoke with KARE11 about the importance of rituals and resilience to help kids’ mental health during COVID-19.

MNAAP President-elect Sheldon Berkowitz, MD, FAAP, co-authored the piece “Transitioning Patients With Complex Health Care Needs to Adult Practices: Theory Versus Reality” which has been published online and appears in the June issue of Pediatrics. Dr. Berkowitz was also published in Minnesota Physician with his article calling for prior authorization reform.

Find more member news at www.MNAAP.org/news/member-news
The Child Friendly Cities Initiative (CFCI) was launched by UNICEF nearly 25 years ago to respond to the challenges of realizing the rights of children at a municipal level. The CFCI framework assists cities to become more child focused in all aspects of governance and services through the implementation of systematic procedures and the meaningful involvement from children. By 2018, more than 3,000 Child Friendly Cities existed around the globe. However, there were none in the United States.

MNAAP Member Charles Oberg, MD, MPH, FAAP, along with Dr. Jeff Goldhagen and Nicholas Spencer, from the International Society of Social Pediatrics and Child Health (ISSOP), met with UNICEF in Geneva in the fall of 2018 to change this situation. Following a workshop in Jacksonville, FL in the spring of 2019, a few selected cities, including Minneapolis, began the effort to make CFCI a reality in the United States.

In collaboration with and under the leadership of the Minneapolis Commissioner of Health, Gretchen Musicant, a strategic planning effort began. On Feb. 14, 2020, the Minneapolis City Council passed and Mayor Jacob Frey signed a Memorandum of Understanding (MOU) with UNICEF to launch the first Child Friendly City Initiative in the United States.

**Pictured:** Child Rights Advocate Rachel Peterson, UNICEF USA Representative Adriana Alejandro Osorio, Minneapolis Mayor Jacob Frey, Minneapolis Commissioner of Health Gretchen Musicant, and Dr. Charles Oberg at the MOU signing.

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Minnesota needs more qualified healthcare providers to diagnose and treat children with Autism Spectrum Disorder (ASD). A study from the Minnesota Autism and Developmental Disabilities Monitoring Network (MN-ADDM), funded through the Centers for Disease Control and Prevention (CDC), found approximately 1 in 44 or 2.3 percent of 8-year-old children were identified with ASD in Minnesota in 2016. The study also found that the average age of first ASD diagnosis was 4 years 8 months.

ASD can be reliably diagnosed as early as 18 to 24 months, and the earlier a diagnosis is made, the sooner the child will be able to access necessary early intervention services and supports. There are critical developmental years before a child reaches kindergarten. The Overview of Medical Identification and Educational Determination of Autism Spectrum Disorder (ASD) resource helps to clarify the difference between a medical diagnosis and an educational determination and why it is important for a family to access both.

Pediatricians can make a difference. To become a Comprehensive Multi-Disciplinary Evaluation (CMDE) provider and complete the evaluation necessary for a child to receive access to early intervention services, contact ASD.DHS@state.mn.us. By enrolling as a CMDE provider, conducting developmental, social-emotional and ASD specific screenings and making the proper referrals, you can change the trajectory of a child’s life and help ensure the best possible outcomes.

Minnesota state agencies have developed the Pathway to Services and Supports for Autism PDF to provide resources and support information in Minnesota for a person with ASD. The Pathways document was assembled to provide a common document for healthcare providers and other professionals to assist families and walk through potential services and supports they could receive. If you would like more information or have questions, visit the MN Autism Resource Portal https://mn.gov/autism/ or contact ASD.DHS@state.mn.us.
Pandemic Scrambles Legislative Session, continued from page 2

As of press time for this newsletter, it appears increasingly likely that a special session will be necessary on or around June 12.

State law requires the Legislature to be in session should the governor wish to make or extend a peacetime emergency declaration. The current declaration expires on June 12, and most observers believe another extension is likely. The extra time for negotiations between legislative leaders and the governor may make passage of a bonding bill more likely, and there could be further actions related to the pandemic to be considered. Complicating plans is the fact that the 2020 budget surplus has morphed into a projected $2.4 billion deficit in the next biennium.

Given the extraordinary circumstances for the session, passage of Tobacco 21 and prior authorization are no small feats. But our work has just begun. Stay tuned to mnaap.org for information about the special session, as well as news about the November elections.

Head Start, continued from page 4

Indeed, all of the above is remarkable but it doesn’t begin to address the Head Start mission of school readiness preparation and engaging parents’ involvement.

Head Start takes a comprehensive approach to meeting the needs of the whole child and family. This two-generation approach supports stability and long-term success for families experiencing economic hardships. Thanks to Head Start’s comprehensive services, most had access to family services including crisis intervention, job training, and parenting education.

Head Start sets academic goals and tests and evaluates outcomes. A prediction model has been developed to determine the children who are most at risk of not meeting the kindergarten benchmarks based on their fall or winter assessment scores. The prediction model considers a child’s literacy and math scores in the fall or winter given their age, gender, race, and English-language status. Teachers are given the names of children in their classrooms whose scores put them at risk of lower developmental growth so they can plan to offer more individualized supports for these children.

Pediatricians must actively support Head Start and Early Head Start. Do not let it be underfunded, it is wonderful and correct way to move children towards academic success and away from poverty.
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Emotional Impulsivity: The Tipping Point of Pediatric ADHD

Sam Marzouk, Ph.D., L.P.

Epidemiological research suggests that between 24 and 50 percent of children with ADHD also have clinically significant Emotional Impulsivity.

Pediatric attention-deficit/hyperactivity disorder (ADHD) is one of the most heterogeneous behavioral health diagnoses. In the current iteration of the diagnostic and statistical manual of mental disorders (DSM-5), ADHD is conceptualized by two broad dimensions of inattention and hyperactivity/impulsivity, each comprising an array of symptoms. Given the numerous possible symptom combinations and diagnostic profiles, individualizing the treatment approach of ADHD is a clinically necessary yet challenging task. Emerging signs and symptoms of pediatric ADHD are often first identified in a primary care setting. This makes pediatric primary care providers well-positioned to make important treatment planning decisions. It is therefore helpful for pediatric providers to not only identify core symptomatology but also key associated features of pediatric ADHD that correlate with a higher risk of associated functional impairment and more longitudinally adverse outcomes.

One such feature that appears to uniquely contribute to heightened functional impairment in children with ADHD is emotional impulsivity (EI). Emotional impulsivity (also referred to as “emotional lability” or “emotional dysregulation” throughout the literature) refers to a diminished ability to modulate an emotional state precipitated by an environmental stressor. Not surprisingly, EI typically leads to subsequent maladaptive behavioral choices (e.g., fights, destruction of property, verbal aggression, etc.). While impulsivity in and of itself is typically understood in behavioral terms, the preceding emotional impulsivity is often overlooked. As a general clinical feature, EI cuts across numerous behavioral health diagnoses and is by no means specific to pediatric ADHD.

What is important, however, is the relationship between EI and pediatric ADHD. Epidemiological research suggests that between 24 and 50 percent of children with ADHD also have clinically significant EI. What’s more, research has shown that children with ADHD and co-occurring EI often have greater core symptom severity, a higher risk for comorbid psychopathology, and poorer long-term outcomes. As a more specific empirical example, Russel Barkley (2010), one of the more prolific pediatric ADHD researchers, longitudinally followed a group of children with ADHD into early adulthood. Barkley found that those with comorbid EI at childhood evidenced greater functional impairment in adulthood across multiple domains (e.g., occupational, social, financial, etc.). Taken together, EI may represent the proverbial “tipping point” of pediatric ADHD in terms of functional impairment and adverse long-term outcomes.

Emotional impulsivity appears to be a particularly important yet overlooked associated feature of ADHD. Given that EI is not identified as a core symptom of ADHD in the DSM-5, providers are more prone to underestimate its importance to the overall clinical picture and may, therefore, fail to assess for its presence. Pediatric providers play an important role in formulating and often coordinating an ADHD treatment plan. The evidence-base surrounding best practices for treating pediatric ADHD suggests that pharmacological and/or psychosocial treatment modalities have the highest efficacy. When EI enters the clinical picture, a more integrated approach inclusive of psychopharmacological interventions, psychotherapeutic interventions, and even occupational therapy may be indicated.
Big Changes Mean Better Services for Shriners Healthcare Patients

This summer, Shriners Healthcare for Children — Twin Cities will move to a brand new, state-of-the-art facility in Woodbury. This move is the final step in the organization’s adaptation to the way families seek health care, and the optimal model to showcase and provide the premier pediatric orthopaedic services offered by Shriners Healthcare – a full-service outpatient clinic.

“We are excited to become a part of the fast-growing health care community in Woodbury,” said Charles Lobeck, Shriners Healthcare administrator. “We’re energized by the possibilities and synergy that will come from building relationships with our new neighbors.”

Shriners Healthcare for Children provides family-centered orthopaedic care for patients in Minnesota, the six surrounding states and into Canada. The new facility will allow staff to provide a wide range of services for children including radiology, child life, rehabilitation, orthotics and prosthetics. When necessary, surgery services will be provided by each patient’s Shriners Healthcare physician at an outside facility. Furthermore, Shriners Healthcare will be offering virtual visits to save families long trips to a facility – especially for those who live a great distance from the clinic.

“In addition to treating patients in our new clinic, we are also excited to offer fast track video visits, which allow patients to connect with our providers through a web-based app from the safety of their homes,” said Lobeck. “We are embracing the ever-changing world of health care and feel that we’re in a position to grow and change. We’re looking forward to seeing our first patient in our new space in late June and all of the possibilities that a new location brings.”
Minnesota Chapter
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

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