Advocating for You and Ohio’s Children in the Clinic, Hospital, Community, and Statehouse

Advocacy for Children & Families
- Provided expert testimony in support of mental health and injury prevention resources.
- Advocating for statewide expansion of the Store It Safe campaign to address the mental health crisis and promote safe storage of firearms.

Advocacy for Store It Safe (SIS)
- Received $400,000 from the state for a 6-month QI program.
- Received $250,000 from CareSource to expand the work within diverse populations.

Payer and Financial Advocacy
- Addressed challenges to reduce administrative burdens.
- Advocated to fix gaps in payment and coverage.
- Engaged payer support of the pediatric medical home.
- Prevented payor audits and recoupments.

Advocacy Wins for Children
- Worked to defeat anti-vaccine legislation to protect child vaccination rates in Ohio.
- Successfully advocated for expansion of coverage for postpartum moms.

Read the full 2022 Annual Report on page 9
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Ohio AAP educates, innovates and advocates for 2,900 pediatricians to positively impact over 1M (and counting) children and their families each year, ultimately enabling them to grow and achieve their dreams.

Ohio Pediatrics: A publication of the Ohio Chapter, American Academy of Pediatrics

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President’s Message

Christopher Peltier, MD, FAAP
President, Ohio Chapter, American Academy of Pediatrics

“Human beings are never going to be perfect. The best we can do is to keep asking for help and accepting it when you can. And if you keep on doing that, you’ll always be moving towards better.”

- L. Higgins

Thursday May 11th seemed like any other Thursday. I went to work in my office, saw patients, and went straight home after seeing my last patient. Nothing extraordinary happened to me that day. But May 11th was indeed an extraordinary day as it marked the end of the federal Public Health Emergency (PHE) for COVID-19. On January 31, 2020, the Public Health Service Act was used to declare a Public Health Emergency in the United States due to the COVID-19 Pandemic. This allowed the quick marshalling of federal resources to fight the virus, including investments in vaccine development; detailed reporting of infections, hospitalizations and deaths; new laws that allowed people to remain on Medicaid without interruption; and access to free testing and vaccines. This is a major milestone and seemingly apparent victory in the fight against COVID. However, the damage has been done. In a little over three years, six million hospitalizations and 1.1 million deaths (with almost 2,000 of those occurring in children) were due to COVID. Over the next several weeks and months, more details will emerge about what the end of the PHE will mean in terms of COVID vaccine, testing, telehealth, and Medicaid eligibility. However, those details are not what I want to focus on here.

Over the past few weeks, I have been reflecting on the toll the pandemic has taken on pediatricians. During the past three years, pediatricians have experienced psychological stress, been victims of public attacks (on social media as well as in person at venues such as school board meetings), and at times, physical threats and violence. In one year alone, during the pandemic, over 220,000 healthcare workers quit their jobs, citing burnout and moral injury. A recent Medscape report noted that one in 10 physicians have considered or attempted suicide. One in 10! And nearly 25% of physicians are clinically depressed and nearly 60% are experiencing symptoms of sadness and feeling down. This past month, my daughter graduated from college and my son graduated from high school. They are both about to begin a new chapter in their journeys. I like to think of the end of the PHE as a similar opportunity for us to begin a new chapter in our journey as pediatricians. A “reset” if you will. But how can we move beyond the trauma of the past three years and combat the stress and burnout that the pandemic has caused?

To help me with this, I have recently begun exploring the concept of self-compassion. Several studies have found that physicians who were more self-compassionate experienced greater work engagement and felt less exhausted due to demands at work. They also are more satisfied with their professional lives. Self-compassion is having a genuine, heartfelt desire to end suffering of yourself and others. Dr. Kristen Neff has identified three elements of self-compassion: self-kindness, common humanity, and mindfulness. Self-kindness entails being warm and understanding toward ourselves when we suffer, fail, or feel inadequate, rather than ignoring our pain or flagellating ourselves with self-criticism. Self-compassionate people recognize that being imperfect, failing, and experiencing life’s difficulties is inevitable, so they tend to be gentle with themselves when confronted with painful experiences rather than getting angry when life falls short of set ideals. Common humanity involves recognizing that suffering and personal inadequacy is part of the shared human experience and something that we all go through rather than being something that happens to “me” alone. Mindfulness is a non-judgmental, receptive mind state in which one observes thoughts and feelings as they are, without trying to suppress or deny them. We cannot ignore our pain and feel compassion for it at the same time. At the same time, mindfulness requires that we not be “over-identified” with thoughts and feelings, so that we are caught up and swept away by negative reactivity.

Since I have begun intentionally practicing self-compassion, I have found that I have been experiencing more joy in my work. I hope that you will join me in exploring self-compassion and that you find it helpful in managing moral injury and burnout. More information about how to practice self-compassion, including a test to determine how self-compassionate you are, can be found at www.self-compassion.org. I hope you find these tools as helpful as I have.

I am truly thankful for all that each of you do for your patients and families. The Ohio AAP is here to support you however we can. Please reach out to me via email (chris.peltier@cchmc.org) or on Twitter (@cpeltier007) with questions or suggestions for the Chapter.

#Believe

Best regards,

Christopher Peltier, MD, FAAP
General Assembly Approaches Summer Recess with Big Votes on State Budget, Gender-Affirming Care Legislation

Danny Hurley
Vice President, Capitol Consulting Group, Inc.

The 135th General Assembly began with a contentious vote for Speaker of the Ohio House of Representatives that saw State Representative Jason Stephens (R-Kitts Hill) and his supporters partner with House Democrats to defeat State Representative Derek Merrin (R-Monclova). Since January, when Stephens secured the Speakership, the House Majority Caucus has remained divided.

Given the political dynamics of the legislature, there are significant disagreements between House and Senate Republicans on several controversial bills as well as HB 33, the state operating budget. The Ohio Chapter is engaged on a number of fronts as lawmakers work to finalize the budget and adjourn for summer recess.

Our top priority remains working to defeat House Bill 68, sponsored by State Representative Gary Click (R-Vickery). This bill was introduced on February 27th and received four committee hearings before passing the House Public Health Policy Committee and the Ohio House of Representatives on a largely party line vote. The bill places restrictions on several aspects of Gender-Affirming Care for minors. Similar bills have passed in other states, however, most have been challenged in court and, in the case of Arkansas, struck down. The Ohio Chapter is working closely with Ohio Children’s Hospital Association and other healthcare provider groups and hospitals to seek amendments or defeat the bill.

Prior to reporting HB 68, the Public Health Policy Committee adopted a substitute bill that added in the text of HB 6, the Save Women’s Sports Act. This legislation is also a priority for the Ohio Chapter to defeat, as it unfairly targets transgender children seeking to play sports in school. As passed by the Ohio House of Representatives, HB 68 will:

- Prohibit gender affirming surgeries on minors (AAP’s Policy Statement on Gender Affirming Care does not recommend these procedures and we have no objection to this prohibition);
- Prohibit the use of hormone therapy and puberty blockers for patients with gender dysphoria, regardless of individual factors or medical indications;
- Require mental health providers to screen for other comorbidities and traumas before diagnosing or treating a minor for gender dysphoria;
- Ban Medicaid from covering gender affirming care services for minors;
- Prohibit a court from considering parental decisions or attitudes regarding their child’s gender identity in custody disputes and divorce cases;
- Prohibits transgender girls from playing women’s sports in high school or college (Save Women’s Sports Act).

The Ohio Senate is expected to take up HB 68 when the General Assembly returns to action in September. The Ohio Chapter provided expert testimony on HB 68 and also supplied lawmakers with copies of AAP’s policy statement and other resources. We will continue to advocate for our members and the patients they serve.

Lawmakers also put the finishing touches on the State Operating Budget for Fiscal Years 2024 and 2025. There were several items of disagreement between the House and Senate, including several items that the Ohio Chapter either supports or has concerns with. These items were resolved in conference committee late last month. Governor DeWine used his line-item veto 44 times before signing the budget. Here are some notable items that were debated and also the focus on a line-item veto:

- **Medicaid Coverage:** Governor DeWine’s budget proposal included an increase in Medicaid eligibility for children and pregnant women to 300% FPL (currently 211%). The House retained this language and also added a continuous coverage provision that would have allowed any child enrolled in Medicaid to remain enrolled until age 4 regardless of health status or family income. The Senate removed both provisions and they were left out of the conference report. The General Assembly did include some statutory rate increases, however Governor DeWine vetoed some of these items and will work to increase Medicaid rates administratively.

- **Vaccine Issues:** The Ohio Senate added two contentious vaccine provisions to their version of HB 33. The first requires public and private colleges and universities to grant medical and nonmedical exemptions for any vaccine requirements they may have for students. The second expands the scope of practice for pharmacists, pharmacy techs, and pharmacy interns related to vaccine administration to children. The HB 33 Conference Committee rejected the pharmacy scope of practice language, but did include the higher education exemption language. Governor DeWine vetoed this provision.

- **Flavored Nicotine Ban and Local Ordinances:** Governor DeWine’s budget proposaovenvor DeWine’s budget proposal included a bold plan to prohibit the sale of flavored tobacco and nicotine statewide. Many local communities have already adopted ordinances to achieve this goal. The House removed this provision and the Senate partially restored it, reinstating a ban on the sale of flavored nicotine products for use in electronic cigarettes. While this was continued on page 6…
Ten thousand bicycle helmets will be distributed to children across the state this summer thanks to a continued partnership between the Ohio AAP Foundation, Ohio Department of Transportation, and the Honda USA Foundation. Recipients of helmets include Ohio AAP members, schools, county health departments, police and fire departments, nonprofits and many more organizations committed to promoting bike helmet safety. All these organizations will hold events during the summer to provide free helmets to children all over Ohio.

As one of the chapter’s longest running injury prevention programs, Put a Lid on It has been educating and providing helmets to Ohio’s children for more than a decade. A combination of efforts is necessary to effectively increase helmet usage rates among children, including raising awareness of the benefits, encouraging model behavior among adults, distributing free resources, and advocating for supportive public policies. Since the program’s launch, we are proud to share nearly 100,000 free helmets have been donated to Ohio’s children and communities in need.

Summer is right around the corner, which means more time spent outside and on bicycles. Children should be wearing a helmet every time they ride their bike this summer because they help prevent injuries and save lives! In Ohio, estimates indicate that just 10-20% of children wear bike helmets, but we know helmets are effective! Up to 75% of bike-related fatalities would be prevented with a helmet and wearing a helmet can reduce the risk of head injury by 85%.

The Foundation would like to thank our members, leadership, staff, and partners for their generous support of the Put a Lid on It program. Whether donating time, resources, expertise, or hosting your own bike helmet safety event, we appreciate YOU!

How can you support Put a Lid on It?
Join us at Goofy Golf
The Ohio AAP’s silliest event is back and better than ever! Join the Ohio AAP Foundation on Friday, July 28th at Royal American Links for an evening of fun, games, and golf! No golf skills are needed! It’s a fun event that allows us to provide thousands of helmets to kids that need them. We hope you can join us for this event – it is always a fun par-tee!

Donate to the Ohio AAP Foundation
Every $5 donated provides a helmet – and if each of our members donates just one helmet, we can reach almost 3,000 kids! To donate towards the Put a Lid on It program, or another program of your choice, visit https://ohioaap.org/donate-now/.

The success of the Put a Lid on It program is only made possible thanks to the generous support and care of our Foundation donors. Thank you again for being a valuable part of the Put a Lid on It program.

Register Today!
Goofy Golf 2023
Friday July 28, 2023
Royal American Links
3300 Miller Paul Rd, Galena, OH 43021
Exciting NEW sponsorships and activities available!
AAP Resources for Pediatricians

Lia Gaggino, MD, FAAP
District V Chairperson

Before I highlight the work of the AAP, I want to thank all of you – primary care pediatricians, medical subspecialists, surgeons, ED physicians, hospitalists, and neonatologists for the work you do, the long hours and the sleepless nights, but more importantly for the love and compassion you have for kids and families. In surveys of physicians around burnout, it is the relationship with patients that saves us. It is the magic in the room.

1. As we pass the three-year mark, pediatricians are finding respite from the pandemic, but the ramifications are still being felt. COVID-19 numbers have finally come down, but we all worry about the next wave, vaccine protocols, billing, administration, and workflows. The AAP advocacy team is working to ease your burdens with vaccine logistics and vaccine hesitancy. Language around vaccines matters, and the most impactful message is “vaccines teach our immune systems to work better.” To learn more, checkout AAP Pediatrics On Call Podcast on reframing the vaccine conversation: https://www.aap.org/en/pages/podcast/reframing-the-vaccine-conversation-diversifying-clinical-trials/

2. The AAP continues to monitor the national landscape and dialogue around racism, disparities, and discrimination and to respond in the policy we publish, amicus briefs we file, and statements we make. Chapters, Committees, Councils and Sections are looking at ways that EDI impacts their work in programming, leadership opportunities and policy writing, and a review of chapter annual reports shows a dedication to implementing meaningful change.

3. The AAP Mental Health Initiatives website (https://www.aap.org/en/patient-care/mental-health-initiatives/) is a repository of resources not to be missed, and the Council on Healthy Mental and Emotional Development (COHMED) will launch this summer. This is a place for members interested in mental health advocacy, leadership, partnership and education. Stay tuned for more to come!

4. Finally, leadership is acutely aware that pediatricians everywhere need real solutions to protect the work they do. A new task force will look at multiple short-term and long-term strategies to meaningfully support members. For member support now, the AAP has created a closed Facebook group offering a safe space to share worries and concerns. If you are interested in joining the Hub, just fill out the intake form, which includes both the email listserv and Facebook group link: http://eepurl.com/ikRxcL.

The Physician Support Line was created for physicians and trainees in need of crisis support.

“The Physician Support Line was created with the mission of physicians supporting physicians as we navigate the many professional and personal intersections of our lives.

For many of our colleagues, discrimination, bigotry, and intolerance towards disadvantaged and unjustly marginalized groups is an undeniable detriment to every aspect of their mental well-being.

We volunteer psychiatrists at Physician Support Line are from diverse backgrounds. We promise to provide emotional support and a safe space for physicians and medical students who are affected by discrimination, bigotry, and intolerance, which we absolutely condemn in all forms. We stand in solidarity with all our medical student and physician colleagues.

We also support full reproductive rights.”

PHYSICIAN SUPPORT LINE
888-409-0141
Call Monday-Friday, 8am - 12pm

continued from page 4…

a positive development, the Senate also included language that prohibits local communities from regulating flavored tobacco or nicotine products. The Conference Committee rejected both the Governor’s proposal and the Senate language banning the sale of some types of flavored tobacco and nicotine products. Governor DeWine vetoed the local preemption language, so no local regulations will be impacted by the budget.

This is by no means a complete list of items that the Ohio Chapter worked on, and there are a number of positive items in HB 33 that were offered by the Governor, House and Senate. Overall, we appreciate the pro-kids approach that the General Assembly and DeWine Administration took and look forward to building upon HB 33.
2023 Spring Meeting
Ohio AAP Members and Partners Coming Together for Vaccine and HPV Education & Advocacy

127 Attendees
73 In Person
54 Virtual

Members, partners, and public health professionals from across the state met this past April for the 2023 Spring Education Meeting!

Spring Meeting began with our leadership and staff gathering to discuss Chapter news and strategize on upcoming education and programs!

Session #1: HPV Clinical Update, Hesitancy and “On the Horizon” for Immunizations – Dr. David Karas led our first session on vaccine safety and how to address vaccine risks and benefits with hesitant patients.

Session #2: HPV Best Practices – We heard about best practices and strategies for increasing HPV rates from our expert panelists, Dr. David Karas, Dr. Nazhat Taj-Schaal, Dr. Tricia Lucin and Natalie Alexander, RN.

Session #3: School Health and Adolescent Vaccines – Our dynamic panelists, Dr. Robert Frenck, Dr. Sara Bode, Dr. Christina Randolph and Lisa Crosby, DNP, APRN, CN discussed how pediatricians, schools and public health advocates can come together to increase vaccine rates!
DEA Extension For Prescribing Controlled Substances

This message and information are provided courtesy of Cincinnati Children’s Hospital Medical Center.

If you prescribe controlled substances and see patients via Telehealth, the following message is for YOU.

The DEA has extended the telemedicine flexibilities enacted during the Public Health Emergency (PHE) for prescribing controlled substances via telemedicine. These flexibilities were originally set to expire or be limited when the PHE expires on May 11, 2023.

DEA Telehealth Rules Update:
1. On May 9, 2023, the DEA and SAMHSA issued the “Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications” – a temporary rule that extends telemedicine flexibilities adopted during the PHE.
2. The temporary rule will take effect on May 11, 2023, and extends the full set of telemedicine prescribing flexibilities adopted during the PHE for six months—through Nov. 11, 2023.
3. For any practitioner-patient telemedicine relationships that have been or will be established up to November 11, 2023, the full set of telemedicine prescribing flexibilities established during the PHE will be extended for one-year—through Nov. 11, 2024.

What does this mean for my patients?
If you have established a practitioner-patient relationship via telemedicine by Nov. 11, 2023, you can continue to prescribe controlled substances through Nov. 11, 2024 via telemedicine for that patient. You will still need a permanent license in the state where the patient is located at the time of the visit.

What happens for patients seen via telemedicine for the first time on or after Nov. 12, 2023?
The DEA and SAMHSA will continue to review public comment over the next six months. We expect further guidance during this time period. Once we receive additional information including the final rule, we will inform divisions.

What do I need to do?
At this time, there is no change. Providers can continue to prescribe controlled substances via telemedicine. Providers should continue to document and follow existing prescribing rules.

What if I need to prescribe for a patient I have never seen in person?
An in-person exam is not required at this time to prescribe a controlled substance via telemedicine.

Ohio AAP Honors The Life and Legacy of Lifelong Leader

It is with great sadness the Ohio AAP shares the passing of Dr. Elizabeth “Libby” Ruppert. As a past Ohio AAP president and the namesake for our most distinguished award, Outstanding Pediatrician of Year, we offer our condolences and gratitude for the huge impact Dr. Ruppert had on child health in Ohio and beyond. To read more about the amazing legacy and work of Dr. Ruppert, you can visit an article from the Toledo Blade at https://rb.gy/45eal.
OUR MISSION:
The Ohio Chapter of the American Academy of Pediatrics promotes the health, safety and well-being of children and adolescents so they may reach their full potential.

Using Education and Quality Programming to Improve Child Health Outcomes!

OHIO AAP AND ITS MEMBERS...

- Received **$3,069,900** in funding for **programs and education**.
- Engaged **2,262 providers**, public health and community professionals, educators, families, and teens.
- Provided **$155,750** in **product incentives** to practices.
- Implemented intentional **Systematic approach to address DEI** and expand partnerships.
- Reviewed **900** new pieces of legislation for the **134th General Assembly**.
- Offered **FREE Annual Meeting registration** to members.

A word from our leaders...

As one fiscal year ends and we look forward to more exciting and transformative work in the next, we are appreciative of all the amazing achievements over this past year. As you read through this year’s report, you will see the many incredible accomplishments of the Ohio AAP, including wins at the statehouse, positive impacts on child health through our programs, timely and crucial educational sessions, community outreach, and so much more! We #BELIEVE the Ohio AAP is one of the strongest chapters in the county thanks to the support of our incredible members, leaders, staff, and partners. Whether in the clinic or hospital, in the community, or at the statehouse, the Ohio AAP will continue to support and protect our members and the families they serve!
What Sets Us Apart: Advocating for You & Ohio’s Children!

ADVOCACY - Our Memberships’ Top Reported Benefit

Advocacy for Children & Families
- Provided expert testimony in support of mental health and injury prevention resources.
- Advocating for statewide expansion of the Store It Safe campaign to address the mental health crisis and promote safe storage of firearms.
- Monitoring legislation that could impact your scope of practice and physician/patient relationships including:
  - Immunizations
  - COVID-19
  - LGBTQ+
  - School safety
  - Legislative interference in the practice of medicine
  - Scope of practice infringement
  - The interstate medical license compact
  - Environmental issues such as lead poisoning

Advocacy for Store It Safe (SIS)
Our biggest advocacy success was not only at the Statehouse, but in primary care offices and the community through the Ohio AAP Store It Safe (SIS) program. The SIS program prevents intentional and unintentional injuries by firearms, addresses adolescent suicides by screening for depression and suicide, and offers lethal means counseling and safe lock boxes.
- Received $400,000 from the state for a 6-month QI program.
- Launched a SIS coalition that includes 21 state/national partners.
- Received $250,000 from CareSource to expand the work within diverse populations.
- Collaboration with other chapters interested in replicating our successful work.

Payer and Financial Advocacy
The Pediatric Care Council brings together pediatricians, medical directors and Ohio’s managed care organizations and commercial insurance to promote children’s health.
- Address challenges to reduce administrative burdens.
- Advocate to fix gaps in payment and coverage.
- Engage payer support of the pediatric medical home.
- Prevent payer audits and recoupments.

Advocacy Wins for Children
- Worked to defeat anti-vaccine legislation to protect child vaccination rates in Ohio.
- Successfully advocated for expansion of coverage for postpartum moms.
- Advocated against harmful legislation affecting adolescent health.
## Impact Highlights

<table>
<thead>
<tr>
<th>Because...</th>
<th>Ohio AAP...</th>
<th>Resulting in...</th>
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<tbody>
<tr>
<td>85% of bike related head injuries can be prevented with a helmet.</td>
<td>The Put a Lid on It bike helmet safety program distributed 10,000 helmets in 58 counties to pediatric practices, community organizations &amp; nonprofits.</td>
<td>Prevented bicycle-related serious head injuries for Ohio children.</td>
</tr>
<tr>
<td>40% of children in Ohio are exposed to second-hand smoke at home.</td>
<td>The Smoke Free Families project referred 70% of caregivers who used tobacco to a cessation program leading to 23% of caregivers quitting.</td>
<td>Reduced exposure to second-hand smoke in children’s homes across the state.</td>
</tr>
<tr>
<td>Suicide is the 2nd leading cause of death in US adolescents, and over 80% of adolescents who completed suicide used a firearm from their home.</td>
<td>Suicide screenings increased from 13% to 71% by Store It Safe QI program participants with 1,200 lock boxes distributed.</td>
<td>Prevented intentional and unintentional injuries by firearms and helped healthcare professionals identify and address the risks of suicide.</td>
</tr>
<tr>
<td>Unintentional injuries cause more deaths every year than all diseases combined.</td>
<td>Social determinant resources were provided to 98% of at-risk families in the Injury Prevention + SEEK program</td>
<td>Addressed social determinants of health and common injury risks for Ohio’s families.</td>
</tr>
<tr>
<td>2/3 of homes in Ohio may have lead paint.</td>
<td>The Lead-Free Ohio program launched a children’s board book to educate and provide guidance for parents on keeping children lead free.</td>
<td>Educated providers on lead poisoning prevention and training to adhere to lead screening guidelines.</td>
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<td>77% of pregnancies in adolescents are unplanned, often leading to significant short- and long-term consequences for both mother and child.</td>
<td>Contraception care provided to over 11,450 adolescents through the Transforming Adolescent Reproductive Healthcare program.</td>
<td>Increased access to comprehensive reproductive healthcare in the primary care setting to address teen pregnancy.</td>
</tr>
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</table>

“A word from our members...”

*I work for a large institution with an established QI infrastructure. Ohio AAP QI programs provide a unique, customized format with coaching and support that help improve our experience and ultimately our outcomes. I plan to continue to work with Ohio AAP in the future as I look to transform our clinics.*

- Sara Bode, MD, FAAP, Nationwide Children’s Hospital
Ohio AAP Foundation

The Foundation serves as the charitable and community-focused branch of the Ohio AAP! The Foundation supports the Chapter’s efforts by creating fiduciary and programmatic partnerships with community, corporate, state, and federal organizations with the purpose of supporting programs to improve the lives of Ohio's children and families.

Put a Lid on It

Educating and promoting bike helmet safety to increase usage and prevent injuries.

- Distributed over 10,000 helmets to 158 organizations, including pediatric offices, hospitals, schools, county health departments, police and fire departments, non-profits and more in 59 counties across Ohio.
- Put a Lid on It has distributed over 92,000 FREE helmets since the program began in 2011.

Store it Safe (SIS)

Preventing intentional and unintentional injuries by firearms and addressing adolescent suicide.

- Distributed 1,200 gun boxes to promote safe storage of lethal means.
- 750 pediatric and community members joined the SIS pledge to help promote safe storage and lethal means counseling.

Ohio Champions for Vaccines (OC4V)

Vaccine advocacy group working to spread accurate information about the disease burden, safety, and effectiveness of vaccines.

- 440 members and community advocates strong.
- 31,380 social media impressions to promote immunization!

The Ohio AAP Foundation raised $44,500 for these impactful programs and more thanks to the generous support of our amazing donors and fundraising events!

2022 ANNUAL MEETING LUNCHEON
From Fear to Medical Freedom: Overcoming the Anti-Vaccine Movement to Increase Rates

$30,920 funds raised

2022 GOOFY GOLF FUNDRAISER
Ohio AAP's silliest fundraiser to support the Put a Lid on It Bike Helmet Safety Program

$10,120 funds raised
Ohio AAP’s 2022-23 Annual Report

Leveraging Funding to Fulfill our Mission

- **Revenue:** $3,700,000
- **Operating Expenses:** $185,000
  - Only 5% of operating expenditures

**Income:**
- Grants/Contracts: $3,252,550
- Dues: $243,700
- Meeting and Event Income: $132,000
- Donations: $41,000
- Other: $30,750

Developed new education and tools for pediatricians, allied health professionals and families to address:
- Atopic dermatitis
- Developmental screenings
- Implicit bias
- Lead screening
- Suicide and depression screening
- Behavioral health and crisis de-escalation
- HPV vaccinations
- Importance of well care
- Oral health
- Teen vaping
- Breastfeeding
- Immunizations
- Interconception care
- Social determinants of health
- Trauma informed care

“Why am I a member of the Ohio Chapter of the AAP? I love getting to meet with fellow pediatricians across the state. If you care about advancing children’s health in Ohio, these are your people. From Advocacy to Quality Improvement, Ohio AAP is working hard to improve the lives of children and pediatricians!”

– David Karas, MD, FAAP

The Leaders Guiding Your Work:

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Experts Recommend 1-2 Ounces/Day of Animal-Based Foods Such as Beef.*

6-8 months
Pureed Cooked Beef

8-10 months
Tender, Moist Shredded Cooked Beef

10-12 months
Tender, Moist Chopped Cooked Beef

Preparation depends on the child’s age and development stage

Influenza and respiratory syncytial virus (RSV) are two of the most common respiratory illnesses affecting people of all ages. Severe illness occurs in vulnerable populations, such as young children, the elderly, and people with underlying health conditions. To prevent the spread of these viruses, it is crucial to implement several effective infection control strategies simultaneously. Following are tips for how to best prepare your medical office to prevent transmission in your patients and office staff.

**Monitor and track infections**

Influenza and RSV epidemics are annual and typically predictable. Regular monitoring and tracking of influenza and RSV within your community is the first step in preventing their spread. Many local and state health departments give updated reports of viral circulation. Additionally, national data from The National Respiratory and Enteric Virus Surveillance System and the Weekly U.S. Influenza Surveillance Report provides up-to-date trends on these and other viral pathogens. Your team can use this information to make informed decisions about timing the initiation of infection control protocols. https://www.cdc.gov/surveillance/nrevss/index.html https://www.cdc.gov/flu/weekly/index.htm

**Implement a screening process**

Employ screening practices to identify patients who may have influenza or RSV before they enter your office. Consider implementing pre-screening questions during appointment scheduling and again upon arrival at the time of visit. Ask about respiratory symptoms and exposure to people with respiratory illness. Encourage parents to leave non-essential family members (i.e., siblings, grandparents) home if they are sick. If a symptomatic person comes into the office, have them wear a mask and practice hand hygiene in the waiting room. If space allows, provide a separate waiting area for symptomatic patients to minimize the risk of transmission to others. Other measures, such as spacing out appointment times, limiting the number of patients in waiting rooms, and minimizing transitions through the office, and utilizing telemedicine can significantly decrease exposure and transmission.

**Provide PPE**

Influenza viruses spread from person to person primarily through large-particle respiratory droplets. However, transmission from virus-contaminated surfaces or objects to mucosal surfaces of the face can occur. Droplet precautions should be used for all suspected cases of influenza or confirmed influenza for 7 days after illness onset or 24 hours after the resolution of fever. RSV can be transmitted by the droplet route but is more often spread by direct contact with infectious respiratory secretions. RSV can survive for many hours on hard surfaces (i.e., tables, counters). Ensure that all staff members have access to appropriate PPE such as masks, gloves, and gowns. Provide masks to patients who present with signs and symptoms of respiratory infection and encourage them to wear them while in the office. Consider implementing policies for continuous use of PPE during periods of high circulation of influenza or RSV.

**Encourage vaccination**

Make sure that both patients and staff are up to date on their vaccinations and encourage them to get vaccinated against influenza annually. Vaccinations for influenza are available for ages 6 months and older. Earlier this year, an FDA advisory committee recommended to approve two RSV vaccines (Pfizer and GSK) for individuals over 60 years of age.

continued on page 16…
Cleaning and disinfection protocols

Ensure that all surfaces, equipment, and objects that patients and staff regularly encounter are frequently disinfected using EPA-approved products. Increase the frequency of cleaning and disinfection in high traffic areas such as waiting rooms, exam rooms, and restrooms.

Stopping the spread of influenza and RSV within your medical office requires a multi-faceted approach. Tracking infections, educating your staff and patients, implementing a screening process, encouraging vaccination, disinfection protocols, and providing PPE for staff and patients are all critical for effective prevention. Further information on preparing your office for these viruses and other resources can be found at the CDC website.

https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm

(https://www.fda.gov/media/165623/download). The FDA formally approved the GSK vaccine in May, 2023. The GSK vaccine lowered risk of symptomatic illness by 83% and severe illness by 94% in older adults (>60). While RSV vaccination in children is a way off, these vaccines represent the most significant step for RSV prevention in decades. Meanwhile, Pfizer has shown RSV vaccine given in pregnant mothers provides substantial protection to infants through in-utero transfer.

https://clinicaltrials.gov/ct2/show/NCT04424416

continued from page 15…

Now Presenting!
Ohio AAP Program Showcase

Take a look at recent and upcoming Ohio AAP program presentations, manuscripts and posters on display around the state and beyond!

Polyarticular Juvenile Idiopathic Arthritis (pJIA)
What? Pediatric Academic Societies (PAS) Meeting
Where? Washington, DC
When? April 27 – May 1, 2023
Presented by Chris Peltier, MD, FAAP with Jennifer Huggins as project investigator

Healthy Mom, Healthy Family (HMHF)
What? Pediatric Academic Societies (PAS) Meeting
Where? Washington, DC
When? April 27 – May 1, 2023
Presented by Jamie Macklin, MD, MPH, FAAP

Smoke Free Families (SFF)
What? Accepted manuscript
Where? Academic Pediatrics
When? May 2023


Injury Prevention + Safe Environment for Every Kid (SEEK)
What? Safe States Annual Injury & Violence Prevention Conference
Where? Denver, CO
When? September 11-13, 2023

Presented by Jamie Macklin, MD, MPH, FAAP and Shadia Jallaq
Ready. Set. Register!
New Quality Improvement Opportunities for Your Practice

**HPV Quality Improvement**
Did you know less than half of Ohio adolescents are fully vaccinated with the HPV immunization?

Ohio AAP’s HPV Quality Improvement Program will build upon the success of past efforts to improve our understanding of how providers and families understand and make decisions about HPV immunization. Providers will learn best practices for effective communication and supporting patients to improve HPV immunization rates in their practices.

Participants in the seven-month QI project will receive:
- **Generous stipend** to support office staff time
- 25 Points of **MOC Part IV Credit**
- Assistance to maximize your **vaccine reimbursement**
- QI coach and team support
- Learning collaborative to share challenges and success with peers across Ohio & other states
- Data reports to measure your changes

Learn more or register at [https://ohioaap.org/qi-programs-moc-iv/hpvqi-project/](https://ohioaap.org/qi-programs-moc-iv/hpvqi-project/)

**Store It Safe Impact Education**
We know brief conversations can save a life!

Ohio AAP’s NEW innovative education program is launching July/August 2023! Practices will participate in a four-month impact education program and will receive practice coaching, resources, and support in making practice changes. Practices will receive education on:
- Lethal Means Restriction Counseling (LMRC)
- Depression Screening
- Suicidality Screening

Program Participation Benefits Include:
- **$500** clinic stipend
- **MOC Part II/CME credit**
- Safety **lock boxes** and family and teen **education resources**
- **No data collection** or chart review
- Priority entry to full QI project

Learn more or register at [https://ohioaap.org/sis-impact-education-registration/](https://ohioaap.org/sis-impact-education-registration/)

**REGISTER TODAY!**

**HPV Quality Improvement**

**Store It Safe Impact Education**
THE EVERYDAY RECOMMENDATION FOR BUILDING A HEALTHY SKIN BARRIER

Developed with pediatric dermatologists, CeraVe Baby replenishes ceramides 1, 3, & 6-II to help restore and maintain baby’s delicate skin barrier.

CLEANSE with Baby Wash & Shampoo

HYDRATE with Baby Moisturizing Lotion and Baby Moisturizing Cream

PROTECT with Baby Healing Ointment

Watch the 2-minute highlights video of an expert discussion on the importance of ceramide-containing skincare for your pediatric patients

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# Transforming Adolescent Reproductive Care Quality Improvement Project

**Progress Dashboard August 2020 – March 2023**

**Program Summary:** The program supported practices using QI methods to improve outcomes utilizing a practice facilitation model, guiding participating clinics in their unique clinical settings, as they work to improve the clinical and operational components of providing comprehensive reproductive care for adolescents.

## Deliverables and Completion

### QI/Practice Facilitation
- Akron
- Columbus
- Cincinnati
- Northern Kentucky

### Sustainability
- Monitor 3 years of data
- 6 months post-QI program, all sites still performing procedures
- Implant-trained providers relocating to other clinics continuing implant procedures in their new clinic
- Clinics requesting training when implant-trained providers relocate

### Above and Beyond:
- Poster presentation at October 2022 National AAP Conference
- Currently preparing manuscript for possible future publication

### Addressing Gaps
- Hands-on procedure mentorship
- Provided procedure “Starter Kits”
- Provided clinic stipend for supplies
- Logistical and resource support
- Pediatrician-tailored education and resources
- Teen-focused resources

### Diversity Focus
- The 12 sites included:
  - Clinics in urban, suburban and rural settings
  - Clinics within large hospital settings as well as private pediatric settings
  - Medicaid populations that spanned between 5-95%
  - 3 clinics specialized in care for youth in foster care

## Budget
- **BUDGET:** 36 month contract $292,547
- **BUDGET TARGET:** Researching new funding options
- **FUNDING OUTLOOK:** Additional funding not secured

### Sustainability
- Monitor 3 years of data
- 6 months post-QI program, all sites still performing procedures
- Implant-trained providers relocating to other clinics continuing implant procedures in their new clinic
- Clinics requesting training when implant-trained providers relocate

**PROJECT COMPLETED**
QUALITY IMPROVEMENT/PRACTICE FACILITATION PROGRAM

Transforming Adolescent Reproductive Healthcare

QUALITY IMPROVEMENT PROJECT

Global Aim: Improve adolescent reproductive healthcare by enhancing youth-friendly services, improving comprehensive reproductive health counseling and building LARC implant procedure capability in pediatric primary care clinics.

QI Components

- 1 Prework Call/Assessment
- 1 Data Meeting
- 1 Learning Session
- FDA-required Merck Clinical Training Program (CTP) for LARC implant procedure training
- 3 On-demand CME/MOC II learning modules
- 3 All-clinic SPARKS trainings
- 3 Action Period Calls
- 9 months of data submission
- Practice coaching/facilitation calls as needed

Specific Aims

1. Integrate the Long-Acting Reversible Contraceptive (LARC) implant in clinic and improve contraception counseling by:
   - Training at least one Nexplanon provider per clinic
   - Training 90% of clinic staff and providers in adolescent-friendly care
2. Increase provider self-efficacy and the clinic’s comprehensive contraception counseling rate by 50%
3. Increase provider self-efficacy and the clinic’s LARC implant procedure rate by 50%
4. Increase the clinic’s adolescent-friendly services by 20%

Creating LARC Implant Capability

- All 9 sites integrated LARC implant procedures into clinic workflow within 9-12 months
- 6 months post-program, all sites still performing implant procedures
- 3 sites used as “comparison clinics” and continued LARC referrals only
- No statistically significant improvement seen in their LARC referral rates
- Key supports identified by participants: Hands-on procedure mentorship, “Starter Kits,” clinic stipends, logistical guidance

Resources

- Procedure starter kits
- Hands-on procedure mentorship
- Digital library of adolescent-friendly resources
- Practice coaching as needed

= Did not meet goal
= Close to goal and/or partially met goal
= Met goal

YOUR BODY. YOUR CONTROL

Scan QR code to get a copy of this resource on your phone!

YoungWomensHealth.org  •  Bedsider.org
Improving Birth Control Counseling

- All 12 sites worked to improve birth control counseling at all adolescent female clinic visits, not just well visits = “No Missed Chances”
- All clinic providers received pediatrician-tailored education: Adolescent Reproductive Health, Contraception 101, Contraceptives for Non-Contraception Reasons
- Youth-friendly training services based on the University of Michigan’s SPARK Trainings
- 8 of the 12 sites met their 50% improvement goal
- Improvement for the cohort was statistically significant (P<0.001)
- Continued improvement trend seen 6 months post-program

Other Markers of Improvement

- 2 areas of self-efficacy evaluated: birth control counseling (all providers) & implant procedures (LARC-trained providers)
  - Birth control counseling = statistically significant improvement (p<0.01)
  - Implant procedures = not statistically significant
- Broad range of youth-friendly clinic services assessed using national survey
  - All sites met their 20% improvement goal

Impact

- Reduced barriers to reproductive healthcare for ~8000 adolescent females across Ohio and Northern Kentucky
- Sustainable improvement evident 6 months later with ongoing LARC implant procedures and reproductive health counseling
- Sustainability data will be monitored for a total of 3 years (through 2024)

“In my 25 years of practice and doing many quality improvement projects, this QI program resulted in the most significant and meaningful changes my practice has ever experienced.”
~ Chris Pelteir, MD, FAAP

Practice Facilitation

- Flexible, rolling enrollment during the COVID pandemic (August 2020-December 2021)
- 3 sites focused on birth control counseling but opted out of LARC implant training and just continued LARC referrals instead = “Comparison Clinics”
- Extra 3 months added for 3 sites that were integrating birth control counseling into clinic for first time
Human Papillomavirus (HPV)

QUALITY IMPROVEMENT IMPACT 2022

Global Aim: Ensure all 9–18-year-olds complete the HPV vaccine series, and that providers feel confident in their vaccine strategy to discuss & improve rates of series completion.

Impact from Wave 1

- 19 practices participated in Wave 1 (17 in Ohio, 1 in NC, 1 in GA)
- Largest improvement with vaccine discussion rate: practices had a 12.3% increase in August compared to baseline
- Increase in provider confidence specifically around addressing vaccine hesitancy
- Creation of HPV education rack cards

Specific Aims

- Increase HPV vaccine series completion rate for 13-year-olds
- Increase rates of HPV vaccine administration for 9-18-year-olds
- Increase discussion at all visits for eligible 11-18-year-olds that have not completed HPV vaccines
- Increase provider confidence in addressing parental concerns

Next Steps

- Wave 2 will operate from October 2023 – November 2024
- 4-6 practices recruited from Ohio
- Up to 18 additional practices from 3 partner AAP Chapters
- Final summit to be held at Ohio AAP's 2024 Annual Meeting

QI Components for Wave 1

- Individual Practice Kick-Off Meetings
- Recorded Webinars
- Pre- and Post-Provider Confidence Surveys
- 3 Learning Sessions
- 4 Practice Coaching Calls
- 6 Months of Data Collection
- 3 PDSA Cycles
- 1 Wrap-Up Meeting
- Individual Practice Post-Project Meetings/Surveys

Focus Topics Included

- HPV Clinical Update
- Vaccine Hesitancy
- Best Practices for HPV Vaccination
- HPV Persona Project
**QUALITY IMPROVEMENT PROGRAM**

**Human Papillomavirus (HPV)**

PROGRESS DASHBOARD: APRIL – DECEMBER 2022

**Program Summary:** Practices will utilize the Model for Improvement and regular QI coaching to improve provider confidence in vaccine discussions and to implement interventions to increase rates of HPV administration.

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**BUDGET:** $150,000

**BUDGET TARGET:** Secured

**FUNDING OUTLOOK:** $180,000 in funding for Wave 2

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**ABOVE & BEYOND**

Outside the Contract Scope

**Practice Engagement Post-Project**

- NC & GA practices participated in podcast focusing on HPV best practices.
- All Ohio practices participated in Spring Education Meeting focused on adolescent immunizations.

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**Deliverables and Progress**

- **Practice Engagement**
  - Engage 8-10 practices (19 total engaged – 17 in Ohio, 1 in NC & 1 in GA)

- **Distributing HPV Rack Cards**
  - Nearly 9,000 cards distributed to practices
  - Now including rack cards as a free resource for TIES trainings

- **Individual Practice Goals Met**
  - 100% of participants indicated that they met or exceeded their individual project goals

  "The support of Ohio AAP and collaboration among the participating groups helped jump start making sustainable improvements to my HPV vaccine practices through small, workable cycles of change. Five stars!"

  Dr. Tricia Lucin
  Hilliard Pediatrics, Inc.

- **Diversity Focus**
  - Wave 2 will have a focus on rural counties in Ohio, specifically those with high HPV-associated cancer rates.

- **Special Highlight**
  - The NC Immunization Branch called and said they noticed that our HPV rates went from 41-48% in the last year. She stated that they hardly ever see NC close to 50%. She asked what we had done to achieve this and I told her about our participation in the HPV QI Project. She said she called to give us kudos!

  Sarah King Townsend, RN
  Vaccine Coordinator,
  Blue Ridge Pediatric & Adolescent Medicine

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= Not likely to meet goal  = On track with challenges  = On track or complete
Ohio AAP Program Partners
Ohio AAP Acknowledges the following partners in support of Ohio Pediatric Programs.

<table>
<thead>
<tr>
<th>Program</th>
<th>Funding Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximizing Office Based Immunizations/Teen Immunization Education Sessions</td>
<td>$300,000 (ODH)</td>
</tr>
<tr>
<td>Parenting at Mealtime and Playtime Education Program</td>
<td>$174,350 (ODH)</td>
</tr>
<tr>
<td>Lead Screening QI Program</td>
<td>$400,000 (ODH)</td>
</tr>
<tr>
<td>Ohio Parents Advocating for Vaccines</td>
<td>$20,000 (Unrestricted Education Grant)</td>
</tr>
<tr>
<td>Atopic Dermatitis QI Program</td>
<td>$250,000 (Nationally-Funded Quality Improvement Grant)</td>
</tr>
<tr>
<td>Practice Transformation Program: Improving Nexplanon Provision in Adolescents</td>
<td>$296,000 (Nationally-Funded Quality Improvement Grant)</td>
</tr>
<tr>
<td>HPV QI Program</td>
<td>$330,000 (Unrestricted Education Grants)</td>
</tr>
<tr>
<td>Interventions to Minimize Pre-term and Low Birth Weight through Continuous Improvement Techniques (IMPLICIT) QI Program</td>
<td>$1.2 Million</td>
</tr>
<tr>
<td>Polyarticular Juvenile Idiopathic Arthritis (pJIA) – Building a System of Care to Improve Patient Compliance and Provider Connections in the Medical Home</td>
<td>$200,000 (Unrestricted Education Grant)</td>
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<td>Maternal Child Health Education &amp; QI Program</td>
<td>$314,000</td>
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<tr>
<td>Atopic Dermatitis: Understanding Health Disparities in Underserved Minorities QI Program</td>
<td>$246,000 (Unrestricted Grant)</td>
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<td>Smoke Free Families QI Program</td>
<td>$400,000</td>
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<tr>
<td>Injury Prevention Plus SEEK Program</td>
<td>$120,000</td>
</tr>
<tr>
<td>Store It Safe (SIS) Program</td>
<td>$575,000</td>
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</tbody>
</table>
Pediatric knee pain is one of the most common complaints seen in the pediatrician’s office at approximately one-third of musculoskeletal-related visits. It is important to recognize common low-risk conditions that can be treated by the primary care provider with good success, such as Osgood-Schlatter disease (OSD). This is a condition caused by stress from patellar tendon traction onto the tibial tubercle apophysis. This condition is seen most frequently in young, active adolescents between the ages of 9 and 15, with peak incidences occurring at times of rapid linear growth spurts. In boys, peak incidence occurs at 12 years-old and for girls it occurs at 10 years-old. This tends to affect boys more than girls and can present bilaterally. When seen bilaterally, it is common for one side to be more painful or for the side of increased pain to change. It may present as gradual onset of knee pain, or after direct trauma to the tubercle. The condition is typically seen in those patients who participate in sports that are quadriceps dominant, and those performing repetitive motions loading the extensor mechanism (jumping, kneeling), with basketball and soccer having the most participants affected.

Families may be concerned because the pain can return after a period of rest if biomechanics or load management are not addressed. A thorough history and physical exam can differentiate pathologies that may cause similar symptoms and require specialty referral. Most of the time, the onset of pain is gradual and associated with a growth spurt along with increased physical activity. Tenderness at the tibial tubercle and pain with resisted knee extension are the common physical exam findings. There may be local swelling over the tibial tubercle that may be more prominent in one knee compared to other, but the knee should never have an effusion, if so, consider other pathology. There may be reports of abnormal gait or limping with activity that improves with rest in the early stages. If the child pushes through the pain then sometimes pain occurs after activity and into the next day. The pain should never interfere with sleep. If there is persistent pain and limping or if the physical exam findings do not fit OSD then alternative diagnoses should be considered. As with all presentations of knee pain, a thorough exam of the ankle and hip are necessary.

When patients present with knee pain, imaging is not always necessary. Osgood-Schlatter’s disease is a clinical diagnosis. Plain radiographs of the knee can be helpful if the patient presents with significant swelling, effusion, systemic symptoms, or inability to bear weight, as these do not correspond with a diagnosis of Osgood-Schlatter.

Treatment for OSD focuses on addressing both overuse and the biomechanical changes that occur with a linear growth spurt. Families can be reassured that this is a self-limited condition and the patient may continue to participate in activity as pain allows as long as the child is not limping. Non-steroidal anti-inflammatory drugs, acetaminophen, and ice application at swelling site for 15 minutes at a time, can safely be done 3-4 times daily for a short period to improve the patient’s pain and swelling. Children should not take medication to mask symptoms so they can play, but can take medication during periods of rest. To address the biomechanical changes, formal physical therapy may not always be necessary initially, but patients should be encouraged to perform daily stretches of the quadriceps, calf, iliotibial band, and hamstring muscles to improve flexibility. As kids undergo growth spurts, muscles may develop tightness and strength imbalances trying to accommodate to the rapidly growing bone. Patellar tendon straps applied at the mid-tendon may be recommended once a patient is seeking return to activity. The strap can prevent significant traction on the tubercle during activity. Not all patients respond to these recommendations, and the patient has attempted these changes without improvement, it is appropriate to refer for evaluation with sports medicine or orthopedics.
Osgood-Schlatter Disease
Alex Mauricio Gale, MD, Cincinnati Children’s Hospital Sports Medicine

Osgood-Schlatter’s disease (OSD) is an overuse injury which causes pain in the front of the knee of a growing child. Overuse injuries occur with repetitive forces on the body. During periods of rapid growth, the repetitive movements needed for sports or activity can cause stress to the areas that are growing. OSD can be present in children involved in running and jumping/landing sports such as soccer, cross-country, track, basketball, and volleyball. The muscles and tendons used to run, jump, land, and cut attach to a small area on the shin that has not fully matured. If these muscles and tendons are activated often, as with running and jumping, then the small area may be irritated leading to swelling and pain at the upper shins. This condition appears commonly during a child’s growth spurt and will improve once growth has stopped.

Signs and Symptoms
Children with OSD often notice gradually increasing pain in one or both knees when they’re engaging in physical activity. At first this pain may be infrequent but can increase over time, usually occurring during periods of increased training, and at times worse towards the end of a season. They may point to their upper shin or beneath their kneecap as location of pain. Swelling may also be present in the same area. If your child is experiencing persistent pain or reports frequent pain with activity, a healthcare provider should evaluate them.

Diagnosis & Treatment
Your physician will ask a thorough history of their symptoms and perform a focused physical exam of the knees but could also examine their hip and ankle joints as abnormalities at this site could be affecting their knees. X-rays are not necessary to diagnose OSD.

Initial treatment includes rest from the running or jumping/landing activities that contributed to the start of their symptoms. Rest helps to decrease pain, prevent further damage, and to encourage healing by preventing the muscle and tendon attached to the area from excessively pulling the area. A brace can sometimes be helpful. Many children affected by this disease notice improvement with stretching the muscles and tendons connected to the knee, including the thigh, calf, and hamstring muscles. If no significant improvement is seen after following these recommendations, then formal physical therapy is often recommended to help reduce their symptoms, strengthen the muscles of the core, hip, and thigh, and to help your child return safely back to sport.

Over the counter medicines like acetaminophen or ibuprofen can be given for pain. Children should not take medicine to mask pain so that they can play or practice. Ice after activity can help reduce pain and can be applied 2-3 times per day for 15-20 minutes at a time. Do not place ice directly on skin.

Prevention & Follow-Up Care
Once your child’s symptoms have improved it is important to continue the stretching and strengthening exercises. Almost all patients have symptom resolution once the growth plate is closed. OSD does not cause problems with growth, but it can cause a bump on the front of the shin near the knee that persists even after your child is fully grown. If symptoms are manageable, there is no need to stop engaging in their favorite sport/activity.
Primary care pediatricians have long known that their patients have better physical and mental health when families fully utilize their medical home. As an urgent care pediatrician, however, I can attest that most of my patients bypass the opportunity to see my primary care colleagues for one of two main reasons, both of which may deprive patients of the benefits of working with the medical home.

One reason is well known: convenience. We work hours outside of typical practice hours. At its best, an urgent care with pediatric expertise assists primary pediatricians once they’ve recommended an urgent care visit to a family that has contacted them. When that is not the case, we nonetheless notify primary care physicians that a visit to us occurred and recommend families follow up with them, knowing the medical home is where families can be reminded of immunizations, preventative care, and where recurring illnesses or injuries can be viewed in a larger context. We know that many visits to us could have occurred at the primary care office with greater benefit and less expense to the patient’s family.

I became more aware of the second reason during the surge in respiratory illnesses from flu, COVID, and RSV last season that filled urgent cares and emergency departments. That season we saw many families enduring long wait times, sometimes after mounting transportation problems, with siblings in tow because the family lacked a sitter. Many visits with their urgent care could have been prevented if the caretakers knew confidently how to manage minor illnesses and injuries at home. Many young families didn’t have the benefit of getting knowledgeable advice from their own parents or nearby relatives on these subjects, but a strong relationship with their primary care pediatrician could have filled this important education gap.

That is why I support the Chapter’s “No Place Like Home” initiative to inform families of the full variety of situations the medical home can address, often at much greater value than the alternatives. My growing field of urgent care pediatrics finds its purpose in assisting the medical home. The Ohio Chapter advocates to families and healthcare payers the central role of the primary care pediatrician within the larger “medical neighborhood” of urgent cares, pediatric subspecialists, surgical specialists, mental health providers, therapy services, and community resources for families.

Dr. Price was a primary care pediatrician for 18 years in Lorain, Marysville, and Columbus before becoming an urgent care attending for Nationwide Children’s Hospital. He co-chairs the chapter’s Pediatric Care Council, a dialog group with health insurance plans. The Chapter advocates for more comprehensive affordable coverage for children and adequate payment to providers.
The Benefits AND Disadvantages of Telehealth

Denise Warrick, MD, FAAP

The COVID pandemic had a profound impact on the practice of medicine, especially in the field of primary care pediatrics. Telehealth and virtual visits became a necessity due to the fear of patients and families coming to doctors’ offices. Patients saw the benefits of telehealth and virtual visits and appreciated the convenience of accessing care from their medical providers remotely. This was especially true for those who live far from the physician’s office or had transportation difficulties. Providers saw this as a unique and effective way to deliver care for certain complaints (e.g., mental health or behavior). However, they also saw the challenges of a limited exam on providing the most appropriate care for a large number of illness complaints.

Reflecting back, we have come a long way since the spring of 2020. Most pediatric offices are back to their pre-COVID volumes of seeing patients in the office again for both ill and well child visits. However, patients still are seeking the convenience of telehealth or virtual visits. Providers are currently trying to navigate the complexity of managing which visits would be appropriate for a virtual visit versus which ones are the best to be seen in person for a more thorough examination. Moving forward, it will be in our best interest, as pediatric primary care providers, to educate our patients and families about what we feel are the best and most appropriate channels for seeking care for specific complaints. Otherwise, patients and families may seek care out of the medical home due to the sheer convenience.

Medicine done poorly in any setting is a risk to our patient’s health, knowledge, and expectations. The recent surge of telemedicine offerings from insurance companies and healthcare systems can be seen as a primary example of how the practice of medicine can vary. Done in the correct way, telemedicine can be a powerful and convenient tool for our patients. Done poorly, it leads to overtreatment and misdiagnosis. This was seen with the recent surge of strep throat. Patients were often treated by some of these telemedicine providers without any confirmation of the infection or examination. We have instances of urinary tract infections being treated by some of these telemedicine providers without any confirmation of the infection or examination. We have instances of urinary tract infections being treated by some of these telemedicine providers without any confirmation of the infection or examination. Each pediatrician can surely find an abundance of examples when antibiotics or other medication (e.g., steroids, inhalers) prescribing is done without any testing or examination.

Our creed is DO NO HARM, but giving unnecessary medications can lead to resistance, increased chance of adverse reactions, shortages of medications, potential masking of a more worrisome condition, which can delay proper treatment, and all these factors can lead to harm. One of my biggest concerns though, is how this affects our patients understanding of medicine and the expectations of treatment this creates. We need to take a step back and make sure that the interventions we are performing are in the best interest of our patients and adhere to best medical practices, and not just a money making or cost cutting method that may lead to more harm than good in the long run for our patients.

Jeff Heaton, MD, FAAP
SAVE THE DATE!
BUILDING TOWARDS RESILIENCE
FOR OHIO’S CHILDREN
RESTORE • REBUILD • RECOVER

KEYNOTE SPEAKER
Roy Guerrero, MD, FAAP

Uvalde Tragedy Before, During and After: Resiliency and Rebuilding a Community

Dr. Guerrero was the ONLY pediatrician in Uvalde

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• Adolescent Trauma Informed Care
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• East Palestine Train Derailment: Lessons for Children’s Health
• Disaster Preparedness in Ohio: Making Sure our Children are Not Forgotten
• Pediatric Acne Update
• New Clinical Guidelines on Obesity
• Sports Medicine Update
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Dairy Every Day is a Healthy Way
Dairy foods help brains, bones and bodies grow.

Why is Iodine Important?
Iodine deficiency is the most preventable cause of mental retardation.

How Much Iodine Do You Need?

<table>
<thead>
<tr>
<th>LIFE STAGE</th>
<th>RECOMMENDED AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 6 months</td>
<td>110 mcg</td>
</tr>
<tr>
<td>Infants 7–12 months</td>
<td>130 mcg</td>
</tr>
<tr>
<td>Toddlers 1–3 years</td>
<td>90 mcg</td>
</tr>
<tr>
<td>Children 4–8 years</td>
<td>120 mcg</td>
</tr>
<tr>
<td>Children 9–13 years</td>
<td>150 mcg</td>
</tr>
<tr>
<td>Teens and Adults 14+ Years</td>
<td>220 mcg</td>
</tr>
</tbody>
</table>

What Foods Provide Iodine?

<table>
<thead>
<tr>
<th>Food Item</th>
<th>PER SERVING VALUE (DV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iodized Table Salt</td>
<td>76</td>
</tr>
<tr>
<td>Low-Fat Milk</td>
<td>87</td>
</tr>
<tr>
<td>Yogurt, Greek, Fat-Free</td>
<td>87</td>
</tr>
<tr>
<td>Swiss Cheese</td>
<td>36</td>
</tr>
<tr>
<td>Cheddar Cheese</td>
<td>15</td>
</tr>
<tr>
<td>American Cheese</td>
<td>18</td>
</tr>
<tr>
<td>Egg, Hard Boiled</td>
<td>26</td>
</tr>
<tr>
<td>Cottage Cheese (Reduced Fat)</td>
<td>39</td>
</tr>
<tr>
<td>Pasta, Cooked in Iodized Salt</td>
<td>40</td>
</tr>
<tr>
<td>Fish Sticks</td>
<td>58</td>
</tr>
<tr>
<td>Shrimp, Pre-cooked</td>
<td>13</td>
</tr>
<tr>
<td>Soy Beverage</td>
<td>7</td>
</tr>
<tr>
<td>Almond Beverage</td>
<td>2</td>
</tr>
</tbody>
</table>

Why do kids need calcium?
Kids need calcium to help build strong bones and teeth. The Dietary Guidelines for Americans, from the U.S. Department of Agriculture, recommend that kids eat 2-3 servings of milk each day, depending on their age. The Food and Drug Administration (FDA) has set a Daily Value (DV) of 1000 milligrams for children age 9-18 years old, 1300 milligrams for children 4-8 years old, and 700 milligrams for children 2-3 years old. Each serving of milk provides 10% of the DV for calcium.

How much is a serving?
1 cup of milk contains 8 ounces of milk, 1 ounce of American cheese, or 1½ cup of cheese. Each of these have a similar amount of calcium.

Growing Children Need Calcium to Build Strong Bones and Teeth!

<table>
<thead>
<tr>
<th>Kids Ages</th>
<th>Amount of Calcium</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr</td>
<td>1 cup</td>
</tr>
<tr>
<td>2-3 yr</td>
<td>½ cup</td>
</tr>
<tr>
<td>4-8 yr</td>
<td>1 cup</td>
</tr>
<tr>
<td>9-18 yr</td>
<td>1½ cups</td>
</tr>
</tbody>
</table>

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