BUILDING TOWARDS RESILIENCE

FOR OHIO’S CHILDREN
RESTORE • REBUILD • RECOVER

OHIO AAP 2023 ANNUAL MEETING
November 3-4, 2023 • Hilton Columbus Polaris

Highlight Topics
• Infant Sleep: Importance, Struggles, Cycles and Safety
• Adolescent Trauma Informed Care
• Anxiety in Primary Care: Treatment and Management
• Advocacy in Ohio
• Diversity, Equity and Inclusion Education Toolkit Rollout
• 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
• Reproductive Health Update
• Eating Disorders in Children and Young Adolescents
• Correcting Blind Spots in Infant Feeding

FEATURING KEYNOTE SPEAKER
Live Q&A via Zoom
Roy Guerrero, MD, FAAP
Uvalde Tragedy Before, During and After: Resiliency and Rebuilding a Community
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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
President’s Message

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

“Unless someone like you cares a whole awful lot, nothing is going to get better. It’s not.”
- Dr. Seuss – The Lorax

I hope everyone had a wonderful summer. During this time of transition from summer to fall, I typically become a bit sentimental. This is especially true this year as my oldest has started her first job as an interventional education specialist in Columbus and we just dropped my son off for his freshman year at the University of Cincinnati (Go Bearcats!), leaving my wife and I to become empty nesters. Over the past few weeks, not only have I been reflecting about the legacy we leave behind for our children, but also the legacy that we leave behind for the profession of pediatrics.

Several recent articles and studies have focused on potential challenges to the pediatric workforce over the coming years. The COVID-19 Pandemic has only served to amplify these challenges. A 2017 study reported that “27% of pediatricians in practice would retire today if it were affordable.” This number was even greater for rural pediatricians. As the percentage of pediatric residents who enter community practice decline and more community pediatricians are considering early retirement, the viability of community pediatrics and the community pediatrician are in jeopardy and ultimately threatening the access to care for children. In the AAP Policy statement on the pediatric workforce, it was noted that “to achieve optimal health and well-being for all infants, children, adolescents, and young adults, sufficient numbers of appropriately-trained primary care pediatricians must be available to provide care.” Recently, pediatric department chairs have focused on identifying strategies to increase the number of high-quality trainees who pursue training in pediatrics and an objective was created to focus on developing “action steps that focus on key strategies to strengthen the pediatric workforce.” These included increasing exposure to various pediatric career opportunities at different critical points in training, including in medical school and residency. By having students and pediatric residents participate in clinical rotations in community pediatric practices, the hope is that more trainees will consider community pediatrics as a viable career choice.

As medical schools and residency programs have increased in size, along with an increase in the clinical demands of community physicians in practice, a “preceptor crisis” has emerged that threatens the ability to sustain the community pediatrics training model of medical students and residents. More than 50% of pediatric departments reported difficulty finding clinical sites for their learners. The community office setting is a vital laboratory where learners are exposed to a variety of office, community and hospital. I love seeing a learner’s “light bulb moment” that occurs when they start current with what is going on in the hospital. I see it when a learner’s “light bulb moment” that occurs when they understand a key concept or make an insightful connection. I truly believe it has been one of the main protectors from moral injury and burn out for me. Several of my former students and residents have become community pediatricians and I am proud that I played a very small role in that.

At the recent AAP Annual Leadership Conference, I authored a resolution that focused on the AAP supporting community preceptors who teach learners. The resolution ended up being voted into the top 5. As a result of this resolution, there will be a meeting for community preceptors at the AAP NCE on Sunday, October 22 from 12:30-1:30 to find out what community continued on page 6...
Statehouse Update

General Assembly Returns to Action; November Election Features Two Major Ballot Issues

Danny Hurley  
Vice President, Capitol Consulting Group, Inc.

The Ohio General Assembly is back in action after a brief summer recess. Lawmakers will tackle a variety of healthcare-related bills while the Ohio Redistricting Commission continues its work to update state legislative maps for the 2024 Election Cycle. There are also two notable statewide issues on the November ballot. Lastly, we will be sharing more information on the upcoming Ohio Medicaid rate increase scheduled to take effect on January 1.

The Ohio Chapter and other groups previously advocated for a boost to primary care rates in hopes of increasing access for Medicaid patients. Look for more information on this rate increase in the coming weeks.

Much of the Ohio Chapter’s energy and focus will be on the Ohio Senate, where several notable bills are being debated. House Bill 68, sponsored by State Representative Gary Click (R-Vickery), would place limits on access to gender-affirming care for minors and also restrict transgender girls from playing women’s sports in high school and college. HB 68 was recently referred to the Senate Government Oversight Committee. AAP is one of the leading organizations opposed to this measure. We are coordinating with a broad group of provider organizations, children’s hospitals, and advocates.

We are also monitoring Senate Bill 144, sponsored by State Senator Mark Romanchuk (R-Ontario). This bill would expand the scope of practice for pharmacists, pharmacy techs, and pharmacy interns to allow them to administer vaccines to children as young as five. At the height of the COVID pandemic, pharmacies were given emergency authorization to administer vaccines to children as young as three, and we are supportive of that authority remaining for flu and COVID vaccines. However, the Ohio Chapter is concerned over the impact this change might have on pediatric well child visits. We worked with lawmakers and interested parties to address pharmacy vaccination for children nearly a decade ago and will engage with legislators as needed on this matter. The Ohio Senate Health Committee is also holding hearings on Senate Bill 126, which would limit the use of noncompete clauses in hospital employment contracts. Sponsored by State Senator Terry Johnson, DO (R-McDermott), a number of physician groups are likely to support this measure.

Over in the House of Representatives, we are eagerly watching three bills and are hopeful to see movement later this year. House Bill 7, sponsored by State Representatives Andrea White (R-Kettering) and Latyna Humphrey (D-Columbus), would enact the Strong Foundations Act, which would adopt several provisions and fund new programs to address maternal and infant mortality and early childhood development. The House may also act on measures to address adverse health insurance practices that impact patients with rare diseases or significant health issues. House Bill 177, sponsored by State Representative Susan Manchester (R-Waynesfield), would prohibit copay accumulator programs. Under these programs, copay assistance given to patients with high-cost prescription drug needs is not applied to the patient’s deductible; as a result, these individuals must still satisfy their deductible after exhausting the assistance. House Bill 156, sponsored by State Representatives Scott Oelslager (R-North Canton) and Gayle Manning (R-North Ridgeville), would protect patient access to drugs prescribed and administered in hospitals for patients with cancer or other significant healthcare issues. Both bills enjoy broad support from hospitals, patient advocates, and provider groups.

Next month, Ohio voters will head to the polls to cast their ballots on two contentious policy issues. Issue 1 is a constitutional amendment to enshrine access to reproductive healthcare services, including abortion care. In the wake of the Dobbs decision, which overturned Roe v. Wade, some states have passed similar measures to restore some of the protections that existed previously. Public polling shows that this issue will pass with a narrow margin, and the Ohio Chapter and many other healthcare organizations have expressed support. Even if Issue 1 were to pass, the issue of reproductive healthcare and abortion access will remain far from resolved in Ohio.

Voters will also decide on Issue 2, which would legalize recreational cannabis use for adults 21 years of age and over. Ohio is the latest state to decide on this and polling shows another close race. Unlike Issue 1, this issue is initiated statute and not a constitutional amendment. Therefore, the General Assembly could modify or update the provisions of Issue 2 in the future should the need arise. The Ohio Chapter is in opposition to this initiative. Both issues are expected to increase voter turnout. Voter registration closes on October 10 and early voting begins on October 11; Election Day is November 7.
You’re Invited!
I am excited to invite you to Ohio AAP’s upcoming Foundation Fundraiser Luncheon, Building Towards Resilience for Ohio’s Children, held Friday, November 3 at the Hilton Columbus Polaris. The Ohio AAP Foundation and chapter are deeply committed to addressing teen suicide and mental health concerns. The prevalence of suicide, anxiety, and depression in teens is on the rise, affecting youth of all ages and backgrounds. Suicide is now the second leading cause of death in people 10-25 years old in the U.S.

We are excited to hear from Dr. Roy Guerrero, the ONLY pediatrician in Uvalde, Texas who treated the victims of the tragedy last year. Dr. Guerrero will address the Uvalde tragedy before, during, and after, with a focus on resilience and building a community. We hope you will join us to hear Dr. Guerrero’s incredible message of triumph over tragedy, while supporting the work of pediatricians in our communities, and transforming our landscape one child at a time. We have single ticket options as well as higher support levels, including table sponsors and above.

Store It Safe
The event will support the spread of the Ohio AAP Store It Safe (SIS) program aimed at reversing the irreversible actions of Ohio’s youth. Recent studies show that 27% of youth who have an elevated suicide risk have access to a firearm. The SIS program is the only program that takes a comprehensive approach to intentional and unintentional firearm injuries, by training healthcare providers to screen for depression and suicide, discuss lethal means, distribute safe storage devices, and provide resources for families. Our tools and resources are ready to deploy – and, through our broad networks, we can reach youth across the state, from rural to urban regions. In addition, we are partnering with legislators, hospitals, and community providers to expand this reach. The fundraising luncheon aims to:

1. Expand Store it Safe in practices and communities across Ohio.
2. Increase awareness about the importance of early intervention and destigmatization of mental health issues.
3. Provide a platform for open discussions and sharing of experiences.
4. Foster a sense of community and support for teens and their families.

Spread the Word
We believe in the power of community and the ripple effect of shared efforts. Feel free to share this invitation with friends, family, and colleagues who might be interested in making a positive impact. Together, we can engage hundreds, even thousands of physicians, community members, public health professionals and advocates this year in sharing best practices in safety and prevention.

We believe that with your participation, we can create a safer and more supportive environment for teens facing mental health challenges. Let’s work together to bring about positive change and promote a brighter, healthier future for everyone.

Reserve your spot today!
https://ohioaap.org/foundationluncheon

Dr. Guerrero was the ONLY pediatrician in Uvalde

VIRTUAL APPEARANCE FROM KEYNOTE SPEAKER
Roy Guerrero, MD, FAAP
Uvalde Tragedy Before, During and After: Resiliency and Rebuilding a Community
Welcome, Fall! The days are shorter and cooler as kids head back to school, offices are ramping up for ADHD evaluations and flu/COVID clinics, and we are getting ready to pack our bags for the October 2023 AAP NCE in Washington DC. We are emerging from the dark days of the pandemic but know that COVID will be with us for the foreseeable future. Vaccines have been a turning point for pandemic recovery, but adoption of the vaccines for kids remains low and misinformation continues. The AAP is actively promoting campaigns for vaccine adoption and the HealthyChildren.org website is a terrific parent resource for up-to-date vaccine information.

With the advent of RSV monoclonal antibodies and the new maternal RSV vaccination, you will be looked to as the experts. The AAP is closely monitoring the RSV landscape and advocating for vaccine logistics and payment to mitigate the distribution complexities and cost challenges. Please reach out to your chapter and national leaders with questions as reports from the field are critical to informing the AAP advocacy team.

National conversations and legislation are posing unique and daunting challenges for our patients, their families and for pediatricians. Equity, diversity and inclusion, gender affirming care and reproductive health are all under fire in our state legislatures and I know that chapters are closely monitoring bills. You all remain steadfast in your commitment to the children and families that you serve, but your dedication can come at a cost. Many of our colleagues across the country have faced disinformation campaigns, professional threats to reputation and for some, personal safety threats. The AAP has created a task force that will be assessing your needs and creating a rapid response to those needs. We know that this is an urgent concern. Again, please let chapters or me know your personal stories, and when the member well-being survey comes your way, please complete it so we have up-to-date feedback.

I want to thank each of you for the work you do. The practice of pediatrics is a calling and there is nothing quite like looking into the face of a child to remind us of the privilege of the profession.

I hope to see you at our District sessions at the NCE in Washington DC, which will be listed in your conference agendas!

Preceptors need to succeed and develop next steps. I will share more details when they are known. If you are interested in teaching a student or resident in your office, I would also encourage you to reach out to your medical school or children’s hospital.

Thanks to all of you who welcome learners into your office and help in teaching and mentoring the next generation. I #BELIEVE it is our best chance to ensure that community and independent practices survive and thrive.

Please reach out to me via email (chris.peltier@cchmc.org) or on Twitter (@cpeltier007) with questions or suggestions for the Chapter. I look forward to hearing from you and hope to see all of you in November at Annual Meeting!

Best regards,

Christopher Peltier, MD, FAAP

“For me, success is not about the wins and losses. It’s about helping these young fellas be the best versions of themselves on and off the field.”

-Ted Lasso
Ohio AAP Partners with Life Side Ohio to Expand Safe Storage and Suicide Prevention Resources

The Ohio Chapter, American Academy of Pediatrics (Ohio AAP) is partnering with Life Side Ohio, a program of The Ohio Suicide Prevention Foundation, to bring its Store It Safe resources to additional youth and families. Ohio AAP’s Store It Safe program is a unique partnership of healthcare providers, firearm advocates, and community organizations established to keep children safe from unintentional gun deaths and teens safe from suicide by firearms, medications or alcohol.

Similarly, Life Side Ohio is a campaign of direct, suicide prevention outreach dedicated to the firearms community. Life Side Ohio educates Ohioans on the importance of suicide prevention with the help of gun owners of various backgrounds across the state who have one common goal: to save lives.

“This is a natural partnership for both organizations as we work together to prevent suicide among our children by focusing on gun safety and storage,” said Melissa Wervey Arnold, CEO, Ohio Chapter, American Academy of Pediatrics. “Both organizations share common ground and recognize that more education and conversation is needed within our communities to address the staggering increase in teen suicide.”

Suicide is the second leading cause of death among 10- to 34-year-olds in the U.S., and one in five adolescents contemplate suicide each day. Teen suicide has increased more than 55 percent in the past 10 years. Furthermore, in Ohio, firearms are the leading cause of death among children and teens.

“As we continue to work around lethal means and suicide prevention, this partnership with the Ohio Chapter, American Academy of Pediatrics is crucial to sharing information and strategies to reduce youth suicide deaths,” said Tony Coder, Executive Director of the Ohio Suicide Prevention Foundation. “With firearm owners, gun shops, and hunting clubs playing an active role in preventing suicides, we are able to make inroads on safe storage and responsible gun ownership messages with all Ohio families.”

The Store It Safe program is poised to save lives by “Reversing the Trend of Irreversible Actions” that occurs in adolescent suicide. By identifying teens with mental health concerns, providing appropriate interventions, and creating barriers to the most lethal means for suicide, like firearms and prescription medications, suicides can be prevented.

To learn more, please visit www.ohioaap.org/storeitsafe.

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**Important Facts and Safety Considerations:**

- **EVERY** youth is at risk for accidental or intentional injury by a firearm – even if they are experienced and supervised with firearms.
- **Each** firearm should only have one person access to it.
- The presence of a firearm triples the risk of an adolescent attempting suicide or attempting suicide.
- **Y** outh who engage in risky behaviors and are prone to responding to small stressors are at risk.
- Even with no history of depression, youth can engage in risky behaviors and attempt suicide.

**EDUCATION ALONE IS NOT ENOUGH.**

**Barriers should be put in place – and can mean the difference between life and death**:

- **90% of** suicide attempts fail. Prevent a fourth result in death.
- **2/3 of all firearm deaths** are due to suicide.
- **Unintentional youth firearm injuries** are a leading cause of death for youth under 18.
- **35% of survivors** make multiple attempts within 10 moments of their decision to attempt suicide.
- Delays in access to firearms is crucial to saving lives.

**Keep in Mind...**

- Family history is a warning sign for suicide.
- **Deaths by** firearms in Ohio and the United States have more than doubled in the past 10 years. Further, suicide has increased more than 55 percent in the past 10 years. Further, suicide has increased more than 55 percent in the past 10 years.

**TYPICAL COST**

- **Under $50:** Cable Locks
- **$5 – $45:** Guzzler, smaller than a safe
- **$100 – $200:** Electronic locks, not discrete
- **$200 – $2500:** Expensive, most secure option for firearms, especially long guns
- **$25 – $300:** Cannon, breakable
- **$500 – $750:** Smartlock, accessible
- **$750 – $1000:** Smartlock, breakable
- **$1000 – $1200:** Smartgun, not breakable
- **$2000 – $3000:** Smartgun, breakable
- **$3000 – $5000:** Smartgun, not breakable

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**Store It Safe Flyer**

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**Store It Safe**

**Ohio AAP, Life Side Ohio and The Ohio Suicide Prevention Foundation**

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**Ohio AAP Partners with Life Side Ohio to Expand Safe Storage and Suicide Prevention Resources**

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**Ohio Pediatrics**

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**Ohio AAP’s Store It Safe program is a unique partnership of healthcare providers, firearm advocates, and community organizations established to keep children safe from unintentional gun deaths and teens safe from suicide by firearms, medications or alcohol.**

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We all share the same goal of keeping Ohio families healthy, whether that be through routine vaccinations, taking care of sick children, or providing access to nutritious foods. Building stronger relationships between pediatricians and WIC will benefit everyone and help us reach our goal, together.

Do you know about WIC? The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutrition assistance for pregnant and breastfeeding individuals, and children five years old or younger who qualify for the program. WIC is a federally-funded program proven to ensure safer pregnancies, fewer premature births, fewer infant deaths, reduction in childhood obesity and anemia rates. WIC offers a wide variety of supplies to support breastfeeding and breastfeeding education through peers and certified specialists. WIC participants are eligible for the Farmer’s Market Nutrition Program, issuing yearly vouchers for fresh fruits and vegetables.

The Ohio WIC Program has 76 sub-grantee agencies with approximately 200 clinics serving Ohio’s 88 counties. Many WIC clinics are located within local health departments or in proximity to federally qualified health centers (FQHCs), allowing avenues for collaboration between WIC and healthcare providers.

Eligibility for WIC is based on three criteria: categorical (pregnant, breastfeeding, or child five years or younger), income (185% of the Federal Poverty Level) and nutrition risk. All Ohioans receiving Medicaid are also eligible for WIC, regardless of income status. WIC enrollment includes a nutritional assessment with a Registered Dietitian (RD), Diet Technician, Registered (DTR), or Registered Nurse (RN), as well as a monthly food prescription (issued in three-month increments), and referrals to community resources. Ohio WIC recipients must make in-person visits to have their benefit added to their WIC Nutrition Card (WNC).

How can you help?
As a pediatrician, you can play a pivotal role in breaking down barriers to enrolling in WIC for families who need it the most. Some common barriers to families enrolling and using the WIC benefits include:

1. Lack of information about eligibility.
2. Difficulty scheduling or keeping scheduled WIC appointments.
3. Challenges with WIC user experience redeeming the benefit.

These barriers will take long-term systems solutions to address, but you can help us get a head start! This work can be done in collaboration with social workers and community health workers who support addressing social needs in the clinic. A few things you can do:

Learn about and develop relationships with the WIC sites near your clinical site. You can find local WIC clinics using the Ohio WIC Clinic Locator, which provides contact details and hours of operation for each site. This information can help you connect families with their closest WIC site.

Ask families about their recent WIC appointments. Ask parents if they’ve heard of WIC or if they’ve seen their WIC health professional lately.

Many WIC clinics use text messaging systems to help families schedule and receive appointment reminders, but we know that there could be more reasons than “I forgot” to a missed appointment. Asking about recent appointments can spark a conversation about any barriers they have to meeting appointments. One example: some families may have transportation barriers. If this is the case, let them know that some health insurance companies provide their members transportation to healthcare related and WIC clinic appointments. If you see an urgent need, after completing the appropriate consent process, you can call the WIC office to discuss the case.

Remind families about resources that can simplify the WIC experience. WIC is making investments to modernize the WIC user experience; one effort is the free WICShopper App. Once linked with their WIC account, participants can use the WICShopper App to scan items while shopping to identify eligible products and keep track of their monthly benefits. Anyone can download the app.

We appreciate everything that you can do to help Ohio families and hope that you add WIC referrals to your toolbox. Scan the code to learn everything you need to know about WIC.
FREE FOR OHIO AAP MEMBERS & STAFF

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

OHIO AAP 2023 ANNUAL MEETING
November 3-4, 2023
Hilton Columbus Polaris

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Exclusive Giveaways for Ohio AAP Members and Paid Attendees

• All attendees will be entered into a Door Prize raffle for a prize with a $500 value.

Highlight Topics

• Infant Sleep: Importance, Struggles, Cycles and Safety
• Adolescent Trauma Informed Care
• Anxiety in Primary Care: Treatment and Management
• Advocacy in Ohio
• Diversity, Equity and Inclusion Education Toolkit Rollout
• East Palestine Train Derailment: Lessons for Children’s Health
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• Sports Medicine Update
• Reproductive Health Update
• Eating Disorders in Children and Young Adolescents
• Correcting Blind Spots in Infant Feeding

You Spoke, We Acted...

• In your evaluations, you asked for general sessions and earlier topics on day one!
• More general sessions, fewer breakouts!
• Expanded education on Nov. 3 with the addition of a new topic – Infant Safe Sleep: Importance, Challenges, and Our Role as Physicians

Earn up to 8 CME/MOC Part II Credits
### 2023 OHIO AAP ANNUAL MEETING

**Schedule of Events**

**Friday, November 3, 2023**

<table>
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<tr>
<th>Time</th>
<th>Topic/Speaker</th>
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<tbody>
<tr>
<td>8:30 am</td>
<td>Registration Opens</td>
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<tr>
<td>8:30 am</td>
<td>Exhibits Open</td>
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| 9:30-11:00 am | Infant Safe Sleep: Importance, Challenges, and Our Role as Physicians  
Mike Goodstein, MD, FAAP |
| 9:30-11:00 am | Executive Committee Meeting (Closed Meeting – Invitation Only)                                    |
| 11:00 am   | Exhibit Networking Break                                                                          |
| 11:30 am   | Ohio AAP Foundation Luncheon & Keynote Address  
Uvalde Tragedy Before, During and After: Resiliency and Rebuilding a Community  
Roy Guerrero, MD, FAAP  
Uvalde Strong for Safe Children, Uvalde Memorial Hospital |
| 1:00 pm    | Exhibit Networking Break                                                                          |
| 1:30 pm    | Instagram Isolation  
James Duffee, MD, MPH, FAAP                                                                         |
| 2:30 pm    | Exhibit Networking Break                                                                          |
| 2:45 pm    | When Anxiety Becomes a Disorder – How to Identify and Manage in Primary Care  
Emily Harris, MD, MPH, FAAP                                                                          |
| 3:45 pm    | Exhibit Networking Break                                                                          |
| 4:00 pm    | Advocacy in Ohio  
Danny Hurley, Capitol Consulting  
2023 Ohio AAP Awards Reception  
Immediately Following the Advocacy Session  
Let’s Raise a Glass to Our Distinguished Honorees  
Open Bar and Hors D’oeuvres |

**#safepedshealthykids • #OhioAAPAM**

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### Schedule of Events

**Saturday, November 4, 2023**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic/Speaker</th>
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<tbody>
<tr>
<td>8:30-10:00 am</td>
<td><strong>Business Meeting Breakfast</strong></td>
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<td>Ohio AAP Update &amp; “Your Reason”</td>
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<td>8:45-9:00 am</td>
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<td></td>
<td>Chris Peltier, MD, FAAP</td>
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<td>Melissa Wervey Arnold, CEO, Ohio AAP</td>
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<td>District V Update</td>
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<td>9:00-9:10 am</td>
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<td>Michael Gittelman, MD, FAAP</td>
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<td>MOBI/TIES Recruitment</td>
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<td>9:10-9:15 am</td>
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<td>Rebecca Brady, MD, FAAP</td>
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<td>Robert Frenck, MD, FAAP</td>
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<td>9:15 am-9:25 am</td>
<td>East Palestine Train Derailment: Lessons for Children’s Health</td>
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<td>9:25-9:40 am</td>
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<td>Nick Newman, DO, MS, FAAP</td>
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<tr>
<td>9:40-10:00 am</td>
<td>Disaster Preparedness in Ohio: Making Sure our Children are Not Forgotten</td>
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<td>Break</td>
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<td>10:05-11:30 am</td>
<td><strong>Focused Topics in Pediatrics</strong></td>
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<td></td>
<td>1. Pediatric Acne Update - Whitney Casares, MD, FAAP</td>
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<td>2. New Clinical Guidelines on Obesity - Chris Bolling, MD, FAAP</td>
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<td>4. Reproductive Health Update - Michele Dritz, MD, FAAP</td>
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<td>11:30 am</td>
<td><strong>Break</strong></td>
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<td>11:35 am-1:00 pm</td>
<td><strong>Concurrent Sessions</strong></td>
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<td><strong>Not Just a Phase: Eating Disorders in Children and Young Adolescents</strong></td>
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<td>Anna Tanner, MD, FAAP, FSAHM, CED-S</td>
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<td>The Emily Program/Accanto</td>
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<td><strong>Correcting Blind Spots in Infant Feeding</strong></td>
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<td>1. HMO and Donor Milk, Probiotics in Formula &amp; Continuum of Care - Amrik Khalsa, MD, FAAP</td>
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<td>2. Undernutrition: Picky Eating and Intuitive Feeding - Chris Bolling, MD, FAAP</td>
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<td>3. Cultural Considerations Infant Feeding and Breastfeeding - Divya Denduluri, MS, RDN, LD, IBCLC (PMP) &amp; Amy Alwood, MS, RD, IBCLC</td>
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## Conference Registration Information

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<table>
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<tr>
<th>Annual Meeting Package</th>
<th>Member and Member Staff</th>
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*All luncheon no-shows (without cancelling by 10/31/23) will be charged $25 to cover the cost of food.

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### CME/MOC Statements

The Ohio Chapter, American Academy of Pediatrics (Ohio AAP) is accredited by the Ohio State Medical Association to provide continuing medical education for physicians.

The Ohio AAP designates this live activity for a maximum of 7.5 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Successful completion of this CME activity, which includes participation in the activity with individual assessments of the participant and feedback to the participant, enables the participant to earn 6 MOC points in the American Board of Pediatrics’ (ABP) Maintenance of Certification (MOC) program.

It is the CME activity provider’s responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit. MOC Part II credit will be entered into the CME data portal entitled PARs and will be shared electronically with the ABP within 30 days of the activity date.

**Target Audience:** Pediatric or family medicine primary care, sub-specialists, hospitalists, general physicians, nurses, residents, medical students, psychiatrists, educators, parents, teens, psychologists, law makers, community members, allied health and all other stakeholders in the safety and health of Ohio’s children.

**Course Description:** This activity is designed to provide health practitioners with the most recent curriculum and strategies aimed at increasing provider confidence in advocacy, mental health, infant feeding, dermatology, reproductive health, anxiety, sports medicine, trauma informed care, and disordered eating.
Ohio AAP Welcome New Members

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<td>Dana Schwartz, MD, FAAP</td>
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Ohio AAP Statement on Reproductive Rights Constitutional Amendment

After careful consideration and discussion, the Board of Directors of the Ohio Chapter, American Academy of Pediatrics (Ohio AAP) voted to endorse the Reproductive Freedom Amendment on two predominate factors. First, the Board stands behind the belief that medical decisions should be among a patient, their family, and their physician without legislative interference in the practice of medicine or in confidential medical care. Second, the Board stands behind the current consent laws in Ohio, and after thorough legal review of the ballot proposal, believes that this amendment will not change the current consent laws that exist. The Board recognizes that reproductive health decisions are a very personal choice not only for patients, but for our members as well. This statement and endorsement of the proposed constitutional amendment should not be considered a political stance by the Ohio AAP around the issue of abortion, but rather an endorsement of protecting the rights and confidential medical decisions between a doctor and their patients and families.

Ohio Pediatricians Support Reproductive Freedom with Protections for Health and Safety Amendment

Lauren Beene, MD, MS, FAAP; Elise Berlan, MD, MPH, FAAP, FSAHM; Arthur Lavin, MD, FAAP; Noam Stern, MD, FAAP

Hours after the U.S. Supreme Court handed down the Dobbs decision, Ohio’s six-week abortion ban went into effect. This extreme ban had no exceptions for rape, incest, or severe fetal anomalies. Our state was thrown into a health care crisis that profoundly complicated our roles as pediatricians. The certainty of access to abortion care was upended and replaced with confusion and fear as both patients and providers struggled to navigate medical care following the loss of rights guaranteed by Roe v. Wade for nearly 50 years.

Suddenly, we were engaged in frantic conversations with desperate and anxiety-ridden patients and families. Mothers asked us to put their young daughters on birth control to ensure they would not become pregnant if they were raped. Teenagers with unwanted pregnancies wanted to know if we could help them find ways to travel to another state so they could get the care they needed. Families with desired pregnancies complicated by severe fetal anomalies found that the state of Ohio took away their options and asked us how to care for babies with no chance of survival. We struggled to respond to the questions we were being asked, as neither our pediatrics training nor our practical experience had prepared us to deal with this politically imposed crisis.

It did not take long for the dire situations we were facing in the privacy of our offices to explode into public view. On July 1, 2022, the Indianapolis Star reported that a 10-year-old Ohio girl had been raped, and at six weeks and three days pregnant, she was forced to flee to Indiana to have an abortion. Sadly, this was not an isolated incident. Reports soon emerged that there had been three children between the ages of 10 and 11 who left Ohio during the same week to receive the care they needed. Statistics show that many more will be forced to do the same with the ban in effect.

The ban also had a devastating impact on the adults in our young patients’ lives. Women were forced to wait for the care they needed as doctors were made to consult with hospital legal counsel. These delays in care led to women suffering life-threatening hemorrhages and infections. Those denied care often spent precious time desperately trying to find an out-of-state hospital that would accept them. And while it is temporarily suspended, the ban could be reinstated as the Ohio Supreme Court is dominated by known
Approximately 70% of adult smokers want to quit.*

Talk with your patients about quitting tobacco.

Three minutes of your time could add years to their lives.

The Ohio Tobacco Quit Line is free to all Ohioans. To refer your patients, please use the QR code or link below.

ohioquits.org

*Centers for Disease Control and Prevention (CDC)
Project ECHO - Extension for Community Healthcare Outcomes

Eva Johnson, MD, FAAP, Case Western Reserve University School of Medicine

About 20% of children 3-17 years in the U.S. have a diagnosable mental health disorder (CDC 2023). In 2021, the AAP declared a national emergency in child and adolescent mental health. The number of children presenting to their general pediatrician with behavioral and mental health issues is increasing, but two-thirds of pediatric primary care providers feel they have inadequate training to treat mental health disorders (Horwitz 2015). With mental health specialists both in short supply and inequitably distributed, pediatric primary care providers need to be able to diagnose and treat patients with various mental health issues, including mild to moderate ADHD, anxiety, and depression.

Improving our knowledge and comfort in diagnosing and treating mental health disorders is critical to serving our patients’ needs as only about 50% of children with a mental health disorder receive treatment from a mental health specialist (Whitney 2019). But finding time for professional education is challenging for many providers. One accessible and effective professional learning program is Project ECHO (Extension for Community Healthcare Outcomes), which uses tele-education to help providers develop skills through both didactic and case-based learning. Project ECHO was started at the University of New Mexico to teach cohorts of rural primary care providers how to treat Hepatitis C. This learning model has since expanded to other health issues, including mental health.

Outcomes from our Project ECHO program at Rainbow Babies and Children’s Hospital, which is supported by data published both by Cincinnati Children’s Hospital’s and Nationwide Children’s Hospital’s Project ECHO programs, found that primary care provider knowledge and self-efficacy in treating specific pediatric mental health disorders increased with participation in a Project ECHO mental health course. Dr. Marni Turell, a Cleveland Clinic pediatrician, who has taken Project ECHO courses on depression and anxiety, discussed how these courses have impacted how she treats children with mental health issues: “It has changed everything. I am now comfortable initiating medication, which I was not doing previously. I am more comfortable monitoring side effects and managing the medication as well. I have a better understanding when referrals should be placed and am able to manage better on my own when referrals are sometimes difficult to get in a timely manner.”

Courses are currently being offered through Cincinnati Children’s Hospital (https://www.cincychildrensecho.com/programs), Nationwide Children’s Hospital (https://www.nation-widechildrens.org/for-medical-professionals/education-and-training/echo), and Rainbow Babies and Children’s Hospital (https://www.uhospitals.org/rainbow/for-clinicians/clinical-resources/project-echo). The Project ECHO mental health courses often take place in the early morning, at lunch time, or in the evening, and the cohorts meet over a number of weeks.

continued on page 19...
As pediatricians, we have many responsibilities, even just in the work setting. Add on a disaster that affects your practice, community, and your patients, and things can get quite stressful very fast. Disasters are unpredictable and largely affect children. And, with the recent increase in disasters, both man-made and natural, it’s not a matter of if, but when they will strike. So where do we start?

Pediatrician’s Role in a Disaster
Children make up 25% of the U.S. population, but children are not little adults. They are different physically, developmentally, and emotionally. This presents unique considerations when it comes to planning for disasters. Pediatricians are experts when it comes to children and the majority of pediatric medical care is delivered in outpatient settings. This is why it is crucial for pediatricians to include disaster planning during counseling.

Pediatricians can not only help educate families and patients they see in their office regarding disaster preparedness but also answer questions during or after a disaster, educate emergency and disaster response teams, and advocate for children to be appropriately served during times of disasters. Things that may seem obvious to pediatricians, like shelter, evacuation, family reunification, nutrition, and safety may not be the case for others who do not work with children on a day-to-day basis.

Community pediatricians can also help local hospitals and emergency departments within their community by advising on best practices to help ensure pediatric capabilities. The National Pediatric Readiness Project (NPRP) is a great example and offers free opportunities and resources.

**Pediatric Office Preparedness**
What happens to a practice when a disaster strikes in your community? What are the effects on the physical office space and staff? Maybe there is already a plan in place in your office to help navigate in times when such unfortunate events occur. If not, there should be.

Pediatrician’s offices face unique and additional problems when disasters occur. To begin, think about preservation of vaccinations, potential readjustment of services, and communication with families. This is why an all-hazards approach to planning is important. The AAP Preparedness Checklist for Pediatric Practices is a great resource for reference.

Existing connections with public health programs such as Vaccines For Children (VFC) program or partnering with local EMS for office emergencies can serve as great starting points for collaborations.

Preparation of an office disaster kit to ensure self-sufficiency for at least 72 hours, educating staff on office disaster plans, encouraging staff to develop personal preparedness plans, considering mitigation of the office space, development of contingency plans, and conducting office drills are all important steps to ensure preparedness.

Patient and Family Preparedness
Families consider pediatricians as one of the most trusted resources when it comes to disaster response and planning. This is why information management and knowing who your trusted resources are is very important. The CDC or your local/state department health alert notifications (HAN) can be helpful in keeping up to date on disasters that may affect you and your community.

FOR FAMILIES
Studies show that in the last two years, 39% of parents reported experiencing an emergency at their child’s childcare center or preschool. Yet an overwhelming number of families are unaware of their child’s school disaster plans nor do they have a family disaster plan. Helping families with disaster planning and providing information surrounding this process when providing anticipatory guidance can be helpful. Here is the four-step process.

1. Build a kit.
2. Make a plan.
3. Be informed.
4. Get involved.

Education around common disasters in your community can help with targeted planning as well. The AAP Family Readiness Kit is a great resource for families.

FOR PATIENTS
Children cope better with disasters when they understand what is happening. For any age, begin by asking what they already know. For younger children, give concrete explanations of what is happening, how it will affect them, and share steps being taken to keep them safe. Older children may benefit from more information. However, limiting media coverage of a disaster or previewing it and watching it together can be effective.
After a disaster, children may show changes in their moods or behaviors, or may choose to hide their emotions. In some cases, they may also show post-traumatic reactions. Regardless of their reactions, it’s important to talk to them after a disaster and to let children have their own feelings and help them cope. There are many resources that can help children understand and cope with disasters.

**Preparedness of Children and Youth of Special Health Care Needs**

Unfortunately, not all emergency planners are familiar with the needs of children and especially those with special health care needs. Help families prepare a disaster plan and kit with a special go bag for the child with special needs, including an Emergency Information Form (EIF). In the go bag, prepare extra medications, especially prescriptions that may be difficult to refill in times of a disaster. And consider any extra supplies, food, or power sources that may be needed. For families of technology-dependent patients, sharing information with EMS and special needs centers ahead of time can be helpful to determine capabilities and access.

**Pediatrician Personal Preparedness**

No one can focus on work if you feel uncertain about the safety of yourself or your family. In any disaster, you yourself need to be prepared. Pediatricians are encouraged to undertake their own personal and family disaster preparedness plan. This step is important to help perform one’s own professional responsibilities in times of a disaster.

Create a disaster kit and plan for your own family, including a list of contacts and destinations in case of an emergency. It’s also important to check in with yourself, especially if you have been affected by disaster. AAP state chapters can be a valuable resource for pediatricians who are affected by such events.

**References**

1. https://emscimprovement.center/domains/pediatric-readiness-project/
3. https://downloads.aap.org/AAP/PDF/Pediatric-PreparednessChecklist1b.pdf
5. https://emergency.cdc.gov/han/

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**Project ECHO**

*continued from page 17...*

weeks to help primary care providers develop proficiencies and practice new skills between sessions. Recent courses from these Project ECHO programs have covered anxiety, depression, autism, suicide risk, trauma informed care, substance use, and eating disorders. The AAP also intermittently offers ECHO courses (https://www.aap.org/en/practice-management/project-echo/) covering mental health and other pediatric topics. As an added bonus, these Project ECHO programs offer free CME credit. Dr. Turrell offers this advice for those providers who are not sure if an ECHO course is worth the time investment: “Don’t even think about it. There is absolutely no downside at all. It has definitely changed the way I practice pediatrics.”

**CDC 2023**


CHILD PREPAREDNESS

For younger children, give concrete explanations of what is happening and share steps being taken to keep them safe.

- Older children may benefit from more information. Limit media coverage or preview it and watch together.

PEDIATRICIAN’S ROLE IN A DISASTER

Pediatricians can not only help educate families regarding disaster preparedness but answer patient’s questions and advocate for children to be appropriately served during times of disasters.

PEDIATRIC OFFICE PREPAREDNESS

- Prepare an office disaster kit to ensure self-sufficiency for at least 72 hours
- Develop an office contingency plan
- Educate staff on office disaster plans and practice office drills
- Areas of focus:
  - preservation of vaccinations
  - readjustment of services
  - communication with families

PATIENT & FAMILY PREPAREDNESS

Families consider pediatricians one of the most trusted resources when it comes to disaster response and planning.

- Know your trusted resources!
  - Centers for Disease Control and Prevention (CDC)
  - Local and State Department Health Alert Notifications (HAN)
  - Red Cross Emergency App

CHILDREN AND YOUTH OF SPECIAL HEALTH CARE NEEDS (CYSHCN)

Prepare a disaster plan and kit with an Emergency Information Form (EIF).

- Stock extra medications, especially prescriptions that may be difficult to refill in times of emergency.
- For families of technology dependent patients, contact EMS and/or special needs centers ahead of time to determine their capabilities and how to access.

REGISTER!

Join us November 9 @ 12:00-1:00 pm for our Disaster Preparedness webinar.

https://ohioaap.org/disasterpreparedness
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 expired 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 became effective 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.

Type 1 Diabetes from a Mom’s Perspective

Mila Ferrer

I’ve been the mom of a son with type 1 diabetes for 17 years and a program lead at Beyond Type 1—a global non-profit helping people with diabetes of all types survive and thrive—for six years. Pediatricians play a key role in my life as a mom and in educating the community on the signs of diabetes. Here’s what all pediatricians should know about supporting kids and families impacted by diabetes and empowering community members to take action to support early diagnosis and supportive care.

My family was lucky our pediatrician promptly identified my son’s symptoms and gave us an accurate diagnosis—many other families do not experience the same, with the signs of diabetes often dismissed or mistaken as the flu, purposeful weight loss, behavioral issues, or other less life-threatening conditions. Of course, a missed diagnosis of type 1 diabetes can lead to death. I want to ensure that all families have a safe level of support and that all pediatricians know how key their role is to families in those initial days and months of diagnosis to see positive outcomes. I would love to see more pediatricians and their staff take the time to learn more about what families with diabetes go through.

Having a pediatrician that showed interest in supporting our family and empowering our son with the skills necessary to thrive with type 1 diabetes was key to our early success. Being empowered with this knowledge about type 1 diabetes is critical for families.
# Ohio AAP Program Partners

Ohio AAP acknowledges the following partners in support of Ohio Pediatric Programs.

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<th>Program</th>
<th>Funding</th>
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<td>Parenting at Mealtime and Playtime Education Program</td>
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<td>Project Firstline</td>
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June 1, 2023-August 31, 2023

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Cindy Wise

The Ohio AAP would like to extend our gratitude to those who generously donated in memory of Dr. Libby Ruppert. We thank Dr. Ruppert’s family who kindly requested donations in her honor and the many generous donors who graciously gave. Your generosity helped raise over $11,000 in support of the health of Ohio’s children!

- Augusta Askari, PhD
- The Associations Product Group at Togetherwork
- Roseanne Ausmiller
- Paul & Kerry Capka
- Connecting Kids to Meals
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- Mary & Rich Sabin
- Cathy & Steve Rowan
- Nancy Schulte
- Mary Sedlacek
- Melanie Shakarian
- Wendy Sowers
- Ed Wade
- Stephen Williger

Type 1 Diabetes from a Mom’s Perspective

1 helped us become an educated family that felt confident in our ability to support our son and keep him healthy. During his pediatric visits, we would talk about his nutrition, mental health, and overall wellness tips that would benefit his diabetes management.

A key way to help support kids and families impacted by diabetes is to connect them with peer-to-peer support programs. I recommend these two programs from Beyond Type 1:

- **Snail Mail** is a pen pal program that gives kids, teens, and adults with type 1 diabetes worldwide the opportunity to connect with a peer who also lives with diabetes, adding another person who “gets it” to their support team.

- **The Beyond Type 1 Community App** is another incredible connection to the diabetes community. The mobile app connects people with type 1 diabetes and their loved ones with like-minded folks to ask and answer questions and share thoughts, struggles, and triumphs. I invite you to join our community; it is a great way to learn about our daily challenges and will help you and your team better understand your patients.

[BeyondType1.org](http://BeyondType1.org) contains many stories about life with diabetes, support resources, and diabetes management education in easy-to-understand terms, perfect for any family impacted by diabetes who could use community or some extra support.
The Ohio AAP embraces Diversity, Equity, and Inclusion (DEI) as a core tenant in our chapter and seeks to collaboratively create DEI growth in our membership, leadership, and programming. We believe this is essential in promoting the health, safety, and well-being of all the children and adolescents we serve. Our five pillars – Child Health, Practice of Pediatrics, Advocacy, Operations and Foundations – have been working synergistically together to create concrete goals and actionable steps to lead us forward in DEI. On behalf of the staff and members doing such good work in the DEI arena, we feel fortunate to give you an update of the great progress we’ve made this year.

At the beginning of this year, we created the first version of the Ohio AAP DEI Toolkit. We used the Ohio AAP’s DEI statement as a starting point, which has been updated and revised since its establishment in 2020 (https://ohioaap.org/dei-toolkit). As with the Ohio AAP’s DEI statement, the DEI Toolkit is a living source of information and guidelines that will continue to evolve on a regular basis. Our intentions are always to be thoughtful, adaptable, and reflective of the world in which we live and practice. We acknowledge that we may see different issues through each individual lens of Diversity, Equity, or Inclusion; they remain separate ideals, but we attempt to address them in all our work.

You now have online access to the DEI Toolkit at the Ohio AAP’s website. Resources within the DEI Toolkit include definitions of common terms, help for planning presentations and example language scripts, bias mitigation strategies when you are the source of bias, our DEI Event Checklist, and other linked resources. We hope this shows our commitment to outcomes, helps members in education and provides practical solutions for DEI needs. If you need help and cannot find it or have a suggestion for other aspects to consider, please tell us – we want you to be a part of our collective growth. We have held multiple discussion and education sessions across the board and staff, and we are extending that to the membership. For example, we just hosted a session with Dr. Toni Richards-Rowley on Anti-racism and Medical Presentations. This was a free webinar for all members and provided CME credit. In addition, we have incorporated DEI evaluations into all our QI and CME programming.

We had a big win this year including DEI in our Annual Meeting speaker pre-meetings. We used the DEI Toolkit to create a speaker checklist, which we have discussed with all our Annual Meeting presenters. We’ve asked each speaker to review our toolkit and pay attention to the DEI elements in their presentations. For example, we’ve asked speakers to consider, “How might your experiences affect your presentation and the views of the audience?” We’ve also asked speakers to seek and include health equity issues relative to their topic of discussion.

Now, let’s talk about what’s on the horizon for DEI in the Ohio AAP. Next up is a discussion at the AAP District V level on how we can do DEI work better and together across our chapters. We can learn from the projects and initiatives of our fellow District V chapters and share our chapter’s recent successes. We look forward to seeing many of you at the Annual Meeting, where we will provide an additional DEI update and invite you to participate in an engaging open discussion and brainstorming session.
Stingers

Justin Leasure, MD, Nationwide Children’s Hospital

A stinger, also referred to as a “burner” or “zinger,” is a brachial plexus stretch or compression injury often presenting with transient unilateral upper extremity dysesthesias and pain. These injuries are common in contact sports and must be distinguished from more serious nerve injury, such as peripheral nerve transection injury (e.g., nerve root avulsion) or spinal cord injury. Most commonly, a stinger is a transient, neuropraxia injury (grade 1 peripheral nerve injury, as per Seddon and Sunderland classification system). Some stingers are consistent with axonotmesis (grade 2) injury. There is debate whether neurotmesis (grade 3) injuries to the brachial plexus, given the permanence of injury, should be regarded as stingers. Once the diagnosis of a stinger is made, it is helpful to understand the management of initial, and any subsequent, stinger injuries in these athletes.

Mechanisms

Stingers are most often seen in American football, however these types of brachial plexus injuries can occur in athletes of all types, especially in sports where falls or large forces or impacts are experienced, including gymnastics, wrestling, rugby, boxing, hockey, weightlifting, etc. The common injury mechanism includes forceful contralateral lateral neck flexion or oblique extension with or without simultaneous ipsilateral shoulder depression, as can be the case with fall onto the superior shoulder. Similar stretch injuries of the brachial plexus can be experienced with forceful traction of the upper extremity away from the body. Additionally, many brachial plexus compression injuries, such as those caused by excessive ipsilateral lateral neck flexion with or without neck extension, also fit within the definition of a stinger. Finally, stingers can be caused by a direct blow to the region(s) overlying the brachial plexus, or, less commonly, with shoulder dislocation or subluxation injuries that produce abnormal stretch forces along the distal plexus.

Symptoms

Stingers commonly present with upper extremity pain (often described as burning into the distal arm, forearm, or hand), numbness, tingling, and/or weakness that usually lasts only seconds to minutes. The athlete may be seen holding the upper extremity motionless to one side or shaking it in an attempt to alleviate these symptoms. It is not uncommon, however, for a more significant stretch injury to last hours or even days or more before resolution.

Diagnosis and Management

When an athlete sustains an injury which produces upper extremity symptoms, a possible cervical spine injury must be considered. The presence of bilateral upper extremity (or combined upper and lower extremity) dysesthesias or pain, midline cervical spine point-tenderness, or profound extremity motor or sensory deficit must prompt appropriate cervical spine injury protocol (e.g., primary and secondary surveys, spine boarding, equipment removal (if appropriate)). Once a cervical spine injury has been ruled out and assessment for other upper extremity injury is negative (such as shoulder dislocation, acromioclavicular joint injury, etc.), management for a stinger may begin. The athlete must be removed from participation and may only return to play once their physical exam is normal, including being pain-free, with complete return of normal cervical and upper extremity range of motion and strength. Particular attention should be made to assessing scapular motion (rhomboid major/minor, serratus anterior) and to testing shoulder abduction (deltoid, supraspinatus), shoulder external rotation (infraspinatus, teres minor), and elbow flexion (biceps brachii, brachialis) given that C5 and C6 are the most commonly injured nerve roots in stinger injuries. Following motor and sensory testing of the remainder of the upper extremity myotome and dermatome, special testing including reflex testing, proprioception, and Spurling’s test (to assess for reproduction of symptoms with cervical root compression) should be considered.

For those athletes with persistent symptoms and/or abnormalities on examination greater than 24 hours, further evaluation with imaging studies should be conducted. Initial imaging includes cervical spine AP, lateral, odontoid, and flexion/extension-view radiographs to assess for bony irregularities and/or cervical hypermobility that would specify contraindication to return to play. MRI of the cervical spine and brachial plexus can be useful in further characterizing abnormalities appreciated on x-ray, or to further evaluate for bony, ligamentous, and/or soft tissue abnormality which may explain persistent or recurrent symptoms. Athletes with three or more stingers in one season, regardless of how quickly symptoms resolve, should be removed from sport and should undergo further imaging testing as above. For symptoms lasting greater than 4 weeks, one may consider electrodiagnostic testing (EMG/NCS) in an attempt to localize the brachial plexus injury and/or distinguish from other peripheral nerve injury.

Prevention

Aside from restricting athletic participation in those athletes with known contraindication due to anatomical abnormality, there remains little concrete evidence for absolute prevention of stingers. Of course, an athlete may reduce risk by participating in sports with less inherent risk, including non-contact or low-impact sport. However, this may not be feasible or desired for many athletes without known contraindication. Ensuring optimal cervical and upper extremity muscle strength and flexibility, as well as using proper equipment and technique (e.g. football tackling mechanics) are likely to reduce the athlete’s risk of experiencing brachial plexus injury.
Stingers

Justin Leasure, MD, Nationwide Children’s Hospital

A stinger, also called a “burner” or “zinger,” is an injury to the bundle of nerves known as the brachial plexus. These nerves travel from the spinal cord in the neck, through the shoulder, and down into the arm. There are two brachial plexuses, a right and a left, and each carry nerve fibers responsible for the movement and sensation of the corresponding arm, forearm, and hand.

As with any part of the body, the brachial plexus can be injured, and this is commonly seen in sports, especially contact sports. Athletes with this type of injury will often have temporary pain, numbness, and tingling of the arm that radiates down to the forearm and hand. As the parent of an athlete with these symptoms, it can be very distressing. It is important that sideline medical personnel distinguish this brachial plexus injury from a more serious injury, such as a spinal cord injury in the neck.

After diagnosing a stinger, it is important to ensure proper management of the injury, including appropriate return to sport. This includes determining what tests should be performed, which depends greatly on the severity of the stinger, length of symptoms, and whether the athlete has had one or more stinger injuries in the past.

Mechanisms

There are various ways in which an athlete may acquire a stinger. One is by abnormal stretching of the nerves of the brachial plexus. This can occur when the head and neck are forcefully stretched away from the shoulder. For instance, if an athlete falls onto the top of the right or left shoulder, the head and neck can be forced to the opposite side, thus stretching the nerves of the brachial plexus and causing injury. Another way is by compression of the nerves; for instance, a football athlete, when attempting a tackle, could experience a quick hyperextension of the neck that then is forced to the right or left. The brachial plexus on that side could be compressed and injured, and the athlete could experience symptoms of a stinger. Other ways to injure the brachial plexus include direct impacts or hits to the shoulder, shoulder dislocations or subluxations (partial dislocations), or when the arms are very strongly pulled away from the shoulder (such as can occur with gymnasts when they swing on bars or rings).

Symptoms

Upon suffering a stinger, the athlete can feel pain, numbness, tingling, and even weakness of the arm, forearm, and hand. The athlete may be seen shaking the arm or keeping the arm motionless in attempt to relieve these symptoms. Symptoms usually last only a very short time, commonly seconds to minutes. The stretched or compressed nerve(s) will, in most cases, return to normal. Sometimes, however, more severe injury to the brachial plexus can occur and may cause more severe and/or longer lasting symptoms. Someingers can last hours to even days or more.

Diagnosis and Management

When an athlete has pain, numbness, tingling, and/or weakness of any extremity (such as an upper extremity in the case of a stinger injury) it is extremely important to ensure the athlete does not have a more serious injury, such as a spinal cord injury. The sideline medical personnel must take precaution and act accordingly as if a serious injury has occurred. This may include spine-boarding the athlete, removing equipment on the field, and applying a cervical collar if there is any question of a spinal cord injury. Once it is determined that a more serious injury has not occurred, the medical team can then further evaluate the athlete with a detailed physical exam. This exam tests the movement, strength, and sensation of the neck and upper extremities of the athlete and can include special tests to assess for nerve injury. Athletes may return to play only after they are pain free and have a completely normal physical exam.

If an athlete has symptoms that last longer than 24 hours, it is appropriate to further evaluate with imaging tests. This usually begins with x-ray images of the neck which will assess for abnormalities in the structure and alignment of the spine of the neck (also called the cervical spine). The athlete may also undergo MRI of the neck and/or the brachial plexus to better assess soft tissues, including the spinal cord and nerves. In some rare cases in which symptoms last longer than four weeks, a test called an “EMG” may be recommended. This test is helpful in determining the location of injury within the brachial plexus nerve bundle, and it can also aid in distinguishing brachial plexus injuries from other nerve injuries in the arm, forearm, or hand.

Prevention

If an athlete is found to have abnormal anatomy of the neck or cervical spine, it may be unsafe to participate in some sports. Of course, athletes can reduce risk of stinger injury by refraining from contact sports, however this may not be desired for many athletes. For those who do play contact sports, it is important to optimize neck and upper extremity strength and flexibility, both of which can be improved with exercises and proper conditioning. Additionally, it is important for the athlete to be fitted with proper equipment and to use appropriate technique (such as proper football tackling form).
Ohio AAP Remembers
Pioneering Leader and Advocate

It is with great sadness the Ohio AAP shares the passing of Dr. Antoinette “Toni” Parisi Eaton. Dr. Eaton served as Ohio Chapter president and was the first woman to serve as AAP president. She is the namesake of the Dr. Antoinette Eaton Advocacy Award presented annually to recognize individuals with exemplary commitment to improving the health and safety of Ohio’s children and adolescents through strong advocacy. Dr. Eaton was a true trailblazer and a passionate advocate for children. We offer our condolences and gratitude for the huge impact Dr. Eaton had on child health in Ohio and beyond. To read more about the amazing legacy and work of Dr. Eaton, visit AAP News at https://rb.gy/9cjzq.

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Reproductive Freedom
continued from page 15...

anti-choice justices and is slated to take up the issue in the coming weeks.

If this extreme ban is reinstated, if our young patients are once again put at risk and we face criminal penalties for practicing evidence-based medicine, we will ask ourselves if Ohio is a safe place to live and practice medicine.

As pediatricians, advocacy is integral to what we do. We are called upon to be the voice of the voiceless. We have a moral and ethical obligation to do all we can to ensure that our young patients have unobstructed access to the care they need, no matter the circumstances. Now, more than ever, our duty goes beyond treating illnesses - it’s about safeguarding the future and well-being of every child under our care.

In order to safeguard the care our patients need, we have been working day and night for more than a year to enshrine reproductive rights and abortion access in Ohio’s Constitution. We have successfully overcome many barriers placed in our path, and now the people of our state will have the opportunity to vote on the Reproductive Freedom with Protections for Health and Safety amendment this fall. We are incredibly thankful that the Ohio Chapter, American Academy of Pediatrics has endorsed our common-sense proposal and declared that medical decisions, including those involving reproductive healthcare, should be made by patients, their families, and healthcare providers, free from government interference.

As the fall election approaches, our well-funded opponents will continue to pour millions of dollars into a misinformation campaign designed to confuse and frighten Ohioans. They falsely claim that the reproductive freedom amendment will alter the state’s existing parental consent laws. This is unequivocally false: the amendment will NOT change parental consent laws. In fact, a nearly identical amendment was passed in Michigan last year, without any impact of parental consent laws there.

We must broadcast this message to our friends, families, patients, anyone and everyone, every day until the polls close on November 7. Tell them: “I am a pediatrician. I deal with parental consent laws every day. The reproductive freedom amendment will NOT change parental consent laws. Full stop.”

Now, we must all continue to do everything we can to preserve the sanctity of the doctor-patient relationship and ensure that our patients and all Ohioans have access to safe, legal, equitable, and comprehensive reproductive medical care including abortion.

We are proud to be members of the Ohio Chapter of the American Academy of Pediatrics. The Ohio AAP’s support in our state means everything to Ohio’s children and the adults in their lives.

If you would like to join us or learn more, please sign up at the following websites:

· Ohio Physicians for Reproductive Rights: www.OhioReproRights.com
· Ohioans United for Reproductive Rights amendment campaign page: www.OURR.win
**Getting Started**

Supporting families with children birth to age 3 with developmental delays or disabilities so they have the best possible start in life.

**CONCERNED about your child’s development?**

1. **Referral**
   Early Intervention, or EI, begins with a referral or self-referral. You will receive a call to explain services and what to expect. An assigned service coordinator helps your family with each step in the process. Your family decides whether to move forward.

2. **Eligibility**
   One of the first steps is to determine if your child is eligible for EI. For some children, EI professionals determine eligibility by evaluating the child, reviewing medical reports, and talking with parents. Other children are eligible because of a diagnosed condition.

3. **Assessment**
   If your child is eligible, your assessment team will learn more about how your child is developing and what their interests are. This team works to understand your family’s routines and what’s important to you and your child.

4. **Individualized Family Service Plan (IFSP)**
   The team, with the family at the center, uses the information gathered to create an Individualized Family Service Plan (IFSP). It details the services needed to help your family meet the outcomes you want, along with when, where, and how these services will be provided. Your IFSP will be completed within the first 45 days of referral and updated at least every six months.

5. **Service Delivery**
   Services must start within 30 days of you signing the IFSP. Services happen during activities that are important to your family in places where your child spends their day such as your home, childcare, or other places in the community. Each child is unique, and EI services focus on the specific needs of your family.

Throughout service delivery, your team will work closely with your family to help build your skills and confidence to support your child. As the EI journey comes to an end for your family, your team will help you make the smooth transition to your child’s next learning environment.

Learn more or start the referral process at www.OhioEarlyIntervention.org

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**Infection Prevention for Back to School**

With children back to school, sickness and cases of infection are on the rise! For the latest information and best practices, check out our Infection Prevention and Control webinar hosted by TIES Medical Director, Dr. Robert Frenck. Refresh on common transmission methods and hand hygiene as well as receive the latest updates on influenza, COVID, and RSV. Visit [https://ohioaap.org/project-firstline](https://ohioaap.org/project-firstline) to view the webinar and find more education and resources!

The CDC’s Project Firstline is a collaborative of diverse healthcare and public health partners that aims to provide engaging, innovative, and effective infection control training for frontline U.S. healthcare workers, as well as members of the public health workforce. Project Firstline’s innovative content is designed so that—regardless of a healthcare worker’s previous training or educational background—they can understand and confidently apply the infection control principles and protocols necessary to protect themselves, their facility, their family, and their community from infectious disease threats, such as COVID-19.
AZSTARYS®—a prodrug innovation that redefines how ADHD is controlled\textsuperscript{1,2}

FIRST and ONLY d-MPH with novel

SDX prodrug and IR activity\textsuperscript{1,2}

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**INDICATION**
AZSTARYS is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 6 years and older.

**IMPORTANT SAFETY INFORMATION**

**WARNING: ABUSE AND DEPENDENCE**
• CNS stimulants, including AZSTARYS, other methylphenidate-containing products, and amphetamines, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing, and monitor for signs of abuse and dependence while on therapy.

**Contraindications**
• Known hypersensitivity to serdexmethylphenidate, methylphenidate, or other product components. Bronchospasm, rash, and pruritus have occurred with AZSTARYS. Hypersensitivity reactions such as angioedema and anaphylactic reactions have occurred with other methylphenidate products.
• Concomitant treatment with a monoamine oxidase inhibitor (MAOI) or use of an MAOI within the preceding 14 days, because of the risk of hypertensive crisis.

**Warnings and Precautions**
• Sudden death has been reported in association with CNS stimulant treatment at recommended doses in pediatric patients with structural cardiac abnormalities or other serious heart problems. In adults, sudden death, stroke, and myocardial infarction have been reported at recommended doses. Avoid use in patients with known structural cardiac abnormalities, cardiomyopathy, serious heart arrhythmias, coronary artery disease, or other serious heart problems.
• CNS stimulants cause an increase in blood pressure and heart rate. Monitor all patients for hypertension and tachycardia.
• Exacerbation of Pre-existing Psychosis: May exacerbate symptoms of behavior disturbance and thought disorder in patients with a pre-existing psychotic disorder. Induction of a Manic Episode in Patients with Bipolar Disorder: May induce a mixed/manic episode in patients with bipolar disorder. Prior to initiating treatment, screen for risk factors for developing a manic episode (e.g., comorbid or history of depressive symptoms, or a family history of suicide, bipolar disorder, or depression).
• New Psychotic or Manic Symptoms: At recommended doses, may cause psychotic or manic symptoms (e.g., hallucinations, delusional thinking, or mania) in patients without a history of psychotic illness or mania. Discontinue if symptoms occur.

**Drug Interactions**
• CNS stimulants have been associated with peripheral vasculopathy, including Raynaud’s phenomenon. Signs and symptoms are usually intermittent and mild; very rare sequelae include digital ulceration and/or soft tissue breakdown. Carefully observe patients during treatment for digital changes. Further evaluation may be required, including referral.
• CNS stimulants have been associated with weight loss and slowing of growth rate in pediatric patients. Monitor height and weight at appropriate intervals in pediatric patients. Treatment may need to be interrupted in children not growing or gaining weight as expected.

**Adverse Reactions**
• Based on accumulated data from other methylphenidate products, the most common (>5% and twice the rate of placebo) adverse reactions are appetite decreased, insomnia, nausea, vomiting, dyspepsia, abdominal pain, weight decreased, anxiety, dizziness, irritability, affect lability, tachycardia, and blood pressure increased.

**References:**
**Azstarys™ (serdexmethylphenidate and dexamethylphenidate) Capsule, CII**  
Rx only

**Brief Summary of Prescribing Information**

**WARNING: ABUSE AND DEPENDENCE**  
CNS stimulants, including AZSTARYS, other methylphenidate-containing products, and amphetamines, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing and monitor for signs of abuse and dependence while on therapy.

1 **Indications and Usage**  
AZSTARYS is a central nervous system stimulant prescription medicine used for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD) in people 6 years of age and older.

2 **Dosage and Administration**

2.1 **Pretreatment Screening**  
Prior to initiating treatment with AZSTARYS, assess for the presence of cardiac disease (i.e., perform a careful history, family history of sudden death or ventricular arrhythmia, and physical exam). Assess the risk of abuse prior to prescribing, and monitor for signs of abuse and dependence while on therapy. Maintain careful prescription records, educate patients about abuse, monitor for signs of abuse and overdose, and periodically re-evaluate the need for AZSTARYS use.

2.2 **Recommended Dosage**

**Pediatric Patients 6 to 12 years of age**
- The recommended starting dosage of AZSTARYS is 39.2 mg serdexmethylphenidate/7.8 mg dexamethylphenidate once daily in the morning.
- The dosage may be increased after one week to a dosage of 52.3 mg serdexmethylphenidate/10.4 mg dexamethylphenidate per day, or decreased after one week to a dosage of 26.1 mg serdexmethylphenidate/5.2 mg dexamethylphenidate per day, depending on response and tolerability.
- Maximum recommended dosage is 52.3 mg serdexmethylphenidate/10.4 mg dexamethylphenidate once daily.

**Adults and Pediatric Patients 13 to 17 years of age**
- The recommended starting dosage of AZSTARYS is 39.2 mg serdexmethylphenidate/7.8 mg dexamethylphenidate once daily in the morning.
- Increase the dosage after one week to a dosage of 52.3 mg serdexmethylphenidate/10.4 mg dexamethylphenidate per day.
- Maximum recommended dosage is 52.3 mg serdexmethylphenidate/10.4 mg dexamethylphenidate once daily.

Pharmacological treatment of ADHD may be needed for extended periods. Periodically re-evaluate the long-term use of AZSTARYS, and adjust dosage as needed.

2.3 **Administration Information**

Administer AZSTARYS orally once daily in the morning with or without food. AZSTARYS capsules may be taken whole, or opened and the entire contents sprinkled into 50 mL of water or over 2 tablespoons of applesauce. Consume all the drug/food mixture immediately or within 10 minutes of mixing; do not store for future use.

2.4 **Switching from Other Methylphenidate Products**

If switching from other methylphenidate products, discontinue that treatment, and titrate with AZSTARYS using the titration schedule described above. Do not substitute AZSTARYS for other methylphenidate products on a milligram-per-milligram basis because these products have different pharmacokinetic profiles from AZSTARYS and may have different methylphenidate base composition.

2.5 **Dose Reduction and Discontinuation**

If paradoxical aggravation of symptoms or other adverse reactions occur, the dosage should be reduced, or, if necessary, the drug should be discontinued. AZSTARYS should be periodically discontinued to assess the pediatric patient’s condition. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

4 **Contraindications**

AZSTARYS is contraindicated in patients with known hypersensitivity to serdexmethylphenidate, methylphenidate, or other components of AZSTARYS. Bronchospasm, rash, and pruritus have been reported in patients who received AZSTARYS. Hypersensitivity reactions such as angioedema and anaphylactic reactions have been reported in patients treated with other methylphenidate products receiving concomitant treatment with monoamine oxidase inhibitors (MAOIs), or within 14 days following discontinuation of treatment with an MAOI, because of the risk of hypertensive crisis.

5 **Warnings and Precautions**

5.1 **Potential for Abuse and Dependence**

CNS stimulants, including AZSTARYS, other methylphenidate-containing products, and amphetamines, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing and monitor for signs of abuse and dependence while on therapy.

5.2 **Serious Cardiovascular Reactions**

Sudden death, stroke, and myocardial infarction have been reported in adults with CNS stimulant treatment at recommended doses. Sudden death has been reported in pediatric patients with structural cardiac abnormalities and other serious heart problems taking CNS stimulants at recommended doses for ADHD. Avoid use in patients with known structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, coronary artery disease, and other serious heart problems. Further evaluate patients who develop exertional chest pain, unexplained syncope, or arrhythmias during AZSTARYS treatment.

5.3 **Blood Pressure and Heart Rate Increases**

CNS stimulants cause an increase in blood pressure (mean increase approximately 2 to 4 mmHg) and heart rate (mean increase approximately 3 to 6 beats per minute). Some individuals may have larger increases. Monitor all patients for hypertension and tachycardia.

5.4 **Psychiatric Adverse Reactions**

Exacerbation of Pre-Existing Psychosis

CNS stimulants may exacerbate symptoms of behavior disturbance and thought disorder in patients with a pre-existing psychotic disorder.

Induction of a Manic Episode in Patients with Bipolar Disorder

CNS stimulants may induce a manic or mixed mood episode in patients. Prior to initiating treatment, screen patients for risk factors for developing a manic episode (e.g., comorbid or history of depressive symptoms or a family history of suicide, bipolar disorder, or depression).

New Psychotic or Manic Symptoms

CNS stimulants, at recommended doses, may cause psychotic or manic symptoms (e.g., hallucinations, delusional thinking, or mania) in patients without a prior history of psychotic illness or mania. If such symptoms occur, consider discontinuing AZSTARYS. In a pooled analysis of multiple short-term, placebo-controlled studies of CNS stimulants, psychotic or manic symptoms occurred in approximately 0.1% of CNS stimulant-treated patients, compared to 0 in placebo-treated patients.

5.5 **Priapism**

Prolonged and painful erections, sometimes requiring surgical intervention, have been reported with methylphenidate products, in both pediatric and adult patients. Priapism was not reported with drug initiation but developed after some time on the drug, often subsequent to an increase in dose. Priapism has also appeared during a period of drug withdrawal. Patients who develop abnormally sustained or frequent and painful erections should seek immediate medical attention.

5.6 **Peripheral Vasculopathy, Including Raynaud’s Phenomenon**

CNS stimulants used to treat ADHD, including AZSTARYS, are associated with peripheral vasculopathy, including Raynaud’s phenomenon. Signs and symptoms are usually intermittent and mild; however, very rare sequelae include digital ulceration and/or soft tissue breakdown. Effects of peripheral vasculopathy, including Raynaud’s phenomenon, were observed in postmarketing reports at different times and at therapeutic doses in all age groups throughout the course of treatment. Signs and symptoms generally improve after reduction in dose or discontinuation of drug. Careful observation for digital changes is necessary during treatment with ADHD stimulants. Further clinical evaluation (e.g., rheumatology referral) may be appropriate for certain patients.

5.7 **Long-Term Suppression of Growth**

CNS stimulants have been associated with weight loss and slowing of growth rate in pediatric patients. In a long-term, open-label safety study with AZSTARYS conducted in pediatric patients 6 to 12 years of age with ADHD, there was a lower than expected increase in height and weight compared to pediatric patients of the same age and sex, on average. Closely monitor growth (height and weight) in pediatric patients treated with CNS stimulants, including AZSTARYS. Patients who are not growing or gaining height or weight as expected may need to have their treatment interrupted.

6 **Adverse Reactions**

6.1 **Clinical Trial Experience**

Clinical Trials Experience with Other Methylphenidate Products in Pediatric Patients and Adults with ADHD. Commonly reported (5% of the methylphenidate group and at least twice the rate of the placebo group) adverse reactions from placebo-controlled trials of methylphenidate products include: decreased appetite,
decreased weight, nausea, abdominal pain, dyspepsia, vomiting, insomnia, anxiety, affect lability, irritability dizziness, increased blood pressure, and tachycardia.

7 Drug Interactions

7.1 Clinically Important Reactions with AZSTARYS

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<tr>
<th>Table 1:</th>
<th>Monoamine Oxidase Inhibitors (MAOIs)</th>
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<tr>
<td>Clinical Impact</td>
<td>Concomitant use of MAOIs and CNS stimulants, including AZSTARYS, can cause hypertensive crisis. Potential outcomes include death, stroke, myocardial infarction, aortic dissection, ophthalmological complications, edema, pulmonary edema, and renal failure.</td>
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<tr>
<td>Intervention</td>
<td>Do not administer AZSTARYS concomitantly with MAOIs or within 14 days after discontinuing MAOI treatment.</td>
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<tr>
<td>Examples</td>
<td>Selegiline, tranylcypromine, isocarboxazid, phenelzine, linezolid, methylene blue.</td>
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<th>Antihypertensive Drugs</th>
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<td>Clinical Impact</td>
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<td>Clinical Impact</td>
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<td>Clinical Impact</td>
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8 Use in Specific Populations

8.1 Pregnancy

Pregnancy Exposure Registry

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to ADHD medications, including AZSTARYS, during pregnancy. Healthcare providers are encouraged to register patients by calling the National Pregnancy Registry for Psychostimulants at 1-866-961-2388.

Risk Summary

There are no available data on AZSTARYS use in pregnant women to evaluate for a drug-associated risk of major birth defects, miscarriage or other adverse maternal or fetal outcomes; however, AZSTARYS contains dexmethylphenidate and seroxatmethylphenidate, a prodrug of dexmethylphenidate. Dexmethylphenidate is the d-threo enantiomer of racemic methylphenidate. Limited literature, based on milk sampling from seven mothers reports that methylphenidate is present in human milk, which resulted in infant doses of 0.16% to 0.78% of the maternal weight-adjusted dosage and a milk/plasma ratio ranging between 1.1 and 2.7. These data are not available on the safety and effectiveness of AZSTARYS in breastfeeding infants. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for AZSTARYS and any potential adverse effects on the breastfed infant from AZSTARYS or from the underlying maternal condition.

Clinical Considerations

Monitor breastfeeding infants for adverse reactions, such as agitation, anorexia, and reduced weight gain.

8.4 Pediatric Use

The safety and effectiveness of AZSTARYS have been established in pediatric patients ages 6 to 17 years of age for the treatment of ADHD. Use of AZSTARYS in patients 6 to 12 years of age is supported by a randomized, double-blind, placebo-controlled, parallel group trial in 155 pediatric patients with ADHD and a 12-month open-label long-term safety trial in 238 patients. Use of AZSTARYS in pediatric patients 13 to 17 years of age is supported by additional pharmacokinetics analysis showing similar plasma concentration-time profiles of dexmethylphenidate in adolescents and adults after administration of the same dose of AZSTARYS. The long-term efficacy of methylphenidate in pediatric patients has not been established. The safety and effectiveness of AZSTARYS in pediatric patients less than 6 years have not been established.

Long Term Suppression of Growth

Growth should be monitored during treatment with stimulants, including AZSTARYS. Pediatric patients who are not growing or gaining weight as expected may need to have their treatment interrupted.

Juvenile Animal Toxicity Data

Rats treated with racemic methylphenidate early in the postnatal period through sexual maturation demonstated a decrease in spontaneous locomotor activity in adulthood. A deficit in acquisition of a specific learning task was observed in females only. The doses at which these findings were observed are at least 3 times the MRHD of 40 mg/day dexmethylphenidate hydrochloride given to children on a mg/m2 basis.
administered orally at doses of up to 100 mg/kg/day for 9 weeks, starting early in the
postnatal period (postnatal Day 7) and continuing through sexual maturity (postnatal
Week 10). When these animals were tested as adults (postnatal Weeks 13 to 14),
decreased spontaneous locomotor activity was observed in males and females
previously treated with 50 mg/kg/day racemic methylphenidate hydrochloride
(approximately 3 times the maximum recommended human dose (MRHD) of 40 mg
dexmethymethylphenidate hydrochloride given to children on a mg/m2 basis) or greater,
and a deficit in the acquisition of a specific learning task was seen in females exposed
to the highest dose (6 times the MRHD of 40 mg of dexmethymethylphenidate
hydrochloride given to children on a mg/m2 basis). The no effect level for juvenile
neurobehavioral development in rats was 5 mg/kg/day racemic methylphenidate
hydrochloride (less than the MRHD of 40 mg of dexmethymethylphenidate hydrochloride
given to children on a mg/m2 basis). The clinical significance of the long-term
behavioral effects observed in rats is unknown.

Serendexmethylphenidate was administered orally to juvenile rabbits at doses up to 280
mg/kg/day (approximately 50 times the MRHD of 52 mg/day serendexmethylphenidate
given to children on a mg/m2 basis), respectively, for 6 months, starting at postnatal
Day 28 and continuing through sexual maturity (postnatal Day 196). No adverse
findings were observed at the highest dose of serendexmethylphenidate.

8.5 Geriatric Use
Clinical trials of AZSTARYS did not include any patients aged 65 and older.

9 Drug Abuse and Dependence

9.1 Controlled Substance
AZSTARYS contains dexmethymethylphenidate hydrochloride, a Schedule II controlled
substance, and serendexmethylphenidate, a Schedule IV controlled substance.

9.2 Abuse
CNS stimulants including AZSTARYS, other methylphenidate-containing products,
and amphetamines have a high potential for abuse. Abuse is the intentional non-
therapeutic use of a drug, even once, to achieve a desired psychological or
physiological effect. Drug addiction is a cluster of behavioral, cognitive, and
physiological phenomena that may include a strong desire to take the drug,
difficulties in controlling drug use (e.g., continuing drug use despite harmful
consequences, giving a higher priority to drug use than other activities and
obligations), and possible tolerance or physical dependence. Both abuse and misuse
may lead to addiction, and some individuals may develop addiction even when taking
AZSTARYS as prescribed.

Signs and symptoms of CNS stimulant abuse include increased heart rate, respiratory
rate, blood pressure, and/or sweating, dilated pupils, hyperactivity, restlessness,
insomnia, decreased appetite, loss of coordination, tremors, flushed skin, vomiting,
and/or abdominal pain. Anxiety, psychosis, hostility, aggression, suicidal or
homicidal ideation have also been observed. Individuals who abuse CNS stimulants
may chew, snort, inject, or use other unapproved routes of administration which can
result in overdose and death.

To reduce the abuse of AZSTARYS, assess the risk of abuse prior to prescribing. After
prescribing, keep careful prescription records, educate patients and their families
about abuse and on proper storage and disposal of CNS stimulants, monitor for signs
of abuse while on therapy, and re-evaluate the need for AZSTARYS use.

9.3 Dependence

Physical Dependence
AZSTARYS may produce physical dependence from continued therapy. Physical
dependence is a state of adaptation manifested by a withdrawal syndrome produced
by abrupt cessation, rapid dose reduction, or administration of an antagonist.
Withdrawal symptoms after abrupt cessation following prolonged high-dosage
administration of CNS stimulants include dysphoric mood; depression; fatigue; vivid,
unpleasant dreams; insomnia or hypersomnia; increased appetite; and psychomotor
retardation or agitation.

Tolerance
AZSTARYS may produce tolerance from continued therapy. Tolerance is a state of
adaptation in which exposure to a drug results in a reduction of the drug’s desired
and/or undesired effects over time.

10 Overdose

10.1 Signs and Symptoms
Signs and symptoms of acute methylphenidate overdose, resulting principally from
overstimulation of the CNS and from excessive sympathomimetic effects, may
include the following: nausea, vomiting, diarrhea, restlessness, anxiety, agitation,
tremors, hyperreflexia, muscle twitching, convulsions (may be followed by coma);
euphoria, confusion, hallucinations, delirium, sweating, flushing, headache,
hyperpyrexia, tachycardia, palpitations, cardiac arrhythmias, hypertension,
hypotension, tachypnea, mydriasis, dryness of mucous membranes, and
rhabdomyolysis.

10.2 Management of Overdose
Consult with a Certified Poison Control Center (1-800-222-1222) for up-to-date
guidance and advice on the management of overdose with methylphenidate.
Provide supportive care, including close medical supervision and monitoring.
Treatment should consist of those general measures employed in the management of
overdosage with any drug. Consider the possibility of multiple drug overdoses.
Ensure an adequate airway, oxygenation, and ventilation. Monitor cardiac rhythm
and vital signs. Use supportive and symptomatic measures.

13 Nonclinical Toxicology

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis
Life time studies to evaluate the carcinogenic potential of serendexmethylphenidate
have not been conducted.

Carcinogenesis
Life time carcinogenicity studies have not been carried out with dexmethymethylphenidate
hydrochloride.

In a lifetime carcinogenicity study carried out in B6C3F1 mice, racemic
methylphenidate caused an increase in hepatocellular adenomas, and in males only,
an increase in hepatoblastomas was seen at a daily dose of approximately 60
mg/kg/day. This dose is approximately 4 times the MRHD of 40 mg
dexmethymethylphenidate hydrochloride on a mg/m2 basis. Hepatoblastoma is a relatively
rare rodent malignant tumor type. There was no increase in total malignant hepatic
neoplasms. The mouse strain used is sensitive to the development of hepatic tumors, and
the significance of these results to humans is unknown.

Racemic methylphenidate hydrochloride did not cause any increase in tumors in a
life time carcinogenicity study carried out in F344 rats; the highest dose used was
approximately 45 mg/kg/day, which is approximately 5 times the MRHD of 40 mg
dexmethymethylphenidate hydrochloride on a mg/m2 basis.

In a 24-week carcinogenicity study with racemic methylphenidate in the transgenic
mouse strain p53-/-, which is sensitive to genotoxic carcinogens, there was no
evidence of carcinogenicity. Male and female mice were fed diets containing
the same concentrations as in the lifetime carcinogenicity study; the high-dose group
was exposed to 60 to 74 mg/kg/day of racemic methylphenidate hydrochloride.

Mutagenesis
Serendexmethylphenidate was not mutagenic in the in vitro Ames reverse mutation
assay, in the in vitro mammalian cell micronucleus assay using human peripheral
blood lymphocytes, in the in vivo rat bone marrow micronucleus assay, or in the in vivo
rat alkaline comet assay.

Dexmethymethylphenidate was not mutagenic in the in vitro Ames reverse mutation
assay, in the in vitro mouse lymphoma cell forward mutation assay, or in the in vivo
mouse bone marrow micronucleus test. In an in vitro assay using cultured Chinese Hamster
Ovary (CHO) cells treated with racemic methylphenidate, sister chromatid exchanges
and chromosome aberrations were increased, indicative of a weak clastogenic response.

Impairment of Fertility
Racemic methylphenidate hydrochloride did not impair fertility in male or female
mice that were fed diets containing the drug in an 18-week continuous breeding
study. The study was conducted at doses of up to 160 mg/kg/day, approximately 10-
times the MRHD of 40 mg of dexmethymethylphenidate hydrochloride on a mg/m2 basis.

17 Patient Counseling Information

Advertise the patient to read the FDA-approved patient labeling (Medication Guide).
Controlled Substance Status/High Potential for Abuse and Dependence:
Advertise patients and their caregivers that AZSTARYS is a federally controlled
substance, and it can be abused or lead to dependence. Instruct patients that they
should not give AZSTARYS to anyone else. Advise patients to store AZSTARYS in a
safe place, preferably locked, to prevent abuse. Advise patients and their caregivers
to comply with laws and regulations on drug disposal. Advise patients and their
caregivers to dispose of remaining, unused, or expired AZSTARYS through the
police or other approved media agencies.

Serious Cardiovascular Risks: Advise patients and caregivers that there is a potential
for serious cardiovascular risks including sudden death, myocardial infarction,
and stroke with AZSTARYS. Instruct patients to contact a healthcare provider
immediately if they develop symptoms such as exertional chest pain, unexplained
syncope, or other symptoms suggestive of cardiac disease.

Blood Pressure and Heart Rate Increases: Advise patients and their caregivers that
AZSTARYS can elevate blood pressure and heart rate.

Psychiatric Risks: Advise patients and their caregivers that AZSTARYS, at
recommended doses, can cause psychotic or manic symptoms, even in patients
without a prior history or psychotic symptoms or mania.
Priapism: Advise patients and their caregivers of the possibility of painful or prolonged penile erections (priapism). Instruct the patient to seek immediate medical attention in the event of priapism.

Circulation Problems in Fingers and Toes [Peripheral vasculopathy, including Raynaud’s phenomenon]:
- Instruct patients about the risk of peripheral vasculopathy, including Raynaud’s phenomenon, and associated signs and symptoms: fingers or toes may feel numb, cool, painful, and/or may change color from pale, to blue, to red
- Instruct patients to report to their physician any new numbness, pain, skin color change, or sensitivity to temperature in fingers or toes
- Instruct patients to call their physician immediately with any signs of unexplained wounds appearing on fingers or toes while taking AZSTARYS.
- Further clinical evaluation (e.g., rheumatology referral) may be appropriate for certain patients

Suppression of Growth:
Advise patients and their caregivers that AZSTARYS can cause slowing of growth and weight loss.

Administration Instructions: Advise patients and their caregivers to administer AZSTARYS capsules whole or opened and sprinkled over applesauce or added to water. If sprinkled, advise patients and their caregivers to consume all the drug/food mixture immediately or within 10 minutes of mixing and not to store for future use.

Pregnancy Registry: Advise patients that there is a pregnancy exposure registry that monitors pregnancy outcomes in females exposed to AZSTARYS during pregnancy.

Lactation: Advise nursing mother to monitor infants exposed to AZSTARYS through breastmilk for agitation, poor feeding, and reduced weight gain.

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Grand Rapids, Michigan

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REF-02284
Milk, cheese and yogurt provide protein, vitamins and minerals that help nourish brains, bones and bodies.

6 MONTHS
Introducing unsweetened yogurt, cottage cheese or shredded and melted cheeses can familiarize baby to new tastes and textures. Pairing yogurt and cheese with pureed or safely prepared fruits and vegetables can help them learn to like a variety of foods and build healthy habits.

12 MONTHS
After baby’s first birthday, add whole dairy milk, which is an important source of calories, fat and essential nutrients to fuel brain development and growth spurts. In fact, health experts* agree dairy milk and water should be the go-to beverages for children ages 1-5 years.

CONCERNED ABOUT LACTOSE INTOLERANCE?
There are lactose-free and lower lactose dairy options so your child doesn’t have to miss out on the nutrition in dairy foods. Lactose-free milk is real dairy milk, just without the lactose. Hard cheeses like Cheddar, Swiss and Colby have very little lactose and the probiotics in yogurt help break down lactose making it easier to digest.

How much dairy?

<table>
<thead>
<tr>
<th>6-12 MONTHS</th>
<th>1-2 YEARS</th>
<th>2-3 YEARS</th>
<th>4-8 YEARS</th>
<th>9+ YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce cheese and yogurt. No dairy milk.</td>
<td>1 ½ to 2 cups total dairy/day (milk, cheese or yogurt)</td>
<td>2-2 ½ cups total dairy/day (milk, cheese or yogurt)</td>
<td>2 ½ cups total dairy/day (milk, cheese or yogurt)</td>
<td>3 cups total dairy/day (milk, cheese or yogurt)</td>
</tr>
</tbody>
</table>

Note: Individuals are encouraged to obtain personalized health and medical advice from their pediatrician.
Upcoming Events and Education

NOVEMBER 3-4, 2023
Annual Meeting 2023
Hilton Columbus Polaris

NOVEMBER 9, 2023
Disaster and Office Preparedness
Webinar

APRIL 19, 2024
Spring Education Meeting
10:00 am - 3:00 pm  •  Location TBD