MNAAP Policy Committee Begins Agenda-Setting Work

Eric Dick, MNAAP Lobbyist

While fall has only recently arrived, planning for the 2018 legislative session has begun in earnest with the first meeting of the MNAAP’s Policy Committee in late September. The 2018 session is slated to begin on February 20.

Despite the difficulty in predicting the issues that will dominate the action at the Capitol in 2018, some predictions can safely be made. As the second year of the biennium, the 2018 session will be dominated by debate on policy issues, rather than the budget-focused nature of the previous session.

Many Capitol veterans are predicting a session with very little substance. Though it’s a policy year, it’s also possible that legislators will have to address budget issues should tax revenue not meet projections. All too often, deficits have been “fixed” by cutting health care programming.

With the governor’s office and all 134 seats in the House of Representatives on the ballot in November 2018, there may be some more interested in scoring political points than passing good policy.

A survey of MNAAP members conducted in the late summer showed significant interest in promoting increased access to health care, as well as ensuring adequate reimbursement. The summer measles epidemic remained fresh on many respondents’ minds, as almost 20 percent of respondents stated that strengthening Minnesota’s weak vaccine laws should be a top priority. Addressing poverty, health disparities, firearm violence, pediatric mental health, and investments in early brain development were also priorities for many MNAAP members.

During the planning meeting, the MNAAP Policy Committee revisited our successes from the 2017 session, as well as noting some of the setbacks for child and teen health. The group discussed the landscape of the Legislature going into 2018, paying particular note to health care financing and the pros and cons of the provider tax.

As many know, the 2 percent provider tax is set to be repealed on January 1, 2020. The tax’s repeal will put tremendous pressure on MinnesotaCare, potentially threatening access to health care. The prospects for an extension of the tax in 2019, however, are exceedingly slim.

The next meeting of the Policy Committee will be scheduled soon. Stay tuned to www.mnaap.org for details.
Local Pediatric Events and Education

Fri, November 17
Minnesota Memorial Pediatric Orthopedic Symposium
Gillette Children’s Specialty Healthcare

Tues, November 28
Pediatric Neuropsychology: Detective’s Approach to Evaluating Brain-Behavior Relationships
Shriners Hospitals for Children – Twin Cities (Auditorium)

Fri, December 1
Motor Delay in Children: Optimizing Care in the Context of Family and Community
Saint Paul RiverCentre
Hosted by Gillette Children’s Specialty Healthcare

Wed, December 6
Partners in Care Webinar: Musculoskeletal Safety in Children: Trampolines, Toys and Trauma
Hosted by Gillette Children’s Specialty Healthcare

Fri, December 8
The Developing Brain and Early Mental Health Initiative: From Research to Practice for Pediatric Care Providers
Hosted by the University of Minnesota Masonic Children’s Hospital

Thurs, February 22 - Fri, February 23
Pediatric Fundamental Critical Care Support (PFCCS)
Embassy Suites, St. Paul
Hosted by HealthPartners Institute and Regions Hospital

Thurs, March 8
Psychiatry Update for Primary Care
Park Nicollet Clinic and Specialty Center
Hosted by HealthPartners Institute

Thurs, April 12 - Fri, April 13
From Head and Shoulders to Knees and Toes: An Orthopaedic Update for Primary Care
DoubleTree by Hilton – Park Place
Hosted by HealthPartners Institute

Thurs, April 12 - Sun, April 15
Child & Adolescent Psychiatry Practical Review
Grand Superior Lodge
Hosted by CentraCare Health

Thurs, April 26 - Fri, April 27
Child Abuse Summit: Tips from the Team
Millennium Hotel, Minneapolis
Hosted by the University of Minnesota Masonic Children’s Hospital

To register or for more information, visit www.mnaap.org/calendar.htm
PEDiatricians’ Day
at the Capitol

March 7, 2018

Tentative Schedule:

1:00 - 2:30 p.m.  Welcome and “Advocacy 101”
                 MNAAP Pediatric Priorities
                 Group discussions with legislators

2:30 - 4:00 p.m.  Meetings with individual legislators
                 Committee meeting attendance, pending space

4:00 - 6:00 p.m.  Debriefing and Appetizers (optional)
                 Axel’s Bonfire Grill at
                 850 Grand Ave. in St. Paul

Register Now:
www.mnaap.org/pedidayatthecapitol.htm

Location:
Minnesota State Capitol
L’etoile Du Nord Vault Room

MNAAP -- Dedicated to the health of all children. Visit us at www.mnaap.org
Fall is here, and with it, bright and vibrant colors, a final burst of life before winter’s senescence. I hope that you have all been able to take some time to enjoy these changing seasons and perhaps draw lessons and some comfort from them. Lessons that beyond the dark and cold winter days ahead comes spring.

These are definitely dark and difficult times we are living in. Last month, a lone gunman shot almost 600 of his fellow human beings, killing 58 of them and himself. We may never know why. Sadly, this mass shooting incident is just one of over 299 this year. So far in 2017, there have been almost 13,000 gun related deaths including those of 599 children between 0-11 years of age and an additional 2,700 deaths of kids aged 12-17.

In response to this carnage, our members of Congress offer “thoughts and prayers” and seem unwilling and/or unable to enact any meaningful gun safety legislation that would make mass shootings like this less likely. Indeed, before the shooting, Congress was getting set to schedule a vote on the NRA-backed Sportsmen Heritage and Recreational Enhancement (SHARE) Act, which among other things would allow the purchase of silencers (apparently to “protect hunters hearing”) and armor-piercing bullets.

What can we as pediatricians do? There are a number of ways to try to impact change, including collaborating with the MNAAP and other advocacy groups to reach out to our state and federal legislators; working with schools and other community groups on safety preparedness and mental health outreach; and in our own practices, addressing firearm safety with patients and their families.

As if dealing with this wasn’t enough, the Trump administration continues to seek ways to weaken and repeal the Affordable Care Act. Recent executive actions to stop subsidies that help low-income Americans pay for health insurance and expansion of association health plans that provide less comprehensive coverage are threats to the health of the poor, the elderly and those with pre-existing illnesses. In addition, the failure of the U.S. Congress to renew funding for the Children’s Health Insurance Program (CHIP) by the September 30th deadline has put access to health care for 9 million children at risk. It is yet another sad example of Congress’s seeming inability to place the wellbeing of our country’s most vulnerable citizens ahead of party and special interest politics.

The same can be said about the administration’s rescinding of the DACA program, which is causing significant anxiety and has injected uncertainty into these young peoples’ futures. In a particularly cruel act, Rosa Maria Hernandez, a 10-year-old girl with cerebral palsy was, after undergoing emergency surgery, taken into custody by U.S. immigration authorities and placed in an immigration shelter against her physicians’ recommendations and away from her parents.

Recent natural disasters have also impacted the health of children. This is especially evident in Puerto Rico and the U.S. Virgin Islands, which are still reeling from Hurricanes Irma and Maria. Around the world so many children are impacted by war, lack of access to adequate health care as well as other natural and man-made disasters. We are witness to the atrocities committed against children in Syria and Myanmar where the Rohingya are facing what can only be described as ethnic cleansing.

Indeed, everywhere you turn there seems to be an active assault on children, the poor, immigrants and other minority populations, and the environment. One could be forgiven for feeling despondent. However, along with many of our fellow pediatricians here in Minnesota, across the country and around the world, it is important to continue to stand up for children. So many of you have been engaged in global pediatric outreach and providing care to those in greatest need. You have raised money, donated time and supplies for relief efforts, and have raised your voices for children. It has been amazing to see so many pediatricians engaged in all these efforts. In particular, it has been incredible to see medical students and pediatric residents so active in advocating for children. The current and next generations of pediatricians are moving full steam ahead.

So just as after winter comes the spring, these difficult times will pass. In the meantime, let us continue to stand in the gap for kids. I wish you all a lovely fall and winter season.
Opening Vaccine Dialogue Across Cultures: Measles Outbreak in Minnesota

By Nusheen Ameenuddin, MD, MPH, FAAP

"Most of you already know Dr. Nusheen, because she sees your kids" is how I was introduced on my home turf at the first of a series of talks with Minnesota’s Somali community. It was during our state’s worst measles outbreak to date.

By the week before Memorial Day this year, Minnesota had already reached 69 measles cases, more than all U.S. cases in the previous year. Because the outbreak primarily affected unvaccinated Somali children, our state health department, American Academy of Pediatrics chapter and others partnered with leaders in the Somali community to train and dispatch teams of imams (religious leaders) and physicians to engage and inform the community about this threat.

I feel privileged to work with a vibrant patient population that includes many Somali-Americans. I met some families as new arrivals to this country, while others have become my second generation of patients. We are fortunate that Minnesota’s children’s health insurance coverage is at an all-time high of 97 percent, thanks to Medicaid and CHIP. But despite having some of the best health measures in the nation, we still struggle with the highest disparity in health outcomes between ethnic groups.

One particular area of concern centered around vaccination rates. In 2004, the MMR immunization rate for Somali children in Minnesota was 92 percent, higher than that of non-Somalis (88 percent). But due in large part to a targeted effort by anti-vaccination groups, MMR vaccination rates dropped dramatically, to 42 percent, over a decade.

Knowing that I would have to counter entrenched vaccine myths, I prepared for my first talk by reviewing pseudoscientific claims on anti-vaccine websites. But years of discussions with vaccine-hesitant parents of all backgrounds had taught me that facts alone would not convince skeptics, particularly when fear was involved.

"It was my job to address parents’ concerns and explain the science, extraordinarily rigorous safety testing and continuous monitoring behind vaccines that most people outside the field of pediatrics do not know."

Taking a page from the 2016 AAP Clinical Report Countering Vaccine Hesitancy, I knew that this dialogue was meant to be ongoing. It was my job to address parents’ concerns and explain the science, extraordinarily rigorous safety testing and continuous monitoring behind vaccines that most people outside the field of pediatrics do not know. Sharing how parents of hospitalized measles patients heard their children gasping for air, feeling helpless to intervene, also reinforced how dangerous this disease was—even with modern medicine to assist.

I found an insightful article by public health nurse Sahra Noor, the CEO of a public health clinic in Minneapolis, who said that in health care, we are trained to talk to the head rather than the heart. She pointed out that it’s not always the message that matters, but the messenger. Her piece changed my entire approach.

It struck me that my own background, as an American Muslim woman physician of Indian ancestry who wears a hijab (religious headscarf) might serve as an asset in establishing connections with the Somali community in other parts of our state where no one knew me. The irony that these same characteristics sometimes seemed to create an unintentional barrier for others was not lost on me. It also helped me appreciate what an honor it was to be invited to speak at mosques during Ramadan, the holiest month for Muslims.

Before each talk, I greeted the audience with the traditional “Peace be upon you,” a gesture warmly returned. Then, I scrapped my didactic lecture and fell back on what I was taught in medical school: listen and learn.

I told audiences that they could ask me anything. Working in tandem with the imam and a Somali interpreter, whose efforts were crucial in establishing trust and relaying the message, I went through a brief debunking of measles, mumps and rubella (MMR) vaccine myths and explained how serious measles was, pointing out that nearly one-third of affected children required hospitalization.

“I learned that before the civil war, Somalia had one of the highest vaccination rates in Africa. Elders shared stories of being wrapped in goat skin while ill with measles and seeing children die from this disease.”

In the clinic, we don’t often have the luxury of time, but I was able to spend a few hours at each place I visited. Kneeling with people on the beautifully carpeted floors of different mosques during Ramadan, breaking fast with shared food, being embraced by women I just met who called me sister even with limited English, and standing shoulder to shoulder in prayer gave me the gift of getting to know people who opened up about their deeper concerns.

I was asked why children “stopped talking” (which is how many in the Somali community describe autism). After explaining what we did and did not know about the causes of autism, it was gratifying to hear a mother tell me that she knows people who opened up about their deeper concerns.

Continued on page 5...
Lessons Learned on Increasing MMR Vaccines During the Outbreak

By Anne Valaas-Turner, MD, FAAP

On August 25, 2017, the Minnesota Department of Health declared an end to the measles outbreak.... along with a collective, statewide sigh of relief. As part of this announcement, Commissioner of Health Dr. Ed Ehlinger thanked all of the health systems, hospitals, clinics, doctors, pediatric clinicians, clinic staff and local public health who worked so hard to contain the Spring epidemic. He also highlighted the Allina Health System, which according to MDH records, provided the most MMR vaccine during the outbreak.

Pediatric staff reflected on this news and identified several key beliefs and lessons that we learned.

Communications: We were immediately notified of the measles outbreak by the MDH vaccine preventable disease listserv. Lesson: It may be useful to include “helpful e-mail lists to join” as part of the onboarding process for new providers.

Team structure: As a pediatrician, I share work space with my assistant, two partners, and their assistants. It was easy to teach the team the new vaccine recommendation, since we all work together in the same space. I will begrudgingly admit that the daily huddle system I sometimes rail against allowed for communication up and down the leadership structure about our measles response. We also got regular updates about the number of MMR doses in clinic, which was helpful.

Relationships: I truly believe that the time spent on rapport multiplies long-term health benefits, and I am grateful to Allina for the time to tend relationships. As a med-peds physician, I know the entire family, and could recommend MMR vaccination for young family members even if they were not present. I’ve partnered with the same medical assistant for the past 8 years, so she knows my families as well as I do, and was also able to catch kiddos in much the same way. Lesson: I’m grateful to my clinic leadership for valuing our collaboration enough to keep us together even through maternity leaves and FTE mismatches.

The power of yes: We immunized any eligible child present in clinic at any opportunity. Sick visit, well visit, sibling tag-along, seen in the lobby while parent is picking up forms.... we vaccinated them all. Our medical assistants and reception staff bore the brunt of adding on extra nurse-only visits, and my gratitude goes to them for just saying yes. Lesson: Say yes during outbreaks

A powerful electronic medical record: Once our vaccine supply was adequate, Allina generated lists of children eligible for MMR who had not yet received it, and notified their parents. This valuable work was appropriately performed at the organizational level, freeing my assistant up to deliver vaccine. We are strong advocates of vaccination and have wide access to the population of patients resisting vaccine.

We are proud of our work in the outbreak and would love to be part of the solution to preventing future outbreaks.
Sterilization of minors is an uncommon procedure in pediatric practices, but an important one to understand if a family requests information about it. This article will help to understand what the ethical issues are and how to proceed if it is requested for your patient. Typically, this issue is only brought up for our patients with complex health care needs for whom it is felt that pregnancy (or fatherhood) would present significant problems for your patient or the potential offspring.

The background of this subject and the main reason why there has been so much oversight provided is that in the past, eugenics and other movements to limit reproduction of certain elements of our society led to mistreatment of our most vulnerable patients. The desire to prevent patients with diagnoses such as Trisomy 21 or mental retardation from procreating and potentially bringing more children with these problems into the population resulted in young adults being sterilized, often without any oversight as to whether this was the right thing to do or not.

As a result of these abuses of the medical system, both the American Academy of Pediatrics (AAP) and the American College of OBGYN (ACOG) have published policy statements on when and how minors can undergo sterilization. The goal of these policy statements is to protect the rights of minor patients who may not be able to speak for themselves and to limit possible harm to them if the procedure is not indicated. Because minor patients cannot legally consent to invasive procedures, their parents are given the right as surrogate decision makers to make decisions for them – as long as they are acting in the best interests of their child.

Children’s Minnesota Ethics Committee first developed a policy on Permanent Sterilization of Minors In Non-life-threatening Conditions in 2005 and revised it in 2016. The process is designed to make sure that other, non-permanent options are considered first (primarily for females) and the best interests of the minor patient are protected.

For female patients, generally the issue is a desire on the part of the parents to make sure their daughter can never become pregnant (especially when the patient would never be able to care for a child and/or would be considered a vulnerable adult and at risk of being sexually abused and becoming pregnant). However, occasionally the issue has been around menstrual suppression, although this is less common now with improved pharmacologic methods to accomplish this.

For males, the main issue is a parental perception that their son would never be able to care for a child, typically due to significant mental impairment.

The process for having a patient approved to undergo a permanent sterilization at Children’s involves multiple steps (and may take 6 months to accomplish) including obtaining supporting documentation from the following:

- Primary clinician explaining why the planned procedure is necessary
- Psychologist explaining cognitive functioning of the patient and patient’s capacity to be involved in decision making
- Social worker explaining whether patient would ever be able to care for a child
- Gynecologist or Surgeon discussing what other less invasive methods have been attempted to achieve the desired goal and what procedure is being recommended
- Parents explanation of why they are requesting the procedure for their child
- Patient thoughts (if appropriate)

Once all of the above documents have been collected, they are forwarded to our Clinical Ethics Department for final review and then to Children’s Chief Medical Officer for final “sign off,” prior to surgery being scheduled.

If the patient is less than 18 years old, court involvement is not necessary. However, if the patient is 18 years old or older, court involvement may be necessary, especially if the parents have not been granted guardianship by the courts.

When faced with a decision regarding sterilization of minors, pediatricians should reference the AAP policy statements, discuss the case with Ob/Gyn or Urology, and consider engaging their ethics consultants.

If you have any questions, please feel free to contact me at Sheldon.berkowitz@childrensmn.org.

References available upon request.
Nearly 1 in 10 Minnesotans are food insecure; that’s a half-a-million Minnesotans who don’t always know where their next meal is coming from. While poverty is a common contributing factor, transportation and geographic factors may also affect families without cars or without a grocery store nearby. Many families are just above the threshold for qualifying for assistance programs and still cannot afford the nutritious food important for their families.

Screening

Screening for food insecurity can be easy, but may require small changes to your office workflow. Screening should be completed at every well child exam, and whenever concerns exist. Screening can be accomplished using a standard, validated, two-question screening tool, known as the Hunger Vital Sign.

- Within the past 12 months, we worried whether our food would run out before we got money to buy more.
- Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more.

A patient or caregiver can respond “Often true,” “Sometimes true,” “Never true,” or “Don’t know / Refused.” An “Often true” or “Sometimes true” response is considered a positive screen and should prompt advice and referral.

The screening may be administered as part of the routine rooming questions asked by your nurse or medical assistant, or it may be completed on a written questionnaire. We feel written screening allows parents to be more honest about their situation, and more discreet about their needs in front of their children.

Either screening method requires education and understanding from nursing staff about the importance of screening for food insecurity and the effects of hunger on children. We also have teenagers who come in alone for well child exams complete the questionnaire. You may chart, notate, or track the child’s food insecurity within your electronic medical record as you see appropriate.

Connecting children with community resources

After a family has been identified as food insecure, just like any other risk factor, the pediatrician must identify interventions to improve the child’s health. Many choices exist to assist families in need, and the process can be simple or more involved.

SNAP Rx: Experts at Hunger Solutions Minnesota are available to direct families statewide to local resources.

When a family is identified as food insecure, after signing a release of information form, their basic information may be faxed to Hunger Solutions. Hunger Solutions will then reach out to the family and connect them with all of the food resources available to them, including SNAP, Fare for All, farmers markets, and discount grocery programs. Providers can also give Hunger Solutions’ Minnesota Food HelpLine number directly to families, although follow-up is less assured. Hunger Solutions will also assist a family in navigating a Bridge to Benefits screen (see below).

Bridge to Benefits: Families who are identified as food insecure may benefit from the Children’s Defense Fund’s (CDF) Bridge to Benefit (B2B) web app. Users can anonymously enter income data and be screened for various government assistance programs that they may not yet receive, and receive links to applications for programs for which they might qualify. Patients can be given B2B’s website, or patients may be assisted on completing the questionnaire by clinic staff before leaving. Clinics may set up their own accounts with B2B to track their own referrals, and CDF will provide free training to staff in using their application. Minnesota pediatricians may watch an archived webinar at the Chapter’s website about the Bridge to Benefits program and how it can be integrated into your clinic. Bridge to Benefits does not identify non-governmental local agencies that may help with access to food.

Work with community partners: Connect with local food shelves, religious leaders, tribal leaders, community development organizations and know what your neighborhood’s resources are. My clinic in rural central Minnesota has cooperated with local farmers and is providing a CSA share (Community Supported Agriculture) of fresh fruits and vegetables twice monthly to food insecure families.

Helping a family with food insecurity is an opportunity to help a child succeed. Connecting a family to resources that can help will help a child achieve their fullest potential.

Resources

2015 AAP policy statement “Promoting Food Security for All Children”: https://tinyurl.com/yanz6v8f

Food Research Access Center’s Food Insecurity Toolkit for Pediatricians: http://frac.org/aaptoolkit

Hunger Solutions Minnesota: 1-888-711-1151 http://www.hungersolutions.org

Bridge to Benefits: http://mn.bridgetobenefits.org
In January 2018, the Minnesota Medical Association, along with MNAAP and other partner organizations, will kick off a campaign to raise awareness of health disparities in the state.

During the month, we will have several opportunities for physicians to learn more about how we can all work together to achieve health equity in Minnesota. Be prepared to celebrate the month with the MMA and its partners.

Find out more here: www.mnmed.org/healthequityMN

Save the Date!

Join more than 100 pediatricians, pediatric providers and advocates.
Disasters Don’t Plan Ahead. You can!

By Paula Kocken, MD, FAAP

This was September’s theme for Disaster Preparedness Month and there certainly were enough disasters to test the theme. Hurricanes, earthquakes, and fires ravaged North America. I am certain that all of us were thinking, “What can I do to help?” I am also certain that many of us gave money to charitable organizations, donated food to groups going to aid the victims, and called our relatives and friends in the areas affected to offer help.

One thing you may not have thought was, “How can I best prepare for a disaster if it happens here?”

The best way to be prepared is to “Make a Plan” by thinking ahead in an organized fashion and creating a strategy for what you would do during the most likely disasters to strike your community. It is the idea of preparing yourself first so you are free to help others. The government has some excellent guidelines and tools listed on their websites that are very helpful and informative. Every time I go to those sites, I learn something new or get a great idea on what I need to do to prepare. Below are some of the ideas I think are the most helpful.

Have a family meeting and discuss which disasters would impact your family. In Minnesota, the top culprits include winter storms, tornados, and floods. If you have children, it is important to talk about what could happen and how they would respond to it. It is a good time for demystifying what the children see in the media while validating their concerns. The AAP Family Readiness kit has many suggestions on what to do and how to talk about disasters with children.

Make a family emergency plan. Ready.gov has great information on how to make a family plan. Here is a synopsis of the important points.

Compile household information: Make a list of all the important phone numbers and email addresses of your family (relatives, trusted friends, schools, work, etc.) and print them in “hard copy.” Also, make copies of important documents like passports, home mortgages, medication lists and other papers. Have the originals available if you need to evacuate your home and send copies to a trusted friend or relative in case the originals are destroyed.

Identify an out-of-town contact: Identify someone, a relative or a trusted friend, outside of your community or state to act as central point of contact. If the emergency is localized to your city, local phone lines may be jammed while long distance calls will work. If your family gets separated during an emergency, they can call this contact and tell them their location.

Confirm emergency places to meet: In the case of an emergency when your family is not together, choose places your family can go for protection or to reunite. Make sure everyone knows and agrees on these places. Write them on the “household information” list.

- Indoor: This is where you would go for protection in your home if a tornado or high-wind storm is coming; usually a windowless room in the basement.
- In your neighborhood: This would be where your family would go if there was a house fire and you would need to leave your home. It could be a neighbor’s house.
- Outside of your neighborhood: This would be if a disaster struck and you were not home and cannot go home. It would be a place to reunite like a community center or library.
- Outside your town or city: If you cannot get home or to your out-of-neighborhood meeting place; or your family is not together and your community is instructed to evacuate the area. It can be the home of an out of town relative or friend.

Share: Make paper copies of your household information list for each member of the household to carry in his or her wallet, backpack, or briefcase. Post a copy in a central place at home.

Store at least one emergency contact under the name “In Case of Emergency” or “ICE” for all mobile phones and devices. Enter household and emergency contact information into all household members’ mobile phones or devices.

Share all the information above with your out-of-town contact. Give them a list of your family’s current medications.

Practice: Seasonally review and discuss your plan with your family. Update phone numbers, medication lists, and review where you would go and what you would take. This is probably the hardest step since it doesn’t feel necessary. If you have school age children, they have all done fire drills, so pattern the practice after a drill. If you have young adult children, review your plan at holidays. Don’t forget to call your out-of-town contact to remind them of their role.

If you are scrambling to gather your important documents or calling numerous numbers to locate your family, you cannot help others. Planning, gathering, and sharing the right information before a disaster hits will permit you to be free to help others.
Increasingly, primary care pediatricians, as well as pediatric subspecialists, are caring for youth who identify as transgender or gender nonconforming (GNC). Rather than an increase in prevalence, this phenomenon is more likely a testament to a gradually improving cultural environment, both nationally and in the state of Minnesota.

In the 2016 Minnesota Student Survey, 3 percent of 9th graders and 2 percent of 11th graders considered themselves transgender, genderqueer, genderfluid, or were unsure about their gender identity. We have a responsibility and an opportunity to lift the health and the spirits of one of our most vulnerable patient subpopulations.

In the AAP’s July 2017 Statement in Support of Transgender Children, Adolescents and Young Adults, Drs. Stein and Remley affirm that the Academy “stands in support of transgender children and adults, and condemns attempts to stigmatize or marginalize them…As pediatricians, we know that transgender children fare much better when they feel supported by their family, school and larger community…The AAP supports policies that are gender-affirming for children.”

Gender nonconformity is not pathological, and so not all of your patients who identify as transgender or GNC will desire or need treatment. However, those who experience gender dysphoria do deserve a discussion with you about treatment or referral. Gender dysphoria is defined as the distress that results from incongruence between one’s gender identity and the sex assigned at birth. That dysphoria, in addition to the minority stress experienced by this marginalized group, are together thought to contribute to their increased risk of depression, anxiety, suicide, and substance abuse. Of the parents we meet in our clinic, many, but not all, are familiar with the “41 percent” statistic, the oft-cited percentage of transgender individuals who have attempted suicide. And these parents are appropriately fearful for their children. What we convey to them – and what you as a pediatrician must stress to your families – is that evidence shows the risks of depression and anxiety to be mitigated by simply providing a supportive and loving environment.

Every pediatrician should familiarize him or herself with the AAP’s publication, Supporting and Caring for Transgender Children. Therein, even those providers who do not intend to prescribe pubertal suppressant or gender-affirming hormone medication can learn the basic timelines and treatment options that should be presented to families in the clinic setting. Furthermore, the general pediatrician can take some simple but critical steps toward creating an environment in which children feel safe discussing their gender identity. For example, use of preferred names and pronouns by all providers and ancillary staff is paramount. More challenging, but equally important, is that we strive to set aside the cisgender, binary biases and assumptions we carry as a result of our medical training and our culture. Gender is increasingly coming to be understood as a spectrum, and our patient’s goals accordingly fall on a spectrum.

Below this article, I have included a table from the AAP’s Supporting and Caring for Transgender Children, which gives a very rough timeline of the common steps involved in gender transition. I have also included a bibliography of books for providers, parents and adolescents, which I hope will help to inform and advance our conversations. As pediatricians, we are in a unique position to empower children to be their full selves, and parents to keep their children safe, happy, and full of promise.

### Resources:
- The Transgender Child - A Handbook for Families and Professionals by Stephanie Brill and Rachel Pepper
- Helping Your Transgender Teen – A Guide for Parents by Irwin Krieger
- The gender quest workbook - a guide for teens and young adults exploring gender identity by Ryan J Testa PhD, Deborah Coolhart PhD, and Jayme Peta MA
When did you know you wanted to become a pediatrician?

When I went to medical school, it was only to be a pediatrician. I had long known children were amazing, and I wanted to spend my life surrounded by them. And I adored partnering with the parents who loved them to help bring comfort. The worst part of medical school was suffering through all those adult rotations. Ugh. I don’t know how those guys do it!

You were recently named Children’s new CMO. What are you most excited to work on in this role?

The privilege that I have in this role is the chance to impact our culture – who we are, what we bring to work, and what we offer those we touch. These are terribly challenging times in medicine, but if we remember why we’re here, and who we’re here with, the calling will grab us all over again. If we see our potential, we will realize it. I’d like to help people see it.

What is one issue you’re particularly passionate about and why?

Safety. Our job is to heal. We can’t possibly heal a child who we can’t keep safe – safe from health care associated conditions, from cognitive error, from inequity, from barriers to access. We’ve come a long way but, if we’re honest with ourselves, we know we’ve got so far to go. This challenge has taught us volumes about humility and courage, and the power of collaboration. No one of us will solve this alone; this one can only be done together.

Why did you decide to join the board of the Minnesota AAP?

When you are busy in medicine, your view can become myopic. I joined the board of the Minnesota AAP to help me see beyond the walls of my own hospital. The energy and passion and commitment of these board members has been both humbling and inspiring.

“...your view can become myopic. I joined the board of the Minnesota AAP to help me see beyond the walls of my own hospital. The energy and passion and commitment of these board members has been both humbling and inspiring.”

What is one thing people are most surprised to learn about you?

Most people don’t realize that I didn’t set out to be a doctor. I studied psychology in college and started off in medicine as a Child Life Specialist at Children’s National in D.C. It was only in that role that I fell in love with the hospital and became curious about the science behind it all. Ultimately, I did all of my premed courses in the evenings and on weekends and went back to medical school about 5 years after I graduated from college. The combination of training in psychology, child development, and finally science, has made medicine so rich. I’m lucky that I didn’t know what I wanted to be when I grew up.

How do you enjoy spending your free time?

These days, my free time is usually about taking care of me. When you’re younger, you assume you are invincible. But life has a way of teaching you that it may not be the case. Now that I’ve learned that, I take better care of my heart and soul so that I can bring my best to those things that matter to me.

What advice has made a profound impact on your life?

Surprisingly, the best advice I got was from my commencement speaker at college. Neil Simon, a popular playwright, talked to us about passion. In his speech, he cautioned, “Don’t listen to those who say it is not done that way. Maybe it isn’t, but maybe you will.” I have kept that with me ever since.
The Providers Will See You Now, Congressman

In early September, South Lake Pediatrics in Eden Prairie hosted a visit with Representative Erik Paulsen. It was his second visit to the clinic to discuss health care and other issues affecting children.

Anne Skemp, MD, reached out to MNAAP for talking points on CHIP reauthorization and DACA. Below is a summary of the visit:

Why did South Lake Pediatrics decide to invite Rep. Paulsen to a meeting? What did the clinic hope to accomplish or communicate?

This was Rep. Paulsen’s second visit to our clinic. The first time, on November 16, 2016, we wanted to highlight our clinic’s relationship to the Somali population in his district and to discuss some of the ways that he could keep that population of children in mind in his legislation. This time, we wanted to discuss the ongoing efforts to repeal the ACA and also topics such as immigration and health care policy affecting minors, such as defunding Planned Parenthood.

How did he respond?

His response was respectful -- he listened to our providers’ stories and points of view on these policies. He was knowledgeable and was able to answer most of our questions, only avoiding answering a few of them!

Did he share how he believes Congress can best protect health care for children?

His ideas on how to improve health care for children mainly centered on insurance: stabilizing rates, continuing the reinsurance program, offering states more flexibility. He reported how he meets regularly with insurers, including the CEOs of HealthPartners and Blue Cross Blue Shield.

Regarding Planned Parenthood, he was surprised to hear that there are few community health clinics providing low-cost health and contraception services other than Planned Parenthood in many areas. We also pointed out that birth control pills are used for many other medical indications besides contraception.

Additionally, Congressman Paulson was surprised by a few statistics regarding the pediatric population and how disproportionately kids would be affected by a cut in Medicaid. He asked for our copies of the materials from MNAAP and children’s advocacy regarding CHIP.

Was there anything he was surprised to hear? Anything your clinic was surprised to hear?

He was surprised that South Lake Pediatrics holds Community Health Care meetings with the Somali population in Eden Prairie a few times each year to discuss immunizations, nutrition, and asthma. These events are attended by 20-40 Somali women and are quite well-received. Speakers have included an imam, a Somali nutritionist from U of M outreach, pediatricians and nurse practitioners from South Lake Pediatrics.

What advice do you have for other clinics who have never reached out to their local or state representatives?

We would definitely recommend that other clinics reach out directly to their state and local representatives. It took at least 6 months of work on the part of one of our clinicians to arrange the initial visit, so be persistent!

Find out who represents your clinic at http://www.gis.leg.mn/iMaps/districts/

2017 Member Survey Results

More than 200 members participated in the chapter’s annual member survey recently. The survey revealed that advocacy is perceived as the #1 member benefit.

There is strong support for improving access to care (32%), followed by stronger immunization requirements (18%), reducing poverty/disparities (17%), and improving mental health resources (11%).

Additionally, 85 percent of members indicated they were satisfied with their membership.

Thanks to all who provided feedback!
This November, Consider Donating to the Minnesota Academy of Pediatrics Foundation

‘Tis the season for giving! There are two opportunities in November for you to make a year-end donation to support the future of pediatrics/

November 16 is Give to the Max Day

&

November 28 is Giving Tuesday.

All donations will support MNAAP projects and initiatives to improve child health and wellbeing in Minnesota.

Watch your email for more information soon...or donate at www.mnaap.org/give.htm

Congratulations, Members!

Dr. Dan Broughton was recently selected as the 2017 recipient of the AAP Holroyd-Sherry Award, recognizing individuals whose lifetime achievements have made a substantial national contribution to the area of children’s health and media. Dr. Broughton is a child abuse expert at Mayo Clinic and a founding member of the National Center for Missing and Exploited Children.

Dr. Sarah Jane Schwarzenberg was recently selected as the 2017 recipient of the AAP Murray Davidson Award, which recognizes an outstanding clinician, educator and scientist who has made significant contributions to the field of pediatric gastroenterology and nutrition. Dr. Schwarzenberg is a pediatric gastroenterologist at the University of Minnesota. Additionally, she serves on the national AAP Committee on Nutrition.
MNAAP has a total of 996 members!

A warm welcome to new members who joined between June 1, 2017 and August 31, 2017

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Christopher Williams, MD
Amilyn Worlobah

2017 Distinguished Service Award

Congratulations to Dr. Lydia Caros who was recently presented with MNAAP’s 2017 Distinguished Service Award, which is given to a pediatrician each year who has dedicated his or her life to improving care for children throughout the state of Minnesota. She was unable to receive the award at MNAAP’s annual meeting in May.

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PEDIATRICIANS’ DAY
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1-4 p.m.
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Friday, May 11, 2018

Thank you to MNAAP’s 2017-2018 sponsors