SDBP
Society for Developmental & Behavioral Pediatrics

Behavioral Developments

THE OFFICIAL NEWSLETTER OF THE SDBP

Dear Members,

Spring 2021

We enter this Spring in a period of flux with the pandemic and with recognition of the work ahead of us. We are reminded of the call to action in our anti-racism and advocacy work as we witness the loss of lives from anti-Asian racism. We recall so many publications that have come before on the toll of gun violence within our communities, including in our own newsletter. We face many challenges ahead, but remain committed to our mission of supporting children and families and one another as developmental-behavioral professionals.

The following are some resources shared by SDBP members focused on talking to children about racialized violence and mass shootings:

Embrace Race: Talking to Children about Racialized Violence
Talking to Kids about Tragedies in the News
Talking to Children about Mass Shootings

This edition features the impressive breadth and depth of work being completed by our members. We start off with an exciting spotlight on SDBP's first New Century Scholar, Autumn Hinds, MD, as well as a wonderful member spotlight from the Advanced Practice Clinician section on Daphna Shaw, DNP, APRN, CPNP-PC. Next, Bethany

IN THIS ISSUE

Ziss, MD invites us to learn more about what it means to take a neurodiversity lens to our work, including examples from her professional practice and resources. Matthew Scott, MD presents a column on improving professionalism in our telehealth practices as part of a special telehealth series. We also have another excellent column from a special series from the Practice Issues Committee, which highlights two innovative programs for improving clinical practices. Finally, we have updates from the DEI Committee and RACE CARD publications as well as match statistics from the Fellowship Section.

SDBP Communications Committee

ALYSSA SCHLENZ, PhD & **SHRUTI MITTAL, MD**
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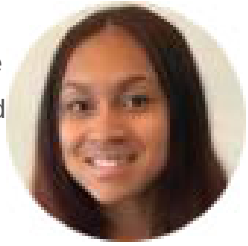
MICHELE LEDESMA, MD
Layout

SDBP's First Scholar in the New Century Scholars Program

ELLEN PERRIN, MD

As part of our ongoing commitment to increase diversity in the field of Developmental-Behavioral Pediatrics (DBP), SDBP has joined the New Century (NC) Scholars Resident Mentoring Program partnering with the Academic Pediatrics Association, the American Pediatric Society, and the American Board of Pediatrics. SDBP has made a two-year commitment to support the participation of a pediatric resident interested in DBP, and members Ellen Perrin and Lynn Starr represented SDBP in this new initiative.



We are thrilled to announce that **Dr. Autumn Hinds** was selected to be the first SDBP-supported NC Scholar in this new partnership! Many of you had the opportunity to meet Dr. Hinds virtually as she attended our 2020 SDBP meeting. She is currently a PL-2 resident in pediatrics at the Nemours

Pediatric Residency program in Orlando FL.

Autumn has always had a passion for pediatrics and for advocacy. She's been involved in community efforts to increase literacy of school aged children, both during undergraduate/medical training and during residency. She also enjoys mentoring teens. Her interest in developmental-behavioral pediatrics was sparked during her DBP rotation her intern year of residency, when she was exposed to the broad scope of DBP and its impact on children at home and at school. She comments that, *"the field of DBP allows children to reach their full potential, regardless of the medical challenges they face."* She plans to work in an academic institution and to be a role model and teacher for rising/training physicians.

Dr. Hinds' senior mentor will be Dr. Jennifer Walton and her junior mentor will be Dr. Kimberlly Stringer. We thank both Drs. Walton and Stringer for their dedication to mentoring and for representing our field and the Society!

The APA New Century Scholars Program is a mentorship program aimed at increasing the diversity of the academic pediatric workforce. Pediatric residents *under-represented in medicine* (UIM) with an interest in pursuing careers in academic pediatrics are recruited in the second year of residency (or third year for incoming chief residents, internal medicine/pediatrics, or other combined programs) to become NC Scholars. Their participation in the program spans two years and the residents selected are matched with junior and senior mentors who provide ongoing support to the scholar during residency, career planning, the fellowship application process, and onward. Senior mentors provide "big picture" advice to the NC Scholar regarding career planning, help in developing specific research and educational scholarship plans, and welcome the NC Scholar into the APA, the SDBP, and academic pediatric "culture". Junior mentors are typically fellows and/or junior faculty who can provide "nuts and bolts" advice to the NC Scholar in areas such as choosing and applying to a fellowship, career development, starting an academic career, selecting a research project, and negotiating work/life balance, etc. The NC Scholar will attend both the PAS and SDBP meetings with their mentors in 2021 and remain in regular contact during the year.

Member Spotlight

Daphna Shaw, DNP, APRN, CPNP-PC

Submitted by **JENNIE OLSON, RN, MS, CPNP, PHMS**

Daphna Shaw is a doctoral-prepared developmental pediatric nurse practitioner in the Division of Developmental Behavioral Pediatrics at the University of Texas Southwestern Medical Center in Dallas, Texas. She enjoys working in an interdisciplinary team to perform developmental and behavioral assessments, medication management, and follow up care for children in the Developmental Behavioral Pediatrics Clinic and in the Down Syndrome Clinic.

Daphna obtained her DNP from the University of Texas at Austin, MSN and BSN from the University of Pennsylvania, and BS in Biology from the University of Florida. She began her career as a nurse practitioner in the Center for Developmental Pediatrics at Advocate Children's Hospital in Park Ridge, Illinois, while completing the LEND program through the University of Illinois at Chicago.

Daphna is currently involved in research projects investigating the incidence of neurodevelopmental disorders in children with Down Syndrome, cultural considerations in pediatric autism assessments, and a national workforce survey of developmental behavioral nurse practitioners. She is the current president of the Greater Texas chapter of the National Association of Pediatric Nurse Practitioners (NAPNAP) and the secretary of the Developmental Behavioral and Mental Health Special Interest Group of NAPNAP. This year, she looks forward to partnering with the pediatric nurse practitioner program at Texas Women's University to create a developmental rotation for students.

Autism SIG

This month, many of you may be prepping events or other outreach activities focused on "Autism Awareness Month" in April. Did you know that autistic people have generally moved to "Autistic Acceptance" or even "Appreciation"? What's in a name? What's the difference between being aware of autism, and accepting and appreciating autistic people?

Autism Level Up, a group co-run by an autistic and neurotypical professional, suggests we should even go past "appreciation" to "empowerment" and "advocacy" as we strive to value neurodiversity.

Clinical Applications of the Neurodiversity Paradigm

BETHANY ZISS, MD

For awhile, I have been describing my practice of Developmental and Behavioral Pediatrics as rooted in the neurodiversity paradigm. Neurodiversity is the simple description that people vary in their thoughts, feelings, sensory processing and other neurological traits. The neurodiversity paradigm further rejects the idea that more typical brains, or neurotypes are inherently more valid than others. It is probably best explained here by autistic scholar Nick Walker. Neurodiversity: Some Basic Terms & Definitions (neurocosmopolitanism.com). More recently, autistic researcher Damian Milton coined the phrase, "Double Empathy Problem" in light of the growing research that, as much as autistic people struggle to understand and empathize with neurotypical people, so also do neurotypical people struggle to empathize with autistic ones. In both situations, typically, the autistic person is blamed. On the ontological status of autism: the 'double empathy problem': Disability & Society: Vol 27, No 6 (tandfonline.com)

Working from the neurodiversity paradigm does not mean forgoing medication or therapies. It does mean considering the aim of therapies and respecting difference as not inherently pathological. We can pretty much all agree that limited communication, difficulty paying attention, significant anxiety, and problems with emotional regulation that may lead to aggression are problems that should be addressed in some way. The neurodiversity paradigm strongly supports speech-language therapy, with a particular eye towards robust AAC for both non-speaking children and those whose speech is not always reliable. The goal is to improve communication options while respecting all communication, including AAC, gestures, single words, scripting and echolalia as being as valid as spontaneous sentences. Similarly, differences in eye contact or a preference for repetitive play can be seen as an autism trait (not "warning sign" or "red flag") for diagnostic purposes without being seen as a behavior to target and change through therapy. This infographic about play is representative of the neurodiversity paradigm. Respecting Autistic Ways of Playing, Interacting & Making Friends – Ed Wiley Autism Acceptance Lending Library (neurodiversitylibrary.org)

Practicing from the neurodiversity paradigm means asking "why" a lot. A child plays alone at recess. Is this because they are being bullied, do not know how join the activity or need "down time" to recharge after a morning of language and social expectations? Sometimes this means the seemingly radical act of asking the child directly if they prefer to play by themselves or with

others. Often, it means asking why this is not already our standard approach, but families are nearly always surprised when I ask and IEPs routinely turn recess into social intervention time without ever checking in with a child's preference. Finally, the neurodiversity paradigm means listening to the voices of autistic adults who are telling us "why" in their talks, blogs and books. My go-to resources to share with families about scripted language, emotional regulation, self-injury and visual supports are all written by autistic people, some of whom are also professionals. After all, some of my young patients may be the next generation of neurodiversity activists, authors, teachers, psychologists, and developmental pediatricians.

Is reduced eye contact a "red flag" or an "autism trait"?
Is the patient in your office a "person with autism" or "autistic person"?
Does your puzzle piece art have the same symbolism for everyone?

Join the Autism SIG on April 14 from 12-1pm EST for an *SDBP Connect* discussion about autism, language, and neurodiversity!

Special Feature

Telehealth

Professional Considerations When Utilizing Telehealth in Your Medical Clinic

MATTHEW SCOTT, MD, CPT, MC, USA
Fellow in Developmental-Behavioral Pediatrics
Madigan Army Medical Center

Use of technology and telemedicine is increasing and it is important to refine our delivery during virtual appointments. As we enter patients' homes virtually, professionalism is just as important as it would be for an in-person visit. However, the particulars of professionalism in a virtual setting are slightly different.

Camera Angles

To build better relationships with patients, medical students are taught to sit at or below patient's eye level when meeting with them in person. Similarly, the camera angle of webcams can be an important part of a patient's perception of and trust in a provider. Historically, studies of camera angle have been limited to the film industry, which has tried to use angles above and

below actors to convey different emotions to audiences. A more recent study (Baranowski) in the film industry found that when the camera angle is above or below eye level, the audience feels the actor is less trustworthy than when the camera is at eye level. Another study (Thomas et al) found that the known power dynamic associated with elevation (i.e., taller people are perceived as more powerful) persisted when webcams were placed above or below a person's eye level. For example, if the physician's camera is placed below eye level, the patient will feel as if he or she is looking up to the physician and may feel more vulnerable or less in control. Since the goal of our interactions is to be partners in health care, raise or lower your camera to be as close to eye level as possible.

"Eye" contact

Maintaining appropriate eye contact during a patient encounter can help the patient feel validated and increase patient satisfaction. However, eye contact through virtual encounters can be challenging to simulate since our eyes naturally focus on the patient's image rather than the camera lens. Gaze angle is determined by how far the physician's gaze is diverted from the camera lens when looking at the patient on the screen, and it significantly affects patients' perceived eye contact with the physician (Tam T, et al). If there is a large gaze angle then it may appear to the patient that the physician is not making appropriate eye contact or is looking away from them. Gaze angle increases when the distance between the camera and the patient on screen increases. It also increases as the physician moves closer to the camera and the screen. If able, the camera should be positioned as close to the on-screen patient as possible, or the physician can back away a little from the camera in order to reduce the gaze angle. With practice, providers will learn when it is more important to prioritize eye contact (looking directly at the camera lens). For example, when delivering bad news, you could look at the camera continuously with shorter glances at the screen to gauge parents' emotions. Other times, such as during the physical exam portion, you may focus more on the screen to better assess the patient. Physicians can also demonstrate they are attentive with more frequent head nodding, forward leaning posture, and minimal distractions.

Surrounding Area

At the beginning of the encounter, move the camera to show the entire room to the patient and family so they know who else may be in the room and could possibly overhear the conversation. Your background should be free of clutter, unprofessional items, and distractions. Many online platforms allow for a digital background, but these can be even more disruptive. Lighting should be in front so your face is evenly lit, with no bright lights behind you. Your name badge should be visible to the family. Check your sound quality, but remember sounds coming from your office, hallway, or neighbors. Also, learners and other observers should be cognizant that they are visible to the patient and should treat being in a virtual encounter the same as if they were also in the exam room with a patient. If we can see them roll their eyes, pick their nose, or get distracted on a phone, the patients and families can see them as well.

While many of these recommendations seem obvious, they require deliberate, advanced planning. Virtual encounters are becoming more common and may even feel routine. This is an

opportunity for us to polish our techniques and find ways to improve our virtual healthcare delivery.

References

1. Baranowski AM, Hecht H. Effect of Camera Angle on Perception of Trust and Attractiveness. Empir Stud Arts. 2018;36(1):90-100. doi:10.1177/0276237417710762

2. Tam T, Cafazzo JA, Seto E, Salenieks ME, Rossos PG. Perception of eye contact in video teleconsultation. J Telemed Telecare. 2007;13(1):35-39. doi:10.1258/135763307779701239

3. Thomas LE, Pemstein D. What you see is what you get: webcam placement influences perception and social coordination. Front Psychol. 2015;6:306. Published 2015 Mar 19. doi:10.3389/fpsyg.2015.00306

Practice Innovations

For this issue, we are pleased to report on the exciting work of our colleague Michael Ching at Kaiser Permanente Hawai'i and give a shout-out to the agency Family Voices for their needed work to expand telehealth access to underserved communities.

Kaiser Permanente BCBA-MD Collaboration

MICHAEL CHING, MD, MPH, FAAP

In 2015, the state of Hawaii enacted legislative and policy changes that mandated insurance coverage of applied behavior analysis (ABA) and other autism therapies. In response, Kaiser Permanente Hawaii (KP) created its program to provide ABA therapy to its members. As an insurer and provider of medical services, KP designed its program to ensure high quality and effective ABA care with a personal touch. One of the key design components of our program was the inclusion of a clinical board-certified behavior analyst (BCBA) at the medical group level to serve as both a clinician and administrator within the ABA program.

At our center, once the developmental behavioral pediatrician diagnoses a child with autism spectrum disorder, they refer the child to a KP BCBA for a functional behavioral analysis,

baseline data collection, and preliminary development of ABA goals. The KP BCBA also educates the family on what high quality ABA should look like and elicits parent preferences for therapy (e.g., center versus home-based, schedule of availability, location).

The BCBA then helps the family to connect with an ABA company in the community who can accept the case immediately or within a short time frame. This is made possible because of the size of our vendor network (currently about 40 companies) and because ABA vendors contact our BCBA when they are looking for clients (due to the size of our patient panel). This ability to serve as matchmaker differs from the common practice in our community where families receive a list of ABA companies and call each one to find availability (and to be placed on a waiting list).

After the community ABA provider completes an evaluation, they send a report and treatment plan to the KP BCBA. These must meet specific quality standards before the KP BCBA authorizes treatment to begin. While a child is receiving ABA therapy, the ABA company sends data and progress updates to the KP BCBA to review progress towards goals at set intervals depending on the severity of the case (e.g., monthly, quarterly).

The KP BCBA conducts regular telehealth and in person visits with patients and families to review their behaviors and ABA progress and experiences. The KP BCBA also serves as a point of contact at KP (in many cases before the developmental behavioral pediatrician) for families struggling with behavior issues at home if they have had unresolved issues after working with their direct ABA provider. The KP BCBA also helps families mediate problems with their direct ABA provider such as when the company does not deliver its promised hours, or conversely when companies report issues happening with families that we may not be aware of (e.g., escalating behavior issues, family disruption).

In addition to the direct clinical responsibilities, the KP BCBA has also served a vital evaluation role, managing metrics on ABA including outcome measures and ABA vendor patient satisfaction. The KP BCBA has also developed several multidisciplinary programs within our center including a PEERS social skills groups and pediatric feeding team.

Our Hawaii region cares for approximately 900 children and adults with autism. While not all receive ABA, our BCBA has been a key member of our DBP care team and has positively impacted the timeliness, quality, and family experience of ABA care. We commend any integrated delivery system or accountable care association to consider the inclusion of a BCBA with a direct clinical role in their ABA program.

Family Voices:

Educating Our Patients' Families About Telehealth

KIMBERLLY STRINGER, MD
GLENN BELKIN, DO

As we know from the last 11 months, telehealth provides multiple advantages including:

1. Easier access for families who travel long distance to our offices. (Inclement weather is not an issue!)
2. Ability to observe kids in their home environment. Many children are more comfortable in their home setting, and we can both watch the play of the younger children and get a better sense of how school-age children and teenagers behave at home.
3. Ability to witness the typical interpersonal relationships between family members.
4. Opportunities for other caregivers to join visits who may live in another household (e.g., co-parents, grandparents involved in keeping child).
5. More care coordination and collateral contact with teachers and therapists who provide in-home services (e.g., early intervention providers).

While many families enjoy the convenience of telehealth, others are wary. As providers, we have a unique platform to educate and allay fears. Family Voices has created curriculum and a webinar to help educate families about Telehealth: https://familyvoices.org/telehealth/curriculum. This curriculum provides solutions to common barriers, such as:

- What to do when family does not have an email.
- How a family can get low-cost internet and find places with reliable internet connections.
- Preparation for a successful Telehealth Visit (e.g., prepare environment, social stories, common troubleshooting issues with audio and video).
- Language: Curriculum handouts and instructions are available in Spanish.

Want to see your work or a colleague' featured in the next *Innovations* column? Please email requests and suggestions to Jason.Fogler@childrens.harvard.edu.

Committee, SIG, & Section News

DIVERSITY, EQUITY, AND INCLUSION COMMITTEE

Recent DEI Activities

Thank you to Jennifer Walton, MD, Adiaha Spinks-Franklin, MD, and Irene Loe, MD for their fantastic training on implicit bias to SDBP leadership on February 26th.

To learn more about implicit bias, check out these excellent resources:

1. Take implicit bias tests: https://implicit.harvard.edu/implicit/takeatest.html
2. Read about the research on implicit bias: https://pubmed.ncbi.nlm.nih.gov/30738896/
3. Take a free implicit bias training:
    a. Kirwin Institute Implicit Bias Module Series: http://kirwaninstitute.osu.edu/implicit-bias-training/
    b. Stanford University - Unconscious Bias in Medicine: https://med.stanford.edu/facultydiversity/faculty-development/cme-course--unconscious-bias-in-medicine.html

DEI Committee meeting coming this April - details to follow.

R.A.C.E. C.A.R.D. stands for ***R**ace **a**nd **C**hildren **E**ducational **C**ollaborative of **A**nti-**R**acist **D**BProfessionals.* RACE CARD was established in 2017 when Dr. Adiaha Spinks-Franklin approached several members of SDBP to ask them if they would join her in creating workshops and materials that address race and racism in children through a DBP lens. Since then, RACE CARD has developed a host of anti-racism training materials. They have conducted training workshops and seminars around the country and collaborate with outside organizations including Embrace Race (www.embracerace.org) to produce anti-racism training materials.

RACE CARD is excited to have new SDBP members join in on anti-racism and social justice work. We all have internalized racist messages while growing up and living in the United States that include white superiority and the inferiority of non-white people. We recognize we all have implicit racial biases that influence our interpersonal

interactions and clinical care skills. RACE CARD is committed to fighting against, changing and unlearning our internalized racism and negative racial biases both implicit and explicit on a daily basis.

Recent RACE CARD Member Publications:

Salathiel Kendrick Allwood, MD:

Medical-Legal Partnerships Benefit Families of Developmentally Disabled Children

Kate Wallis, MD:

Insights from Behavioral Economics: A Case of Delayed Diagnosis of Autism Spectrum Disorder

Jennifer Walton, MD:

Racism in Pediatric Health: How to Talk to Children about Racism

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FELLOWSHIP TRAINING SECTION

Results of the 2020 Developmental-Behavioral Fellowship Training Match

DIANE LANGKAMP, MD
Co-chair

Pediatric Subspecialty Match Day was on December 16, 2020. Congratulations to all candidates who matched and will be starting Developmental-Behavioral Pediatrics fellowships in July 2021! A brief summary of the DBP Match is listed below:

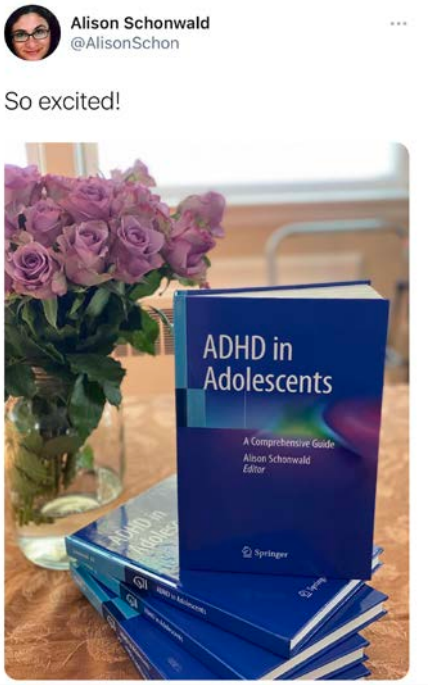
- 34 fellowship programs participated, 2 withdrew.
- 35 candidates participated in the Match.
- 32 applicants matched to a fellowship program. Of those who matched, 15 (46.9%) are M.D. graduates, 11 (34.4%) are US citizens but graduates of foreign medical schools, 4 (12.5%) are foreign graduates, and 2 (6.3%) are D.O. graduates.
- 3 candidates did not match and included 2 D.O. graduates and 1 foreign graduate.
- 24 (75%) programs filled. 9 fellowship positions were left unfilled.

Some programs that had unfilled positions on Match Day may have since filled those positions. Rates of unfilled DBP fellowship programs are similar to those in other generalist fields including Academic General Pediatrics and Child Abuse.

Announcements

- WORKSHOP submissions will close next week! For instructions and to submit, click here.
- The 2021 SDBP Research Grant Submissions are now open!
- SDBP has created an online educational package on the management of Complex ADHD, consisting of recorded sessions from the 2020 Annual Meeting. Click here for details and to purchase!
- Calls for Abstracts (concurrents/posters/papers) and to apply to the Research Scholars Symposium for the 2021 Annual Meeting will go out soon - look for announcements in your inbox and on the website!
- Content from the 2020 SDBP Annual Meeting will be available until the end of April 2021, so you still have time to catch up on all the things you may have missed! You can log on to the meeting platform here.

Social Media Roundup



Feedback, questions, and submissions can be sent to **Alyssa Schlenz** alyssa.schlenz@childrenscolorado.org or to **Shruti Mittal** shrutimittal88@gmail.com.