



The Alabama Pediatrician

First Quarter 2016

From the President

Addressing Threats to Medical Home



Cathy Wood, MD, FAAP
Chapter President

In the midst of a busy practice day, even in a year of vaccine success for the flu, I am sure that you, in your multi-tasking mode, are mentally thumbing through the most recent developments in your practice lives. At our Alabama Chapter-AAP January board

meeting a good part of the discussion of emerging issues involved Teladoc.

Teladoc, for those of you who are not aware, is a direct-to-consumer program with whom Blue Cross Blue Shield of Alabama (BCBS) has partnered to deliver consumer-requested telephone health care. Many Blue Cross customers in Alabama have received membership cards with directions for use and member numbers. Initially, it appeared that consumers were responsible for 100 percent of the \$40 charge, but we have since learned that Blue Cross in some cases is reimbursing for a portion of the charge.

As pediatricians, we have spent years developing our practices as medical homes and have been encouraged by the recent response of BCB recognizing providers who have qualified as a medical home. Regardless of whether your practice has pursued medical home status, the advent of direct-to-consumer telehealth delivered outside of the primary care setting is disruptive, potentially dangerous and threatens our practice lives.

Since our January board meeting, we have written a letter to Blue Cross stating our concerns and have met directly with medical representatives of BCBS.

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Register now! 2016 Spring Meeting at Grand Hotel is going to be the best yet!



**Conference will feature third annual "Grand" Pentathlon Benefitting Reach Out and Read
April 28 – May 1, 2016 • Marriott Grand Hotel, Point Clear, AL**

The Chapter executive office and CME Chair David Gremse, MD, FAAP, are looking forward to our 2016 Spring Meeting, to be held once again at the historic Marriott Grand Hotel in Point Clear, Ala.

Dr. Gremse has ordered a fantastic educational line-up for the conference with a focus on mental health, substance abuse and social issues. Topics include: ADHD, cannabis/cannabinoids use in youth, employing the brief intervention component of "Screening, Brief Interventions, and Referral to Treatment" for substance use problems, helping adolescents address challenges and pitfalls during the transition from home to college life, how to help adolescents with gender issues, the medical evaluation of physical abuse in children, and much more.

In addition, Children's of Alabama is sponsoring a separate symposium on concussions that is sure to be of benefit and interest to attendees.

In addition to a Saturday evening dinner on the patio by the bay, networking opportunities include our Grand Pentathlon benefiting Reach Out and Read. The event will afford attendees, family members and exhibitors to participate in five events at their own pace – bicycling, swimming, kayaking, walking/running and reading – to become eligible for great prizes.

Register now using the brochure mailed to you in early February, or online at <http://tinyurl.com/jjbk46u>.

Make plans to attend now—we'll see you at The Grand!

REMOVABLE MEDICAL HOME POSTER INSIDE

Chapter Office and Staff Alabama Chapter – AAP

- Linda P. Lee, APR
Executive Director
- Linda M. Champion, MPA
Project Coordinator
- Jill H. Powell
Meeting and Membership
Coordinator

19 S. Jackson St.
Montgomery, AL 36104
(334) 954-2543
Toll-free (866) 293-4783
Fax: (334) 269-5200
llee@alaap.org
www.alaap.org

Alabama Chapter – AAP

Mission:

The mission of the Alabama Chapter of the American Academy of Pediatrics is to obtain optimal health and well-being for all children in Alabama, and to provide educational and practice support for its membership so the highest quality of medical care can be achieved.

Values:

Children must be highly valued by society.

Each child must develop to his/her highest potential.

Children must have strong advocates for they have no voice of their own.

Pediatricians are essential to achieving optimal child health. The work of pediatricians, and the profession of pediatrics, must endure and grow even stronger.

Vision:

Children in Alabama are happy and healthy; Alabama pediatricians are professionally fulfilled and financially secure.

State Legislative Update: Medicaid funding in jeopardy

At time of writing, state lawmakers are only one-third of the way through the legislative session and already the Alabama Senate passed a General Fund budget that will cripple Alabama Medicaid, eliminate the primary care bump and leave millions without much-needed medical services.

In a memo released by the Alabama Medicaid Agency, Commissioner Stephanie Azar explained that level funding of \$685 million for Medicaid will create a significant impact for Alabama, including:

- Elimination of Regional Care Organization Program – 1115 waiver and related funds would be lost. This will result in the loss of \$747 million in waiver dollars filtering through the state's economy over the next five years.
- Elimination of Health Home Program – Program designed to decrease emergency room utilization and improve health outcomes, such as decreasing stroke, heart attack, and diabetes complications.
- Eliminate Primary Care Bump – Primary care physicians are currently paid at Medicare rates. Elimination of this bump would reduce rates for those physicians to 2005 reimbursement rates. Further required cuts beyond this are described below.
- Eliminate all optional programs – Including hospice (comfort care for individuals with terminal conditions), adult eyeglasses, outpatient dialysis and PACE (Program for All-inclusive Care for the Elderly), which is a managed care program designed to help at-risk individuals remain out of the nursing home.

The budget passed committee with a \$100 million shortfall for Medicaid, which is the state's largest agency. According to an article on WSFA-12, Gov. Robert Bentley appropriated the additional \$100 million in his budget proposal, paying for it with a transfer of funds from the Education Trust Fund, something lawmakers seem to be unwilling to do. With increased taxes seemingly off the table, new funding for Medicaid may only be available through budget cuts at this juncture.

The Chapter urges members to continue advocating for adequate funding; talking points are being distributed and are available on the Chapter website under Advocacy → "Current Issues" at www.alaap.org.

Pre-K Funding

In other news, at time of writing, an Education Trust Fund budget with a \$14 million increase for our state's First Class Pre-K program has passed committee in the House and is poised for further movement. The Alabama Chapter-AAP is supportive of this amount but joins the Alabama School Readiness Alliance's Pre-K Task Force in advocating for its full recommendation of a \$20 million increase, which was proposed by the Governor. If appropriated, recommended increase would grow the total amount of First Class Pre-K funding from \$48.5 million to \$68.5 million and keep the state on track to meet the ASRA Pre-K Task Force's vision for fully funding First Class Pre-K by 2023.

13th Annual Pediatric Legislative Day

This year, the Chapter joined forces with VOICES for Alabama's Children by having its 13th annual Pediatric Legislative Day at the site of VOICES's Advocacy Day on March 22, which culminated with a Pre-K Rally on the State House steps and visits with lawmakers.

"VOICES has long been a strong partner of the Chapter's, and we were delighted to join them this year, especially since we share common legislative priorities," said Linda P. Lee, APR, Chapter Executive Director.

Medicaid RCOs plan approved by CMS; more answers to the myriad RCO questions

On February 10, Governor Robert Bentley and Medicaid Commissioner Stephanie Azar announced the Alabama Medicaid Agency's regional care organization (RCO) plan to provide medical care to most Alabamians on Medicaid has been approved by the Centers for Medicare and Medicaid Services (CMS). As long as Medicaid is funded at its \$785 million request for Fiscal Year 2017, Regional Care Organizations will proceed and will be operational on October 1, 2016.

What does that mean for you as a pediatrician? Suffice to say that there have been a handful of very active pediatricians representing you on workgroups at Alabama Medicaid to assure that our voice is heard, that care for children covered by Medicaid is not disrupted, and that administrative hassles are as minimized as possible. With that being said, changes and some of the hassles associated with them are unavoidable. There are still questions being answered, but for now, here is our digest of knowledge, as best as we currently understand (note that contracts between the Medicaid Agency and RCOs and RCOs and providers are not yet available or finalized at time of writing).

RCO Digest

Provider Contracts

Providers will contract directly with the RCOs of their choosing. Contracts will be distributed this spring (after approval by Medicaid/CMS). All contracts have standard language required by Medicaid/CMS. See *"Pros and Cons of Contracting with More Than One RCO."* Because several RCOs operate in different regions, their contracts may share provisions across the state. All RCOs will also share similar contract language based on Medicaid-required terms. RCOs must contract with any provider willing to accept the payments and terms offered comparable providers.

Patient Panels

Panels will not have a number limit imposed by Medicaid. Panel size will be determined between the provider and the RCO.

Recipients will be contacted by a third-party, objective enrollment broker during late summer/early fall 2016 for them to make a choice regarding which RCO they want to be in (recipients can only be in one RCO).

Recipients will be provided with the name(s) of the RCOs with which their current provider is contracted. The recipient may choose which RCO he or she wants to be enrolled in.

If the recipient does not choose an RCO, he/she will be auto-assigned to an RCO based on his/her previous visit history/relationship with providers contracted with the RCO, with priority given to previous visit history/relationship (See Auto-assignment Logic at <http://tinyurl.com/zddpr58>).

If no previous or significant provider history/relationship exists, enrollees will be assigned to an RCO randomly.

Physician Choice/Assignment

Once assigned to the RCO, that RCO will be responsible for assigning the patient to the providers; RCOs have indicated they will rely on previous provider-patient relationships.



Commissioner Stephanie Azar and Governor Robert Bentley announce CMS's approval of Medicaid's RCO proposal

Referrals

Pre-existing referrals and consults should be honored by the RCOs for up to 90 days. After that time, the RCO must find a qualified provider to fill the need (it may be the same provider if they are contracted with the RCO). A change in a referral or consult prior to the 90-day cut-off would have to be agreed to by the client.

EPSDT and Prior Authorizations

EPSDT coverage is a federal requirement. What processes (referrals, types of referrals, etc.) are used to meet that requirement may be different from current Medicaid processes and may vary from RCO to RCO. Referrals and prior authorizations cannot be more restrictive than the current Medicaid program without approval by Medicaid (more clarification to come on this).

NEWS FROM MEDICAID

Changes in covered services for pregnant women

In order to meet the federal requirements for coordination of benefits and minimum essential coverage, the Medicaid Agency has received approval from the federal government to provide full Medicaid for SOBRA (Pregnant Women) recipients. This means that SOBRA (Pregnant Women) who were once eligible for pregnancy-related services ONLY may now receive full Medicaid benefits throughout pregnancy and postpartum, whether the services were pregnancy-related or not. A Primary Medical Provider (PMP) referral is NOT required to receive non-pregnancy related services.

Emergency Services for Non-citizens - Changes have also been made to provide emergency services for non-citizen pregnant women throughout their pregnancy and during the postpartum period. These emergency services do not have to be pregnancy-related. Previously, non-citizen pregnant women only received service through the HPE billing process for inpatient delivery services and all other pregnancy-related services were billed manually. The changes allow most non-citizen pregnant women claims for emergencies to be billed through HPE. These claims will require the certified emergency indicator in order to be considered for payment including deliveries.

Coverage and Billing - These coverage and billing changes will be retroactively effective back to November 1, 2015. If a non-related service for a SOBRA pregnant woman, or an emergency service prior to delivery (for a non-citizen pregnant woman), was provided on or after November 1, 2015, the provider is allowed to submit/resubmit the claim and Medicaid will consider it for

Pros and Cons of Contracting with More than One RCO:

Pros:

- Will be more likely to keep all my patients currently active in my panels, especially if practice is on a RCO region border.
- Will not have to worry about out-of-network hospital care, i.e. during newborn nursery call, or new patients who present who are not already assigned to my RCO
- Competition in marketplace may help with contract negotiations

Cons:

Administrative hassle of dealing with:

- Multiple claims systems
- Multiple sets of provider standards (quality measures) and differing incentives and multiple care coordinators to get to know and referral options

Medicaid RCOs plan approved by CMS; more answers to the myriad RCO questions

Care Standards and Quality Measures

EPSDT continues.

Providers adhere to standards set by each RCO's Provider Standards committee (comprised of 60 percent physicians from the community) and based on measures selected by the state RCO Quality Assurance Committee.

Reimbursement

Individual RCOs will receive capitated payment from the state; providers will be paid through the claims systems of each RCO with which they are contracted. The minimum payment amount shall be the prevailing fee-for-service rate, unless otherwise jointly agreed to by the provider and the RCO by contract. The payment amount may be higher based on incentives, etc.

Eligibility

Medicaid eligibility will continue to be vetted by Alabama Medicaid. Once someone is found eligible, his/her information goes to the enrollment broker for RCO selection (see Patient Panels).

Care Coordination

Individual RCOs will hire or contract with Care Coordinators of their choice.

Pharmacy

Continues through Alabama Medicaid

Provider Credentialing

Continues through Alabama Medicaid; providers will NOT need to re-credential with each RCO.



Mark Benfield, MD

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Special Interests of Pediatric Nephrology of Alabama:

Primary Pediatric Nephrology

- Hematuria
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- Urinary Tract Infections and Reflux
- Enuresis
- Electrolyte Problems
- Kidney Stones

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- Nephrotic Syndrome
- Glomerulonephritis

Hypertension

SLE

Chronic Loss of Kidney Function

Transplantation

Congenital Anomalies of the Kidneys and Urinary Tract

Metabolic Syndrome

1425 Richard Arrington Jr Blvd South Ste 206; Birmingham, Alabama 35205

Phone (205) 558-3200

WWW.PEDNEPHAL.COM

Chapter leadership addresses direct-to-consumer telehealth threat to medical home

As Cathy Wood, MD, FAAP, mentioned in her president's column on page 1, the Chapter has been reaching out to Blue Cross Blue Shield of Alabama to express concern over its partnership with an out-of-state company that is providing many of its plans with a resource for Blue Cross-covered members to call and receive telephone care outside of the medical home.

The Alabama Chapter-AAP vehemently opposes this practice and has reached out to the Medical Association of the State of Alabama (MASA), other primary care specialty societies and of course, Blue Cross, to speak out against direct-to-consumer telehealth services and urge for regulation of such practices to protect and maintain continuity of care provided in the medical home.

Some of the actions we have taken:

- A resolution was submitted to the Medical Association Annual Session asking MASA to urge state regulation to protect the medical home;
- A letter was sent to Blue Cross officials in early February;
- The Chapter leadership took part in a face-to-face meeting with MASA leadership and other societies on February 1 with the Blue Cross Medical Director, Darryl Weaver, MD, to express our concern and call for payment of telephone care for PMD providers themselves;
- The Chapter has developed two educational pieces for you to use to educate your patients about the importance of the medical home:
 - a poster, inserted in this newsletter, for you to use in your practice (complete this form at <http://tinyurl.com/hlsnpgb> to order more)
 - the following talking points, which you can tailor to the needs of your own practice, and use for letters or handouts for your patients (these will also be sent in the Chapter's newsletter and to the practice managers).

Don't take shortcuts with your children's health! Put a "Medical Home" Roof Over their Heads!

As you may know, some parents are opting to use urgent care, national telephone care companies and in-store clinics for their children's healthcare. As your child's pediatrician, I ask you to consider these facts:

- Children deserve a medical home—a place where their care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective.
- Getting care for your child from multiple healthcare professionals—who do not know your child's total picture--hampers our ability to coordinate the best care for your child. This "fragmenting" of care often results in patient safety and quality problems such as misdiagnosis, too many medicine prescriptions, etc. and compromises the important relationship that we have developed with you in our team approach to your child. Remember, a medical home is a home; "quick care" options are hotel rooms!
- Pediatricians are specially educated and trained in diagnosing and treating your child's care—giving your child a medical home "roof" over his head from birth through high school. We are not just about shots and growth charts, but are concerned with preventing disease and illness across your child's entire spectrum of development—physical, mental, social and emotional. Plus, having an established relationship with his/her doctor teaches your child about how to manage his/her care later as an adult.
- It's "after hours;" when can it wait and when should you call me? As your pediatrician, I'll educate you on getting the best care when you need it.
- Do you really want to walk into a strip mall storefront to find someone to say your child is fit to participate in a particular sport, or get a diagnosis over the phone for your child, when no one in the place or on the other end of the line knows anything about your child?

Don't take shortcuts with your child's health!

How to Contact Your Chapter Leaders

President

Cathy Wood, MD, FAAP
Ph: (334) 272-1799
cdocwood@aol.com

Vice President/President-elect
Wes Stubblefield, MD, FAAP
Ph: (256) 764-9522
stubblefield.wes@gmail.com

Secretary/Treasurer
Katrina Skinner, MD, FAAP
Ph: (251) 928-5568
katski@bellsouth.net

Immediate Past President
Michael Ramsey, MD, FAAP
Ph: (334) 793-1881
mj_ramsey@msn.com

Area 1 Rep. (Huntsville)
Kevin Ellis, MD, FAAP
Ph: (256) 265-2464
kellis@huntsvillepediatrics.com

Area 2 Rep. (Tuscaloosa)
Bruce Pettitt, MD, FAAP
Ph: (205) 752-7337
bpetitt@westalabamapeds.com

Area 3 Rep. (Birmingham)
Kenneth Elmer, MD, FAAP
Ph: (205) 206-8480
kelmer@swclinic.org

Area 4 Rep. (Anniston)
Naresh Purohit, MD, FAAP
Ph: (256) 721-9799
narapur@aol.com

Area 5 Rep. (Troy)
Elizabeth Dawson, MD, FAAP
Ph: (334) 566-7600
nelso71@hotmail.com

Area 6 Rep. (Mobile)
Norma Mobley, MD, FAAP
Ph: (251) 344-7044
drmobley@mobilepeds.com

CME Chair
David Gremse, MD, FAAP
Ph: (251) 434-3919
dgremse@health.southalabama.edu

UAB Pediatric Residency
Program Rep.
Cason Benton, MD, FAAP
Ph: (205) 638-9585
cbenton@peds.uab.edu

USA Pediatric Residency
Program Rep.
LaDonna Crews, MD, FAAP
Ph: (251) 434-3917
lmcrews1@aol.com

Event Calendar

April 20-21, 2016

AAP Leonard P. Rome CATCH Visiting Professorship, sponsored by UAB Department of Pediatrics "Poverty Status, Education, Health Equity in Children and Adolescents" Children's of Alabama Birmingham, AL

April 28 – May 1, 2016

2016 Spring Meeting & Pediatric Update
Grand Hotel Marriott Resort
Point Clear, AL

September 30 – October 2, 2016

2016 Annual Meeting & Fall Pediatric Update
Hyatt Regency Birmingham-The Wynfrey Hotel
Birmingham, AL

Alabama pediatric QI stories abound!

By Cason Benton, MD, FAAP, Director, Alabama Child Health Improvement Alliance

Every continuous quality improvement collaborative has a story. The Alabama Child Health Improvement Alliance (ACHIA) has developed a one-page "360" to quickly tell the improvement story for its Healthy Active Living and Help Me Grow Alabama collaboratives: why the topic is important, who participated, what improved, as well as lessons learned. Check them out on the next two pages!

In other ACHIA news:

- *Prevent HPV Cancers Today! An ACHIA HPV QI Collaborative*, presented in conjunction with the Alabama Chapter-AAP, the Alabama Academy of Family Physicians, and the Alabama Department of Public Health, got underway this month. It is ACHIA's largest collaborative yet with 11 practices and 59 pediatricians and family physicians from across Alabama participating.
- "The Big Sort": All health issues for children are important—but what are the most critical issues for Alabama child healthcare providers to prioritize in the next few years? Asthma? ADHD? Screening for delay? The University of Alabama at Birmingham School of Public Health is leading ACHIA partners and others interested in child health in a process to sort and prioritize health topics. The results will be used to channel energies for future ACHIA collaboratives and other continuous quality improvement endeavors. At the Chapter's Spring Meeting at the end of April, we will present more information about the sort process and how members can participate.



Act Early Alabama wants to support your early identification and referral for children with suspected developmental delays, including Autism Spectrum Disorders.

How Do I Act Early?

Identify red flags and refer for EVALUATION and INTERVENTION when a child deviates from a typical development path and or when ASD is first suspected!

Please contact us at www.autism.alabama.gov/act_early_alabama.html to request training and/or materials for your practice or visit www.cdc.gov/autism for general Learn the Signs. Act Early. materials.



Autism Society of Alabama is also available to answer your questions regarding Screening, Assessment and Treatment of Autism Spectrum Disorders.

1-877-4AUTISM

www.autism-alabama.org

bamaht@autism-alabama.org

Healthy Active Living: An ACHIA Obesity Prevention and Treatment QI Collaborative

August 2014 – August 2015

Participating Practices: Athens Limestone Pediatric Clinic, Charles Henderson Child Health Center, COA Adolescent Center, Dothan Pediatric Healthcare Network, Huntsville Pediatric Associates, Mobile Pediatric Clinic. Partners in Pediatrics. Purohit Pediatric Clinic. UAB Primary Care Clinic. USA Midtown Pediatrics



Background

Approximately 35 percent of Alabama's children are obese, which leads to our adults being #1 in the country for hypertension and #3 for diabetes. Despite expert recommendations for childhood obesity prevention and treatment being available since 2007, few doctors apply them to their patients, including only 53 percent applying the easiest step of Body Mass Index (BMI). Because Pediatricians follow the child from birth they have a unique opportunity to impact obesity rates through evaluation, prevention and treatment of obesity.

At the same time, barriers to weight management exist:

- Lack of training to adequately measure and classify weight, height, body mass index and blood pressure
- Lack of training in motivational interviewing and engaging families in talking about weight management
- Lack of referral services for dietitians
- Concerns of time and staff commitment

Project Goals

- Increase proper use of BMI/nutrition and physical activity counseling for prevention and treatment, use of blood pressure/classification, motivational interview/self-management—all too at least 80%
- Apply motivational interviewing techniques to assist children and families in setting achievable nutrition and physical activity goals.

Project Aims

At health supervision visits for children and youth 2 – 17 years of age practices provide and document:

- BMI Percentage and Classification (90% of visits)
- BMI Classification (90%)
- Nutrition and Physical Activity Counseling (80% of visits)
- Blood Pressure Percentile (80% of visits)

For children with BMI ≥ 85 :

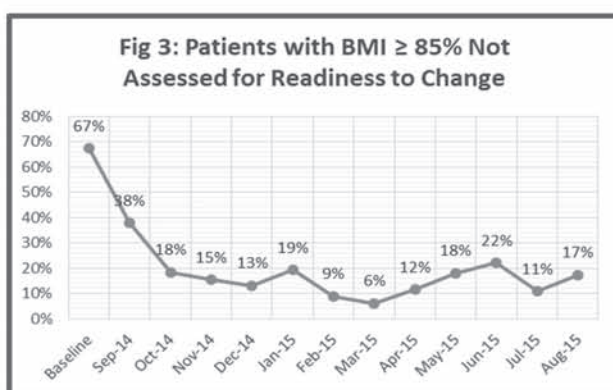
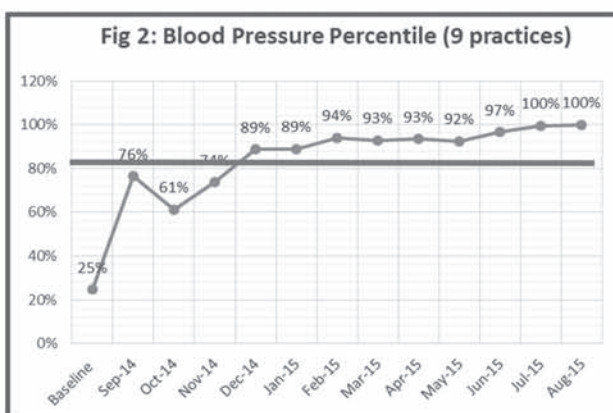
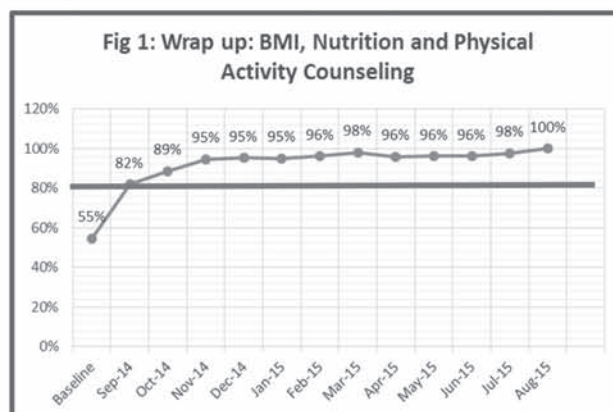
- Assess readiness to change (80% of visits)
- Support self-management goals (80% of visits)

Lessons Learned

- Practices discovered they were not using proper techniques to correctly assess and classify height, weight and blood pressure and found the hands-on sessions to be of great value in improving assessments.
- Involving the entire clinic in the collaborative increased the effectiveness of motivating change in patients.
- Applying motivational interviewing techniques was effective in working with children, adolescents and families.
- Discussing real-world scenarios on the monthly calls stimulated good ideas to take back to the practice.
- Identifying and referring to local community resources for supplemental nutritional counseling and physical activity helped patients reach goals.
- Project duration could be shortened without affecting results
- Clinics in rural areas were limited in community resources and other referrals

Participants	Project Partners	Project Support
10 Practices from all regions of Alabama	USA Department of Pediatrics	The Caring Foundation
41 pediatricians, 77 pediatricians in training	UAB Department of Pediatrics	ALL Kids
90,000 patient visits per year impacted	AL Chapter-AAP	ADPH-Title V

Process Measure Results



Name of Measure	Type	Numerator	Denominator	Goal
Fig 1 Wrap up of BMI Percentile, Nutrition and Physical Activity	Process	Number of children aged 2 - 17 who present for a health supervision visit and who had the following documented in the medical record on the day of the visit: Wrap-up: documentation in the medical record indicating the date of ALL of the following: 1) BMI Percentile AND 2) Counseling for Nutrition AND 3) Counseling for Physical Activity	Number of children aged 2 - 17 who present for an annual health supervision visit	N/A
Fig 2 Blood Pressure Percentile Documented	Process	Number of children aged 3 - 17 who present for a health supervision visit who had Blood Pressure Percentile documented in the medical record on the day of the visit	Number of children aged 3 - 17 who present for a health supervision visit	80%
Fig 3 Readiness to Change Assessed	Process	Number of children aged 2 - 17 with a BMI $>$ or $=$ to 85% who present for a health supervision visit and who had the following documented in the medical record on the day of the visit: Readiness to Change - Yes OR No	Number of children ages 2-17 who present to PCP for health supervision visit and have a BMI $>$ or $=$ 85%	80%

Help Me Grow Alabama: A Developmental Screening QI Collaborative

May 2015 – January 2016

Participating Practices: Alabama Multi-Specialty Group, PC, Bama Pediatrics, Crimson Pediatrics, Enterprise Medical Clinic, Infants' and Children's' Clinic, P.C., Mobile Pediatric Clinic, Prattville Pediatrics, Purohit Pediatric Clinic, University Medical Center, USA Midtown Pediatrics, Whatley Health Services



Background

Early detection of developmental and behavioral problems improves long-term mental and physical health as well as developmental outcomes for children. Primary care providers see almost all children in the community in the first few years of life and thus are well positioned to assess and monitor children's development and emotional well-being. At the same time, barriers to behavioral/ developmental monitoring exist:

- Lack of time and support staff
- Insufficient knowledge of assessment tools
- Challenges connecting to referral services

Project Goals

- Improve primary care infrastructure where children with developmental and/or behavioral challenges are identified through early screening
- Improve the referral of families and children with developmental and/or behavioral challenges to services and supports in a coordinated early childhood health and developmental system.

Project Aims

- Practices will implement the use of ASQ-3, MCHAT-R/F, and ASQ-SE at the 9-, 18-, 24-, and 36-month preventative care visits to increase the rate at which children are screened for risk of developmental delay, autism, and behavioral problems to 80%.
- Practices will increase the rate of appropriate referrals to services and supports to 80%.

Participants	Project Partners	Project Support
11 Practice from all regions of Alabama	Help Me Grow Alabama	Community Foundation of Greater Birmingham
18,700 children seen annually ages 0 – 36 months	Reach Out and Read	Project LAUNCH (SAMSHA)
2,445 WCC over 5 months of data collection	Alabama Partnership for Children	The Caring Foundation
102 children at risk referred	Alabama Chapter-AAP	

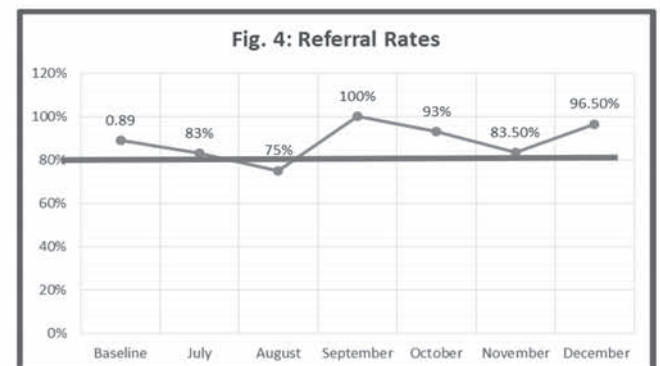
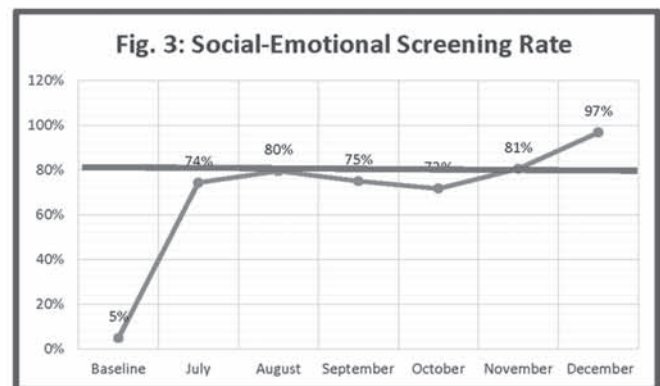
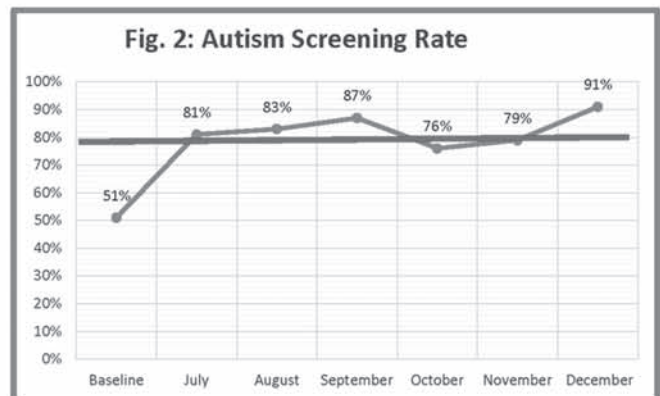
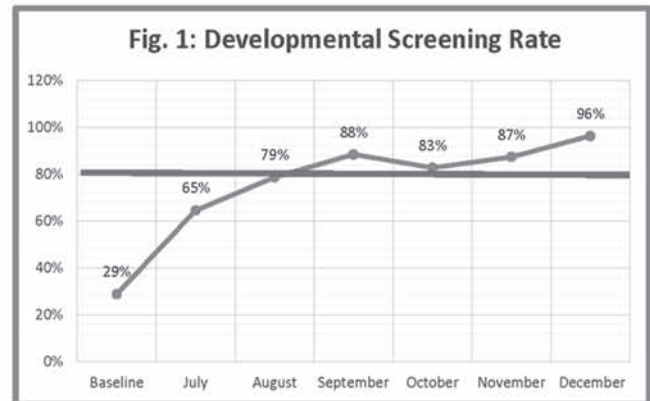
Lessons Learned

- Practices were surprised at how easy it was to integrate screens into practice workflow.
- Help Me Grow care coordinators were a great link for both referrals to Early Intervention and to obtain services for those who did not qualify for Early Intervention.
- Using multiple platforms for learning, data, project submission and CME was confusing and led to interoperability errors.
- Because ASQ-SE is not a recommended universal screen, it may be more productive to refer children suspected of being at risk to Help Me Grow to complete ASQ-SE.

Measures

Name of Measure	Type	Numerator	Denominator	Goal
Fig 1 Developmental Screening Rate	Process	# of children with completed ASQ-3	# of children presenting for 9-, 18-, 24-month visit	80%
Fig 2 Autism Screening Rate	Process	# of children with completed MCHAT-R/F	# of children presenting for 18- or 24 month visit	80%
Fig 3 Social-Emotional Screening Rate	Process	# of children with completed ASQ-SE	# of children presenting for 36-month visit	80%
Fig 4 Referral Rate for children with failed screen	Process	# of children referred for services	# of children with a failed ASQ-3, MCHAT-R/F or ASQ-SE	80%

Process Measure Results



Reach Out and Read All About It!

By Polly McClure, Reach Out and Read-Alabama Statewide Coordinator

Third annual Grand Pediatric Pentathlon returns to The Grand Hotel

For the third year, the Chapter is delighted to present at its Spring Meeting “The Grand” Pediatric Pentathlon, a five-event activity for the whole family, designed to allow you to take advantage of all the Spring Meeting resort has to offer while helping raise funds for Reach Out and Read-Alabama! The past two years’ events raised more than \$20,000 for the program.

We are also excited to announce that Michael Ramsey, MD, FAAP, Immediate Past President has agreed to chair this year’s event.

“Continuing with the success of the past two years, our pentathlon will include a one-mile run/walk, 30 minutes of biking, 30 minutes of kayaking, one hour of swimming (bay or pool) and an



hour of reading for fun,” said Dr. Ramsey. “Anyone can be a part of this--sign up your family, friends, and office staff. The events have no start and no finish, and no one is timed – complete all five events and enter to win the prizes that are awarded at dinner on Saturday night.”

Each \$50 registration will support one child’s library of books from six months to five years and earn the participant a free event tech shirt with the Pentathlon and sponsor logos. Join the fun now; sign up on the Spring Meeting registration form!

Reach Out and Read-Alabama celebrates 10 years of stories!

In the last 10 years, pediatric healthcare providers have prescribed more than 1.6 million brand-new books to the state’s youngest and most underserved children. Currently, 60 of Alabama’s pediatric practices and clinics serve as Reach Out and Read-Alabama program sites in 30 counties. These 60 program sites serve 40 percent of the state’s children under the age of five.

As recommended by the American Academy of Pediatrics (AAP), Reach Out and Read incorporates early literacy into pediatric practice, equipping parents with tools and knowledge to ensure that their children are prepared to learn when they start school. The program is an effective intervention because parents trust and value the advice they receive from their child’s medical provider. During regular, one-on-one visits with the doctor, families grow to understand the powerful and important role they play in supporting their children’s development. Parents gain the confidence and skills that enable them to support early language and literacy at home.

“Prescribing a book during each check-up gives us the opportunity to connect with parents and create a partnership in the lifelong journey of learning for their children. What’s even better is that new studies are documenting the effectiveness of the unexpectedly complex interactions that occur when you put a small child on your lap and open a picture book,” said Cathy Wood, MD, FAAP, Alabama Chapter-AAP President and a Montgomery pediatrician.

For more information on how you can help, contact Polly McClure, RPh, statewide coordinator, at pmcclure@roralabama.org.



From the President continued

This is a work in progress. We continue to communicate regarding this issue and will meet again in March at Pediatric Council.

Now, we as pediatricians who deliver comprehensive quality care on a daily basis (including “telehealth” that we are not allowed to bill for within our contracts with third-party payors) must educate our families about our availability, our “specialty” status and why care delivered at our direction is the quality that their children need and deserve.

As I have stated many times in monthly practice meetings – it is our responsibility to take “ownership” of our patients’ medical needs and step up to the management of their healthcare lives. We have big work to do.

Look for some materials in this newsletter to help you in your communications to patients on the importance of continuity of care and the medical home.

5 REASONS

ALABAMA PEDIATRICIANS SHOULD APPLY FLUORIDE VARNISH & PERFORM ORAL HEALTH RISK ASSESSMENT

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Alabama Chapter



24% of US children 2 to 4 years of age, **53%** of children 6 to 8 years of age, and **56%** of 15-year-olds have caries experience (ie, untreated dental caries, filled teeth, teeth missing as a result of dental caries).

- 1 It's quick**--Pediatricians who have implemented fluoride varnish say that it only takes an extra 90 seconds or less per patient encounter;
- 2 It's easy**--Did you know you do not have to clean or dry kids' teeth to apply varnish? Varnishes can be applied in your office without special tools or fancy techniques;
- 3 You WILL make money**--Not only is fluoride varnish and oral health risk assessment reimbursed well above cost by Medicaid and ALL Kids through the 1st Look program, but fluoride varnish is also covered by Blue Cross and Blue Shield of Alabama. Materials only cost \$1.30 per patient - look up the reimbursement and you do the math!;
- 4 It's worth it**--Not only is oral health part of the UPSTF and Bright Futures periodicity schedules, but who has not seen a young child with a mouth full of caries? Let's put an end to this most chronic infectious disease of childhood! Grant Allen, MD, FAAP, who has done this program for years now, says he hardly sees dental caries in his Medicaid population anymore; and,
- 5 Families like it**--Dr. Allen reports that it is his practice's second most popular program after Reach Out and Read.

**Join your fellow pediatricians.
Prevent dental caries today!**

AND...

The **training is convenient**: take it online (1.25 hours) at your leisure AND get enduring materials CME.

After training, you'll receive a **list of helpful suppliers** to get you started, as well as tips on adding it to your practice flow (again, it's quick and easy!)

You'll also get payor information so you know **exactly how to code it**.

Learn from your peers:

Shadow a fellow pediatrician who is already doing fluoride varnish application and has agreed to demo it in his/her office.

Want to get started?

Take the Online Training:
<http://tinyurl.com/mbjyqr8>



Questions? Contact Grant Allen, MD, FAAP, AL-AAP Chapter Oral Health Advocate, at 256-710-3162 or allen_grant@hotmail.com.

**Take a
1st Look**
A Healthy Smile = A Healthy Child

Advocacy: One Pediatrician's Humble Viewpoint

By Nola Ernest, Chapter Legislative Chair

When I was an intern, one of my mentors told me, “As long as there are children in this hospital who might not make it home, our work is not done.” This struck a resounding chord within me and reminded me of a famous quote by Danny Thomas (founder of St. Jude Children’s Research Hospital): “No child should die in the dawn of life.”

I am grateful, as a community pediatrician, that I do not encounter death frequently (although, even infrequent encounters with the death of a child are enough to impact us deeply). However, I am cognizant that all of my patients will encounter death eventually and the foundation of health established in their youth can play a huge impact on when that time comes. Moreover, as pediatricians, we have the ability to impact not only the duration of life, but also its quality--helping “our kids” grow into happier, more successful contributors to society.

Even looking at that above paragraph is overwhelming at times. Being a pediatrician is a huge undertaking! How are we ever supposed to do it all?

Advocacy.

Advocacy isn’t “one more thing” to add to your busy schedule. It is what you already do--calling an insurance company to discuss a denied prior authorization for Synagis for a patient that meets the AAP criteria, educating parents on how to request a special education evaluation or 504 plan from their school, talking to your partners about the importance of fluoride varnishes in the medical home, providing input on an Emergency Plan enacted by DHR--it is all advocacy. And, more importantly, it makes a difference.

I often tell parents that they are the best advocates for their kids--and, as the “expert” on their child, that is true--but parents can’t do it alone. The knowledge and support that a pediatrician provides is invaluable.

If you are anything like me, though, there are other times, when you’ve written so many letters and have had so many phone calls, that you begin to wonder “Why is this child even in this situation,” and “What more can I do?”

I have been thinking a lot recently about Dr. Mona Hanna-Attisha. If you don’t know her name by now, you should – she is the pediatrician who helped to expose the Flint, Michigan water crisis. As the story goes, she had dinner with a friend, who was a water expert and used to work for the Environmental Protection Agency. Casually, the friend mentioned that the city of Flint was not doing enough to prevent the lead from aging water pipes from getting into the water supply. Personally, I may have been the one to think – “Wow. That’s awful. Kids could be really hurt if they were exposed to lead,” and then go back to my practice and watch as the lead values of my patients slowly went up. I am afraid that I may have been the one to think, “Somebody is working on it,” or “Somebody else will do something.” Thankfully, Dr. Hanna is not me. Instead, she decided to do a little digging and compared her clinic’s routine lead levels from before and after Flint switched their water supply from Lake Huron to the Flint River. The results were staggering, as they saw a 300 percent increase in positive lead screens from children from certain neighborhoods. She took this research public and, amid backlash from critics accusing her of inciting hysteria, she stood her ground until someone listened. You know the rest of the story.

This is the kind of pediatrician I want to be. I don’t just want to ask the question, “What more can I do?” I actually want to do something!

We are all advocates for our patients and the work we do should not be undervalued. But, if you have ever wanted to do more, I have an opportunity for you. I would like to personally invite you to participate in our 13th Annual Legislative Day this year in Montgomery on March 22. On this day, we will lend our collective voice to urge lawmakers to “Put Kids 1st” during this year’s session.

Additionally, you will learn more about the legislative process and who you should talk to if you ever have a “Flint Water Crisis” in your neck of the woods.

From preventing death to improving quality of life for the children of Alabama--your voice matters. Don’t be silent.



At the AAP’s recent National Conference & Exhibition, Nola Ernest, MD, FAAP, shows why advocacy for children is important.

Many thanks to our advertisers

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Cancer Prevention Vaccine

- ▶ Each year in the U.S. there are 26,000 cancer cases that could be prevented with Human papillomavirus (HPV) vaccine.
- ▶ HPV vaccine can prevent 9 strains of cancer, including cancer of the cervix, vulva, vagina, penis, anus, mouth and throat.
- ▶ Three doses of HPV vaccine should be given to adolescents aged 11-12 years before exposure to the virus.
- ▶ Alabama, has the lowest HPV vaccination rates for males and below the national average for females.
- ▶ HPV vaccine is free for eligible patients through the Vaccines for Children Program.

What can you do in your practice or organization to increase HPV vaccine administration rates?

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Let's hear it from our Departments of Pediatrics!

Research in the Department of Pediatrics at UAB and Children's of Alabama

By Mitch Cohen, MD, FAAP, Chair, Department of Pediatrics, UAB; Physician in Chief, Children's of Alabama

In the Department of Pediatrics, we seek to discover new knowledge to improve the health of the children of Alabama, the region and, the world. The clinical advances and research discoveries in our annual research report have an impact on children's lives (www.childrensal2015.org). That impact will be our legacy. In FY 2015, the Department of Pediatrics faculty had more than 200 publications, research funding from the NIH of \$15 million, and total research funding of \$25 million.



Mitch Cohen, MD, FAAP

One important area of research is cancer survival. Five-year rates for childhood cancer survival now exceed 85 percent. However, this progress has come at a price – the survivors carry a high burden of morbidity and are at risk for premature mortality. One of these adverse outcomes is the increased risk of HPV-related malignancies. Given that this is a preventable outcome, Wendy Landier, PhD, is conducting a study funded by the NCI to understand the factors responsible for HPV vaccine non-initiation among childhood cancer survivors, as well as the safety and immunogenicity in these survivors. Findings from this study will be used to develop the next phase of the study – i.e., targeted intervention to improve vaccination rates.

Acute lymphoblastic leukemia is the most common cancer in children. While over 95 percent of children enter remission, 20 percent experience relapse within five years. Durable remissions require two years of daily oral chemotherapy (6-mercaptopurine). Through NCI-funded research, Smita Bhatia, MD, MPH, has demonstrated that a large proportion of children do not adhere to oral chemotherapy and that non-adherence is associated with an increased risk of relapse. She and Dr. Landier are now co-leading a national Phase III trial to improve adherence to oral chemotherapy.

The adverse events encountered by childhood cancer survivors are directly related to the chemotherapy and radiation used to treat the children for their primary cancer. Dr. Bhatia is leading a national NCI-funded study to understand the molecular pathogenesis of these adverse outcomes and develop prediction models to identify those at highest risk. She is leading a large multi-institutional trial (funded by the NCI) to study pharmacologic interventions to reduce the risk of radiation-related breast cancer in childhood cancer survivors.

While progress has been made over the past five decades in cancer treatment for young children, far less progress has been made in improving survival rates for adolescents and young adults (AYAs) diagnosed between the ages of 15 to 39. Cancer is the leading cause of death in people ages 15-39, so it is important to understand why the outcome in these patients has not seen the same improvement as that in young children or older adults. Julie Wolfson, MD, and her team's work has revealed that care at an NCI-designated Comprehensive Cancer Center (CCC) or Children's Oncology Group (COG) site mitigates the poor outcome in AYAs. Potential barriers to accessing these CCC or COG sites for AYAs include age, non-private insurance, low socioeconomic status, and distance from the nearest age-appropriate site. Dr. Wolfson's group currently is evaluating a comprehensive approach to acute lymphoblastic leukemia disparities in AYAs that encompasses these sociodemographic elements along with clinical and biological factors.

At UAB and Children's of Alabama, we aim to build on these successes and expand the size and, importantly, the impact of this research funding in the coming year. We anticipate growth not only in our core areas of significant accomplishment – virology, therapeutic drug development, and cancer and rheumatology outcomes – but also in newer areas where the recruitment of talented young researchers will ensure continued and expanded success.

News from Medicaid continued from page 3

reimbursement. Claims that are pregnancy-related will require a pregnancy-related diagnosis code or a postpartum diagnosis code. Co-pays may be applied for services that are non-pregnancy related.

A provider may reference the fee schedules for a list of covered services on the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx. The fee schedules are not an all-inclusive list of procedure codes covered by the Agency.

Prior Authorization - For SOBRA adult recipients who now have full Medicaid benefits, retroactive to November 1, 2015, providers may submit a prior authorization (PA) for a date of service on or after November 1, 2015, if the procedure code requires a PA. For dates of service from November 1, 2015, to April 30, 2016, the PA must be received by HPE by June 30, 2016, for review. All other PAs for a date of service May 1, 2016 and after must be submitted timely, prior to rendering the service, and adhere to the normal submission guidelines in the Provider Manual: Chapter 4, Obtaining Prior Authorization, and other applicable Chapters, such as Chapter 14, Durable Medical Equipment.

Eligibility - A recipient's age, healthcare requirements, and place of residence may further define her eligibility for Medicaid-covered services. For this reason, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response. Eligibility responses have been changed to reflect the correct coverage for these women.

Providers are ultimately responsible for confirming recipient eligibility for services.

Let's hear it from our Departments of Pediatrics!

USA Pediatrics: Focus on Quality Improvement and Simplifying MOC Part 4

By David Gremse, MD, FAAP, Chair, Department of Pediatrics, University of South Alabama

All of us strive to provide the best care to our patients. The parents of our patients trust that we as pediatricians are delivering state-of-the-art care to their children. Maintaining board certification is one tangible mark of professionalism that recognizes our expertise in pediatrics to provide the best care to children.



David Gremse, MD, FAAP

Many physicians have complained that maintenance of certification is time-consuming, expensive, and in many cases irrelevant to their practices. The ABP is exploring ways to simplify the process and to make it more relevant to all pediatricians.

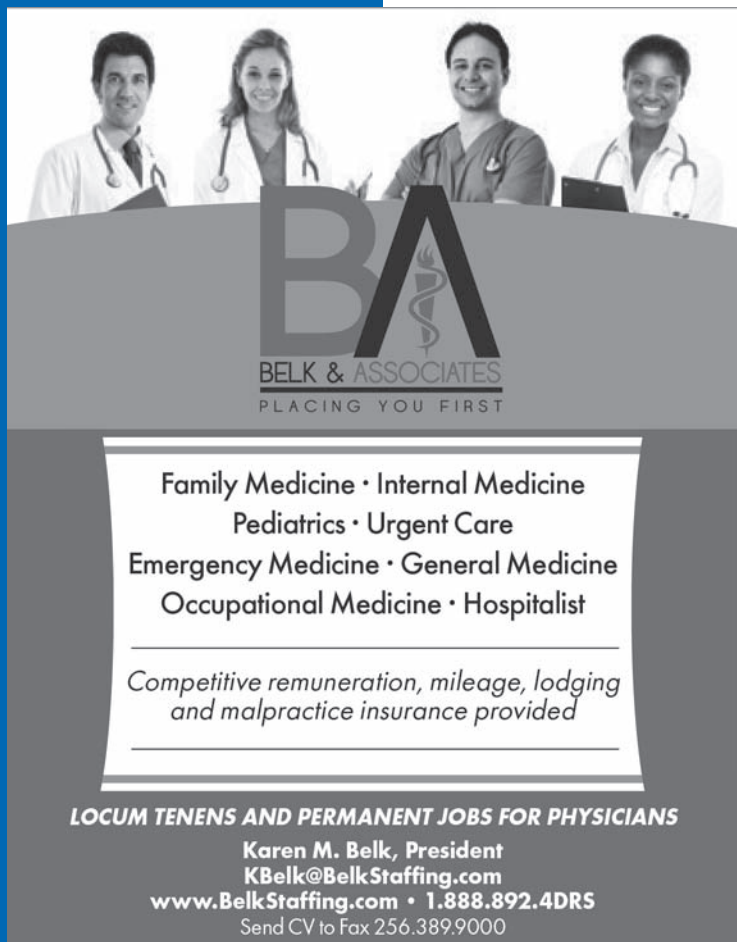
The USA Department of Pediatrics is participating in a pilot program with the ABP called MOC QI Tracker to reduce the hassle in earning MOC Part 4 credit. Our pilot project focuses on Asthma and Medication Safety. Instead of self-auditing charts and having pediatricians type the results in a form, this program extracts data from the electronic health record and automatically generates a run chart that is sent to the participant via a link in an email. The run chart is reviewed with staff to discuss potential areas

of improvement. Subsequent run charts are generated automatically for review to track progress. After a sufficient number of PDSA cycles, the participant receives an email to sign an attestation form documenting they did what they said they did during the project and MOC credit is awarded.

If the pilot project is successful, a version of this program may be made available to all pediatricians to make it easier to participate in meaningful practice improvement activities.



David Smalley, MD, FAAP, Katrina Trammell, MD, FAAP, Suzanne Respass of Children's of Alabama, and Wes Stubblefield, MD, FAAP, address pediatric concerns at Alabama Medicaid's PMP workgroup.



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coding

O By Lynn Abernathy Brown, CPC

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MODIFIERS USAGE CRITICAL TO PAYMENT

Modifiers have become a critical function of clean claim submission. Lately, more claims are denied or bundled because of the lack modifiers or modifiers used incorrectly.

Modifiers that most commonly are left off of claims:

Modifier 25 – Attached to Evaluation and Management codes only (99201-99499)

The patient's condition requires a significant, separately identifiable E/M service above and beyond the other service provided.

Added to E/M codes when:

- Surgical codes are on the same claim such as Cerumen removal, Wart Removal, etc.
 - Surgical codes 10021-69990 require Modifier 25 on any E/M on claim
- Vaccine or Injection administration codes are on the same claim (such as 99391-25, 99212-25, 90460)
 - Administration codes 90471-90474, 90460-90461, 96372
- Another E/M code is on the same claim (such as Well 99391 and Sick 99212-25)
- AL Medicaid EPSDT screening 99381EP – 99395EP require Modifier 25 after the EP if Mod. 25 is needed
 - AL Medicaid Surgical code example, 99391EP25 with 17250 Umbilical cauterization
- All pulmonary codes require Modifier 25 on E/M
 - Evaluation and Management codes (E/M) 99201-99499
 - Pulmonary Codes 94010, 94060, 94640, 94664 (94### series)

Modifier 59 – Attached to Procedures or Medical Service codes only

Modifier indicates that a procedure or service was distinct or independent from other services performed on the same day.

- Added to Procedure/Service code only when there is another CPT or HCPCS listed in the NCCI edits which would otherwise be bundled.
- 87070 Throat Culture requires Modifier 59 be added when 87086 Urine Culture is on the same claim
- 94664 Inhalation Education/Demonstration of how to use the equipment at home requires Modifier 59 be added when performed with 94640 Inhalation treatment
- 96372 requires Modifier 59 when 90460 is on the same claim

It is critical that emphasis is given to adequately train the staff entering charges and scrubbing claims so that clean claims are sent to payors with the appropriate modifiers the first time. Adding extra modifiers in the hope that the claim will be paid is not the answer. There are specific resources that tell every billing person when to appropriately attach a modifier and where. The biller must know the resource based on the payor in order to appropriately attach the modifiers.

Note: Resources Update Quarterly

- bcbsal.org - AL BCBS-Fragmented Edits, Bundling
- Medicaid.gov-NCCI edits
- CMS.gov - NCCI Edits

If there is no one in your office monitoring this information, the practice is likely losing money. Assigning someone to monitor the remittances from the payors would be well worth the effort. Thousands of dollars could be written off incorrectly if someone is not paying attention to this essential billing function.

DISCLAIMER: Children's of Alabama does not accept responsibility or liability for any adverse outcome from the advice of Lynn A Brown, CPC, for any reason, including inaccuracy, opinion and analysis that might prove erroneous, or the misunderstanding or misapplication of extremely complex topics. Any statement made by Lynn A Brown, CPC does not imply payment guarantee by any payor discussed.

Practice Management Association update: Blue Cross E&M audits

By Rosalyn Rowley, AL-AAP Practice Management Association Chair

One of the main purposes and functions of the Practice Management Association is the exchange of helpful pediatric practice management information among our colleagues across the state. So, from one practice to others, I wanted to share this information regarding Blue Cross and Blue Shield of Alabama's E&M audits. We have experienced the audit in our office and thought maybe others were also and wanted other physicians to be aware.

Here are some frequently asked questions.

- **Who is Emdeon?**
Blue Cross and Blue Shield of Alabama has contracted with Emdeon, an independent company, to review the use of the Evaluation and Management (E&M) codes and billing of Modifier 25 for all physicians participating in the network as part of ongoing claim review activities.
- **How did I (provider) end up in this program?**
An analysis was conducted of E&M claims paid between October 2014 and September 2015 for the purpose of identifying those physicians who are billing level 4 & 5 codes or Modifier 25 significantly more often than other physicians within the same specialty treating patients of similar age. Your office was identified to be billing a volume of level 4 & 5 codes (and/or) Modifier 25 considerably higher than the expected billing distribution as was determined by the average billing behavior of other physicians within your specialty.
- **Who am I compared to?**
Providers within your specialty, billing for the same services to Blue Cross.
- **What data did you use?**
All claims received and paid by Blue Cross between October 2014 and September 2015.
- **How did you determine my specialty?**
Emdeon uses the provider's primary taxonomy code. Taxonomy is a 10-digit designation defining a provider's specialty from the publicly available National Plan & Provider Enumeration System (NPPES) from the Centers for Medicare & Medicaid Services. Emdeon double-checks the specialty designation from NPPES against behavior in the Emdeon Multipayer data and re-assigns specialty if appropriate to a more accurate designation.
- **Am I being asked to repay money?**
No, we are not attempting to recover money. Rather, the program has been implemented to help providers identify where their billing behavior is far above their peer group, and to ensure billings follow Blue Cross' policies.
- **What do I need to do to be removed from the program?**
First, this inquiry should be re-directed to discuss possible reasons why the data is trending as an outlier, and to help determine the best course of action. Claims for outlier providers are monitored on a daily basis and outlier status is updated. If criteria are no longer met for outlier status, the provider will fall out of the program.
- **Will you begin holding claim payments?**
No, claim payments will not be held; however, Emdeon could temporarily suspend electronic claims for physician validation and resubmission.
- **Who can I contact at Blue Cross to voice my concerns?**
The provider should contact Emdeon first with questions. Emdeon has access to specific information to further explain the program and address specific concerns. The provider is welcome to contact their plan representative as well, but their representative will not be able to provide detailed responses.
- **Do you provide onsite training?**
No, however Emdeon will consult with you via telephone and web conferencing if requested.
- **Did you consider my patient population?**
Yes, Emdeon does consider this factor when establishing a provider's peer group.
- **Did you consider my geographic region?**
No. The same intensity of service to report a high-level E&M code should be provided regardless of location.
- **Should I stop billing higher levels of service to prevent future audits?**
No. Providers should accurately report the service(s) to their patients. They are also encouraged to review [payer] documentation guidelines to ensure criteria are met to report any level of service.

PUBLIC HEALTH NEWS

Lead poisoning prevention:
We are all in this together!

Alabama is so lucky to have a state Department of Public Health (ADPH) committed to prevention and detection of lead poisoning among our most vulnerable young citizens. For years, even after loss of federal funding, ADPH's Alabama Child Lead Poisoning Prevention Program (ACLPPP) has worked to educate providers and the public by promoting prevention, as well as delivering case management services to all children with a confirmed blood lead level (BLL) of $> 10 \mu\text{g}/\text{dL}$ and investigating lead hazards for children with a confirmed BLL of $> 15 \mu\text{g}/\text{dL}$.

And the good news is that each year, there are fewer and fewer children, not only in Alabama but across the United States, who have reported confirmed lead levels, thanks to public awareness and improved safety standards—getting Alabama closer to its goal of eliminating childhood lead poisoning.

The Flint water crisis of this past fall, however, has heightened awareness across the country and has, unfortunately, given rise to erroneous reports indicating that some Alabama counties have more of a problem than most in the country, citing that more than 30% of children screened in those counties tested positive. This is incorrect and misleading, due to the fact that the CDC data driving the reports have missing information and do not fully capture the thousands of children tested. In actuality, only 123 children had BLL greater than $10 \mu\text{g}/\text{DL}$ in Alabama in 2014 out of 40,953 tested.

Even so, ADPH officials have Medicaid data that show that approximately 50 percent of the children eligible for EPSDT (ages 1-5) are screened for lead—meaning half of those children are NOT being screened.

“We want to stress that lead screening is

important for all children, especially for those eligible for Medicaid, many of whom are living in older homes with lead paint,” said Tom Miller, MD, Acting State Health Officer.

ACLPPP strongly encourages pediatric healthcare providers to screen all children at ages 12 and 24 months for lead poisoning. All lead test results should be reported to ADPH. The reference value of $5 \mu\text{g}/\text{dL}$ will constitute case management services. Report to ADPH using the ADPH-FHS-135 form. Providers have the option of obtaining the lead level and Hct or Hgb at 9 or 12 months of age. A BLL screening is also indicated for a child who:

- Is 36 to 72 months of age and has not previously received a BLL screening;
- Has a change in risk status;
- Presents with symptoms of possible lead poisoning, such as severe anemia, seizures, constipation, abdominal pain, and/or changes in behavior.

For more information, please visit http://www.adph.org/acldpp/assets/LEAD_Screen_Mgmt_Guidelines_2013_R.pdf or contact Jacqueline Harris, RN, BSN, Program Director, at (334) 206-2966 or 1-800-545-1098. Forms and educational materials are available at www.adph.org/acldpp.

Reporting all positive laboratory results of HBsAg (Hepatitis B surface antigen)

The Alabama Department of Public Health Immunization Division is requesting physicians, physician assistants, and certified registered nurse practitioners to report all positive HBsAg test results for pregnant women. Prenatal care providers should test every pregnant woman for HBsAg, preferably in the first trimester, regardless if the woman has been previously vaccinated or tested.

To report a perinatal hepatitis B case, complete the VPD REPORT Card at

<http://tinyurl.com/gocmrwa>. Providers are responsible for their own reporting and should not assume the lab is reporting. Please include the name of the planned delivering hospital and the healthcare provider who will care for the newborn in the “Comments” section of the report.

For more information, go to <http://tinyurl.com/jxznqcb>. If you have any questions, please contact Brenda Vaughn, Immunization Division, at 800-469-4599.

Guidance for pediatricians on caring for children who may have Zika

On February 19, the Centers for Disease Control and Prevention (CDC) expanded guidelines on caring for children with possible Zika virus infection to include those up to 18 years of age.

Officials also updated an algorithm on caring for infants whose mother traveled to areas where the mosquito-borne virus is circulating. The guidance was published in a Feb. 19 Morbidity and Mortality Weekly Report as researchers continue to study possible links between Zika in pregnant women and microcephaly in their babies.

The CDC's updated guidelines say infants should receive routine well-child preventive care if they are not born with microcephaly or intracranial calcifications and their mother tested negative for Zika or was not tested.

Symptoms of Zika typically include fever, rash, joint pain and conjunctivitis. If children exhibit at least two of those within two weeks of traveling to an affected area in Latin America or the Caribbean, pediatricians should suspect Zika.

Zika also should be suspected in an infant with two of these symptoms in his first two weeks of life if his mother traveled to one of the affected areas within two weeks of delivery.

CHAPTER BRIEFS

State pediatricians invited to child poverty advocacy mini-conference April 20-21

By Jaime McKinney, MD, FAAP, Chapter CATCH Coordinator

The UAB School of Medicine Department of Pediatrics invites Chapter members to attend its AAP Leonard P. Rome CATCH Visiting Professorship program, Poverty Status, Education, Health Equity in Children and Adolescents, set for April 20 - 21 at the Bradley Lecture Center at Children's of Alabama. This two-day advocacy mini-conference includes sessions on Enhancing the Community Pediatrics Experience, Social Determinants of Health and Health, Education & School-based Health Centers and Establishing Community Partnerships.

Through these sessions, in addition to a Wednesday evening town hall meeting with local community leaders, we hope to broaden our current advocacy efforts, enhance our residents' community experience, and address the social determinants of health that greatly impact our communities.

We hope Chapter members can attend. No pre-registration is necessary. For details, visit <http://tinyurl.com/z2sv8k2>.

Cantu honored as Outstanding Woman Award



Rebecca Cantu

The University of Alabama at Birmingham Commission on the Status of Women recently selected the 2016 Outstanding Women Awards, with Rebecca Cantu, MD, FAAP, Pediatric Hospital Medicine Fellow, honored with the Outstanding Woman UAB Postdoctoral Fellow Award. The commission presented the awards to those honored as Outstanding Women for 2016 at a reception March 17, 2016 at the UAB Alumni House.

Congratulations, Dr. Cantu!

Emergency Medicine pediatricians receive FEMA funding for community project

Congratulations to Kathy Monroe, MD, FAAP, and Michele Nichols, MD, FAAP, from the University of Alabama at Birmingham Pediatrics Division of Emergency Medicine, for garnering funding from the Federal Emergency Management Agency (FEMA) for a community initiative, Sound Off. The project is a starter site for the Sound Off FEMA Grant, for which they will work with Birmingham Fire and Rescue and a local school to provide fire safety education.



Ed Colvin, MD, FAAP, receives honor from the Just Keep Smiling Foundation

Just Keep Smiling Foundation honors Colvin

Edward Colvin, MD, FAAP, a pediatric cardiology at the University of Alabama at Birmingham School of Medicine, was recently honored at the Just Keep Smiling Foundation's annual dinner for his key role in jump-starting this Birmingham-area organization, which helps support families with seriously ill children. Over the 10 years, they have disbursed more than \$450,000 in monetary support and helped over 2,000 families.

Kudos, Dr. Colvin!

Lal tapped for Clinical Science Young Investigator Award

The Southern Society for Pediatric Research (SSPR) has selected Charitharth "Vivek" Lal, MD, FAAP, a University of Alabama at Birmingham neonatologist, as one of three finalists for the SSPR Clinical Science Young Investigator Award. Congratulations, Dr. Lal!



Charitharth Lal

Hartig selected as the top recipient of the 2015 RIME Faculty Development Award



Jason Hartig

Jason Hartig, MD, FAAP, University of Alabama at Birmingham med-peds residency director, was selected as the top recipient of the 2015 Research and Innovations in Medical Education (RIME) Faculty Development University of Alabama School of Medicine Award. The main purpose of the RIME award is to promote teaching skills in medical education, foster curriculum innovation and showcase scholarship and research

findings in medical education for the 21st century. Congratulations, Dr. Hartig!

Raulerson honored as 2016 Woman of Vision



Marsha Raulerson

Congratulations to Marsha Raulerson, MD, FAAP, Chapter Past President (2003-2005), who has been honored as MOMENTUM's 2016 Woman of Vision. A 501(c)(3) Alabama organization, MOMENTUM addresses the unique challenges facing women in leadership positions and through skills-based

training and mentoring, helps build capabilities of emerging Alabama women leaders. At its recent conference in Birmingham, the organization highlighted the contributions of five Alabama women, including Dr. Raulerson, who have made significant contributions to the advancement of women in leadership roles and have positively impacted the community in business, culture and/or politics. Well-done, Dr. Raulerson!



Cathy Wood, MD, FAAP, and Myriam Peralta-Carcelan, MD, FAAP, visit their Congressmen at the Cannon Office Building in Washington in February. The visits were part of the Chapter's annual pediatrics-specific Congressional meetings on Capitol Hill during the Medical Association of the State of Alabama's Government Affairs conference.

Best Practices: Managing Facebook for a Practice

By Megan McGiffert, MD, FAAP Tuscaloosa Pediatrics

I manage our office Facebook page myself. It is extremely easy for anyone who is familiar with Facebook and has a personal account. I use my personal page to follow medical sites, news sites, other pediatric practices, and "mommy sites" where I get articles and jokes from and share them to our office page. I also subscribe by email to the AAP *Smartbrief* and share articles from there. This also keeps me up to date on the latest medical news. Our parents love our page and we get good feedback.

If you have a doctor or nurse in your office who uses Facebook regularly already, then he or she would be a good candidate to run your page. I would recommend that someone with a medical background be in charge so the appropriate articles are posted, but my office manager has access too so she can post updates such as office closings or other announcements.

Someone also just needs to keep a close eye on the page to watch for inappropriate postings by others, such as angry parents or spam from anti-vaxxers, as we have had that happen from time to time.

We have a local freelance computer guy updating our website at present. We have instructed him to make it as editable as possible so that in the future, the text and photos can easily be changed out by us.

Overall I feel we have a good social media presence at minimal cost to the practice. I would not consider myself to have much more than the average knowledge of computer skills.



Public Health News continued

Mothers diagnosed with Zika virus who live in an area with active transmission should continue to breastfeed, according to the CDC.

"Zika virus RNA has been identified in breast milk, but attempts to culture the virus have been unsuccessful," the CDC report said. "No cases of Zika virus infection associated with breastfeeding have been reported."

For infants and children who contract Zika through mosquitoes, the disease typically is mild just as it is for adults, and treatment involves supportive care, according to the CDC. The infection is a nationally notifiable disease and should be reported to local, state or territorial health departments for purposes of research and testing.

Health officials continue to recommend that pregnant women avoid travel to areas where Zika virus is spreading as there are no vaccines available. People who do travel to areas where Zika is being transmitted should take steps to avoid mosquito bites.

For the most up-to-date information on Zika and other mosquito-borne diseases in Alabama, the Alabama Department of Public Health (ADPH) has established a dedicated website: <http://adph.org/MOSQUITO/>. Contact the ADPH Infectious Diseases & Outbreaks Division at (800) 338-8374 if you have patients with a travel history and signs and symptoms consistent with Zika virus infection or know of pregnant women with a travel history whether symptomatic or not.

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