



The Tennessee Pediatrician

A publication of the Tennessee Chapter of the American Academy of Pediatrics (TNAAP)

TN AAP Wins 2016 Large Chapter Award!

TN AAP President's Letter

Gail Beeman, MD, FAAP, TNAAP President

The Tennessee Chapter of the AAP was named the Outstanding Large Chapter for the year 2016. The impact of the activities and accomplishments of the Chapter increased over the last few years. The Chapter was a finalist in three previous years. 2016 was our year to win!!

The chapter won in large part due to the continued success and relevance of its four educational programs. Together they provided free technical and clinical support that was essential to pediatricians across our state. In addition, two other initiatives stood out: 1) the chapter's legislative successes in 2016 and 2) the chapter's ongoing efforts to engage residents through the Tennessee State Pediatric Conference. For the first time, pediatric residents presented original abstracts at the conference. This

new tradition will continue during the 2017 conference along with a new resident quiz bowl!

Please join me in congratulating our staff, past officers, board members, and all those who work so hard to make our chapter **OUTSTANDING!**



TN AAP leaders receiving award from AAP District IV Chair, Jane Foy, MD, FAAP.

AAP Top Ten Resolutions for 2017

Every year at the AAP Annual Leadership Forum in Chicago, pediatric leaders from across North America vote on dozens of issues that are important to children and pediatricians. After all are discussed, the resolutions are rated to identify the most important and interesting. This year the top three resolutions have to do with advocacy for children who are immigrants – access to legal representation, timely reunification of children with their families, and policies that do not compromise

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EXECUTIVE DIRECTOR

Ruth E. Allen

the health and wellbeing of children who are immigrants. It was noted that these resolutions were focused on the impact to children and families under certain circumstances, not taking a position on the pros or cons of immigration reform. The discussions included passionate stories from physicians who have witnessed heart-breaking events at our country's borders.

The topics of the top ten resolutions are as follows:

1-3 - Issues for children who are immigrants

4 - Mental health access for children

5 - Epinephrine supply for entire school population

6 - New policies for dental anesthesia (phase out single, operator-anesthesia model)

7 - Evidence-based firearm safety with policy-informed research

8 - Call for statement from national leaders against hate and discrimination

9 - Unused medication take-back programs for safe disposal

10 - Chapter membership recruitment and retention

The National Board of the AAP will respond to each of these issues in the near future.

Pediatricians' voices are important and help form the priorities and policies at AAP. The resolution process is YOUR opportunity to recommend changes regarding something you feel passionate about. If you are interested in submitting a resolution next year, please contact me, our Executive Director or a TNAAP board member. We love to hear from you and have people who can help you draft your resolution.

Figure 1

UnitedHealthcare Community Plan

Access Reports: <https://www.hospitalbenchmarks.com/uhc/Login.aspx>

Questions related to reports: 615-372-3509

Advocate Team (Episodes)

- Episode Practice Performance Manager- Provider Relations
 - Cathy Dean (West TN) Email: cathy_e_dean@uhc.com
 - Samaki Nash (Middle TN) Email: Samaki_r_nash@uhc.com
 - Emily Worrell (Middle TN) Email: Emily_worrell@uhc.com
 - Tonya Lawrence (Chattanooga Area) Email: tonya_a_lawrence@uhc.com
 - Joanna Roy (East TN) Email: Joanna_roy@uhc.com
- Provider Questions for BH Episodes of Care - Email bh_payment_reform@uhc.com

AMERIGROUP

Amerigroup Website: <https://providers.amerigroup.com/Pages/Home.aspx>

- Documentation Guide: https://providers.amerigroup.com/ProviderDocuments/TNTN_OnlineReportingRegAccessGuide.pdf
- Availity -Provider Online Reporting Portal - www.availity.com

Deborah Bien, LPN, LHCRM, CPHQ,
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Figure 1 (above) and Figure 2 (right) provide instructions and contact information for accessing MCO reports



Tennessee Payment Reform Updates from the Executive Director

Ruth E. Allen, TNAAP Executive Director

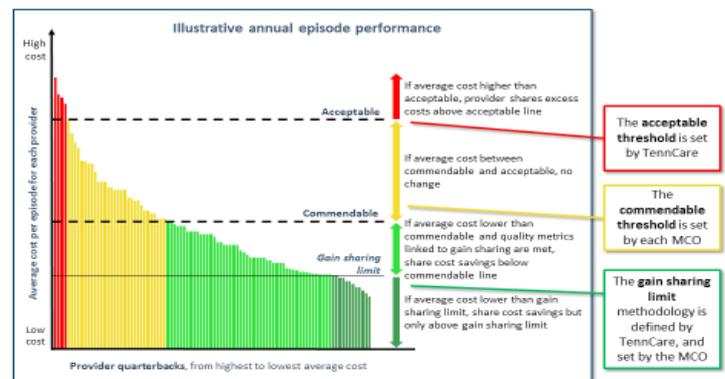
With the demands coming at pediatricians from more directions than ever, it's hard to keep up with everything. Tennessee's payment reform activities are no exception. To make it worse, the subject is complicated and it seems difficult to find all the answers in one place.

While these factors are real, I encourage you to "dip your toe in" to understand how it will begin to impact you and your practice financially in the immediate future. So what's happening?

The state has "topic-specific episodes" (e.g., asthma, ADHD, otitis media) that have been grouped into "waves" of implementation. Each episode has a Technical Advisory Group (TAG) that provides input into the episode and then the parameters are defined by the state. These parameters include who will be defined as the "quarterback" responsible for that particular episode, who will also be subject to potential financial gains or losses depending on the exact financial outcome of expenses for that specific patient episode.

The episodes are established and are initially launched in a preview period. Reports are made available by the MCOs for "quarterbacks" to see how they are performing. After

Guidelines for Setting Episode of Care Thresholds



The following Episodes are in the Preview Period and will transition to the performance Period in January, 2018:

ADHD, Anxiety, Non-Emergent Depression, Tonsillectomy, Breast Biopsy, Otitis Media, Skin and Soft Tissue Infection, HIV Pancreatitis, Diabetes Acute Exacerbation

The following Episodes are already in the Performance Period:

Perinatal Respiratory Infection, Asthma Acute Exacerbation, Pneumonia Total Joint Replacement, Bariatric Surgery, Acute PCI, Oppositional Defiant Disorder (ODD), COPD Acute Exacerbation, Coronary Artery Bypass Graft (CABG), Colonoscopy, Congestive Heart Failure (CHF), Non-acute PCI Valve Repair and Replacement, Cholecystectomy, Upper GI Endoscopy (EGD), GI Hemorrhage Outpatient UTI Inpatient UTI

the preview period, they are moved into actual performance periods where the financial gains and losses are realized.

The graph above provides an example of risk and gain sharing levels in a given episode.

In the table to the left you will see which episodes are in the Preview period vs. performance period (I have listed those that appear pediatric-related in italics)

Have you seen your reports? Do you know how you are performing and if you will have a gain or loss?

Figures 1 and 2 illustrate how you can find your reports with each MCO. Have questions and/or need more information? Need help reading your report?

Feel free to contact:

Janet Sutton, CPC, RHIT

Coding Educator

TN Chapter of the American Academy of Pediatrics

615-447-3264 or janet.sutton@tnaap.org

Jacqueline R. Woeppel, ScD

Healthcare Innovations Consultant

Tennessee Medical Association

615-460-1651 or jackie.woepfel@tnmed.org

Figure 2

BlueCare

Log in at www.bcbst.com by clicking on the Log In/Register to BlueAccess link found in the top right hand corner of the page

Questions related to the provider reports - BCBST: 800-924-7141

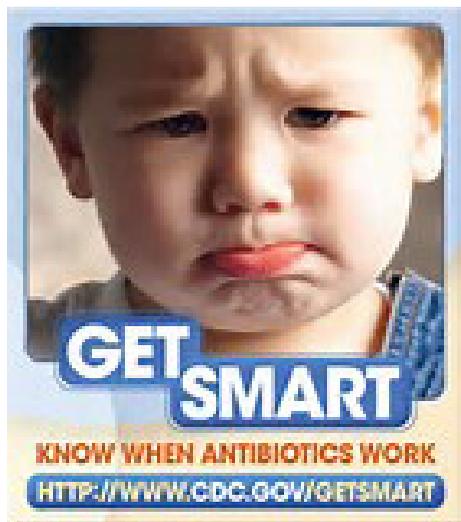
Additional Information (FAQ, Portal, Payment Reform, etc.) <http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html>

GET SMART TENNESSEE

How Tennessee Physicians Can Reduce Antibiotic Overuse

Pamela Talley MD, MPH, Deputy Director Healthcare Associated Infections and Antimicrobial Resistance Program, Tennessee Department of Health

In 2013 the Centers for Disease Control and Prevention outlined 18 different bacteria for which the threat of antibiotic resistance is concerning or even urgent. The World Health Organization has warned that antibiotic resistance is one of the biggest threats to global health today. In September 2017, the UN General Assembly held



a high-level meeting on antibiotic resistance, only the fourth time the body had ever addressed a health issue. The media periodically reports on “nightmare superbugs”

that are resistant to most or all known antibiotics, including a report in February 2017 of a *Klebsiella pneumoniae* isolate from a Nevada patient that was resistant to every antibiotic available in the United States.

Despite those scary headlines, many patients don't think twice about taking unnecessary antibiotics for a viral cold illness or acute bronchitis “just in case” or receive intramuscular Ceftriaxone under the false impression that “stronger” must be “better”. A study published in the *Journal of the American Medical Society* in 2016 found that at least 30% of antibiotics dispensed in the U.S. community pharmacies, or up to 47 million prescriptions each year, are unnecessary. In hospitals, studies indicate that 30-50% of antibiotics prescribed are unnecessary or inappropriate. Unfortunately, the public has little appreciation for the real risks involved in taking

antibiotics including serious allergic reactions or the sometimes deadly diarrhea, *Clostridium difficile*. Antibiotic misuse increases the possibility of developing a resistant “superbug” that can then be spread to family members or in healthcare settings.

Tennessee needs to wake up to our own alarming statistics. In 2014, Tennesseans took almost 40% more antibiotics (1162 antibiotic prescriptions dispensed per 1000 population) than the national average (835 per 1000) and more than twice as many as the states with the lowest use (570 per 1000). Those states with relatively low use do not have fewer bacteria than we do in Tennessee—they have a different medical culture, likely with different patient expectations and providers who may be more willing to prescribe judiciously. Currently, we are 5th worst in the nation in outpatient antimicrobial prescribing. We do not want to “win” this race to the bottom. Fortunately, there are evidence-based interventions that reduce inappropriate outpatient prescribing that can be found through the CDC's “Get Smart: Know When Antibiotics Work” materials (available at <https://www.cdc.gov/getsmart/community/improving-prescribing/interventions/index.html>). We, patients and providers both, need to find the will to change.

Join me at the Tennessee State Pediatric Conference this October 7 where I will talk more about this important issue and what we can do to improve antibiotic prescribing. (more info page 5)

REASONS ANTIBIOTIC PRESCRIBING GUIDELINES ARE NOT FOLLOWED

- 

Belief that non-recommended agents may be more likely to cure an infection
- 

Concern for parent or patient satisfaction, a common method by which clinicians are evaluated
- 

Fear of infection complications and related negative consequences

www.cdc.gov/getsmart

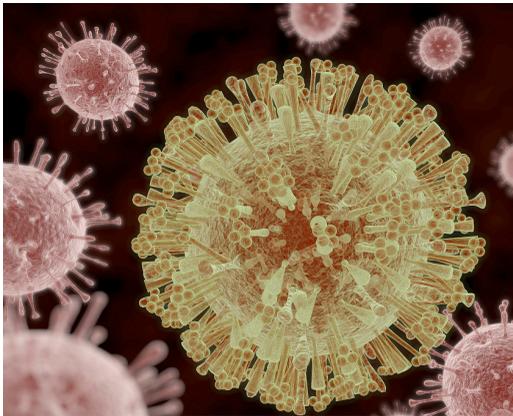
 

Sanchez GV, et al. Effects of primary care provider knowledge, attitudes, and practices on antibiotic drug selection, United States. *Emerg Infect Dis.* 2014;20:2041-7. 11/2014

Tennessee State Pediatric Conference

October 7, 2017 • Cool Springs Marriott • Franklin, TN

Focus on Pediatric Infectious Disease



We are excited to be hosting the 4th Annual Tennessee State Pediatric Conference, Saturday, October 7, 2017 at the Cool Springs Marriott Hotel and Conference Center in Franklin, TN. This year's conference, "Focus on: Pediatric Infectious Disease" will bring together pediatricians from across the state to learn and network together. Now, more than ever, the opportunity to make connections with our colleagues is critical to the sustainability of pediatric practice in an environment of constant change. Please plan to join us and remember to come and celebrate our fellow pediatricians who will be recognized during our "Excellence in Pediatrics" awards event Friday, October 6. It's always fun to get together to celebrate each other and the successes in our field! Hope to see you there! — Michelle D. Fiscus, MD, FAAP, 2017 Tennessee State Pediatric Conference Course Director

2017 Session Topics:

- Zika Virus: What We Know So Far
- Cutaneous Infections and Infestation
- Second Annual Resident Presentations
- State Health Round Table
- Pediatric Pandemic and Bioterrorism Preparedness
- TennCare Update
- Update on Pediatric Diarrhea
- Networking Happy Hour with New Resident Quiz Bowl



Presented by the Following Partners



Developmental and Behavioral Screening: What About the Parent?

Quentin Humberd, MD, FAAP, START Medical Director

Pediatricians and other health care providers caring for kids in Tennessee recognize that screening tools are not just for the kids. Parents, and particularly mothers, are a big part in making sure babies have a positive and nurturing environment. So, what should we do as child providers when we are not the provider for the parent? This article will discuss the issue of screening tools for parents, with a focus on postpartum depression screening for mothers, and provide some hints and tips on how you should accomplish this very important task.

Most professionals recognize the science behind postpartum depression screening is increasingly showing the benefits for screening in the primary care setting (1), and the American Academy of Pediatrics has supported a system of care and advocacy approach to increase recognition and treatment of postpartum depression since 2010 (2). The most common questions for practices have centered around implementation, coding and documentation when the provider is not also caring for the mother in that setting. We will list below the essential elements needed to address each of these.



1. Implementation of Postpartum Depression Screens

Become familiar with the recommendations around postpartum depression and then decide at which visits you will screen. Given the peak times for postpartum depression specifically, the Edinburgh Postpartum Depression Scale (EPDS) would be appropriately integrated at the 1-, 2-, 4-, and 6-month visits. The Edinburgh scale is a simple, 10-question screen that is completed by the mother. A score of ≥ 10 indicates risk that depression is present. An affirmative response on question 10 (suicidality indicator) also constitutes a positive screen result. The screen is in the public domain and is freely downloadable. It is available in

English and Spanish. (2) Other measures such as the 2-question depression screening and the 9 question PHQ-9 have been proposed but are not currently recommended per the USPSTF (3). Practice preparation and training prior to using the EPDS is important, but not difficult. TNAAP has resources on their website to get you started, including sample practice letters to provide to mothers ensuring proper consent for screening prior to implementation. You may find this at http://tnaap.org/start/start_screening_tools. While you are there you can decide if you would like your practice to receive a full Screening TNAAP Tools and Referral Training (START) program at your office, and contact us to set that up.

2. Coding for Postpartum Depression Screening

On Jan 1, 2017, new codes were implemented to report health risk screening, and these included the Edinburgh. Code 96161 will be reported for use of a standardized instrument to screen for health risks in the caregiver for the benefit of the patient. It is intended that code 96161 will be reported to the patient's health plan as it is a service for the benefit of the patient. The code that had been used by states and some health plans for this screening 99420, has been deleted. Billing will be under the child using 96161, but recognize that the instrument itself, a score and interpretation would NOT be included in the child's record. The child's record should reflect that consent for screening was obtained from the mother, and where the mother indicated she wanted the results of screening to be sent. Screening for postpartum depression does not require that the PCP treat the mother. The infant is the provider's patient. However, the primary care provider has a role in supporting the mother and facilitating her access to resources to optimize the child's healthy development and the healthy functioning of the family. For the mother, the infant's provider provides information for family support, therapy resources, and/or emergency services as indicated. The primary care provider does provide guidance, support, referrals, and follow-up for the infant and the dyad relationship. (2)

3. Documentation of Postpartum Depression Screening

As mentioned earlier, screening for depression in the mother does not mean that the primary provider of the child is assuming the medical care of the mother. A detailed review of the legal and ethical issues involved in screening for postpartum depression in the primary care setting supported this as well. The review concluded with the statement "We believe that from the perspective of feasibility, and now from the legal and ethical standpoints, the

benefits of screening outweigh the risks.” (4) Proper documentation of maternal depression screening should include consent from the mother in the child’s record, and indicate that EPDS depression screening was done at XX visit. No results, interpretation or scoring would be included to prevent inadvertent release of the mother’s protected health information via the child’s record. The record should reflect that the screen was sent to the mother’s provider, in accordance with the consent in the child’s record. This should provide support for the billing and coding should the record come under audit, as the screen, score and interpretation would be located in the mother’s record. Recognize that “positive” or “negative” terms are also not recommended. Simply document the screen was completed.

Appropriate responses to positive screens in the primary care setting will depend on the severity of symptoms and the assessment of the provider, but you should consider a menu of options to support the mother and the baby. These range from reassurance (maternity blues) to supportive strategies (maternity blues, minor depression) and referral for specific interventions (minor and major depression). (2) Determining the resources available to your practice is crucial in setting you and the mother up for success. Other practices have addressed this need in a variety of ways, and we are happy to share options and strategies with you as part of our support to your practice. Let us know how we can help and good luck in your screening efforts. We know it can make a difference in the lives of the children and families we all serve.

References

1. Matern Child Health J. 2017; 21(1): 9–20. Published online 2016 Aug 12.
2. Pediatrics. 2010 Nov;126(5):1032-9.
3. JAMA. 2016;315(4):380-387.
4. Legal and ethical considerations: risks and benefits of postpartum depression screening at well-visits. Pediatrics. 2007;119(1):123–128

Schedule START Training with TNAAP!

Contact Susan Rollyson at
susan.rollyson@tnaap.org

start

SCREENING TOOLS AND REFERRAL TRAINING

Echo Autism: Bringing the Best Autism Care to Local Communities

Vanderbilt is partnering with primary care providers in the community in a research study through a virtual learning network, ECHO Autism. Autism medical and behavioral specialists at Vanderbilt will work alongside primary care providers in the community to provide increased knowledge, learning, and confidence in treating patients with autism.

Vanderbilt will offer twice-monthly ECHO Autism Clinics over a 6-month period, beginning June 8, 2017 through November 30, 2017. The clinics will use a secure video conferencing technology that allows you to interact with a team of autism specialists at Vanderbilt as well as other participating primary care providers in the community. The clinics will last approximately 2 hours and no PHI will be disclosed. CME credits will be offered for attending the clinics, and providers will be compensated for their participation in the study. Joining the clinic is easy and can be done from your phone or any device with video-conferencing ability. Ultimately, we hope to determine if participation in a collaborative telehealth intervention will result in improved learning, clinical practice behavior and efficacy among primary care providers. If you are a primary care provider who is interested in more information about the study, please contact the coordinator, Bethany Drury at: 615-343-1729 or Bethany.Drury@Vanderbilt.edu

See more at: <http://vkc.mc.vanderbilt.edu/vkc/echo/#sthash.H6RNPB7a.dpuf>



Tennessee Legislative Update

Chris Ford, Tennessee AAP Government Relations

The 2017 Session of the 110th General Assembly concluded its regular session on May 10th. TNAAP tracked 266 pieces of legislation this session, including bills related to child health and safety, the professional practice of medicine, and insurance payment.

This year saw the passage of several bills we supported, perhaps the most significant of which is the culmination of a four year battle for the Provider Stability/Payer Accountability Act SB0437/HB0498 (Watson/Sexton), requiring health insurance companies to give a 60-day notice to a healthcare provider when reimbursement rates change, if such changes are a result of a policy change at the sole discretion of the payer. The new law also limits fee schedule changes to once in a 12-month period, and requires a 90-day notice of those changes. The first of its kind in the nation, the new law is a solid win for providers.

"The first of its kind in the nation, the new law is a solid win for providers!"

Several bills impacting school systems which passed with TNAAP's support include:

- SB0458/HB0448 (Bell/Forgety) authorizes public schools to properly secure and maintain an opioid antagonist on site.
- SB0117/HB0121 (Briggs/Terry) requires the state board of education, the health department and others to adopt rules regarding the dispensation of medication for adrenal insufficiency at public schools.
- SB0598/HB0388 (Haile/Brooks) requires local school systems to provide parents with information on the influenza disease and the effectiveness of the vaccine at the beginning of every school year.



More than 50 pediatricians joined the Tennessee AAP on the Hill March 14 making it the largest group yet! Be sure you make plans to attend this important event next year!

- SB0341/HB0720 (Niceley/Parkinson) authorizing school counselors to make referrals to private counselors with parental consent, ensuring professionals who spend the schooldays with children have the ability to help obtain behavioral health treatment when necessary.

SB0410/HB0521 (Overbey/Ramsey), would have required all public schools to have Automated External Defibrillators and to provide training for their use. While it did not pass it is expected to return next year.

The tragic Woodmore School bus crash in Chattanooga that resulted in the death of five elementary students and injury of three dozen others has been the impetus for multiple pieces of legislation this session, including:

- measures to place cameras on school buses SB0462/HB0392 (Bell/Brooks, K),
- require stronger background checks for bus drivers SB0149/HB0089 (Haile/Rogers),
- establish a school transportation supervisor program SB1210/HB0322 (Norris/Hawk), and
- require seatbelts on all new school bus purchases after 2019 SB0381/HB0395 (Gardenhire/Favors)

TNAAP members provided testimony supporting the need for legislation, all of which passed through the committee process but only the transportation supervisor bill made it through the budget process. These or similar bills will be back in 2018.



The middle Tennessee group discussing important legislation with Senator Kerry Roberts.

Other bills that did not pass include:

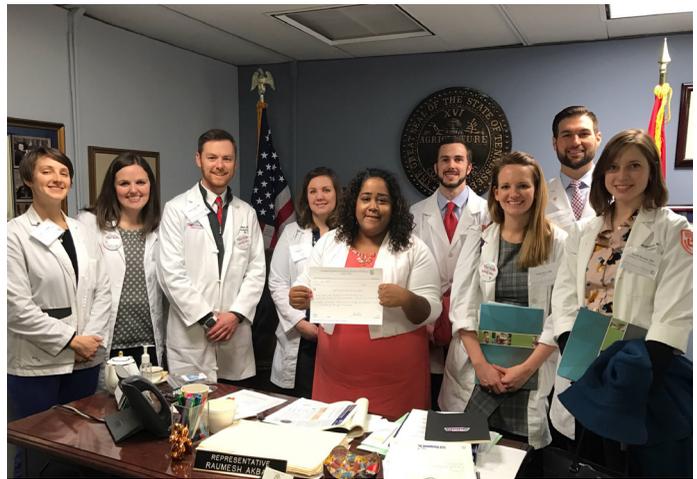
- SB0035/HB0035 (Bailey/Windle) which would have required health insurance policies to cover breathing and heart rate monitors for certain infants covered under the policy or contract. Nuances around heart monitors that are not necessary and the safety challenges those create caused our legislative team to request the sponsors to move this bill to next year so we can work with them to examine policy that might better align with the SIDS reducing outcomes they are seeking to address in the legislation.
- SB0298/HB0413 (Briggs/Williams) seeking to alter and eliminate maintenance of certification requirements for physicians, was referred to summer study following several weeks of intense negotiations between the sponsors, TMA, hospitals and other stakeholders.
- SB0205/HB1034, SB0132/HB0041 and SB0364/HB0013, all focused on elimination of the “professional privilege tax” for physicians (and other professions subject to the fee) gained passage through the committee process but ultimately failed.
- SB0049/0622 (Massey/Favors) sought to enact the “Tennessee Lactation Consultant Practice Act” establishing a new board of lactation consultants under the department of health and specifies powers and membership of the board failed in the House Health Sub-committee.
- SB0790/HB0667 (Dickerson/ Hill) would have “authorized licensed and registered dental hygienists, in addition to settings in which licensed and registered dental hygienists may engage in the provision of

preventive dental care under the general supervision of a dentist, who are already subject to listing the name, address, telephone number and license number of their employer (supervising) dentist, to also engage in the provision of preventive dental care for patients who are 17 years of age or less under the general supervision of a dentist through written protocol in a medical practice that contains a pediatrician.” It is likely to reappear in 2018.

- Additional bills dealing with medical cannabis, “bathroom bills”, the continuation of the anti-LGBT “counseling bill” and the Patients For Fair Compensation Act all fell by the wayside for 2017.

Special thanks to all of you who participated in our advocacy efforts including conversations with your local senators and representatives and participation in our Day on the Hill!

At the national level, TNAAP is actively communicating with our elected officials regarding concerns about drastic cuts to key child health programs. Our activities continue to include personal visits to their D.C. legislative offices as well as meetings and correspondence at the local level.



Top: TNAAP members from West Tennessee pose for a picture with Senator Raumesh Ackbari during the 2017 TNAAP Day on the Hill.

Bottom: TNAAP Members met with Speaker Beth Harwell during the Day on the Hill

Summary of Changes for 2017 “Recommendations for Preventive Pediatric Health Care”

Janet Sutton, CPC, RHIT, AHIMA Approved ICD-10-CM Trainer, TNAAP Coding Educator

The 2017 Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) has been approved by the American Academy of Pediatrics (AAP) and represents a consensus of the AAP and the Bright Futures Periodicity Schedule Workgroup. The periodicity schedule is revised annually to reflect the most current recommendations and can be found on the AAP website at https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.

Following are the latest updates to the 2017 periodicity schedule:

HEARING

Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.

- Footnote 8 has been updated to read as follows: “Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per the AAP statement ‘Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs’ (<http://pediatrics.aappublications.org/content/120/4/898.full>).”
- Footnote 9 has been added to read as follows: “Verify results as soon as possible, and follow up, as appropriate.”
- Footnote 10 has been added to read as follows: “Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See ‘The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies’ ([http://www.jahonline.org/article/S1054-139X\(16\)00048-3/fulltext](http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext)).”

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows:

“This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See ‘Promoting Optimal Development: Screening for Behavioral and Emotional Problems’ (<http://pediatrics.aappublications.org/content/135/2/384>) and ‘Poverty and Child Health in the United States’ (<http://pediatrics.aappublications.org/content/137/4/e20160339>).”

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

The header was updated to be consistent with recommendations.

DEPRESSION SCREENING

Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.

Footnote 16 was added to read as follows: “Screening should occur per ‘Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice’ (<http://pediatrics.aappublications.org/content/126/5/1032>).”

NEWBORN BLOOD

Timing and follow-up of the newborn blood screening recommendations have been delineated.

- Footnote 19 has been updated to read as follows: “Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>), as determined by The Secretary’s Advisory Committee on Heritable

Disorders in Newborns and Children, and state newborn screening laws/regulations (<http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf>) establish the criteria for and coverage of newborn screening procedures and programs.”

- Footnote 20 has been added to read as follows: “Verify results as soon as possible, and follow up, as appropriate.”

NEWBORN BILIRUBIN

Screening for bilirubin concentration at the newborn visit has been added.

- Footnote 21 has been added to read as follows: “Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See ‘Hyperbilirubinemia in the Newborn Infant ≥ 35 Weeks’ Gestation: An Update With Clarifications’ (<http://pediatrics.aappublications.org/content/124/4/1193>).”

DYSLIPIDEMIA

Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: “Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases.”

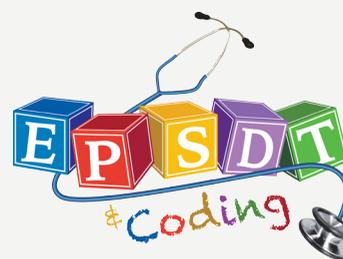
HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: “Adolescents should be screened for HIV according to the USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm>) once between the ages of 15 and 18, making every

effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.”

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: “Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See ‘Maintaining and Improving the Oral Health of Young Children’ (<http://pediatrics.aappublications.org/content/134/6/1224>).”
- Footnote 33 has been updated to read as follows: “Perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>). See ‘Maintaining and Improving the Oral Health of Young Children’ (<http://pediatrics.aappublications.org/content/134/6/1224>).”
- Footnote 35 has been added to read as follows: “If primary water source is deficient in fluoride, consider oral fluoride supplementation. See ‘Fluoride Use in Caries Prevention in the Primary Care Setting’ (<http://pediatrics.aappublications.org/content/134/3/626>).”



Northeast BeHiP Learning Collaborative

Leading the State Towards Behavioral Health System Change

Michelle D. Fiscus, MD, FAAP, BeHiP Medical Director

BeHiP (Behavioral Health in Pediatrics) is on a mission to create a state-wide collaborative of pediatricians who have been trained to navigate the foster care system in Tennessee and provide superior care to the children it serves.

In early 2017, we took the first step towards reaching this important goal. On February 18, 2017, BeHiP held its first training day for the BeHiP Foster Care Learning Collaborative in Greeneville, TN. This day-long training was attended by the participating pediatricians and their staff, the northeast regional Center of



Excellence for Children in State Custody (COE), the Regional Intervention Program (RIP), Youth Villages, Frontier Health, TN Association of Alcohol, Drug, and Other Addiction Services (TAADAS), Camelot Care Center; TN Suicide Prevention Network, the TN Department of Children's Services, TN Department of Health, Health Connect Americas, and the National Alliance on Mental Illness (NAMI). This training may very well have been the first-ever face-to-face gathering of these entities in the northeast region of Tennessee and accomplished the goals of connecting rural pediatricians with their regional behavioral health resources, as well as elevating the confidence and competence of pediatricians in caring for children with complex behavioral health concerns.

On March 16, 2017, BeHiP began monthly video conferences with its Foster Care Learning Collaborative participants. This collaborative is comprised of the 3 pediatricians who completed the February training, the child psychiatrist and psychologist from the ETSU Center of Excellence for Children in State Custody, the regional health nurse, and the patient health advocate from the Department of Children's Services, Frontier Health, Blue Cross Blue Shield of TN, and BeHiP Faculty and Staff. The 90-minute conferences include a 15-20 minute didactic that is presented by the COE psychiatrist and is based upon a case that has been submitted by one of the

participating pediatricians. The case is then presented by the child's pediatrician, management recommendations are made by the team, and possible systems changes are discussed. It quickly became clear that there is great need for this type of collaborative in the northeast, and the initial conference was not only successful in removing barriers to patient care in general, but also expedited the delivery of appropriate behavioral health care to the patient discussed during the conference. Here's what transpired: The first collaborative session involved the discussion of an adolescent male who was in state's custody due to neglect. No medical records were available to the pediatrician at the time of initial consultation. The patient suffered from asthma, Tourette's Syndrome and anxiety and his biological mother had declined treatment of these conditions. The patient had been evaluated by a behavioral health provider and prescribed Strattera. The pediatrician presenting the case sought advice as to options for working with a biological parent who refused treatment, proper procedures for obtaining a second opinion for behavioral health medication management, and assistance in navigating the DCS system. All session participants were able to contribute to the discussion and make management recommendations.

As a direct result of the session, the pediatrician contacted the DCS health nurse and obtained the patient's medical records which revealed that the patient's mother had influenced the behavioral health provider to prescribe a medication that is not typically recommended for management of Tourette's Syndrome or anxiety. A second opinion was obtained through another behavioral health network and, due to a new referral procedure developed through this collaborative, the patient received an evaluation within three business days. It was determined that Strattera was not the best choice given this patient's diagnoses, and another treatment was initiated. Medical neglect charges were filed against the biological mother and the patient was placed in an appropriate foster care home.

Through the BeHiP learning collaborative, partnerships were developed between rural pediatricians and their regional behavioral health and DCS systems of care. Pediatricians who previously had little knowledge of how

to obtain assistance from DCS in order to advocate for their patients were given simple tools and direct contacts that resulted in swift and meaningful interventions. Historically, the disconnect between pediatricians caring for children in foster care and the DCS and behavioral health systems has been a source of great frustration. Through BeHiP, physicians are gaining important knowledge around navigating their regional systems of care so that they may advocate for their patients' needs.

This is ONE pediatrician who participated in ONE collaborative meeting about ONE child with a nearly

immediate outcome capable of significantly impacting the life of not only this child, but of other children within this pediatrician's practice.

The northeast is indeed leading the charge towards behavioral health systems change in Tennessee!

For more information on how to join the BeHiP Foster Care Learning Collaborative, please contact Heather Smith at heather.smith@tnaap.org or 615-758-1211.

TNAAP's Quality Improvement Movement

Rebecca Robinson, MPH, Quality Coach, PHiT

TN AAP's Pediatric Healthcare Improvement Initiative for Tennessee (PHiT) offers a variety of quality improvement projects to assist pediatric practices. Each project is designed around several core elements: enhanced medical education, evidence-based process changes, standardization of key metrics, high value resources, collaborative learning, personalized quality coaching, **Maintenance of Certification Part IV credit, and CME.**

Best Practice Provider Resource (BPPR)

This project allows practices to collect data on a high-value metric panel in the ambulatory pediatric practice over the course of one year through monthly quality improvement efforts and quarterly data collection. The data collected from the BPPR allows practices to target quality improvement efforts in selected areas including, Early Well Care, Asthma, Adolescent Well Care, and Behavioral Health.

Breastfeeding Sustainment in the Newborn Period

This project will assist your practice in identifying, implementing and maintaining process changes regarding breastfeeding support. The practices will increase breastfeeding rates at the newborn visit and will assist mothers with sustaining breastfeeding as long as mutually desirable by the mother and child.

Newborn Tobacco Exposure Reduction

This project will assist your practice in identifying, implementing, and maintaining simple steps to assess newborns' tobacco exposure and increase the rate of caregivers that decrease tobacco exposure to improve the health outcomes of their children.

Asthma Education

This project will present, incorporate and sustain the use of high-value, chronic-care management processes for patients with asthma in a primary care office.

Human Papilloma Virus (HPV)

This project reviews the impact of HPV-related cancers and the most effective practice changes to prepare your staff to identify eligible patients and successfully administer the vaccine series to the practice's adolescent population.

Behavioral Health (Behavioral Health in Pediatrics -BeHiP)

This project provides pediatric healthcare providers with tools and strategies to screen for, assess, and manage patients with emotional, behavioral and substance abuse concerns. It also encompasses strategies to provide for more efficient workflow (including information on coding), more effective care, and improved family and physician relationships.

For additional information contact Becky Brumley (becky.brumley@tnaap.org) or Becca Robinson (rebecca.robinson@tnaap.org) or visit www.tnaap.org/phiit.



Pediatric Healthcare Improvement Initiative for Tennessee

Tennessee EPSDT Screening Rates Declining

Deanna Bell, MD, FAAP, TNAAP EPSDT & Coding Program Medical Director

Janet Sutton, CPC, RHIT, AHIMA Approved ICD-10-CM Trainer, TNAAP Coding Educator

EPSDT (Early and Periodic Screening, Diagnosis and Treatment) is a program of check-ups and treatment and/or referral for needed services for all TennCare eligible children birth until age 21 and has been part of Federal Medicaid program since the 1960s. States share responsibility for implementing the benefit, along with the Centers for Medicare & Medicaid Services (CMS) and have an affirmative obligation to ensure that Medicaid-eligible children and their families are aware of the EPSDT benefit and have access to required screenings and necessary treatment services.

In 1989, The Omnibus Budget Reconciliation Act strengthened EPSDT by establishing State reporting requirements and mandating that the Secretary of Health and Human Services set participation goals for the States. An overall goal of 80 percent beneficiary participation in EPSDT was established for each State. States are required to report annually to CMS certain data about their delivery of services under the EPSDT benefit. The CMS-416 report calculates how many children were eligible for EPSDT services vs how many children actually received the services. CMS and states use this data to monitor EPSDT performance. The data is collected through claims, so it is important that we report EPSDT services correctly on claims by coding accurately so that all EPSDT services performed are captured and reported to CMS.

The graph below illustrates the average compliance rates for EPSDT visits in Tennessee year over year from 2013-2016. The expected average is 80%. As you can see Tennessee's average has dropped 12 percentage points in the last three years.

The State is working with TN AAP, the TennCare MCOs and the provider community to identify barriers and increase the EPSDT screening rates in TN. The following strategies may help to improve the screening rates in Tennessee:

Overcoming Barriers to Delivery

Missed Opportunities

- Implementing a System to Identify Patients Without Well Care Services Completed
- Organizing Office Flow to Accommodate Adding Well Care to Acute Visit

Educating Families

- Including Well Care Goals in Anticipatory Guidance
- Strong MD Recommend of Next Well Visit
- Schedule Next Well Visit at Current Visit

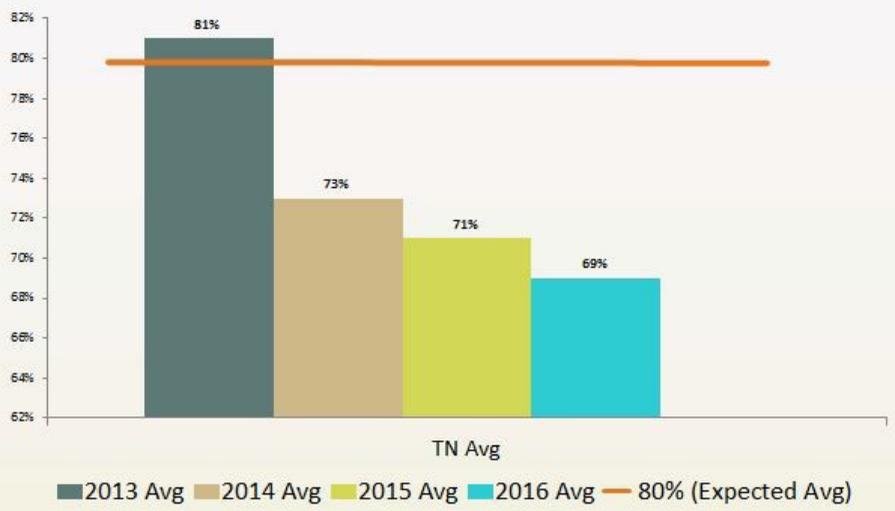
Patient Recall

- Chart Review
- Opportunity for Improved Data from MCO on Patients with Gaps
- Developing Office Protocols for Review and Recall

Timing and Special Events

- Limiting Vacation During High Volume Times
- Reminder Signage for School and Sports Physicals Early in Need Window
- Coordinating Need for Schools to Get Sports Physicals and the Requirements of EPSDT

2013-2016 CMS-416 Rates TN Average



Adolescent Friendly Practices

- Adolescent Only Visits or Visit Segments
- Clear and Thoughtful Protocols with STD Screening
- Asking Permission to Talk about Sensitive Subjects
- Always State and Respect the Secure Nature of Conversation

Tracking Physician Utilization and Adjusting Staffing to Meet Demand

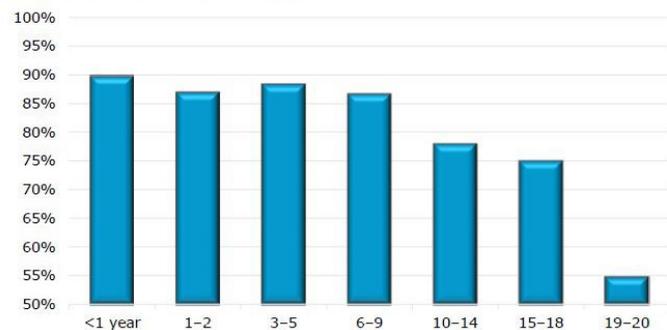
- Regularly Tracking Third Available Well Child Visit
- Advertise Faster Throughput During Lower Demand Times (Early Afternoon or April-May)
- Adding Late Hours or Weekend Hours When Physical Demand Increases for School or Sports Seasons
- Add Incentives Like Decreased Overhead Allocation or Production Bonuses for Well Care

Once we are getting kids in the office for their well visits, it is important that we are performing all of the components for the EPSDT visit in accordance with Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (periodicity schedule). TennCare contracted with QSource in 2016 to perform a medical record review of EPSDT visits to assess the documentation compliance in several areas: history, measurements, sensory screening, developmental/behavioral assessment, physical exam, procedures, oral health, anticipatory guidance, and immunizations by age group.

Overall scores were lowest in Procedures (71.8%) and Immunization Compliance (73.8%). Only 38.6% of children had documentation of influenza vaccinations and newborn metabolic screening follow-up was reported at only 60%, reinforcing the concept that if it wasn't documented, it wasn't done, so far as the audits are concerned.

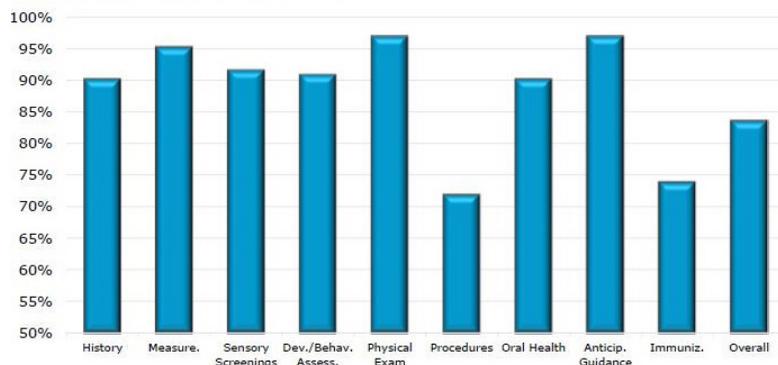
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EPSDT Compliance by Age Group



Age Group in Years						
<1 year	1-2	3-5	6-9	10-14	15-18	19-20
89.7%	86.9%	88.3%	86.6%	77.9%	74.9%	54.7%

EPSDT Compliance by Component



History	Measure.	Sensory Screening	Dev./Behav. Assess.	Physical Exam	Procedures	Oral Health	Anticip. Guidance	Immuniz.	Overall
90.1%	95.2%	91.5%	90.8%	96.9%	71.8%	90.1%	96.9%	73.8%	83.5%

As many of us might expect, we are still struggling with performance on components more related to adolescent visits; overall compliance for the 15-18 year age group was 74.9% while compliance in the 19-20 year age range was 54.7%. Specific areas of struggle are Alcohol and Drug Use Assessments (69.8%), cholesterol screening (53.5%), HPV immunizations (42.9%), and meningococcal immunizations (56.3%). The concept of yearly check-ups through adolescence is still a struggle for our populations, and one that needs to be reinforced.

Tennessee AAP (TNAAP) provides comprehensive EPSDT training, including documentation and coding instruction. To schedule a training, contact Janet Sutton at janet.sutton@tnaap.org or 615-447-3264. TNAAP also provides MOC Part IV credit for participation in their quality improvement program, PHiiT, focusing on several EPSDT projects. Overview of this program is available at www.tnaap.org/phiit/bpp_resource.



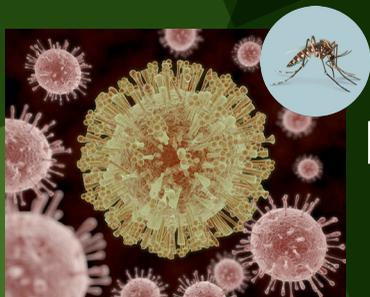
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If you are interested in participating in this board please email Casey Lamarr, casey.lamarr@tnaap.org.

