February 2018

Legislative Session to Begin Feb 20

Eric Dick, MNAAP Lobbyist

With the arrival of the New Year, the 2018 legislative session looms large in the front of legislators and advocates. The session, scheduled to start on February 20, promises to be chaotic and likely acrimonious.

The 2017 legislative session ended with the Governor line item vetoing the funding for the Legislature over a conflict over tax cuts, and that disagreement is likely to leave a mark on the 2018 session.

Senate President in Question

Further complicating the session’s trajectory is the status of the Lt. Governor. Senator Franken’s resignation in early January set in motion a series of events that led to Senate President Michelle Fischbach – a Republican – being elevated to Lt. Governor under Governor Dayton – a Democrat.

Senate DFLers have argued that an individual cannot serve in both the executive and legislative branches and have sought to remove her from the Senate. If forced to resign her Senate seat, the Senate’s partisan split would be 33-33. Under Senate rules, 34 votes are needed to pass legislation rather than a majority of members present. The results of a deadlock are hard to predict, though it may lead to gridlock, or alternatively, some bipartisan agreements. This issue is certain to be headed to the courts.

Watching Washington

As is often the case, Minnesota’s legislative session will be shaped by action in Washington, D.C. The passage of a tax bill in D.C. will have enormous impact at the Capitol. Legislative Republicans are likely to seek to pass a “tax conformity bill” to bring Minnesota’s tax laws into alignment with the federal tax code. Such a bill will likely have a significant price tag, and many in the health care advocacy community are concerned that offsets to pay for the tax bill may require cuts to state spending. All too often, those cuts have come at the expense of health programming for the state’s most vulnerable.

CHIP

A deal to end the federal government’s partial shutdown earlier this year brought good news in the form of a six year extension of CHIP, the Children’s Health Insurance Program (CHIP) a federal program that provides funding for health care coverage for children. This action will relieve some pressure on the state’s budget and ensure continued coverage for children in low-income households.

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LOCAL PEDIATRIC CME EVENTS

Feb 14
Webinar: Feeding a Child with a Cleft Lip/Palate
Hosted by Gillette

Feb 22-23
Pediatric Fundamental Critical Care Support
Embassy Suites, St. Paul
Hosted by HealthPartners Institute and Regions Hospital

March 2-4
CentraCare Health Collaborative Institute: Bridging the Gap Between Primary Care and Psychiatry
Grand View Lodge

March 7-8
8th Annual Improving Neonatal Outcomes Conference: When Routine Isn’t Routine
Park Nicollet Clinic and Specialty Center
Hosted by HealthPartners

March 8
Webinar: A Continuum of Care for Craniofacial Disorders
Hosted by Gillette

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

April 6
Cardiac Arrhythmias: An Interactive Update for Internal Medicine, Family Practice and Pediatrics
Earl Brown Heritage Center
Hosted by U of M

April 12-13
2018 Education in Palliative and End-of-Life Care (EPEC) -- Pediatrics
Radisson Blu
Hosted by Children’s Minnesota

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

April 15-16
Child & Adolescent Psychiatry Practical Review
Grand Superior Lodge
Hosted by CentraCare

April 25-27
Clinical Gait Analysis: A Focus on Interpretation
Hosted by Gillette

April 26-27
Child Abuse Summit: Tips from the Team
Millennium Hotel, Minneapolis
Hosted by U of M

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

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

4:00 - 6:00 p.m. Debriefing and Appetizers (optional)
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MARCH 7 2018

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Word from the President
Andrew Kiragu, MD, FAAP

Since this is my first message of the year, I want to take this opportunity to wish each one of you Happy New Year! It is my sincere hope that the holiday season went well for you and your families.

As we embark on 2018, it is instructive to reflect on the year we have had and the one that lies ahead. I recently reviewed my message to you from around this time last year, and it is interesting -- albeit somewhat sad -- how many of the concerns we had remain the same.

We begin this year much in the way we started 2017, with potential hurdles and a great deal of uncertainty but also with hope and opportunities for our patients and their families. The past year, however, has brought stark clarity about what the new political dispensation in our country means for the children we care for.

Through our collective efforts, the Affordable Care Act has survived, but it is wounded and the protections it provides to children and families’ remains at risk. On a positive note, the Children’s Health Insurance Program (CHIP) was reauthorized for six years in late January. CHIP provides healthcare for over 9 million children. The Congressional Budget Office (CBO) estimates that CHIP will save the government about $6 billion over the next five years.

I applaud the efforts by many of our members to contact our state’s congressional delegation and the leadership in Congress to push for renewal of this program.

Similar efforts are also required on behalf of another group of young people, the so-called dreamers, whose protection by the Deferred Action for Childhood Arrivals (DACA), was rescinded by the president last year. Unfortunately, many of our politicians have chosen not see the faces of the millions of children and young people whose lives hang in the balance.

In spite of all these challenges, the work we do every day -- whether it is the clinical care we provide, the groundbreaking research we do, or the education of the next generation of pediatricians -- continues.

As pediatricians, we are privileged to care for children, who are a beautiful reminder of God’s blessings. I would like to thank all of you for the work that you do in the service of children and their families. I am proud to call you my colleagues.

May God richly bless each one of you and your families and may He richly bless the children we care for and their families.

Andrew Kiragu, MD, FAAP, MNAAP President
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Twitter handle: @mundumuragu

Continue Recommending Flu Vaccine!

The Minnesota Department of Health encourages providers to strongly recommend the flu vaccine throughout flu season.

Reports of low vaccine efficacy from Australia should not discourage providers from recommending flu vaccination to their patients. We do not know the vaccine effectiveness for the circulating strains in the U.S. yet. Vaccination is the best way to prevent flu and mitigate its serious effects. Providers should also consider flu high on the list of possible diagnoses for ill patients, especially those with upper respiratory symptoms, and use antivirals to treat hospitalized patients and high-risk patients with flu symptoms.

For more information and resources, go to www.mdhflu.com or www.cdc.gov/flu.
**Extension for C&TC Requirements**

The implementation date is delayed for certain screening components or health services of the October 2017 version of the C&TC Schedule of Age-Related Screening Standards (Periodicity Schedule) (DHS-3379) (PDF).

Providers have until March 1, 2018, to implement the following components:

- Weight for length percentile for infants up to two years of age
- Inclusion of social determinants of health as part of the health history
- Human immunodeficiency virus (HIV) screening at least once between ages 15 and 18 years (regardless of reported sexual activity or risk factors)
- Dyslipidemia risk assessment
- The addition of the near visual acuity (plus lens) screening beginning at age 5 years for children who pass their distance screening and do not already have corrective lenses
- The addition of high frequency hearing screening at age 11 years (6,000 Hz at 20 dB)

If you submitted claims for preventive health screening visits provided on dates of service of October 1, 2017, or later, but did not enter the two-letter HIPAA-compliant referral code because you had not implemented one or more of the new requirements, you may replace these claims if you provided the rest of the required screening components. Replace these claims indicating a complete C&TC visit by adding the appropriate two-letter referral code.

If you have already implemented all of the October 2017 C&TC Schedule of Age-Related Screening Standards, please continue to follow those standards between now and March 1, 2018. Continue to work toward implementation if you have not yet implemented the March 1, 2018, requirements.

Review the Child and Teen Checkups section of the MHCP Provider Manual for more details of the requirements. Review both page 1 and page 2 of the C&TC Periodicity Schedule for additional details and clarification of the October 1, 2017 revisions and the C&TC FACT Sheets for each component.

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**Building a Dental Home Network for Children with Special Health Care Needs**

For children with SHCNs, dental care is the second most common unmet health problem. This information is certainly alarming as more than 180,000 children with SHCNs live in Minnesota. Currently, the number of oral health providers with requisite knowledge, techniques, and comfort needed to simultaneously manage the dental, medical, behavioral, and psychosocial aspects of care for these children is inadequate to meet the demand especially in greater Minnesota. Furthermore, communication among dental and pediatric healthcare providers across Minnesota is disorganized and cumbersome for families to navigate when dental referrals are made.

However, a new dental home project aims to create a network of dental providers, pediatric healthcare providers, community health workers, family advocates, continuing dental education experts, and caregivers to promote oral health for children with SHCNs.

The project -- with support provided by a grant from the Robert Wood Johnson Foundation Clinical Scholars program -- is led by an interdisciplinary leadership team: Jeff Karp, DMD, MS, a pediatric dentist and clinical associate professor at the University of Minnesota School of Dentistry; Peter Scal, MD, MPH, an associate professor in the division of Academic General Pediatrics at the University of Minnesota School of Medicine; and Mark DeRuiter, PhD., CCC-A, CCC-SLP, a clinical professor with the University of Arizona’s Speech, Languages, and Hearing Science Department.

The University of Minnesota based team is excited to launch its telementoring program as a collaborative replication site of the University of New Mexico’s Project ECHO Institute. Project ECHO is recognized nationally as an educational model to support practicing clinicians provide quality patient care especially in under-resourced and rural communities by moving knowledge instead of patients.

The first round of teleECHO clinics will be held monthly between January and June 2018. Future clinics will launch in Fall 2018. Primary care and subspecialty pediatricians interested in participating in the teleECHO clinics can learn more by visiting the project’s website at: [www.smile.umn.edu/dentalhomes](http://www.smile.umn.edu/dentalhomes).

Questions can also be directed to Dr. Karp (jmkarp@umn.edu) and Dr. Scal (scal0005@umn.edu).
The MNAAP Policy Committee has met twice in preparation for the session. The group has studied the political landscape at the Capitol, and has closely reviewed the results of a poll of MNAAP members asking for their thoughts on which issues the chapter should prioritize.

Mirroring the results of the poll, members of the Policy Committee have focused upon preserving and expanding access to affordable health care, promoting health equity, and investing in prenatal to five initiatives. The group presented its recommendations for legislative priorities to the MNAAP Board on February 7.

The group also discussed different tools to use to influence legislators and the debate in St. Paul. The MNAAP’s “Pediatricians Day at the Capitol” is a critical piece of our advocacy efforts, and is set for March 7 this year. Register now at www.mnaap.org

Taking a cue from the MNAAP’s resident and young physician leaders, the chapter will work to amplify our voice through the use of social media. Tools like Twitter can be enormously impactful at the Capitol. As I often joke, the only people more interested in Twitter than millennials are legislators. A remarkable number of legislators use Twitter, and “tweeting” at them can be a fantastic way to capture their attention.

We live in a very challenging political climate, both in St. Paul and Washington, DC. Now, more than ever, pediatricians should use their voice to speak on behalf of children.
Here's a statistic that may be hard to hear: Only 10 to 20 percent of health outcomes are attributable to health care. For all our education, training and expertise, there is only so much we as physicians can do if we choose to only work within our clinics or hospitals.

The term health disparity is well known and while health equity is recently more ubiquitous, how is it different? Put simply, health disparities define the problem, health equity defines the solution.

Minnesota Doctors for Health Equity (MDHEQ) came together to equip physicians for this work. We have done that by engaging physicians to use their power and privilege in several different areas of action:

- **Individually**: As “citizen-physicians” who are engaged in our democracy and use our expertise to inform public and private discussions that promote equity in our communities. We have shared different books/articles that can inform one around equity, started a book club about racism and medicine, given examples through our monthly newsletter about discussions you can have with colleagues and patients around equity, discussed how you can engage your legislators and hosted a workshop on being a citizen physician and one on facilitating difficult discussions.

- **At work/in your health care system**: We are (mostly nowadays) all part of or affiliated with large health systems. As the main drivers of everything these systems do physicians can demand equity throughout our organizations. We are building coalitions of physicians within health systems to look at how do these systems interact with their community. Not just from a PR standpoint but less obvious decisions like what businesses do they buy food from for their conferences? Are they tracking health outcomes by race/income/language/sex? What do they do with that data? Health care employs 5 percent of the ENTIRE workforce in MN. Holding the systems we work in accountable for equitable practices can have a far reaching impact.

- **With community organizations**: What are local efforts that we can use a physician’s 3 Ps (Power, Privilege, Plenty, coined by University of Minnesota Med-Peds Program Director Mike Aylward, MD, FAAP) to raise up? We have had conversations with Simpson Housing Services and Voices for Racial Justice in the Twin Cities so far.

- **Within our professional associations**: The MNAAP has long had a tradition of putting our patients’ interests first. We understand that kids can’t vote, but we can. Other physician organizations have talked about equity but when it comes to legislation that can help address the inequities our patients face, like the Provider Tax, they have actively worked against patients’ interests. We are engaging members of physician organizations around the state to be active in their chapters, so these organizations truly reflect what all their members believe is best for patients. We recently co-hosted the MMA’s Health Equity Forum with many of our members serving as speakers or table facilitators.

- **Through legislative advocacy**: As former Commissioner of the MN Department of Health and Med-Peds Dr. Ed Ehlinger would often say, there is health in all policy. We have had four op-eds published in the last year by members providing a physician voice to support policies that would improve access to care. We have had members testify at a State Senate committee hearing in support of a MNCare Buy-In as well as several members testify at their City council meetings in support of stricter tobacco legislation.

In one year, MDHEQ has grown from a handful of physicians to a movement that now includes 110 physicians from across the state, over 40 of which are pediatricians!

We are excited to work with any physicians interested in gaining or sharing the knowledge and skills required to be agents of change. No matter how small or large a step members wish to take, we invite you to join us as we work to educate, connect and activate our colleagues to be champions for equity. Visit www.mdhealthequity.com

This article has been shortened due to space limitations. Visit www.mnaap.org/newsletter/ to read the full article.
Searching for The Holy Grail: A Perfect Screen for Social Determinants of Health

Questions and Answers

Diana Cutts, MD, FAAP, Hennepin County Medical Center; and Rich Sheward, deputy director of innovative partnerships at Children’s HealthWatch

Why screen for social determinants of health?

In the United States, we spend increasingly more money per capita on medical services compared to other industrialized nations, while we spend increasingly less on social services. Thus, despite medical advances and increased health care spending, underinvestment in addressing patients’ socioeconomic needs inhibits progress in achieving improvements in our nation’s health.

Social needs that contribute to health disparities have historically been a concern for public health, social service, or religious and charitable organizations. But now, in no small measure lead by those within the pediatric community, we recognize an expanded role in identifying and addressing social needs which is squarely positioned within, and not separate from, systems of health care delivery.

Innovation and advances in pediatric practice and the patient-centered medical home provide convincing evidence that screening for basic unmet social needs can facilitate successful connections with community resources, with resulting improvements in health. In addition to potential benefit to individuals, screening provides important information for healthcare systems and communities, essential to decisions regarding reimbursement rates and program development.

Okay, I’m convinced there is value in screening – what screen should I use?

Hold on there, tiger! Unfortunately, there is a lack of validated, multidimensional, comprehensive screening tools for pediatric care professionals. Truth be told, there has been wide variation in how researchers and health care organizations develop, validate, and implement tools for identifying/addressing patients’ social needs.

The lack of standardized workflows/screening tools has largely resulted in ad hoc efforts to assess patients’ social needs with varying degrees of success and validation in terms of sensitivity, specificity, or evidence that outcomes are altered. This is currently an area of tremendous flux and study, as we move along the learning curve.

Social Determinants of Health is a new priority in the fourth edition (2017) of the AAP Bright Futures Guidelines, which includes questions that explore child and family social needs in a systematic way, woven into each well child visit.

Providers may also want to become familiar with Minnesota resources for families:

- The Minnesota Food HelpLine (1-888-711-1151) assesses the caller’s situation and provide solutions to their food needs.
- Although Bridge to Benefits, a free online screening tool (mn.bridgetobenefits.org) developed by Children’s Defense Fund-Minnesota, does not screen for social determinants of health, it does assist in determining eligibility for federal assistance programs and tax credits. HelpLine Hours: Monday-Friday 8:30 a.m. to 4:30 p.m.

Is there any potential harm in screening, or certain care situations when it should not be undertaken?

Some pediatric practitioners have argued that screening for social needs and identifying risks and conditions that may require resources beyond the scope of clinical care, without the capacity to ensure referral and linkage to appropriate treatment, is ineffective and potentially unethical.

Others have argued that screening reveals social injustices and speaks to the important role of public health surveillance, which often lays the groundwork for programs that do not yet exist.

Most clinicians would readily agree that screening should not be performed in the context of care for an acute life-threatening event. Some would argue that primary care is the best environment for screening, but others would point out the potential value of screening in multiple other situations, including acute, in-patient, and specialty care sites.
Rigorous consideration of validation and replicability of screening needs further study, with careful consideration of how screens are delivered (verbally, by whom vs paper vs computer), which may strongly influence disclosure.

The Wilson criteria, the standard applied in the last 40 years for screening processes, has been more recently synthesized into an emerging new criteria framework may also provide some helpful guidance (see box to the right).

What does the future hold with regard to screening for social needs?

Clearly, continued research, innovation, and development of policies and programs is needed. Efforts that foster innovation and flexibility through the use of Accountable Care Organizations and Medicaid waivers can play an important role.

One of the biggest investments in the field is the Centers for Medicare & Medicaid Services innovation initiative of $157 million toward creation of the Accountable Health Communities (AHC) Model.

Although this 5-year initiative only began in 2017, one promising aspect of this model is the engagement of all the relevant service providers within a community (including health care services, public health, and social services) to achieve shared goals for a defined population.


\* The screening program should respond to a recognized need.
\* The objectives of screening should be defined at the outset.
\* There should be a defined target population.
\* There should be scientific evidence of screening program effectiveness.
\* The program should integrate education, testing, clinical services and program management.
\* There should be quality assurance, with mechanisms to minimize potential risks of screening.
\* The program should ensure informed choice, confidentiality and respect for autonomy.
\* The program should promote equity and access to screening for the entire target population.
\* Program evaluation should be planned from the outset.
\* The overall benefits of screening should outweigh the harm.

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MNAAP -- Dedicated to the health of all children. Visit us at www.mnaap.org
Sounding the Alarm on School Start Times: Later is Attainable

Julie Dahl, APRN, CNP, president of the MN Sleep Society, Respiratory Consultants; Julie Baughn, MD, FAAP, Mayo Center for Sleep Medicine, Children’s Center; Robin Lloyd, MD, FAAP, Mayo Center for Sleep Medicine, Children’s Center

It is widely known that adequate sleep is required for optimal health and learning. Yet adolescents nationwide are sleep deprived. Why?

As children transition to adolescence, their biological sleep clocks shift to a bedtime of about 10:45 p.m. With early school start times, adolescents are unable to get the quality sleep they need.

In Minnesota, 87 percent of high schools start before 8:30 a.m. and 60 percent of adolescents report inadequate sleep.

Clear evidence

Consequences of poor sleep include poor academic performance and an increased risk of mental health issues. In the setting of sleep deprivation, there is also a 1.7 times greater risk of sport-related injury and negative affects on athletic performance.

When school start times are later, total sleep time significantly increases for adolescents, which leads to less tardiness, fewer school absences and improved outcomes in core classes like math and reading.

Safety and health benefits are also achieved with later start times. Evidence shows fewer car accidents involving adolescents in communities where start times are changed, with one study showing a 16.5 percent drop in the average crash rate.

Later school start times, even by about 30 minutes, can lead to less risk-taking behavior and an improved mood. Coaches at schools with later start times report better performance and decision making as athletes remember plays better.

Concerns about temporary disruptions

Other factors are considered when adjusting start times, including busing, athletic schedules, and child care. Occasionally elementary schools must start earlier to keep transportation costs neutral. Younger children are wired to wake up earlier than adolescents.

Currently there is not enough data to determine “how early is too early” for younger students with only a handful of articles on this topic. However, schools in 45 states have been able to work through barriers and come up with solutions.

Informing stakeholders

Pediatricians are in a perfect position to educate parents that sleep, like activity and nutrition, is a pillar of health and is critical for short- and long-term health benefits.

Those of us in sleep medicine, along with primary care providers and school health professionals, ask for your support to follow the policy recommendation from your national organization and others in calling for middle and high schools start times of 8:30 a.m. or later.

A well-rested child is a healthy child who can meet his or her full potential in school and beyond. One key point to keep in mind is the nature of biology. Adolescent sleep schedules are never going to change. School start times can.

This article has been shortened due to space limitations. Visit www.mnaap.org/newsletter/ to read the full article, including footnotes and charts.

Schools Implementing Later Start Times

Edina (1996)
Minneapolis (1997)
Mahtomedi (2005)
South Washington (2009)
St. Louis Park (2010)
Moorhead (2012)
Alexandria (2014)
Saint Paul (2015)
Buffalo/Hanover/Montrose (2016)
Wayzata (2017)
Mounds View (2018)

Check out “The Impact of Sleep Loss in Childhood” at the May 11 Hot Topics in Pediatrics Conference.

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Last year more than 150 people attended one or more sessions. Join us as your schedule allows for part or all of the day!

Agenda, details and online registration at www.mnaap.org/annualmeeting.htm
The Nitty Gritty of Providing Adolescent Confidential Services

Dave Aughey, MD, FAAP, Children’s Minnesota

Minnesota’s “Minor Consent” statute allows adolescents to receive confidential sexual health services. The statute does not mandate that clinicians need to provide confidential care. But if services are provided confidentially, the clinician is obligated to do everything possible to ensure 100 percent privacy for the patient.

This is an implied contract between the clinician and the patient and is consistent with “Do no harm.” When confidentiality is broken, not only is the patient’s trust violated, but a variety of harms may occur.

The clinician needs to be responsible for identifying when clinical encounters fall under the umbrella of being “confidential.” This is relatively easy when the entire encounter is for “confidential sexual care.” It becomes more challenging when the confidential care is a component of another visit, either an acute care or a preventive visit.

Documentation

Protecting privacy can be complex and challenging when one considers the nuances of care delivery. Documenting the care provided necessitates that the documentation itself needs to be sequestered in a separate and private area of the EMR that is not viewable on the patient’s portal or accessible if a parent requests records for that visit.

Also, confidential records should not be released by a general release of information signed by a parent unless the minor has specifically consented to the release.

Billing

Another issue which may expose a confidential encounter relates to the EOB for that visit. For patients covered by Medical Assistance, EOBs are suppressed by these plans for visits using billing codes related to confidential issues. However, for patients using private insurance, this is generally not the case and one should assume that the parent will receive an EOB. A mailed EOB is a very common reason for adolescents unintentionally having parents find out about a confidential encounter.

A similar issue is related to the handling of lab charges for an encounter. An itemized listing of lab charges may reveal a Chlamydia or HIV test having been done. Less obvious is when a parent directly calls the lab or billing office to inquire, “What is this lab charge for?” This has happened in our facility.

Follow up

Another component of confidential care delivery is the ability to contact an adolescent patient for follow up or lab results. Most EMRs or registration protocols do not collect telephone numbers of adolescents or have the capacity to do this. Most health care systems also do not permit sharing of results by directly texting or emailing patients due to HIPPA concerns.

Assess concern for privacy

When I am seeing a patient for sexual health issues, I ask the patient, “How important is it that this visit be private and that a parent doesn’t find out?”

If the patient is covered by Medical Assistance, my confidence is high about being able to provide complete confidentiality. Our clinics have EMR documentation options and policies for release of information practices that should ensure privacy. For these confidential encounters, there should be no systems issues that might compromise privacy. In the strictest interpretation of privacy for adolescents, no evidence should ever exist that the patient was ever seen on the day of the clinic visit. However, one can only ensure privacy if “everyone along the way” does their job correctly, including all support staff.

If a patient has private insurance, I also ask, “How important is it that a parent doesn’t find out?” Compared to even 10 years ago, a surprising number of patients say, “It’s not that important as my mother already knows,” or, “I tell her everything.”

Refer, if necessary

However, if the response is that it’s very important to maintain complete privacy, I explain the various ways that a parent might find out. I then refer the patient to a clinic which has the ability to provide 100 percent confidentiality, which usually means a school-based clinic that offers this or a sliding scale community-based clinic. It is incumbent that clinicians know where to refer adolescent patients for confidential care that is local, affordable and reliable.

RESOURCES

AAP Committee on Adolescence
http://pediatrics.aappublications.org/collection/committee-adolescence

National Adolescent and Young Adult Health Information Center
http://nahic.ucsf.edu/

PATCH - Medical Records and Confidentiality

Sometimes doing the right thing means recognizing one’s limits and having contingencies for offsetting them. As someone who has seen the repercussions of having confidentiality broken, it is so important that we do this right.
Minnesota continues to be a leader in the country for timely and well-executed newborn screening. In 2017, Minnesota’s program added three new disorders (X-ALD, MPS I, and Pompe disease) to the newborn screening panel. In 2018, Minnesota will be one of the first states to start screening for spinal muscular atrophy (SMA).

About SMA

SMA is the leading genetic cause of early childhood death, affecting as many as one in every 6,000 live births. SMA is a neurodegenerative disease, characterized by muscle weakness and atrophy resulting from the deterioration and loss of the lower motor neurons.

SMA is caused by mutations in the SMN1 gene. A second gene, SMN2, often called the “back-up gene,” informs which type a child has. There are four types of SMA based on age of onset and highest motor milestone reached. While onset of symptoms range from birth to adolescence, the symptoms tend to be nonspecific. Type I is the most common and most severe with death occurring within the first two years of life.

Promising treatment

Until recently, families often had little hope given treatments focused on symptom management, rather than symptom mitigation. A year ago, that changed when the drug Spinraza (nusinersen) was approved by the FDA to treat all ages and types of SMA.

Newborn screening seeks to identify children with rare, hidden disorders before the onset of symptoms in order to prevent serious health complications. Given the recent FDA approval of Spinraza, SMA became a relevant disorder for consideration of newborn screening. Over the past year, Minnesota’s Newborn Screening Program worked closely with the CDC to develop and refine a test method for population-wide screening of SMA.

Screening specifics

In parallel, Minnesota was equipping the program’s Advisory Committee on Heritable and Congenital Disorders with information about SMA to help them evaluate its candidacy for newborn screening.

In October 2017, Minnesota advisory committee members voted to recommend to the Commissioner of Health the addition of SMA to the newborn screening panel. The addition of SMA was approved in December 2017 and Minnesota will begin screening for SMA early in 2018.

Minnesota’s Newborn Screening Program expects to identify approximately 6-14 newborns with SMA each year.

Interpreting results

In Minnesota, SMA screening will target the specific genetic change that is responsible for about 95 percent of cases. This specific change is the loss of exon 7 in both SMN1 genes. Minnesota will not be screening to determine the number of SMN2 genes. This means that children identified to have exon 7 absent will very likely have SMA, though the type will be unknown.

Upon the identification of an abnormal result, the program’s genetic counselors will contact the primary care clinic to discuss the result. They will provide the clinician with the result, a provider fact sheet, a family fact sheet, and a resource list of treatment centers available for consultation. These treatment centers will perform a comprehensive diagnostic evaluation on the child, including the determination of SMA type.

It is important to point out that while the program expects to identify all cases of SMA resulting from the loss of exon 7 in both SMN1 genes, there are about 5 percent of cases caused by different, rarer genetic changes. Minnesota’s current method will not screen newborns for these other changes, and therefore, false negative results are likely.

As with all disorders on the newborn screening panel, if you have clinical suspicion, diagnostic testing should be pursued regardless of a child’s newborn screening result.

The program’s genetic counselors remain a resource to you and your patient’s family should you have questions.
How would your local hospital respond to 15 pediatric victims of a disaster presenting to the emergency department (ED) in one hour?

A surge of pediatric patients can come from a mass casualty event like the Boston Marathon or from a chlorine spill at a pool.

The National PedsReady project from 2013 showed, on average, only 60 percent of Minnesota hospitals are sufficiently prepared for a pediatric surge of patients.

Through a grant from the AAP, I am working with a multidisciplinary group and the Minnesota Department of Health (MDH) to create and roll out an educational curriculum to improve the care of young patients during a large volume event.

Our goal is to create the curriculum, present a synopsis of the project to the state, and video each part to have it available for download.

Disaster preparedness curriculum

The curriculum is focusing on the clinical and non-clinical aspects of disaster preparedness with significant numbers of pediatric patients. Clinical aspects of traumatic and non-traumatic etiologies will be considered. Specific pediatric concerns involving triage and decontamination will be addressed. Non-clinical concerns of incident command, facility readiness and crisis standards of care will be discussed. Finally, we will have a segment on pediatric special populations.

Traumatic causes of pediatric mass injuries will focus on pediatric-specific concerns like the fast progression from hemorrhagic shock to arrest, the difficulty in accessing the mental status of infants and young children, and the complexity of getting IVs and administrating fluids. Much of this section will focus on recognition, treatment, and equipment. Non-traumatic etiologies of disasters will also be addressed, including poisoning, both accidental and intentional (terrorism). Biological causes of mass casualties, like anthrax and epidemics that focus on children will be discussed.

Pediatric triage and decontamination have unique aspects. We are working with Emergency Medicine System providers to use best practice protocols for adequate triage. These focus on close attention on respiratory distress and vital signs. From the experience of previous disasters, triage may not be done at the scene but at the door of the ED, therefore, ED nurses will need to know these tools. Decontamination, paying close attention to temperature of the water, empowering families to help the younger children and keeping families together are all advised.

The pediatric concerns in incident command and facility readiness are only slightly different than in standard disaster preparedness. Opening the Incident Command Center early and involving pediatric experts for advice in this disaster is key. The major concerns for facility readiness involve having child safe areas, appropriate ratios of adults to children for monitoring different age children and plans for reuniting families. In a truly pediatric incident, there may be many non-verbal, unidentified children. Currently, there is no perfect way to handle this identification challenge but having a plan to work with and have it ready is important.

Crisis standards of care are used when conventional care is not possible. An example of this would be if there was a shortage for pediatric ventilators, alternate methods for ventilation would be needed. MDH has a pediatric form for working from conventional care through contingent into crisis mode. (www.health.state.mn.us/oep/healthcare)

Special populations

Finally, we will address the concern of special pediatric populations during disasters. This includes those with autism or special health care needs or non-English speaking families. For those with autism, we are asking advice from autism specialists and looking for straightforward communication tools. We are in bedding in the guidelines awareness of children with special health care needs. Instructions in multiple languages and picture based communication are being utilized for non-English speaking families.

We hope to teach Minnesota hospitals and care givers how to respond to the unthinkable. The roll out will include all regions of MN this summer. We will meet with hospital administrators and providers describing the curriculum. Videos explaining the modules will be on the MDH web site by this fall.

Therefore, when many pediatric patients come in from a carbon monoxide poisoning, a bus crash or a school shooting, caregivers will set up their incident command center, triage at the ED door, stabilize, treat, and transfer the sickest, confident that they were prepared.

Check out “Disaster Planning for Clinics and Hospitals” at the May 11 Hot Topics in Pediatrics Conference.
Autism spectrum disorder (ASD) has been added to the list of qualifying medical conditions for Minnesota Medical Cannabis. Patients certified to have ASD will be eligible to enroll in the program on July 1, 2018 and receive cannabis extracts from the state’s approved vendors beginning August 1, 2018.

Minnesota joins only Pennsylvania and Georgia in specifically including autism among their lists of qualifying conditions for young people. In Delaware, autism is a qualifying condition for adults only.

The Science Behind the Law

What are the facts and current state of the science behind this law? Let’s do a basic review. We do have an endocannabinoid system (ECS) in our bodies and brains. The endogenous ligands are not products of cannabis plants, but rather are eicosanoid products of the arachidonic acid system in our bodies. The ECS appears to be involved in cellular signaling underlying multiple processes, including, but not limited to, inflammatory and neuromodulatory.

Data regarding cannabinoids and ASD can be found in the Minnesota Department of Health’s research brief: http://www.health.state.mn.us/topics/cannabis/rulemaking/autismbrief2.pdf

It is up to the individual provider to determine if the evidence in this brief provides enough support to justify certifying a patient with ASD. In summary, there are promising data that support the continued study of ECS in ASD and related conditions, and clinical trials may soon produce a medication. For example, purified cannabidiol (CBD) is undergoing clinical trials in pediatric seizure and a number of other indications, including ASD. There is likely to be a vetted, regulated drug in the foreseeable future.

Valid Concerns

However, the bulk of the studies cited in the research brief come from predominantly rat models, which are enlightening but not a substitute for human study. The small remainder highlighted are human studies, but cannot be equated namely because they do not all investigate the same cannabinoids.

It is worth noting that in 2015, ASD was rejected as a qualifying condition in Michigan because the state’s Director of the Department of Licensing and Regulatory Affairs expressed concern that approval applies not just to more severe cases, but to any in the spectrum. He further stated that even though parents applying to the program would need the approval of two medical doctors, there was no requirement that either doctor be experienced in treating autism. His final determination was based in part on corroborating testimony by Dr. Harry Chugani, chief of pediatric neurology at Children’s Hospital of Michigan and recognized national authority on autism.

Yet, the same scenario is true here in Minnesota.

Finally, there is a problem equating the state’s medical cannabis programs with clinical trials. The products are not subject to the same regulatory scrutiny as those undergoing the FDA testing and regulatory process. There is no scientific rigor in patient selection, inclusion/exclusion criteria, data collection or analyses, or safety monitoring. For example, there is evidence of a clinically significant drug-drug interaction between CBD and the anti-seizure drug, clobazam. That discovery was the result of a rigorous research study.

To certify or not?

Regardless of how one interprets the science, we now have “medical cannabis” available for people with ASD in Minnesota. What is a pediatrician to do? Should you certify? Do you have to certify? The overall, probably unsatisfying answer is, except where limited by your own clinic or system policies, the decision is between you and your patients/caregivers. You are under no legal or other obligation to either register as a provider, or certify any patients.

Whether you certify or not, we are all increasingly faced with multiple challenges, including requests for information/education, upset caregivers and colleagues who may disagree with a provider’s decisions, and others providing certification even while we remain the bona fide treatment provider for a child’s ASD-related condition.

When contemplating the use of the extracts of the cannabis sativa plant as contained in Minnesota Medical Cannabis products, keep in mind that there are multiple cannabinoids, most of whose functions are incompletely understood, much less combinations thereof. There is not one discrete diagnosis of “autism,” but rather a range of severity, symptoms, and co-morbidities.

Is there liability concern for those who certify patients? The most recent answer to that question is, possibly. Check out http://onlinelibrary.wiley.com/doi/10.1002/cpsy.30204/full for more information.

If you are considering certifying a patient, be an expert in the ASD field with a bona fide treatment relationship who is truly following the child’s progress, not the generalist just “helping the family out”.

Sometimes helping is hurting.
What made you decide to become a pediatrician? Describe your journey into medicine.

I am from a small town in North Dakota and we had some pretty great role models for doctors, very dedicated people. I am an enrolled member of the Turtle Mountain Band of Ojibwe. My mother really wanted her children to work for the Indian Health Service (IHS), and as it turns out, three of us ended up with dedicated careers in the IHS.

My pediatric rotation was on the Navajo Reservation in Arizona with a really great group of pediatricians. I met those people and felt immediately inspired to do what they were doing. My husband and I worked as pediatricians on reservations from 1997-2009, then he commuted to work on my home reservation in North Dakota until 2017. In 2010 I started working at the Indian Health Board (IHB) of Minneapolis, focusing on the urban American Indian population.

I am a pediatrician for the IHB of Minneapolis, a federally qualified health care center that is partially funded by the IHS. I love my job and the mission of the IHB. I enjoy working with families from the Phillips neighborhood and beyond.

The Native American population that you work with is affected by major health disparities. How does your knowledge of these disparities change the way you deliver care?

I am cognizant that poverty and homelessness affect many children in Minnesota and I feel proud that pediatricians are on the front lines to help these families. All pediatricians are do-gooders because so many of the patients we care for are on Medicaid. Poverty, generational trauma and discrimination are the root cause of so many of the problems children face. Caregivers are under tremendous stress. People do not have generations of success in Minnesota to fall back on, but they often do have relatives who will take them in.

People are stressed by extended family drug use. People are affected by the drug trade, addiction, human trafficking, child neglect. Gentrification of neighborhoods and loss of affordable housing are big issues right now with many working families living in long-term shelters, which are not rent-free. Temporary living is actually costly and very difficult to secure.

I try to be very easy going about my schedule, not being too strict about people being late because they may have had a bad day one way or another. We provide transportation for all scheduled appointments.

Our health center is making strides toward integrating Native culture into practice and I am trying to be part of that by starting a program to provide kits to help moms and caregivers save the baby’s umbilical cord to be put into a beaded umbilical amulet, a symbol of the permanent connection between mom and baby. Many tribes follow this tradition. This is a project our clinic is sponsoring and my daughter is working on the logistics as a school project.

Which pediatric issues concern you most?

Preventable birth defects related to maternal alcohol/drug use and other stresses on the uterine environment. Helping mothers who are struggling with addiction.

Integrating the social determinants of health into medical practice.

Increasing awareness of Long Acting Reversible Contraception (LARC) and Plan B for teens and moms. Pediatricians could do a better job with birth control.

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

I am a healthy foods person, but do not like to cook or spend time in the kitchen. Sometimes I just cut up vegetables and fruit for dinner and that’s it. I work 3 days per week and I have a wonderful, organized husband who loves to see me use my creative brain.

What do you enjoy doing in your free time?

I love Minneapolis parks and natural spaces. I run around the Chain of Lakes, often two or three lakes. I am an advocate for Minneapolis Public Schools and feel strongly that public schools are the foundation of democracy. There are so many needs in the public schools and I have volunteered about 100 different ways (and had lots of fun doing it). I like to garden and have organized the Kenwood Elementary School Garden since 2010.

My main hobby is watching my kids’ activities: soccer, dance, music, swimming, running, etc. I would like to do more art and sewing.
Immunization Work Group Updates

HPV and immunization training and quality improvement projects were in full swing during 2017. Here are updates on immunization projects from the past months:

• Over 206 medical students at three campuses in Minnesota (Twin Cities, Duluth and Mayo) participated in a student- and pediatrician-led immunization simulation training. Students produced the training video with three scenarios of difficult patient encounters and all participants were observed and critiqued in dyads as they dealt with the patient/parents who objected to HPV vaccination. Over 95% of the participating medical students reported improved skills in delivering a strong provider recommendation. It is important to note that these were medical students who had not all committed to a pediatric interest, but found the training helpful for dealing with pediatric and adult immunizations.

• A project to improve resident communication with vaccine hesitant families using simulation is ongoing at Hennepin County Medical Center. Four scenarios were designed, including influenza vaccine refusal, MMR denial in a Somali immigrant family, HPV concerns and an alternative vaccine schedule request. Residents have the opportunity to work with trained simulated caregivers. All first-year residents in the University of Minnesota Pediatric Residency Program participate as part of an outpatient rotation. Each session begins with a short presentation on effective communication strategies, including the C.A.S.E. method and presumptive vs participatory approach to vaccine discussions. Pre-and post-simulation data were gathered about resident comfort with these difficult conversations (Likert scale 1 – 5, with 1 being least comfortable, 5 being most comfortable). After simulation training, residents report higher levels of comfort regarding conversations with vaccine-hesitant families (pre: 3.0 vs post: 4.2). Residents also felt they had more strategies for talking to vaccine-hesitant families (2.8 vs 4.0) and were more confident utilizing reliable vaccine resources (2.8 vs 4.4). 91% of residents reported they planned to change their approach to vaccine-hesitant families following the training.

• Clinics participating in the HPV quality improvement project used tracking and reminder recalls as a way to improve HPV rates in 2017 along with the adolescent immunization platform rates. Over 399 patients (ages 11-12 years) were followed/reminded for up-to-date HPV status. At the beginning of this project only 9% were UTD for HPV. At the completion of the QI project, 74% of the patients were up-to-date with HPV immunizations. Clinic staff report that the key changes were checking and flagging charts/patients prior to the physician clinic encounter so as to highlight the need for starting/completing the HPV series.

Vaccine Exemptions: Where Does Minnesota Stand?

By Margo Roddy, MN Department of Health; Diane Peterson, Immunization Action Coalition

Compulsory vaccination for children enrolled in childcare facilities and schools has been a major contributor to the long-standing success of the immunization program in Minnesota and in programs across the country. The recent occurrence of large measles outbreaks has served to shine a bright light on the role that non-medical exemptors play in fueling the spread of disease in school, childcare and community settings.

A chart has been developed that provides detail on the variable ways that states implement their non-medical exemption procedures (i.e., the compulsory steps parents must complete to secure a non-medical exemption). You can view the chart at http://mnaap.org/immunizationresource.htm

Minnesota requires that the parent obtain a notarized signature to exempt from a vaccine requirement for non-medical reasons. Other states have moved to requiring more substantial steps, including receiving education from a doctor or public health prior to opting out. Meanwhile, California has eliminated the non-medical exemption as an option for their schools.

Statewide in Minnesota, non-medical exemptions for all vaccines for kindergarteners have been stable over the past 7 years, from 1.60% in 2010–11 to 1.69% in 2016–17. While the statewide non-medical exemption rate remains low, some Minnesota schools, school districts and counties have higher rates that leave more children vulnerable to disease.

To see a list of kindergarten exemption rates by county, school district, and individual school, visit http://www.health.state.mn.us/divs/idepc/immunize/stats/school/index.html.
MEMBER NEWS

Charles Oberg, MD, MPH, FAAP was recently elected as a member of the American Pediatric Society (APS). In November, he visited the refugee camp in northern Jordan on the Syrian border with the Syrian American Medical Society (SAMS). It is the second largest refugee camp in the world with 80,000 inhabitants. “I was ‘adopted’ by a little orphan who just warmed my heart,” he said.

Amy Burt, DO, FAAP, joined UCare as the not-for-profit health plan’s associate medical director. Dr. Burt comes to UCare from North Memorial where she was medical director for primary care, urgent care, occupational medicine and urgent centers.

Malini DeSilva, MD, FAAP, was hired as deputy medical director for Infectious Disease Epidemiology, Prevention and Control at the MN Department of Health.

Daniel Broughton, MD, FAAP, is now chairing the MNAAP senior pediatrician quarterly luncheons.

MNAAP has a total of 1004 members!

A warm welcome to new members who joined between September 1, 2017 and November 30, 2017

Jennifer Arnold, MD  Sacha Kumar, MD
Richard Boesch, DO  Riwaaj Lamsal, MD
Deirdre Croke, MD  Hannah Lee, MD
Teja Dyamnahalli, MD, MPH  Sharon Li, MD
Judith Eckerle, MD  Andrea Lyke
Alissa Farrell, DO  Marta Michalska-Smith, MD
Maggie Flint  Megan Mehring, MD
Polly Godfrey, MD  Sean Pyper, MD, PhD
Shelby Graf  Miriam Shapiro, MD
Monica Gressett  Jill Simons, MD
Shipra Gupta, MD  Krishnan Subrahmanian, MD
Emily Halverson, MD  Allison Taber, MD
Catherine Heith, MD  Erica Ting, MD
Melissa Hersey, MD  Jessica Ulrich
Denise Klinkner, MD, MEd  Anna Weitz
Nicholas Kucher, MD

We are actively recruiting exceptional part-time or full-time BC/BE pediatricians to join our primary care team in Sartell, MN. Our current primary care team includes family medicine, adult medicine, OB/GYN and pediatrics. Several other specialty services are also available onsite. Electronic medical record experience is preferred but not required. We use the Epic EMR system at all of our clinics and admitting hospitals.

HealthPartners Medical Group continues to receive nationally recognized clinical performance and quality awards. We offer a competitive compensation and benefits package, paid malpractice and a commitment to providing exceptional patient-centered care. St. Cloud/Sartell, MN is located just one hour north of the Twin Cities and offers a dynamic lifestyle in a growing community with a traditional appeal.

For more information, please contact diane.m.collins@healthpartners.com or call Diane at 952-883-5453, or 800-472-4695, x3. Apply online at healthpartners.com/careers. Job ID# 45587. EOE

Join MNAAP for a series of webinars on pediatric mental health.

Coming up...

Thursday, Feb. 8th
12:15 - 1:00 p.m.
Clinical Care for Complicated ADHD and Medication Non-Responders
Rachel Lynch, MD, FAAP, Mayo Clinic

All mental health webinars are recorded and archived at mnaap.org/mentalhealth.htm

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If you are a member, you should be receiving:
- Weekly emails from MNAAP President Dr. Andrew Kiragu -
- Bi-weekly legislative updates during the legislative session -
- Quarterly newsletters from the Chapter -

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