Ohio AAP Advocates for New Immunization Legislation
Building a Network of Parents and Pediatricians to Move the Needle

#iVax because of my sweet little preemie. I am terrified of the flu and was genuinely excited to take her to get her first flu shot at 6 months!

#iVax because in medicine I see the flu frequently and if I get it, I want an immune system that’s prepared to fight it off.

#iVax because my son is immunocompromised and cannot receive some vaccinations. For him, it wouldn’t just be chicken pox, measles, flu or any other illness. It would be a hospital stay and major risk to his life.

#iVax because I want others to be vaccinated to protect those who can’t be vaccinated.

Addressing Ohio’s Vaccine Opt-Outs
Legislation on Our Watchlist
Pediatricians Running for Elected Office
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Issue Focus

The Ohio AAP’s Advocacy Pillar coordinates the Chapter’s state legislative efforts and overall messaging. Pillar members also aim to be the “experts at the table” for children’s issues in the State of Ohio. The pillar leaders spend many hours at the Ohio Statehouse, meeting with representatives and other children’s and physician organizations, to advocate for members and the children of Ohio. If you would like to get involved, contact Melissa Wervey Arnold at marnold@ohioaap.org.

Ohio Pediatrics: A publication of the Ohio Chapter, American Academy of Pediatrics

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Ohio Chapter
Recent American Academy of Pediatrics strategic priorities have included the child in poverty, epigenetics and toxic stress. All three represent different aspects of the same finding: a child’s early experiences shape how they develop, how they react to adversity, how they behave, and eventually, who they become.

Toxic outcomes tied with adverse childhood events (ACEs) are clear dangers. But it’s not the events that are toxic, but rather the child’s reaction to those events. Powerful protections can be instilled in a child early in life. As Andy Garner, MD, PhD, FAAP, past-president of the Ohio AAP, likes to say, “it’s all about relationships.”

We discussed adversity and poverty with Sampson Davis, MD, a product of urban disadvantaged Newark, New Jersey, who returned to the city’s hospital system after medical school (see profile on page 19). Dr. Davis will be the keynote speaker at the Children’s Hunger Alliance’s Menu of Hope luncheon on February 22, 2018 at the Hyatt Regency Columbus (https://www.childrenshungeralliance.org).

Dr. Davis only recognized the fact his family was poor when he became old enough to read the signs. The stress of finances. The periodic food insecurity. Making a meal out of hot dog buns and juice. He described a growing understanding of poverty during his teen years. It embarrassed and frustrated him. Davis acknowledged that for many teens, the awareness of poverty and its barriers often leads to depression or even suicide. He understands the lure of alcohol, tobacco, and drugs as a temporary respite from unrelenting daily challenges. But for Davis, poverty’s limitations led to a personal commitment to succeed and to help others do the same.

When Davis discussed the supports that helped him succeed, he cited not only a few key personal relationships, but also several critical programs in his neighborhood. Later, looking back, he realized how much he had depended on “food stamps” (now called the Supplemental Nutrition Assistance Program [SNAP]), on school meals, and summer activity programs that provided quality nutrition and social connections.

Dr. Davis offered a perspective on what we can do as physicians, irrespective of our medical field. “Poverty is a marathon,” he said. “The family in your office isn’t looking for you to fix everything in their life.” What they want from their doctor is “encouragement that they’re doing a good job.” They need to be inspired to keep trying. And they are looking for “a place to start and some basic resources to get them started. That’s all they need.”

The Ohio AAP is working to help make screening easy for the physician and effective for the family. We have a simple two-question food insecurity screen and all the resources any Ohio family needs to help deal with the problem (available at http://ohioaap.org/food-insecurity/). Even more promising are efforts to efficiently screen and respond to all the social determinants of health. Stay tuned.

President’s Message

Robert Murray, MD, FAAP
President, Ohio Chapter, American Academy of Pediatrics

Two New Programs Launched in January

The Ohio AAP launched two brand new quality improvement programs in January 2018!

On January 26, the “Smoke Free Families Ohio Learning Collaborative” launched with a learning session featuring Michael Gittelman, MD, FAAP, medical director for the program and president-elect of the Ohio AAP. This collaborative will address caregiver smoking during well visit appointments.

The following week, on January 30, the “Injury Prevention Plus SEEK” program held their learning session. Participating practices will utilize the Ohio AAP’s injury prevention screening tool, along with the nationally recognized Safe Environment for Every Kid (SEEK) tool, to screen for child abuse and mental health risks.

If you are interested in getting involved in a quality improvement program, contact Elizabeth Dawson at edawson@ohioaap.org or (614) 846-6258.
Ohio AAP: Vaccines Will Always Be a Priority

Over the past several years, the Ohio Chapter, American Academy of Pediatrics (Ohio AAP) has advocated to pass two pieces of legislation regarding vaccinations. In 2014, the Chapter spearheaded the effort to reinstate a law requiring vaccination for children entering preschool, day care or head start. In 2015, the Ohio AAP lobbied to pass legislation requiring the meningococcal serogroup ACWY vaccine for incoming 7th and 12th graders as school vaccine requirement.

Despite these efforts, Ohio’s immunization rates are still lower than the Healthy People 2020 goal of 90%. The 2016 National Immunization Survey (NIS) showed just 68% of Ohio children ages 19-35 months of age have the seven-dose series recommended by the Advisory Committee on Immunization Practices (four or more doses of DTaP, three or more doses of polio, one or more doses of measles-mumps-diphtheria [MMR], full series of haemophilus influenza type b [Hib], three or more doses of hepatitis B, one or more doses of varicella, and four or more doses of pneumococcal [PCV]. In addition, Ohio rates for most childhood vaccines lag behind the national average.

National Immunization Survey (NIS) data show while more than 80% of Ohio teens 13-15 years of age have received the Tdap and Meningococcal ACWY vaccinations, the human papillomavirus (HPV) vaccination continues to lag well behind. Just 41.8% of teens are considered “up-to-date” on the vaccination, which is an estimate of teens who have either (a) received at least three doses or (b) received two doses and the first dose was initiated before age 15 and the time between the first and second doses met the minimum interval requirement.

While research and medical advancements have given the United States the safest and most effective vaccines in history, anti-vaccine sentiment is on the rise. Much blame may be placed squarely on the internet and Facebook. A recent study reported in the Washington Post analyzed hundreds of thousands of anti-vaccine comments on Facebook over a three-year period. It found that while in the real world, anti-vaccine networks are sparse, Facebook allows these like-minded people to find each other with hundreds of groups all over the country.

It is noted in the article that “the result is a highly self-reinforcing network that moves information quickly and efficiently. If one page somehow shuts down or loses its influence, others in the network quickly pick up the slack.”

The study also found that most of the discussion on these pages focus on support, offering first-hand anecdotes about the supposed harm from vaccines, tapping into parental fears. The groups also position themselves in a positive way to make the user feel better about being involved – not as “anti-vaxxers” or “anti-vaccine,” but rather “pro-choice,” or “pro-vaccine safety.”

While Facebook is the simplest, easiest place to meet other like-minded people – the internet as a whole has a wealth of legitimate-looking websites presenting information appearing to be reliable to further muddle the Google researcher.

The Ohio AAP is working to address the epidemic of misinformation with “Ohio Parents Advocating for Vaccines” or Ohio PA4V. This group focuses on providing factual information online in the form of handouts and videos.

Amanda McGowan, a mother in Dayton, lost her spleen during surgery on her pancreas several years ago. Without the spleen acting as an essential part of her immune system, she’s extra susceptible to diseases and relies on herd immunity to make sure she is around to parent 6-year-old Peyton.
“Peyton knows that shots are important to our family. He knows I rely on other people getting vaccines to help protect me,” said Amanda. “I want others to be vaccinated to protect those who can’t. A law enforcing vaccines would be great – it can protect those who can’t protect themselves.”

Samantha Spears, from Cincinnati, is concerned about people refusing vaccines because her son cannot receive certain immunizations. August, 2, has Systemic Juvenile Idiopathic Arthritis. August, who has also been diagnosed with autism, receives a biologic drug every two weeks that suppresses his immune system so that it doesn’t continue to attack his body.

“I’m terrified,” said Samantha. “August runs a huge risk of terrible complications that can be triggered by illness. It wouldn’t just be chicken pox, measles, flu or any other illness. It would be a hospital stay and major risk to his life and progress.”

In addition to correcting misinformation, the Ohio AAP is also working on legislation to finally address Ohio’s vaccine opt-out and data laws. Current law allows parents to opt out for medical reasons or reasons of conscience. The Ohio AAP proposes that before opting out of vaccines, which will remain an option, a parent or caregiver would be required to have a documented conversation with a health care provider. This preserves the parent’s choice, however, it mirrors other states who require a conversation about risks of vaccines before opting out so families are making an educated choice.

“It’s so important to get the facts about vaccination and sometimes it can be hard to sort out fact from fiction when searching online,” said Sarah Denny, MD, FAAP, co-chair of the Ohio AAP’s Advocacy Pillar. “We want parents to have a conversation with a health care provider to ensure they have been counseled with accurate information before they make their decision.”

In addition, schools are required to report their data to the Ohio Department of Health. However, not all schools do so and if they do, that information is not readily available to the public.

“It’s an emergency situation when there is an infectious disease outbreak at a school,” said William Cotton, MD, FAAP, Ohio AAP Advocacy Pillar co-chair. “We believe every parent should be able to look at the rates of vaccine opt-outs at their child’s school to know if there may be a risk.”

The Ohio AAP is working with legislators on the proposed legislation that would not only require schools to report their vaccination and opt-out rates to the State but also require the state to publish those rates online.

With the anti-vaccine groups so organized on Facebook, the Ohio AAP expects online attacks.

“We have been through this before,” said Melissa Wervey Arnold, CEO of the Ohio AAP. “We know they will criticize us, flood our social media pages and even call our office. But we know that we are taking the right steps to help protect Ohio children from dangerous vaccine-preventable diseases. Ohio kids need us to fight for them and we are rising to the challenge.”

The Ohio AAP will be making specific requests of its membership in the coming months as the legislation is introduced and discussed in committee hearings. To get alerts about potential opportunities to take action – including making calls, social media posts, and legislative meetings – make sure you are signed up for the Ohio AAP’s Peds on Call advocacy group. You can sign up here: http://ohioaap.org/peds-on-call.

The Ohio AAP is also addressing vaccination rates with several of our programs and are seeing many gains! Go to page 9 to read more.

References:
The Ohio General Assembly enters 2018 with a full plate of high-profile issues and healthcare-related legislation. Lawmakers will be focused on passing a state capital budget, tackling Congressional redistricting reform, and shoring up Ohio’s unemployment compensation program. The state Medicaid budget appears stable for now and lawmakers in Washington recently approved continued funding for CHIP.

Many lawmakers will also be focused on seeking reelection or pursuing higher office in a contentious election cycle. The Ohio General Assembly will work from January to May with a brief recess around the Easter holiday. Barring a major issue, the legislature will recess from June through the November election. The Ohio AAP remains focused on pushing pro-immunization legislation this year and working on a handful of key healthcare related bills.

**House Bill 416 (Health Price Transparency)**
State Rep. Steve Huffman (R-Tipp City), a physician and chair of the House Health Committee, introduced this measure at the request of the Ohio Hospital Association and Ohio State Medical Association. HB 416 is intended to be a practical alternative to Ohio’s current health price transparency law. The bill would require healthcare providers to give patients an estimate of the cost of a procedure that is scheduled for at least seven days in advance if requested by the patient.

Ohio’s current health price transparency law was enacted two years ago in a state budget bill. It requires a cost estimate for all non-emergency procedures regardless of whether or not a patient requests it. Many healthcare organizations and hospitals argued that this requirement was unworkable and would drive up costs. Following unsuccessful attempts to modify the statute, several healthcare groups including the Ohio Chapter of the American Academy of Pediatrics, filed a lawsuit last year. The suit, which is ongoing, placed the law on hold, meaning physicians do not need to comply at this time.

HB 416 would repeal the existing law and put into place a more workable alternative. Critics argue that it does not go far enough. The current law’s architect, State Rep. Jim Butler (R-Oakwood) is crafting another price transparency proposal that more closely aligns with the existing statute. At this point it is unclear if the General Assembly will act on this measure during the first part of 2018. HB 416 was referred to the House Insurance Committee where it has received only one hearing.

**Scope of Practice Bills**
The Ohio Chapter has been monitoring three scope of practice bills that have been introduced in the 132nd General Assembly. These bills have not advanced out of the House Health Committee and all face opposition from the physician community. House Bill 131, sponsored by State Reps. Theresa Gavarone (R-Bowling Green) and Bill Reineke (R-Tiffin) would expand the scope of practice for physical therapists to include diagnosing patients and ordering diagnostic exams. The bill has had several hearings and a number of positive changes have been made. However, the Ohio AAP remains concerned over new authority being granted to physical therapists as it relates to the pediatric population.

House Bill 191, sponsored by State Rep. Anne Gonzales (R-Westerville) would grant independent practice to nurse anesthetists. In the last General Assembly, the legislature enacted House Bill 216, which expanded the scope of practice for all nurse practitioners except nurse anesthetists. HB 191 seeks to grant CRNA’s new authority, but the removal of the physician supervisor requirement is a non-starter for the physician community. The final scope bill of concern is House Bill 326, sponsored by State Rep. Bill Seiwe (R-Cincinnati). The bill grants certain psychologists limited prescribing authority; it has not received a hearing yet.

The bill has split the physician community in Ohio with some specialty groups and the Ohio State Medical Association supporting the measure while the Ohio Chapter, American Academy of Pediatrics and other groups oppose it. The Ohio Hospital Association and Ohio Association of Health Plans also oppose HB 273. The bill appears on hold for now following a meeting between several national physician organizations and the American Board of Medical Specialties, which occurred last month.
Pediatricians Running for Elected Office

The recent political climate has inspired many new people to enter races for elected office, including pediatricians. In California, pediatrician Richard Pan, MD, FAAP, is a state senator who lead the charge to address vaccine opt outs in schools. Ralph Northam, MD, a pediatric neurologist, took the oath of office as the governor of Virginia on January 13, 2018. Also in California, pediatrician Mai Khanh Tran, MD, FAAP is running for US Congress.

It is exciting to see that regardless of the numerous challenges facing practicing pediatricians, to impact large scale change for children, many pediatricians right here in Ohio are looking to public service as a way to further their dedication to the health and well-being of Ohio’s children.

In Ohio’s 21st House District, Beth Liston, MD, FAAP, a pediatric hospitalist at Ohio State University Wexner Medical Center, is running for office in the upcoming election. Liston has always been interested in public health but decided about a year ago that it was time to run for office.

“I am running for office because I believe we need a voice talking about the human impacts of our policies and not just the financial ones,” said Dr. Liston. “This is about healthcare certainly, but there are health effects in so many different areas.”

Several other Ohio pediatricians have experience in serving in elected office. Thomas Phelps, MD, FAAP, a primary care pediatrician at Cleveland Clinic Community Pediatrics Chesterland, just completed his four-year term as a member of the West Geauga Local School Board.

“Being a pediatrician in the town I live, I heard a lot from my patients about what was going on in the schools, said Dr. Phelps. “Pediatricians have a huge opportunity on a school board because families know you and you hear about a lot of what they are going through.”

Louis Goorey, MD, FAAP, a retired pediatrician in Worthington, served on city council for 40 years. It was a patient’s E. coli infection after falling in a creek that led to him run for office.

“All the city manager blew me off,” said Dr. Goorey. “But the health department investigated and found two or three homes were dumping sewage into the stream. It was that experience that really got me interested in what they were doing – or not doing – in Worthington.”

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MOC Changes: Have Your Voice Heard
Ohio AAP Spring Education Meeting
Friday, April 20, 2018
11:30 a.m. - 3:30 p.m.

Dublin Integrated Education Center
6805 Bobcat Way, Dublin, Ohio

11:30 a.m. – 1:00 p.m.

Trust Me, I’m a (Certified) Doctor: Innovations and Improvements in Maintenance of Certification
Marshall Land, MD, FAAP, American Board of Pediatrics

• Recent changes in the process of Maintenance of Certification (MOC)
• The 10-year test will soon be replaced by an ongoing “take at home” exam designed as a learning experience and allowing the use of reference materials
• Qualifying CME activities are now eligible for MOC Part II points, which are reported automatically in a diplomate’s portfolio
• MOC Part IV credit is available for work already being completed in your workplace
• Opportunity for ABP to listen to diplomates for their ideas and comments

1:00 – 3:30 p.m.

MOC Part II: Secondhand Smoke Causes SIDS – Help Prevent Infant Mortality at the Statehouse and in Your Community
Judith Groner, MD, FAAP & Danny Hurley, Capitol Consulting

• Describe the relationship of smoking during pregnancy and poor pregnancy outcomes (fetal death, prematurity)
• Increase awareness of contribution of smoking during and after pregnancy to Sudden Unexpected Infant Death
• Identify who is at greater risk of smoking during pregnancy and to identify some of the unique issues of pregnancy
• Discuss opportunities for pediatricians to prevent post-partum tobacco use
• Explain tobacco legislative efforts including the 21 Rule

Free Registration: http://ohioaap.org/education-meetings
Questions? Contact Elizabeth Dawson at edawson@ohioaap.org

The Ohio Chapter, American Academy of Pediatrics (Ohio AAP) is accredited by the Ohio State Medical Association to provide continuing medical education for physicians. The Ohio AAP designates this live activity for a maximum of 5 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Successful completion of this CME activity, which includes participation in the activity, with individual assessments of the participant and feedback to the participant, enables the participant to earn 5 (five) MOC point in the American Board of Pediatrics’ (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider’s responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit. MOC Part II credit will be entered into the CME data portal entitled PARS and will be shared electronically with the ABP within 30 days of the activity date.

This event is supported by:
Ohio Immunizations: Addressing Rates at the Provider Level

The Ohio Chapter, American Academy of Pediatrics is addressing vaccination rates along many avenues—including at the provider level with continuing medical education and quality improvement (QI) programs. The Chapter’s longest-running program is the Maximizing Office Based Immunization (MOBI) program, which is an in-office, peer-to-peer, continuing medical education presentation focused on childhood vaccinations. The program is funded through the Ohio Department of Health. It began in 1996 and has expanded to include an adolescent vaccine program (Teen Immunization Education Sessions [TIES]) and cover all counties in Ohio.

Public health nurses presented 739 MOBI and TIES programs across the state in 2017. Data collected during these presentations at pediatrician, family practice, federally-qualified health centers, hospital-based clinics show an increase in knowledge in all topic areas. The presentations also include a plan-do-study-act portion in which the nurses work with the attendees to choose an improvement strategy to test in their clinic. End-of-the-year data showed 80% of the PDSA worksheets returned that selected an “act” step, choose to adopt the change.

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Knee Pain in the Adolescent Athlete: Rethinking Osgood Schlatter Disease

Timothy Foster, MD
Cincinnati Children’s Hospital Medical Center, Division of Sports Medicine

Knee pain is a common complaint amongst active children and adolescents. One of the most common etiologies of knee pain in this population is Osgood-Schlatter Disease (OSD). OSD affects about 20% of athletic adolescents as opposed to about 5% of non-athletic adolescents and affects males more than females (3:1).1,3 Traditionally, OSD has been thought to be self-limited with no associated long-term morbidity; however, studies have shown prolonged pain and activity limitation that lasts into adulthood in some of those with OSD. In this article, we discuss the history of OSD, its common presentation and treatment course, and a new treatment option for those with recalcitrant symptoms.

Osgood-Schlatter Disease, also known as tibial tubercle apophysitis, was first described in 1903 by Robert Osgood and in 1908 by Carl Schlatter.1,3 It was originally recognized as an acute, traumatic injury to the developing tibial tubercle as a result of strain placed on it by the patellar tendon during exercise.1 OSD is now thought to be a result of chronic tensile forces applied to the tibial tuberosity by the quadriceps muscles via the patellar tendon causing microfractures in the developing soft apophyseal cartilage and, eventually, chronic avulsion of bone and cartilage fragments.1,7,8,11,12

The biggest risk factors for development of OSD are increased activity, overall body weight, and growth rate as these contribute to larger stress to the physis. As it is an injury to the developing cartilage, girls tend to develop symptoms earlier in life than boys; on average, girls become symptomatic between 8-12 years of age while boys range from 10-15 years of age.11 The symptoms are present bilaterally in up to 30% of patients.11

While radiographs may reveal fragmentation of the tibial tuberosity, musculoskeletal ultrasound allows for recognition of the soft tissue pathology associated with OSD. Abnormalities described in more mild cases include soft tissue edema superficial to the apophyseal cartilage with possible fragmentation of the ossification center. More severe cases reveal thickening of the distal patellar tendon insertion and possible inflammation of the deep infrapatellar bursa.1,4,8,11

Clinical symptoms include pain worsened by activity, edema, and a bony prominence at the patellar tendon insertion on the tibial tuberosity.2,11,12 Traditional wisdom is that symptoms are effectively managed conservatively (stretching, ice, NSAIDs, activity modification, etc.), are self-limited, and resolve completely within two years with physeal closure.2,7,8,11,12 In fact, large case series have shown that 88-91% of patients respond to conservative management; however, timelines in the literature range from weeks to years. One retrospective survey found that athletes needed an average of three2 months of complete activity cessation and seven3 months of some activity restriction to resolve symptoms. Another retrospective review that followed patients for nine years found that only 76% had no activity restrictions.2 Radiographic studies have found that in almost 10% of patients, the bone fragments never fuse; these patients continued to have anterior knee pain with physical activity and kneeling.11

With the emerging focus on regenerative medicine techniques, those 10-25% of patients with recalcitrant OSD may have hope for a quicker, more complete recovery. One such technique is a prolotherapy injection with hyperosmolar dextrose into the patellar tendon. In a study by Topol, et al published in Pediatrics in 2011, patients with OSD who had pain with sport for at least three months and had completed at least two months of conservative management were randomized into either continued conservative management, injection with just 1% lidocaine, or prolotherapy injection with a mixture of 1% lidocaine and 12.5% dextrose.13 Those treated with the prolotherapy injection were significantly more likely to be asymptomatic with sport at both three months and one year compared with those receiving conservative management or lidocaine injection.

Osgood-Schlatter Disease is a common source of knee pain, affecting about one-fifth of growing athletes. Athletes are at greatest risk in times of increased physical stress on the growth plate such as during a growth spurt. The vast majority of cases improve with conservative management, however, in up to a quarter of patients, pain can be prolonged and debilitating. There are currently no literature-guided recommendations for imaging in suspected OSD; however, it is this clinician’s practice to obtain knee radiographs for those with new-onset knee pain in order to rule out more severe...
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*Ohio Department of Health, 2013 Ohio Youth Risk Behavior Survey, Center for Disease Control
Paving the Way: The Ohio AAP Partners with Practices to Improve Adolescent Health Care

Adolescence is a time of rapid development and change – physically, cognitively, socially and emotionally. Arguably during the time of the most need, well-care visits decline rapidly. Studies have found that only 69% of adolescents age 12-19 reported having a primary care visit during the past year and Medicaid claims data suggests that only 39% of Ohio adolescents had an annual comprehensive well visit in the past year.

Additionally, adolescents are more likely to engage in activities that risk their overall health, including alcohol and drug use, unprotected sex, poor eating and exercise or physically-endangering behaviors. Furthermore, many mental health conditions – such as depression and anxiety -- often first manifest during the adolescent years. Three out of four adolescents 12-19 years of age report engaging in at least one risky behavior. The CDC reports 16% of high school students have seriously considered suicide. Eighty-eight percent of adult daily smokers began smoking before they were 18 years old.

To address these trends and the unique needs of adolescents, the Ohio AAP is excited to announce a new and innovative initiative to the program menu. The Ohio QI2U-Adolescent Health program is a small, hands-on quality improvement collaborative offering MOC Part IV credit and individualized, tailored, collaborative, practice-based mentorship. Five practices are currently enrolled in the program. The collaborative kicked off in January 2018, with an onsite pre-collaborative assessment in each practice to evaluate adolescent-friendly services/culture, gather baseline data, set goals, and provide relevant education and training.

Participating practices set goals in three primary areas: (1) improving adolescent well visit rates, (2) increasing youth friendly services and culture in the practice and (3) improvement in site-specific quality metrics selected by each practice, based on site needs and practice goals. Implementing workflows to standardize confidentiality during adolescent appointments and improving the initiation of HPV vaccine rate are examples of practice-specific goals that have been chosen by participating practices.

Michele Dritz, MD, FAAP serves as Medical Director and Primary Practice Mentor for the program. Additionally, three adolescent health experts, Ellen Rome, MD, FAAP, James Fitzgibbon, MD, FAAP, and Gaya Chelvakumar, MD, serve as medical advisors. These adolescent health experts will provide mentorship and support, to assist practices in developing, implementing and evaluating a site-specific improvement plan.

In addition to the Ohio QI2U-Adolescent Health program and to support practices across the state, the Ohio AAP and Ohio Department of Health are also hosting three webinars focused on improving adolescent health care. Go to http://ohioaap.org/adolescent-health-webinars-2018/ to learn more and to register.

If you would like to learn more about these programs, please contact the Program Manager, Kristen Fluitt at kfluitt@ohioaap.org.
Foundation Focus

Early Literacy Awareness Month
March 2018

Reading aloud is widely recognized as the single most important activity leading to literacy acquisition, yet less than half of children under age 5 are read to each day. In 2018, the Ohio AAP Foundation Pillar will work to improve this number by conducting Early Literacy Awareness Month in March. As trusted sources for all aspects of child health, pediatricians can inspire other healthcare providers, community organizations, and families to discuss early literacy and read to children whenever possible.

Ohio AAP members are invited to get involved in this campaign through simple actions, including:

• Learn more and find resources, like talking points and social media posts, at http://ohioaap.org/early-literacy/
• Join the conversation on social media using #BooksBuildBrains
• Read with your own children, grandchildren, or others in your life
• Use March as a targeted month to discuss early literacy at all visits with families of children birth – 5 years
• Take part in a book drive! Collect books in your office to use with your patients or another community organization, or find a donation location through a resource like https://www.betterworldbooks.com/go/donate
• Make a donation for Early Literacy to the Foundation Pillar at http://ohioaap.org/donate-now/- as little as $5 can provide a new book for a child

The Ohio AAP has a long history of supporting Early Literacy as a part of pediatric care and childhood health. As the state organization for Reach Out and Read through 2011, the Ohio AAP oversaw the distribution of more than two million books to Ohio’s children. More recently the Ohio AAP has continued to encourage pediatricians, other healthcare providers, and community organizations to share the importance of early reading with families. Early Literacy has been incorporated into many existing programs of the Ohio AAP, including programs on parenting, injury prevention, and nutrition/physical activity.

If you have questions about Early Literacy Awareness or the Ohio AAP Foundation Pillar, please visit http://ohioaap.org/early-literacy/ or contact Hayley Southworth at hsouthworth@ohioaap.org or (614) 846-6258.
The Ohio AAP Gratefully Acknowledges our 2017-2018 Chapter Supporters

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Richard Tuck, MD, FAAP and Cynthia Tuck
Denise Warrick, MD, FAAP and Steven Warrick, MD, FAAP
1. What are the rules with safe sleep with twins/pets?

All infants under one year of age need to have their own separate sleep surface, preferably a crib, bassinet, or play-yard. Sharing a sleep surface with another infant, another human being of any age, or a pet increases the risk of suffocation, as those individuals may roll over or lie on the infant’s nose or mouth, and is not recommended.

2. Are there guidelines for using devices that claim to monitor an infant’s breathing while asleep?

There are no data that any commercially available devices reduce the risk of SIDS or other sleep-related deaths. Studies on these devices have shown that there are a high number of clinically insignificant alarms produced by these machines, both in at-risk and in healthy, term infants, causing parents unnecessary distress. The AAP does not recommend the use of these devices.

3. When can toddlers have a blanket in the bed?

Infants greater than one year of age, as well as toddlers, can have small pillows and stuffed animals, as well as blankets in their bed. By the time their first birthday arrives, children typically develop the muscle strength and head control to move blankets or other items in the bed off of their faces (and away from their noses and mouths) if needed. Given this extra mobility, however, parents need to remember to keep cords (from electrical appliances, window blinds, etc.) and other items that could strangle their children out of the sleep environment, as these represent the greatest sleep hazard to curious toddlers.

4. How old can a baby be swaddled safely?

The AAP does not have strict recommendations on when to stop swaddling a baby. In general, when an infant shows signs of attempting to roll, parents should discontinue swaddling their infants. As a more specific example, in the Netherlands (a country with low rates of sleep-related deaths), doctors recommend not to initiate swaddling after four months of age, to stop swaddling as soon as the child attempts to roll over, and always stop swaddling after six months of age.

5. Can I really practice safe sleep and breastfeed at the same time?

Absolutely! The following tips can be given to new moms who desire to breastfeed while maintaining safe sleep practices:

- Keep your baby close by the bed in his/her own crib or bassinet. With your baby beside you, you need only roll over, pick her up, and place her next to you to breastfeed.
- Soft chairs and couches are NOT safe sleep environments – don’t be fooled into thinking that falling asleep in a chair or couch is a safe alternative to bed-sharing. Studies have shown that falling asleep while breastfeeding a baby in a chair or couch is actually more hazardous than falling asleep in an adult bed during breastfeeding.
- When breastfeeding in bed at night, it is always best to create a safe environment, free from pillows, blankets, sheets or anything that could potentially suffocate the baby. Moms should wear warm clothes, sleep with one small pillow, and tie back long hair.
- If you do fall asleep while breastfeeding, always move the baby back to his/her safe sleep space as soon as you wake up.
- Try to develop the habit of sleeping during the day when the baby sleeps, if possible.

6. Is a Rock and Play™ safe for babies to sleep in during naps or night-time?

No, a Rock and Play™ is not safe for babies to sleep in at any time, as it does not conform to the standards of the Consumer Product Safety Commission for a safe infant sleep surface. Infants may be able to roll out of or over in the device; infants may also re-breathe exhaled carbon dioxide while in the device, leading to suffocation. Infants should always sleep alone on a flat, firm surface.

7. My baby has bad reflux and always spits up; I’m afraid to put him on his back for fear that he may choke in his sleep! What should I do?

It is safe for babies, even those with reflux, to sleep on their backs as long as they do not have specific face or neck anatomic abnormalities that need corrected (Pierre Robin sequence or unrepaired Type III/IV laryngeal clefts, in particular). Sleeping on the back does not increase the risk of choking, because the anatomy of a baby’s airway prevents him or her from breathing in what they spit up. Parents of babies with reflux also should not raise the head of their crib mattress, as this has not been shown to reduce reflux and can lead to unsafe sleep positions if the baby rolls.
The Business Side of Medicine for Resident Physicians

Kathleen M. Matic, MD

As residents, we are frequently sheltered from the vast and complicated business aspects of medicine. Many graduating residents are not educated on important topics like malpractice insurance, contract negotiations, physician compensation, and how to maintain certification with the American Board of Pediatrics. The goal of this article is to open the discussion about some of the aspects of business that directly affect graduating residents in regards to employment contracts. Resident physicians should consider obtaining help from both legal consultation and financial advisors to assist with the more difficult aspects of the business side of medicine.

Physician Contract Negotiations

Most hospitals and private practice groups have representatives that engage in physician contract negotiations. Learning the basic terminology of a contract can be difficult for even the most educated of physicians, so it is usually recommend to have a healthcare attorney review your contract before engaging in contract negotiations. Healthcare attorneys are different than other lawyers (i.e. malpractice attorneys), so seeking a lawyer that is well versed in physician contract negotiations is recommended. When negotiating your first contract, graduating residents typically have little to no guidance on the basic etiquette of contract negotiations. Some general recommendations regarding physician contract negotiation etiquette include:

1. Above all, remain calm and professional.
2. Make a list of your “deal breakers” and consider being flexible about everything else.
3. It is ok to walk away if terms cannot be agreed upon. Leave a good impression (no matter the outcome of the negotiation process.)
4. Do not have your healthcare attorney (who is reviewing your contract) engage in the majority of the discussions with your potential employers. You should try to always be the one who speaks directly with the contact at the organization.
5. Do your research and compare industry standards for compensation for your specialty. Research typical job requirements, call schedules, etc. for a physician in your specialty and at your level of training.
6. If it is not on paper, it never existed. Get all discussions regarding your contract in writing prior to signing the contract.

Physician Compensation and Benefits

Physician compensation is a complex topic, so resident physicians should have a good understanding of exactly how you will be compensated as an attending physician. Components of physician compensation include:

- **Base Salary vs. Productivity Based Salary:** Typically, a physician’s salary is the amount paid annually over the term of the contract. A base salary is usually guaranteed and independent of productivity. Productivity based salary can be reimbursed based on “RVU” (relative value unit) production by the physician or collections-based reimbursement. Physicians should understand the exact way that their salary will be computed and reimbursed.

- **Salary Bonus:** Salary bonuses are usually productivity based. Physicians should be knowledgeable on how the proposed bonus will be calculated, under what conditions a bonus will be paid, and lastly, under what circumstances a bonus will need to be paid back to the employer. Take note that after a certain number of RVUs, the physician may be paid at a discounted rate per RVU.
• **Sign-On Bonus**: Sign on bonuses are typically a one-time bonus for signing a contract. Physicians should understand how the sign on bonus will be paid (i.e. monthly vs. lump sum payment) and under what conditions the bonus will need to be paid back to the employer. For example, if you are terminated without cause, will you need to pay back your signing bonus? If you terminate your contract (with or without cause) before the contract expires, will you be required to pay back the signing bonus?

• **Student Loan Repayment**: If a contract includes student loan repayment for the employee, resident physicians should pay close attention to the terms of the student loan repayment. Most importantly, under what circumstances would a physician need to repay the employer for student loan payments made on their behalf?

• **Professional Liability Insurance**: Physician contracts may or may not include liability or “malpractice” insurance. It is recommended that physicians negotiate malpractice insurance into their contract. There are different types of malpractice insurance which include but are not limited to:
  - Occurrence Based Malpractice Insurance: Covers the physician for any incident that occurs during the policy period regardless of when the claim is filed. Occurrence malpractice is typically more expensive and seems to be offered less frequently to physicians.
  - Claims Based Malpractice Insurance: Covers the physician for any incident that occurs during the policy period only while the physician is employed and the policy is enforced. When physicians are offered “claims based” malpractice insurance they should also carry “tail coverage” which will cover the physician when they are no longer employed (and therefore, no longer have an active “claims based” malpractice policy).
  - Should an employer NOT cover “tail insurance” as part of the contract, physicians should research the personal cost for this policy before signing a contract as the expense can be incredibly high.

• **CME Time and Reimbursement**: Continuing education costs physicians both time and money and is required to maintain board certification with the American Board of Pediatrics. Physicians should consider negotiating both reimbursement and time into their contract.

**Other Benefits**
- Physicians should examine their contract for other benefits including but not limited to: vacation time, health insurance, sick leave, maternity leave and expense reimbursement. Some potential expense reimbursements include moving expenses, cell phone expenses, staff privileges fee reimbursement and medical society member fee reimbursement.
- If you are interested in research, you may need to negotiate research funding, time to conduct research and funding for a support staff to assist with your research (Example: clinical research coordinator, graduate student salary, etc.)
- Pay close attention to the retirement benefits offered in your contract. Attending physicians are sometimes eligible for other retirement account options not available to other hospital employees. Discuss benefits/risks with a financial advisor.

**Physician Contract Terminology**
Some basic terms found in physician contracts are listed below. It is recommended that physicians obtain legal counsel from a health care attorney that is well versed in physician contract negotiation prior to signing an employment contract.

• **Contract Term**: A contract term can be defined as the time frame in which a contract is valid. Physicians should note whether the contract is terminated after the contract term has ended, or whether renegotiation is required. Sometimes included in this section of a contract is information about a “Probation Period”, where an employer can terminate a contract within a certain time period (Example: 90 day probation period), which can effectively take a two year contract to only 90 days in length.

• **Termination of Contract**: A section of the contract should be dedicated to how, when and why a contract term will end. It should include specific information on how and when an employer OR employee can terminate the contract. Some contracts will include information on how an employee will be notified of impending termination and if applicable, if an opportunity exists to improve or remediate issues before termination is final.
  - Notice Provisions: Physicians should pay close attention to the requirements for termination of contract including how much time in advance an employee must provide an employer prior to leaving a job (Example: 90 day notice to employer). This section of the contract should also include the terms in which an employer must give an employee notice prior to termination of a contract.
  - Termination Without Cause: The employer (or employee if applicable) can terminate the contract for any reason, regardless of cause.
  - Termination With Cause: The contract should outline specific circumstances that would cause an employer to terminate a physician’s contract. Examples include failure to maintain qualifications, neglecting duties outlined in the contract, etc.

• **Non-Compete Clauses (AKA Restrictive Covenants)**: This section of a contract should include information that prohibits a physician (employee) to practice within a certain distance or location and for a certain time period after termination of a contract.

...continued on page 27
Gynecomastia: A Self-Esteem Issue for Boys
Andrea Paul-Taylor, Shriners Hospitals for Children—Cincinnati

Gynecomastia is the abnormal development of glandular tissue in males causing breast enlargement. It can affect one or both breasts, sometimes unevenly. The disorder, though usually not physically harmful, can have devastating effects on a boy’s self-esteem.

Nearly two-thirds of boys going through puberty will develop some range of gynecomastia. The cause is not completely clear, but nearly always involves excess levels of the female hormone estrogen. All males produce some estrogen, but during puberty the levels can create a hormone imbalance, triggering breast enlargement. It can appear as early as ten years of age, with a peak onset between ages 13 and 14, followed by a decline in late teenage years.

Although boys with weight issues may develop breast enlargement, true gynecomastia occurs regardless of weight. In most cases, time will correct the hormone imbalance over a period of months to a year, but about eight percent of cases persist.

The medical community considers gynecomastia to be a benign condition, but the real risk is in the damage to self-esteem. Even in mild cases, the boy may fear situations and avoid peers because of possible teasing or bullying. Gynecomastia can prevent boys from developing a positive body image and cause psychological and emotional damage. Surgical intervention for gynecomastia may be needed to reverse negative physical and emotional symptoms, and male breast reduction is typically a simple and safe procedure. Shriners Hospitals for Children—Cincinnati has board-certified plastic surgeons skilled in correcting this disorder.

Despite the emotional and psychological toll adolescent gynecomastia can take on a boy, the condition is generally regarded as a “cosmetic” issue, therefore surgical reduction is usually not covered by most insurance plans. Cincinnati Shriners Hospital provides its world-class care regardless of the family’s ability to pay, so every child has the chance to live a life free from stigma and embarrassment.

Pediatricians can help families decide the best course of treatment, but a physician’s referral to Cincinnati Shriners Hospital is not needed. To request an appointment, call 855-206-2096 or email us your information at helpachild@shrinenet.org.
Pediatricians Can Provide Support, Resources and Hope to Children Living in Poverty

Today, Dr. Sampson Davis is a board-certified emergency medicine physician working with a half dozen hospitals, a successful author and sought-after speaker, runs a foundation and is a regular correspondent and frequent guest on radio and television shows. It is a long way from his childhood home in Newark, New Jersey, surrounded by poverty, crime and drugs.

“As a child, I didn’t realize I was poor because everyone around me was poor,” said Dr. Davis. “In my adolescence is when I started to realize it.”

Davis’s mother had six children and had to depend on assistance programs like food stamps. By the end of the month, they were often out of food with no resources to get more. They’d often ask neighbors for help or Davis would walk two miles to the grocery store to earn quarters helping people load their cars with groceries. Once, his mother gave him money to ask a food truck operator for their leftover hot dog buns.

“I felt so embarrassed in that space, so vulnerable. Once he realized why I wanted it, he took a loaf of buns and gave it to me and told me to go home and that’s what we ate for dinner,” he said. “That was survival and that lit a fire inside of me. I may not be in control of my day but I shouldn’t let it determine my tomorrow.”

Dr. Davis shares how supportive role models are what helped him stay positive and work hard.

“At an early age, I saw how hard my mom worked. I saw her be the last at the table to eat or not eat at all,” he said. “She was my hero.”

That drive led Davis to set a goal with two friends in high school to become doctors. That’s why he returned to Newark after medical school.

“My dream was to be a concrete image of something that was positive. I remember being a kid I was looking for role models.”

More than half a million children in Ohio live in food-insecure households. Davis knows that pediatricians can play an important role in those children’s lives in sharing resources and providing support.

“Figure out a way to lend a hand. Step outside the hospital or office walls and get to know the community,” he said. “People don’t want to be pitied but most people want you to point them in the right direction.”

The most important thing is to be there for those children because they need you on their side.

“I know how it feels not to have and I know if someone didn’t take a chance on me, I wouldn’t be here today. I’m not the only bright-eyed kid with hope and aspiration. I was fortunate to be able to fulfill my dream.”

Dr. Sampson Davis is the keynote speaker at the Children’s Hunger Alliance’s Annual Menu of Hope Luncheon on Thursday, February 22, 2018. Menu of Hope was created with the goal of raising funds to provide healthy meals and nutrition and physical education to Ohio’s at-risk children who do not have consistent access to the nutrition they need.

... continued on page 26

This luncheon helps provide over one million healthy meals to Ohio children who struggle with hunger.

Join one thousand community leaders, business supporters, advocates and friends to advance the mission of Children’s Hunger Alliance.

February 22, 2018
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www.childrenshungeralliance.org
Updating Your Coding for 2018!

Richard H. Tuck, MD, FAAP

Additions and deletions to your coding regimen are minimal this year. General coding considerations and guidelines are unchanged.

ICD-10 code changes became effective 10/1/2017. Additional clarification has been provided regarding the preventive medicine codes "with and without abnormality:"

- Z00.129 - Routine child health exam w/o abnormal findings
- Z00.121 - Routine child health exam with abnormal findings

An abnormality can be known at the time of a visit, or can be discovered at the visit. The key requirement is that the problem requires an update and/or management at the time of the visit. This abnormality should be supported with a related ICD-10 diagnosis. Listing an abnormality, without documenting some intervention does not support using the codes designated with abnormal findings.

Note that the Newborn health exam codes <8 days of age, and 8-28 days of age, are not further distinguished by with or w/o abnormal findings.

An additional 2018 coding clarification has been that the term “outpatient hospital” is added to all observation care services to clarify they are to be reported when a patient is admitted to an outpatient hospital observation service.

By the way, the ICD-10 code of the year is R63.3 PICKY EATER!

CPT 2018 immunization additions:
- 90621 - Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp)
- 90651 - HPV vaccine, 9 valent

Influenza vaccines:
- 90682 - Quadrivalent (R1V4), derived form recombinant DNA, HA protein
- 90756 - Quadrivalent (ccIV4), derived from cell cultures

Pulmonary:
- 94617 - Exercise test for bronchospasm, including pre and post spirometry, and pulse oximetry

CPT 2018 introduces a new code set of psychiatric collaborative care management codes, which although initially confusing, provide the potential for other care management codes in the future, for other conditions. These codes recognize the work provided by coordinating staff, the managing physician, and consulting specialist.

The psychiatric model is a specific evidence based collaborative care model involving a Behavior Health Care Manager under the direction of a treating physician, a treating physician, and consultation with a psychiatrist:
- 99492 - Initial psychiatric care management, first 70 minutes, first month
- 99493 - Subsequent psychiatric care management, first 60 minutes, subsequent month
- 99494 - Each additional 30 minutes

2018 General Behavioral Health Integration Care Management Services:

Clinical staff for patient with behavioral health condition, > 20 minutes in a calendar month
- 99484 - Care management services for behavioral health conditions, at least 20 minutes clinical staff time.

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Running for Office...continued from page 7

For Dr. Phelps, getting out of his exam room and into the community to find out more about what was concerning people was important. After he won the election and began his term, he found that school board was much more political than he had thought.

“As a pediatrician, it’s in our DNA that we want people to like us. As a public official, you have to be prepared for lots of people to not like you for whatever it is that you stand for.”

Dr. Liston said campaigning has brought her out of her comfort zone.

“The biggest challenge is feeling like I am asking people for things,” she said. “In medicine, I always feel my role is to provide a service, to help others. In politics, I have to ask for time, money - even just a vote. It can be uncomfortable.”

All agree pediatricians are uniquely positioned to serve their community in an elected office as long as they are ready to put in the work.

“It was very fulfilling to serve. I would encourage anyone to do it,” said Dr. Goorey. “But you can’t just run and serve on one issue. You have to learn about the board range of issues you’ll be dealing with.”

“People are so interesting and I get to see small snippets of what people really care about. It is humbling and inspiring,” said Dr. Liston.

“It’s a great way to further connect with the community you work in,” Phelps said. “You get a whole different view of the area than what you do in your exam room. It revitalized my connection to the community.”

While there are no pediatricians, there are several other physicians currently serving in Ohio’s General Assembly and U.S. Congress representing Ohio. Stephen Huffman, MD, a family medicine doctor from Urbana, is serving his second term as State Representative for the 80th Ohio House District and is running for the Ohio Senate Seat in the 5th District. Terry Johnson, DO, who lives in McDermott, Ohio, is a member of the Ohio House of Representatives serving the 90th District. In the U.S. Congress, Brad Wenstrup of Ohio’s 2nd Congressional District, is a Doctor of Podiatric Medicine.

Addressing Rates...continued from page 9

The Ohio QI2U-MenB program is still underway but mid-point data analysis shows some exciting results as well. This program features a new, innovative program model called “Practice Coaching,” in which a nurse educator acts as the facilitator of the program throughout the nine-month time period. The nurse educator, Beth Barker, RN, BSN, travels to the practice, provides personalized education and strategies, and collects and enters data for the program. Data from the 20 practices involved in the program show:

• 154% improvement over baseline in administration of at least one dose of the meningococcal B vaccine
• 289% improvement over baseline in administration of at least two doses of the meningococcal B vaccine
• 27.96% increase from baseline in attendance of adolescent well visits
• 35.63% decrease from baseline in missed opportunities for up to date adolescent well care and MenB immunizations

The Ohio QI2U-MenB team is excited to announce it will share results from the program including best practices in a Maintenance of Certification (MOC) Part II presentation during Annual Meeting 2018. More information will be shared at a later date.

In addition to these programs, the Ohio AAP continues to include immunizations in many other programs being run by the Chapter, including the upcoming OhioQI2U-Adolescent Health program. See pages 9 and 12.

If you have questions about any of these programs or would like to get involved, contact Melanie Farkas at mfarkas@ohioaap.org.
District V Update

Richard H. Tuck, MD, FAAP
District V Chairperson

A New Year for You and the AAP

As we face the New Year, we do it with conviction and the firm foundation that the practice of pediatrics is rooted in our AAP core values: The American Academy of Pediatrics is dedicated to promoting optimal health and wellbeing for every child as well as helping to ensure that Academy members practice the highest quality health care and experience professional satisfaction and personal well being. This cannot be stated too often, as it is central to the value provided to children in our society and to every FAAP.

The Academy achieves this mission through the provision of high levels of value to member pediatricians, pediatric medical and surgical subspecialists, trusted advice to families, and professional leadership opportunities. Enhancing the health of children is indeed in the heart of every pediatrician and at the center of all the work our AAP does.

These values are clearly visible in our five year strategic plan, which has now competed year one, with significant progress made toward these strategic goals and objectives:

1. Strengthen the Academy’s impact on child health through policy, advocacy, and education.
2. Enrich member value and engagement.
3. Strengthen the policy development and dissemination process.
4. Enhance the Academy’s communication with members and stakeholders.
5. Support strong bi-directional relationships, interaction, and leadership development between AAP and chapters.

This strategic plan enables the Academy to focus energy, resources, personnel, and the board in moving forward in positive ways, while continuing to address the complex myriad of ongoing programs dedicated to children and the providers who support them.

This past year has been especially difficult with the current political challenges to the gains for children made by preserving the Affordable Care Act. We fought to sustain the critically important CHIP program which became a primary legislative objective for the end of 2017 and beginning of 2018. While there was consistent support for the program from the people of our country and the legislature, sourcing the funds had become a seemingly insurmountable political obstacle and bargaining tool. Once again, children were caught in the middle!

On the positive front, the AAP has now moved into our new home in Itasca, Illinois. It is located close to our previous headquarters in Elk Grove Village. The move was accomplished the second week of December with the careful planning and hard work of our dedicated national staff. We now face the challenge of meeting the down payment requirement. I am hoping that each and every one of you has contributed in some way to the For Our Future Campaign (FOF). If you have not, please go to: aap.org, go to the bottom of the home page, and make a contribution. We would like to see every AAP member be a part of this historic venture.

While navigating aap.org, please note the significant improvements in the format, search functions, and user-friendly point of service structure. This is part of the Digital Transformation Initiative started last year. This, too, will be an ongoing high priority as the AAP remains committed to addressing the rapidly changing world of digital transformation.

Thank you for your support and appreciation for all our American Academy of Pediatrics does for you. Be a part of it all by contributing at aap.org. Together we are the AAP!
osseous abnormalities. In those with refractory symptoms, regenerative medicine injections, in particular prolotherapy, may offer a more complete and quicker recovery.

References:

Exciting Things Happening with Good4Growth!

The Ohio AAP team, including Robert Murray, MD, FAAP, Ohio AAP President, worked with an innovative video team to create new parent videos on the topics of discipline and routines with sleep and meals. The short videos also include video clips and interviews with kids from child care centers enrolled in the Good4Growth program!

The clips will be available soon on the Good4Growth Family Resource Website (www.ohioaap.org/parent-resource-page). They will also be used in education and posted on the Bloomz mobile app.
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Poverty...continued from 19

More than 575,000 Ohio children – or more than 1 in 5 – live in a household where they will experience hunger or inadequate access to healthy food. The health effects of food insecurity in children can vary from developmental delays to behavioral issues to an increased risk of obesity due to eating highly processed, calorie dense foods.

“One of the greatest tragedies in our nation is witnessing a child go hungry especially in a country that has so much,” said Dr. Davis. “Children’s Hunger Alliance is leading the movement in making sure our children are not only receiving daily nutrition but also given healthy food options. By supplying them meals, our children can focus on what matters most – childhood, education, family, friendship, growth and their future.”

Go to www.childrenshungeralliance.org for more information.

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Every Kid Healthy Week
April 23–27, 2018
EveryKidHealthyWeek.org
Ohio AAP Welcomes Our New Members

Christopher Blunden, MD, FAAP
Beth Ann Bubolz, MD, FAAP
Jean Chia, MD, FAAP
Sofia Chinchilla
Mary Costello, MD, FAAP
Katherine DeLozier
Alejandro Diaz, MD
Katharina Hayes, MD, FAAP
Sarah Luthy, MD, FAAP
Andrea Maxwell, MD
John McDonnell, MD, FAAP
Mary Lou McGregor, MD, FAAP
Uche Onyewuchi, DO
Ceena Philipose, MD, FAAP
Christopher Schneider
Amanda Sessions
Mayuri Vegasana, MD, FAAP
Julie Wigton, MD, FAAP
Anita Yalamanchi, DO, FAAP

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- Important terminology to note about a non-compete clause include the geographic location and distance that a physician will be barred from practicing once a contract is terminated. Another important topic to consider about the non-compete clause includes terms under which the clause will be enforceable (Example: if a physician is terminated without cause will the non-compete clause be enforceable?)
- Some non-compete clauses may outline the procedures that will occur after termination of the contract (both with and without cause). Examples include how patients will be notified about a physician leaving a practice, who will be responsible for drafting the letter to patients to notify them of the physician leaving, and who will fund the postal service charges for mailing notice to the patients.

• Intellectual Property Rights: Physicians should pay particular attention to clauses in a contract that discuss who owns the rights to supplemental income, patents, innovations, etc. earned by a physician. Many contracts will include a clause stating that the employer owns any supplemental revenue earned and patents obtained (Example: a physician is paid from a presentation given and the practice or hospital is entitled to the money earned, not the physician).

References:
• Swanson, Debbie. (2017) Mistakes you’re about to make on your employment contract.Practice Link, (27), PP 67-77
• Turner, Marcia. (2017) You + Them, Creating a Deal That Works For you Both. Practice Link, 27 (4), PP 47-54
Calendar of Events

February 22, 2018 • Adolescent Health Webinar: Adolescent Health 101

March 2018 • Early Literacy Awareness Month

April 12, 2018 • Adolescent Health Webinar: Making the Most of Adolescent Well Visits

April 20, 2018 • Spring Education Meeting Columbus

May 2018 • Bike Helmet Awareness Month

May 10, 2018 • Adolescent Health Webinar: Owning It: Preparing Adolescents & Families for Transitioning to Adult Care

July 27, 2018 • Executive Committee Retreat Columbus

August 10, 2018 • Glow Ball Fundraiser Blackhawk Golf Course, Galena

September 21, 2018 • Casino Night Fundraiser Crowne Plaza Dublin

September 21-22, 2018 • Annual Meeting Crowne Plaza Dublin

Dues Disclosure Statement

Dues remitted to the Ohio Chapter are not deductible as a charitable contribution, but may be deducted as an ordinary and necessary business expense. However, $40 of the dues is not deductible as a business expense because of the Chapter’s lobbying activity. Please consult your tax advisor for specific information.

This statement is in reference to fellows, associate fellows and subspecialty fellows. No portion of candidate fellows nor post-residency fellows dues is used for lobbying.