



Nebraska Medicine

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Child Health in Nebraska

Caring for our future



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Medical
Association

Advocating for Physicians and the Health of all Nebraskans

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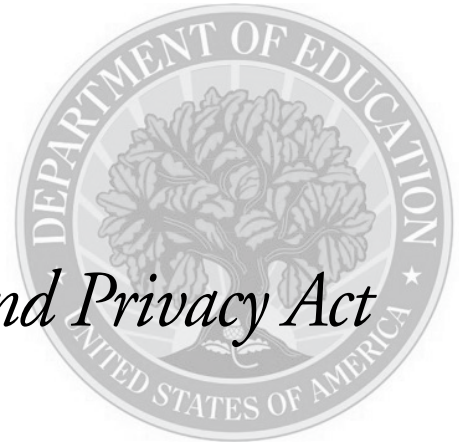
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President's Message

The Family Educational Rights and Privacy Act FERPA: Different than HIPAA

by Harris Frankel, MD
NMA President

In my role as chief medical officer for Nebraska Medicine, I have the executive oversight/accountability for enterprise privacy. While we are all mostly familiar with HIPAA, many of us may not be as familiar with FERPA. In this issue dedicated to pediatrics/children, I thought it would be reasonable to highlight some of the basic differences between FERPA and HIPAA in the context of “students,” recognizing adolescents and adults may occupy the role of students.

The Family Educational Rights and Privacy Act (FERPA) was established by Congress to protect the privacy rights of students and their parents. The act allows students and their parents the ability to access the student’s educational records and challenge the content or release of those records to third parties. According to FERPA, a student is an individual who is enrolled in and actually attends an educational institution. Attendance may be in person or by correspondence.

Under FERPA, educational institutions receiving federal funding for programs administered by the Department of Education must comply with certain rules/regulations regarding the handling of educational records,

including maintenance and disclosure thereof. Educational records are defined as those records belonging to a student and maintained by an educational institution/agency or other party acting on behalf of same. A student’s health records, including immunization data and other records maintained by a school nurse or UHC (university health center) are considered part of the student’s education record and are protected from disclosure under FERPA.

FERPA prevents the disclosure of “personally identifiable information” (PII) without the consent of a parent or eligible student (aged 18 or older) unless an exception to the law is applicable. FERPA classifies an additional domain of protected information referred to as “directory information.” Directory information is defined as “information contained in an education record of a student that would not generally be considered harmful or an invasion of privacy if disclosed.” Lists containing students’ names, addresses, and telephone numbers are examples. Social Security numbers are not permitted in directory information.

HIPAA, on the other hand, prohibits covered entities from disclosing “protected health information” (PHI) to any third party unless the subject individual authorizes such in writing or as otherwise permitted by the rule.

Under HIPAA, PHI is defined as individually identifiable health information, held or transmitted by a covered entity or business associate in any form. Education records covered by FERPA are also specifically excluded from the definition of PHI. In most cases, the HIPAA Privacy Rule does not apply to an elementary or secondary school because the school either: (1) is not a HIPAA covered entity or (2) is a HIPAA covered entity but maintains health information only on students in records that are by definition “education records.”

Under FERPA, public health agencies may access education records, including student health data held by the school/institution or its agent, so long as the school/institution or its agent has received written consent from a parent or eligible student.

FERPA recognizes certain exceptions that allow schools to disclose PII from a student’s education record without consent. Exceptions favor protecting the student’s privacy and therefore may pose challenges for health agencies when attempting to access student health data. HIPAA contains a robust exception which allows public health authorities to receive PHI without prior consent of a patient or his or her representative.

I hope this helps. □



Executive Vice President's Message

by Dale Mahlman
NMA Executive Vice President

Last fall, the NMA staff held an “internal” strategic planning session. Our focus was to create a team mission that would serve our membership and customers, both internally and externally. We developed a mission statement: “The NMA team is dedicated to educating, serving and advocating for our customers in the promotion of organized medicine.” We live by this daily. Our intent is to be a progressive and customer oriented organization.

One of the reasons we held the session was to engage staff with the understanding that the NMA is more than a job, it's a profession of providing great customer service to our members, colleagues and the public in general.

I'm a big believer that people should enjoy their work and profession (if possible), and have fun on a daily basis. Most of us spend more waking hours with our co-workers than we do with our families. As a result, I think that everyone's workplace should be a place they look forward to going each day.

I think the same can be said for

physician offices and hospitals. Given my reluctance or avoidance with either, the initial interaction usually sets the tone for me. When I meet someone who genuinely likes what they are doing and is interested in why I am there, it immediately sets me at ease.

I recently underwent a procedure at a local hospital, and I will tell you that my first reaction wasn't positive. It was a weekend, and the admissions office was not open. I wandered around for a few minutes before I came in contact with a radiology technologist who asked me if they could help. This person made eye contact with me and personally made sure I was in the right place to be admitted. She didn't have to, but she took the time to help a customer even though it was outside of her job description. Shouldn't that be the norm in any place of business?

So where am I headed with all of this? My wife sometimes asks me why I bother to wave at people that drive by as we are walking the dog or are out in the yard. I guess that is just who I am. I like to speak to strangers rather than look down or away, especially in the elevator on my way to work. I won't lie, making people uncomfortable in the elevator is always fun to watch. Walking down the street

I say hello to people I meet, and on evenings out I often speak to people I don't know. I guess maybe that is a bit unusual. However, life is short and we can all use a little bit more kindness in our lives.

Make your office a place where your employees want to come every day. Discuss the importance of reflecting a positive and welcoming environment with your office staff. Ask them to be mindful of conversations they have in front of patients, especially those about other patients. When you see your patient in the exam room, ask them if they felt welcomed or comforted when they came in to your practice. Showing empathy and compassion are, in my opinion, a critical element in patient care. For me personally, watching my aging mother's primary care physician sit down, say hello and put her hand on my mother's arm demonstrated the compassion that everyone needs in their health care experience.

Lastly, smile. You have the knowledge, skills and honor of making a difference in people's lives. And we are blessed to have each and every one of you working to improve the health care of Nebraskans. □



NMA forms The Nebraska Medical Association Insurance Group

Effective June 1, 2016, physicians, physician families and physician employees now have a new option when they need insurance coverage. The Nebraska Medical Association has partnered with 1st Insurance Group to create a new agency: The Nebraska Medical Association Insurance Group (NMAIG). The new company will provide services statewide.

With so many insurance agencies merging or closing recently, why would the NMA enter the insurance business? “We’ve been exploring the idea for quite a while,” said Dale Mahlman, executive vice president of the NMA. “A number of other medical societies around the country have agency operations. It’s a way to bring unique products that are competitively priced to our members. Another reason is to ensure that the products endorsed by the NMA are the best available.”

NMAIG will be located in Omaha and will be staffed by Scott Morris and Derek Briscoe who have many years of experience working with physicians. Morris has 25 years of employee benefits experience and currently manages the NMA insurance program with Blue Cross Blue Shield of Nebraska. Briscoe, who has 20 years of insurance experience, will manage the professional liability and business insurance. “I’m excited about the opportunity. As far as I know, there is no other insurance agency in the state whose business is to exclusively serve the needs of physician,” said Morris. “Consumers in Nebraska are fortunate to have many good agencies across the state, but we will serve a need dedicated to the physician market.”

NMAIG will sell all insurance products including but not limited to:

- Professional liability insurance through NMA’s endorsed carrier COPIC
- Business insurance
- Executive benefits
- Individual and key person life and health products
- Employee benefits
 - Health
 - Dental
 - Vision
 - Life
 - Disability
 - Cancer
 - Critical illness
 - Accident
- Retirement plans
- Wellness programs
- Personal lines
 - Homeowners insurance
 - Auto
 - Umbrella

“We will continue to work closely with our carrier partners to grow. That includes COPIC for professional liability, Blue Cross Blue Shield of Nebraska for medical insurance, Lincoln Financial for life and disability and Ameritas for dental. All these companies have a great track record of working with physicians within our state. We are looking to grow that list through exclusive product endorsements,” said Mahlman.

Briscoe added, “We look forward to the opportunity to discuss NMAIG offerings with physicians in Nebraska. Given recent carrier profitability nationwide, most

notably in medical professional liability, pricing is at historic lows. As a result, our aim is to provide additional services and resources, including early intervention and resolution programs which will become more prevalent in the future. We believe that COPIC deploys these services and solutions better than anyone in the market place.”

“COPIC values the strong relationships we have with the folks at the NMA and NMAIG and we continue to work closely with them on meeting the needs of their members, legislative efforts, and other initiatives that improve health care in Nebraska. Since our expansion into Nebraska in 2002,” stated Gerry Lewis-Jenkins, COO at COPIC, NMA’s endorsed medical professional liability carrier, “we have remained committed to earn the respect and trust of members of the health care community and the organizations and individuals who represent them.”

For more information please contact Dale Mahlman, executive vice president, Nebraska Medical Association, at 402-474-4472. ☐



Allergy testing: choosing the right test for the right patient

by Hana Niebur, MD
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Cases

#1: A 5 year-old female presents to your office with a four month history of rhinorrhea, sneezing, nasal congestion, and cough. She has tried over-the-counter allergy medications with little relief. Symptoms were worse in the spring but are still present. There is a family history of asthma in the father. The family adopted a cat one year ago.

#2: A 2 year-old male presents to the Emergency Department with sudden onset urticaria, wheezing, and one episode of emesis. Parents report that symptoms started while they were eating dinner at a Chinese buffet. They do not think that the child had any new foods but note that peanuts, tree nuts, fish, and shellfish were part of the buffet. He is also on Amoxicillin for acute otitis media. The parents gave the last dose in the morning.

#3: A 13 year-old male presents to the Urgent Care with redness, swelling, and pain involving his right arm immediately after he was stung by a flying insect followed by diffuse urticaria 10 minutes later. He thinks it was a wasp, but is not sure. He does not have wheezing or hypotension.

Background

Type I or immediate hypersensitivity reactions encompass a spectrum of disease from allergic rhinitis to anaphylaxis.

Mast cells facilitate these reactions, either by direct stimulation (e.g. opioids) or by IgE-mediated recognition of a particular allergen. Upon activation, mast cells release their contents including histamine, tryptase, and activators of the bradykinin, leukotriene, and coagulation pathways. These mediators lead to local or systemic symptoms including urticaria, angioedema, rhinorrhea, bronchospasm, vomiting, diarrhea, and hypotension.

Types of Allergy Testing

Skin testing was first introduced in the 1860s for the evaluation of Type I hypersensitivity. While devices, extracts, and techniques have evolved, the concept remains unchanged. In the prick-puncture method, a sharp instrument is dipped into an allergen extract and pressed against the skin on the upper back or volar forearm. Positive and negative controls, using histamine and saline respectively, are also placed. The wheal and flare response is measured after 15-20 minutes.

Sensitivity and specificity of prick-puncture method depends on several factors but is approximately 90-95% and 75-80% respectively. Variabilities affecting accuracy include operator expertise, certain skin conditions such as dermatographism, and extract potency and stability. Skin testing can be performed on children as young as one month though wheal size tends to be smaller in patients under two years of age. Medications that inhibit mast cells including antihistamines, tricyclic antidepressants, and long-term oral or topical corticosteroids must be stopped before skin testing.

Asthma medications such as leukotriene inhibitors and inhaled corticosteroids and bronchodilators can be continued.

Intradermal testing, in which a small amount of allergen is injected into the subcutaneous tissue, increases sensitivity but has poorer specificity due to irritant reactions. Intradermal testing can be useful for less potent environmental allergens such as dog dander and is typically included in the evaluation of drug and venom hypersensitivity. It is painful, which limits its use in children, and is contraindicated in food allergen testing due to the risk of anaphylaxis.

The first in vitro test for immediate hypersensitivity was the radioallergosorbent test (RAST) developed in 1967. Patient serum is incubated with allergens, and IgE bound to those allergens is detected by a radiolabeled marker. Automated ELISA sandwich assays, which measure IgE by "sandwiching" it between an allergen and a detector antibody, have largely replaced RAST. Each system (e.g. ImmunoCAP and Hy-Tec) has its own reference range, so comparisons cannot be drawn between different platforms. Sensitivity averages between 70-75%, but specificity varies especially if total serum IgE is significantly elevated.

The gold standard for allergen testing is the provocation challenge, in which an individual is exposed to an allergen and symptoms are measured. While provocation challenges are well-established for rhinitis, conjunctivitis, and asthma, they are typically only performed in the research setting. Provocation challenges

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Allergy testing: choosing the right test for the right patient

(continued)

are the gold standard for diagnosing food and drug allergy but may cause anaphylaxis.

Other forms of allergy testing exist, but most have not established diagnostic validity for Type I Hypersensitivity including cytotoxic tests, provocation-neutralization, electrodermal testing, applied kinesiology, iridology, hair analysis, and food specific IgG or IgG4. The basophil activation test, which evaluates expression of activating markers in response to allergens, is not currently FDA-approved but shows promise for the future of diagnosing Type I hypersensitivity.

Implementation in Clinical Practice

A detailed history is essential in selecting appropriate allergy testing. Crucial details include amount and form of the suspected allergen, timing and progression of symptoms, treatment provided, previous history of exposure, and reproducibility of symptoms with re-exposure.

The extent of allergy testing varies by disease. Testing for rhinitis, conjunctivitis, and asthma always includes perennial allergens with the addition of seasonal allergens in early childhood. Outdoor allergens should be limited to relevant allergens for the area. Skin testing is preferred given its higher sensitivity and specificity, but IgE testing offers reasonable accuracy and is the best option when interfering medications cannot be stopped or when allergen extracts are unavailable.

Testing for dermatologic allergies is less clear-cut. Unless a trigger is suspected, allergy testing is not recommended for chronic urticaria since most cases are idiopathic. Patients with atopic derma-

titis benefit from aeroallergen testing, particularly dust mite. Food testing is not indicated unless their disease flares correlate with ingestion of certain foods or if the patient is under the age of five with severe, recalcitrant eczema.

Medications, foods, and insect venom from the order *Hymenoptera* are the most common causes of anaphylaxis. Testing should be delayed until at least six weeks after anaphylaxis since false negatives often occur in this time frame. Prick-puncture and intradermal skin testing for some medications, notably penicillin, has excellent diagnostic accuracy. However, many medications are too irritating to permit skin testing or non-irritating concentrations are not established. IgE testing is available, though sensitivity and specificity are limited.

Food reactions present the greatest diagnostic dilemma since they can be due to Type I hypersensitivity, Type IV hypersensitivity, toxic reactions, and intolerance. For example, food protein-induced proctocolitis and eosinophilic gastrointestinal disease both require removal of offending foods for symptom improvement. However, neither disease is mediated by IgE or mast cells, so allergy testing is generally unhelpful. A careful history focused on IgE-mediated symptoms within two hours of ingestion can indicate when food allergy testing is appropriate. For other types of food reactions, food diaries with trial elimination diets are often used.

Skin testing for food allergies has similar sensitivity to inhalant allergen testing, with sensitivity of 90-95%. However, specificity is poorer, typically

around 60%, and worsens in patients with atopic dermatitis. Screening for food allergies without clinical correlation is not recommended and can lead to elimination diets that may compromise nutrition and increase future risk of allergy. Large wheals and certain IgE levels dependent on food and patient age have excellent positive predictive values for foods such as milk, egg, and peanut (Table 1). However, some cases require a provocative challenge to establish the diagnosis. Food allergies must be re-evaluated since they resolve in 80% of children by five years of age.

Table 1: Predictive Value of Specific IgE Allergy Testing Based on Positive Provocative Challenge

	>95% Positive	~75% Positive
Food	sIgE (kU/L)	sIgE (kU/L)
Egg white		
<2 years	≥7	
≥2 years	≥2	
Cow's milk		
<1 year	≥15	
≥1 year	≥5	
Peanut	≥14	
Fish	≥20	
Soybean		≥30
Wheat		≥26

Adapted from Kulis M et al. *Diagnosis, Management, and Investigational Therapies for Food Allergies. Gastroenterology. 2015;148(6):1132-1142.*

Hymenoptera venom testing should be offered to all patients with anaphylaxis and patients 16 years and older with diffuse cutaneous reactions. Due to difficulty in verifying the insect species and cross-reactivity within the order, testing to all five species should be performed. IgE panels are available but have limited

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Vision screening in children

by Donny W. Suh, MD, FAAP
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Children's Hospital and Medical Center

Amblyopia, the primary target condition of preschool vision screening, is caused by deficient visual stimulation of an eye during the years of visual development. Untreated amblyopia prior to the age of 7 to 8 can lead to permanent vision loss. The estimated prevalence of amblyopia in the United States is approximately 4%. For detection of amblyopia or its risk factors, vision screening is recommended as a component of the well-child examination by the American Academy of Pediatrics (AAP), the American Academy of Ophthalmology (AAO), and the American Association for Pediatric Ophthalmology and Strabismus (AAPOS).

Appropriate visual assessments during vision screening can help identify children with amblyopia at an earlier age for more effective treatment.

Examination of the eyes and visual system should begin in the nursery and continue throughout childhood during routine well-child visits. Newborn infants should be examined using inspection and red reflex testing to detect structural ocular abnormalities, such as cataract, corneal opacity, and ptosis. Instrument-based screening (photoscreening devices), if available, should be first attempted between 12 months and 3 years of age and at annual well-child visits until acuity can be tested directly. Direct testing of visual acuity can often begin by 4-5

years of age prior to kindergarten, using age-appropriate symbols (HOTV or Lea optotypes). Children found to have an ocular abnormality or who fail a vision screening should be referred to an eye care specialist appropriately trained to treat pediatric patients.

Vision screening with visual assessment can also help us to detect organic eye disorders including retinal abnormalities, cataracts, glaucoma, retinoblastoma, strabismus, neurologic and rheumatological disorders. Ocular problems can be the first and only presenting symptoms of various systemic conditions. Timely treatment and referral of these conditions can help the pediatricians and specialists make accurate diagnoses of potentially life threatening conditions. However, vision screening cannot be expected to detect all causes of amblyopia and other eye disorders.

Preterm infants should initially be evaluated under the guidance of the American Academy of Pediatrics policy statement and referred for a specialized eye examination by an ophthalmologist experienced in evaluating and treating infants. Similar referrals to a specialist should be made for newborn infants with family histories of congenital cataracts, retinoblastoma, or metabolic disease or for whom systemic disease associated with serious ocular abnormalities is suspected.

A referral should take place promptly if symptoms of blurred vision, constant eye rubbing, or strabismus are present. Also, a history of epiphora associated with photophobia or the presence of cloudy or enlarged corneas should

prompt timely referral to rule out glaucoma. Ptosis, when associated with anisocoria, can be the harbinger of neuro-ophthalmologic disease, Horner syndrome, and should also warrant referral. A bright or yellow red reflex or, conversely, a dull or absent red reflex, can be an indication of a significant abnormality that necessitates further evaluation by a pediatric eye care specialist.

Otherwise healthy children should be screened in the primary care setting at the intervals provided in Table 1.

Instrument-based screening devices (photoscreening devices) for vision screening are available commercially and have had extensive validation, both in field studies and, more recently, in the pediatricians' offices. Screening instruments detect amblyopia, high refractive error, and strabismus, which are the most common conditions producing visual impairment in children. If available, they can be used at any age but have better success after 18 -24 months of age. Instrument-based screening can be repeated at each annual preventive medicine encounter through 5 years of age or until visual acuity can be assessed reliably using visual acuity charts using optotypes. Using these techniques in children younger than 6 years of age can enhance detection of conditions that may lead to amblyopia and/or strabismus compared with traditional methods of assessment. The recent U.S. Preventive Services Task Force statement supporting the use of these technologies for preschool vision screening should prove useful in ensuring payment for these services.

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Vision screening in children (*continued*)

The use of optotype-based acuity algorithms remains current practice for children aged 4 years and older; however, acuity screening becomes more reliable and efficient in children aged 5 years or older. Instrument-based screening may be a helpful alternative in screening uncooperative or developmentally delayed children of any age.

Summary

Evaluation of the visual system should begin in infancy and continue at regular intervals throughout childhood and adolescence. Serial visual system screenings using validated techniques, including optotypes and vision-screening devices, provide an effective mechanism for the detection and subsequent referral of potentially treatable visual system disorders.

Visual Acuity Testing

- Ages 36 through 47 months: If attempted at this age, the critical line to pass screening is the 20/50 line.
- Ages 48 through 59 months: The critical line to pass screening is the 20/40 line.
- Ages 60 months and older: The critical line to pass screening is the 20/30 line (or the 20/32 line on some charts). □

TABLE 1: Periodicity Schedule for Visual System Assessment in Infants, Children, and Young Adults

Assessment	Newborn to 6 mo	6–12 mo	1–3 y	4–5 y	6 y and older
Ocular history	x	x	x	x	x
External inspection of lids and eyes	x	x	x	x	x
Red reflex testing	x	x	x	x	x
Pupil examination	x	x	x	x	x
Ocular motility assessment	—	x	x	x	x
Instrument-based screening: when available	—	B	x	x	C
Visual acuity fixate and follow response	F	x	x	—	—
Visual acuity age-appropriate optotype ¹ assessment	—	—	E	x	x

B: If possible in cooperative child

C: Instrument-based screening at any age is suggested if unable to test visual acuity monocularly with age-appropriate optotypes.

E: Visual acuity screening may be attempted in cooperative 3-y-old children, if not Instrument based screening if available.

F: Development of fixating on and following a target should occur by 6 months of age; children who do not meet this milestone should be referred.

The clinical report Procedures for the Evaluation of the Visual System by Pediatricians is available at www.pediatrics.org/cgi/doi/10.1542/peds.2015-3597.

1) <http://pediatrics.aappublications.org/content/137/1/1.51#fn-8>

Pediatric behavioral problems in primary care

by Arwa Nasir, MBBS, MPH

Vice President, Nebraska Chapter AAP

Division Chief of General Pediatrics

Associate Professor, Department of Pediatrics

University of Nebraska Medical Center

Behavioral problems are the most common conditions encountered in primary care. It is estimated that one

out of every five children has a diagnosable behavioral or mental health disorder. In addition, there are a larger number suffering from behavioral problems that do not meet the threshold for diagnosis under the DSM. Nevertheless, these

disorders cause significant morbidity.

Pediatric behavioral problems are particularly important because they can alter the developmental trajectory of the child. Also, childhood behavioral problems tend to persist into adulthood. Many mental health conditions seen in adults have their onset in childhood.

The primary care office is the first point of contact for families and children within the health care system. Primary care physicians are the default mental health providers for the majority of children and adolescents suffering from behavioral health problems. This is especially true in rural areas where there is a particular shortage of psychiatrists and other mental health providers. A recent study conducted in Nebraska showed that between 30-40% of children presenting to primary care pediatricians have

behavioral concerns.¹ This study surveyed Nebraska pediatricians regarding their experience in taking care of children with behavioral problems. Results showed that pediatricians feel that for most children with behavioral problems, the primary care office is the ideal setting in which to provide mental health care. This view is shared by a policy statement from the American Academy of Pediatrics which states that the long-term trusting relationship with the pediatrician provides significant advantages when caring for the mental health needs of this population.²

Pediatricians participating in the study indicated that barriers exist to the provision of optimal care for children with behavioral problems in the primary care office. These included the current fee for service model of reimbursement which tends to reward the number of episodes of care and procedures over counseling. Other barriers include insufficient training in behavioral health and unfamiliarity with some of the newer psychiatric medications. Most pediatricians in the study felt that their pediatric training did not adequately prepare them to manage the load and severity of behavioral problems encountered in their own practices.

The majority of pediatricians surveyed agreed that most behavioral problems that they encountered in children represented maladaptive behaviors rather than organic psychopathology. This is consistent with recent research establish-

ing the mechanisms through which toxic stress and early childhood environments and experiences influence the behavioral and physical health of children.³ Prevention of pediatric behavioral problems may be achieved through interventions that address the psychosocial determinants of health and reduce toxic stress.

Better training in primary care behavioral health during residency, better reimbursement and better integration of behavioral health services in the primary care setting were identified as steps that are likely to improve care of children with behavioral health problems. The integration of behavioral health services in primary care has been shown to improve access and compliance with referrals to behavioral services for children and families. Early identification and management of behavioral problems in children, and referral when appropriate to behavioral health services, remain the primary responsibility of the primary care provider. □

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- 2) Committee on Psychosocial Aspects of Child and Family Health and Task Force on Mental Health. Policy statement--The future of pediatrics: mental health competencies for pediatric primary care. *Pediatrics*. 2009;124(1):410-21.
- 3) Garner AS, Shonkoff JP, Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood A and Dependent Care, Section on Developmental and Behavioral Pediatrics. Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*. 2012;129(1):e224-31.



Childhood obesity

by Cristina Fernandez, MD
Medical Director,
HEROES Program
Children's Hospital and Medical Center

1) THE PROBLEM

Obesity is "an accumulation of adipose tissue that is of sufficient magnitude to impair health" – Robins

The latest National Health and Nutrition Examination Survey (2011-2012) showed that approximately 17.7% of children and adolescents aged 2-19 years old were obese. Similar data was reported back in 2007, but the disparity between Caucasian vs. Hispanics, African American and Native American is worsening, as well as in older adolescents.

NHANES National Obesity Data (Obesity= BMI \geq 95th percentile)

Age	1963-1970	2007-2008 ¹	2009-2010 ²	2011-2012 ³
2-5 Years	<5%	10.4%	12.1%	8.4%
6-11 Years	4.2%	19.6%	18.0%	17.7%
12-19 Years	4.6%	18.1%	18.4%	20.5%
Total	<5%	16.9%	16.9%	16.9%

1) Flegal KM, JAMA, 2010

2) Ogden CL, JAMA, 2012

3) JAMA: 311, (8) Feb. 2014

2) DEFINITION

Body mass index (BMI) is "the accepted standard measure of overweight and obesity for children two years of age and older." For children between the ages of two and 20, a normal weight is defined as having a BMI between the 5th and <85th percentile for age and sex. The World Health Organization (WHO) recently added BMI curves for the first two years of life. Children are considered

overweight if they have a BMI between the 85th and 95th percentiles for age and sex, and children greater than or equal to the 95th percentile for age and sex are considered obese. Based on these criteria, obese pediatric patients will present with an excess accumulation of adipose tissue and a BMI in the 95th percentile or greater for their age and sex. In 2012, the AAP added a new curve for the morbidly obese patient. See Chart 2 below.

3) CONSEQUENCES

The cumulative effect of decades of obesity from childhood through adulthood is severe, thus, efforts placed on treating obesity in childhood may have lasting impacts. Effective interventions targeting the complex interplay of multiple systems (home-school-media-medicine) influencing childhood obesity are needed.

Childhood obesity has been shown to be associated with an increased risk of many co-morbidities including: Type 2 diabetes mellitus or prediabetes, hypertension, dyslipidemia, liver disease,

pulmonary hypertension, genitourinary disease, gastric reflux, chronic sleep disorders including sleep apnea, asthma association, infertility, orthopedic disorders, increased risk for cancer and mental health related issues like poor quality of life, low self-esteem, poor academic performance, depression, anxiety, peer victimization, body dissatisfaction, risk for abuse substances and eating disorders. The reality is that many of these obese children and adolescents will become obese adults. Thus, it is of utmost importance to have a long-term proposal to reverse this trend of obesity, and improve the weight related comorbidities and quality of life aspects involved.

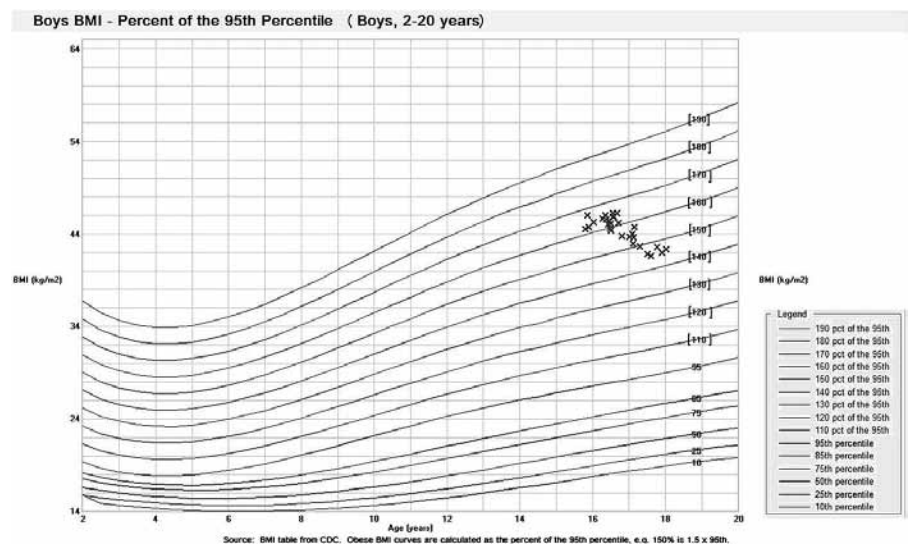
4) IMPACT

The CDC reports that obesity and its associated health problems have a significant economic impact on the U.S. health care system. Medical costs associated with overweight and obesity may involve

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Chart 2



What's new in children's oral health in Nebraska

by Jessica A. Meeske
*Pediatric Dental Specialists of Greater
 Nebraska and Trustee,
 American Academy of Pediatric Dentistry*

Dental caries continue to be the most common chronic childhood illness in children throughout the U.S. and Nebraska. While children with dental insurance have good access to dental care, many uninsured and children on Medicaid have difficulty accessing care. Often, primary care and emergency room physicians find themselves seeing these children in their clinics or hospital ERs.

With about one half of all children in Nebraska on Medicaid, last year only about 60 percent of these kids had any dental visit including preventive, restorative, or emergency. This means 40 percent of these children did not see a dentist or do not have a dental home. Dental caries can be painful and lead to more serious infections that affect children's overall health and cause many missed hours of school. So what can physicians do to help their youngest patients prevent dental caries?

The most effective public health measure to reduce incidence of tooth decay is to assure access to water fluoridation, yet only about 70 percent of Nebraskans have fluoridated water. (This is a great

way the Nebraska Dental Association [NDA] and NMA could partner on a legislative bill.) The second way physicians can help reduce decay is to provide oral health counselling and screening exams during well child checks. Anticipatory guidance for oral health can begin around six months of age or about the time the first tooth erupts. This should include appropriate feeding practices (not sleeping with fermentable beverages), minimizing high sugar diets, and brushing as soon as the first tooth erupts. When demonstrating how parents should brush a child's teeth, be sure to show them that one-half a pea size amount of fluoridated toothpaste is the right amount to use. In addition, you want to encourage parents to find a dental home for their child around their first birthday. While all dentists are trained to begin seeing children for a first dental visit by age one, it can be challenging for pediatricians and family practice physicians to know which dentists in their community are willing to see children this young.

Physicians can also apply fluoride varnish to children who are high caries risk. The application process takes less than 30 seconds and is a billable procedure. Fluoride varnish applied four times per year can reduce risk for dental caries by as much as 30 percent. Be sure to ask the parent if the child is receiving fluoride varnish from other public agencies such as WIC and Head Start. The American

Academy of Pediatrics (AAP) Section on Oral Health also has some wonderful dental health resources for physicians including where to purchase supplies such as fluoride varnish, flip charts on dental health, and managing dental emergencies. It can be found at <http://www2.aap.org/oralhealth/PracticeTools.html>. One new initiative from the AAP is the Brush, Book, Bed program. This encourages parents to brush their child's teeth, read a book together, and establish a regular bedtime. Details of the program can be found at <http://www2.aap.org/oralhealth/docs/BBBGuide.pdf>.

The NDA is working on a bill to expand scope of practice for dental hygienists and assistants. Where medicine has mid-level providers to help physicians see patients for routine care and minor issues and procedures, dentistry does not. This bill, while not a mid-level provider model, would allow dentists to delegate to trained staff. The goal is more patients seen and to help dental practices be more efficient regarding care to lower income. Also, LB 80 passed. LB 80 updated sedation laws which were out of date. Careful attention was given to ensure the sedation laws within dentistry promote patient safety and were done in conjunction with current American Society of Anesthesiologists and AAP sedation guidelines. The regs still need to be worked through and a hearing date is pending. □



Caring for the adolescent and young adult patient: we can do better!

by Amy E. Lacroix, MD
Associate Professor of Pediatrics
Director of Adolescent Medicine
UNMC

Okay, let's be honest. Adolescent health is not a top priority for many physicians (and often not for the adolescent and their parents either). After all, this is a time when patients are young, vital, and generally very healthy.

So who deals with the complex changes of adolescents? All of us. In most cases, adolescents are healthy people. They get an occasional illness that requires attention (Strep throat, mono, cellulitis, etc.), but otherwise we rarely see them unless they need a sports physical. When we do see them, it's important to make the most of our time.

How can we make sure we aren't missing the BIG STUFF? First, ask the adolescent what they need. Many teens are in clinic due to a mandate: a sports physical, a parental concern, or an injury that needs clearance. Make sure to let them know that you are there for them, confidentially.

And let's remember what adolescents' biggest causes of morbidity and mortality include. What is the number one reason for hospital admission for adolescents? Easy: childbirth. Mortality: MVAs, suicide, and homicide. Illnesses: acute care, physicals for sports, contraception, STIs, and behavioral concerns (sleep issues, parent-child conflict, drug use, depression, etc.)

How do we support these young adults in the best way possible and make

the most of our time with them?

First, follow the rules. There are recommendations that can help us focus on what is vital. At all health care visits (and some others) we should be administering a brief depression screen (PHQ9-Adolescent or other). The U.S. Preventive Service Task Force (USPSTF) (<http://www.uspreventiveservicestaskforce.org/>) has assigned depression screening with a "B" recommendation, which means it makes a difference. This is the same level of recommendation as mammography for women over 50. For the positive screens, learn your community resources!

What about sexual health? The CDC and USPSTF recommend that we screen for STIs yearly on any female who is sexually active and on males who are high risk (MSM, multiple partners, no protection, live in high risk area). That means that we have to ask the questions. In private.* Always.

Let's make sure that sore throat is viral, not only by doing a rapid strep, but by making sure we know if the child is participating in oral sex. If you don't know the 5 Ps of taking a sexual history, you can take a refresher course here: (<http://www.cdc.gov/std/treatment/sexualhistory.pdf>). Pediatric providers have been shown to spend precious little time with their patients in taking a sexual history. As it turns out, the more time you take the more you find out. (<http://archpedi.jamanetwork.com/article.aspx?articleid=1791584>) What about HIV testing? Again, the CDC says to test anyone at risk starting at age 13 and repeat as indicated as an opt-out test for

that matter. Is anyone besides me outraged that Nebraska is one of only two states that still requires signed consent for HIV testing when nearly 10 years ago it was abandoned as an obstacle? I also believe we should advocate for private payers to keep state-mandated private STI testing confidential.

Two more items that deserve everyone's attention. First, despite the fact that teenage pregnancy/childbirth is the leading reason for hospitalization in adolescents, counseling on birth control alternatives and current recommendations are often not discussed. LARCs (long acting reversible contraceptives) should play an increasing role going forward. The implant (Nexplanon™) and IUDs (so many now) are here to stay for adolescents and young adults. They are easy to insert, well tolerated, and the most effective means to prevent pregnancy that isn't permanent. If you have teen/young adult patients, you should recommend them as first line options based on recommendations from ACOG: (<http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception>). If you and your patients need more information, visit <https://bedsider.org/> (my personal favorite) or https://www.colorado.gov/pacific/sites/default/files/PSD-TitleX2_understanding-effectiveness-english-poster.pdf). If you don't know how to insert an implant, you could learn how to perform these



(continued on Page 17)

Office-based literacy promotion

by Annie Zimmer, MD
Boys Town Pediatrics

Last year in Nebraska, one in five third graders was not reading proficiently for their grade level. Third grade reading proficiency is the best known predictor for success in high school and beyond. The accuracy of this indicator nine years in advance underscores the importance of preparing children to be ready to learn from infancy.

In the mid 1980s, psychologists Betty Hart and Todd Risley set out to discover why Head Start was not successfully increasing academic success. They found that Head Start was not reaching kids early enough. Their now-famous research found that by age 3 children from high-income households had heard 30 million more words than their low-income counterparts. In addition, there was also a gap in the complexity and context of words. Hart & Risley went on to prove that more than half the variance in vocabulary of an 8 or 9 year old can be explained by the language exposure they received prior to age 3. Early language exposure is crucial. Regularly reading with their infants and toddlers is the most important thing a parent can do to prepare their child for school and learning.

Regularly sitting with children and reading books to them provides irreplaceable benefits to the rapidly-developing mind of a young child. Reading, singing, rhyming, and talking with babies provides the building blocks for language, literacy, and learning. Work demands and busy family schedules make this kind of quality time easy to neglect. Televisions, phones, or tablets become easy substitutes, but studies show

that screens do not provide the same level of benefit as hearing the words directly from another human or seeing the words in traditional books. In addition to increasing language skills, regularly scheduled reading time is also socially beneficial. I can think of no better parent-child interaction than reading a book together. For young ones this usually involves some lap time, which can be very nurturing and a source of security, especially when it happens on a regular basis. Reading time naturally lends itself to affection and interaction. Babies point at familiar pictures. Toddlers ask questions. Preschoolers finish rhymes. By kindergarten, kids are often taking over and reading to parents. With each of these milestones, parents naturally engage and affirm their children. Routinely reading with children fosters continued social and linguistic development.

So why does this need to happen in the doctor's office? Research shows that we can make a difference. Office-based literacy programs have been around since the late 1980s. They are well-studied and have been found to perform exactly as intended. The most reputable office-based literacy program is Reach Out and Read. The program is simple: providers give an age-appropriate book to infants and toddlers during their well visits and encourage their parents to read to them. Medical practices that participate in Reach Out and Read have found a six-month developmental increase in receptive language among toddlers. They have also found that it is dose-dependent. Kids who interact more with a literacy program in the doctor's office have a larger increase in those language skills. When doctors talk to parents about reading and provide them with a book for their child, parents are more likely to read regularly with their child and more

likely to name reading as a favorite activity with their child. Children whose primary care physician promotes reading during well visits have greater vocabularies and score higher in language development.

As a primary care provider, I'm always thinking about how to best use the very limited time of preventative care visits. I aim to identify the topics that are most worth discussing and ensure that the conversation is meaningful. In pediatrics, the genres of anticipatory guidance are endless—nutrition, development, sleep, behavior, safety, discipline—just to name a few. When I was first exposed to office-based literacy promotion as a resident, I was skeptical. It felt like just another thing to forget to do. But in the last eight years, reading has climbed the ranks of things I want to talk about with my patients and their parents.

One of the things I love most about promoting literacy is how positive the conversations can be. When I first bring it up at the 6-month well-child visit parents usually aren't even thinking about reading books with their baby, but it is exciting at subsequent check-ups to learn how parents are adopting it into their routine. Parents enjoy telling me about their child's favorite books and how their child initiates or participates in reading time. They take a lot of pride in their babies and toddlers during these conversations. The opportunity to give the child a book at the beginning of the visit also helps assess the child's developmental abilities as you observe the child's interaction with the book and their parent during the visit.

Literacy promotion is not intuitive to the doctor's office, but when you look at the research and consider the potential impact on a child's lifelong health, it makes perfect sense. □



The importance of sleep for children

by Jill Reel, MD, Pediatrician
Blair Clinic and Memorial Community
Hospital and Health System

When parents bring their children in due to behavioral problems, one of the first things I ask them is how much sleep the child is getting. Sleep, proper nutrition, and positive reinforcement for good behavior are three of the most important factors affecting behavioral problems in children.

The National Sleep Foundation Recommends:

Newborns (0-3 months): 14-17 hours a day

Infants (4-11 months): 12-15 hours a day

Toddlers (1-2 years): 11-14 hours a day

Preschoolers (3-5) 10-13 hours a day

School age (6-13) 9-11 hours a day

Teenagers (14-17) 8-10 hours a day

Young adults (18-25) 7-9 hours a day

Adults (26-64) 7-9 hours a day

Older adults (65+) 7-8 hours a day

When the child is a newborn, it is important to encourage parents to put the babe down to sleep, drowsy, but awake, so they quiet themselves to sleep. Babies should be placed on their backs to sleep to prevent SIDS (Sudden Infant Death Syndrome). There should be nothing in the crib or bassinet, but the baby in a sleep sack or sleeper or swaddled in a very light weight blanket (like they use in the hospital when the baby is born). Bumper pads are not recommended. When parents put the babe down the baby will sometimes make moaning and groaning noises that may sound as if they are uncomfortable. These are actually

self-quieting noises that will help them put themselves to sleep. If the baby, less than six months old, is crying hard or for several minutes it is okay to encourage parents to pick up the baby. They should see if the child needs burped, a diaper change, or fed. After correcting the issue the parents should again try to let the baby quiet itself to sleep. Babies over six months may be allowed to cry longer as long as they have been fed, changed, and there are no other concerns.

For older children, encourage parents to give the child a 15 minute warning to finish whatever activity they are doing as it will be time to get ready for bed. They should then help their child brush their teeth, make sure they use the bathroom, read a book, and then lights out. The parents should tell the child they should not get out of bed. If they do get out of bed, the parent should usher the child back to bed with very little discussion. Positive reinforcement such as praise or stickers on the calendar should be given for staying in their beds all night. Also, letting others (such as grandparents) know within earshot of the child that the child is a good sleeper positively reinforces that child's sleep habits. Again, the child should be drowsy but awake when you leave the room.

A transitional object, such as a square of material or child-safe soft doll or stuffed animal, may be introduced around nine months of age. This can be something a parent gives the child at each nap or at bedtime. It's preferably something washable. I encourage that they have two of the same object so one can be at home and one at daycare. Or,

one could be washed while the child has the other.

For toddlers and older children, every time the child gets out of bed parents must usher them back to bed. Usually three nights of putting the child down drowsy but awake and putting them back to bed when they get up will put an end to the sleepless nights. Again, positively reinforcing the child for going to bed so nicely, sleeping in their own big bed, and stickers on the calendar will go a long way in producing a good sleeper. Very rarely a child does have a true anxiety disorder. If the parent has been consistent with these recommendations and are unsuccessful, the child should see their doctor. Stimulants, decongestants and steroids are also some common culprits causing sleep problems. Steroids are best given in the a.m. with food and water. Cortisol levels increase in the a.m. so consider giving Flonase and Budesonide in the a.m. as well.

In school age children and older, a big factor to consider is caffeine intake. Caffeine intake, even if it is early in the day, may disrupt sleep. The room should be very dark and quiet. Turn off all electronics. Parents should set an alarm clock instead of letting their child use their phone for an alarm. Studies show we don't sleep as deeply if we are subconsciously listening for a phone or computer message. Getting an hour of exercise a day will also help school age children sleep better at night. They can avoid naps and should get up and go to bed at approximately the same time every day, including on



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The importance of sleep for children *(continued)*

weekends. Keeping their room at 65-70 degrees Fahrenheit also improves sleep as does not eating a couple of hours before lying down.

And because many of us ourselves are sleep deprived, Gregg Jacobs, PhD, a psychologist and insomnia expert at the University of Massachusetts sleep-disor-

der clinic who has based his program on 20 years of research at Harvard Medical School, recommends the following tips for adults: going to bed when tired and only using bed for sleep or reading before bed for no longer than 30 minutes. If awake at night, allow 20-30 minutes to fall back asleep. It is okay to read, but if

you can't fall asleep in that time, move into another room and do something relaxing until you feel drowsy. He also encourages not fretting about sleep which may cause stress. Jacobs found that seven hours is enough for most adults. He also recommends tapering off sleep medications.

Good night and good rest. □

Allergy testing: choosing the right test for the right patient *(continued)*

sensitivity. Skin testing is the diagnostic method of choice but can be painful since several concentrations of intradermal injections are used for the greatest accuracy.

Case Discussion

#1: The child's symptoms are consistent with Type I hypersensitivity with timing of symptoms suspicious for pollen and/or cat dander allergy. Allergy testing by the prick-puncture method is the preferred test given its excellent sensitivity and specificity for cat and pollen sensitivity. Pulmonary function testing should also be considered since the cough may be associated with allergic asthma.

#2: The boy's symptoms are consistent with anaphylaxis. Contamination can be an issue at buffets, and the timing is more consistent with a food allergy than a drug allergy, though both should be considered. Testing should

be delayed for six weeks due to the high risk of falsely negative results immediately following anaphylaxis. Food allergy evaluation should start with skin testing by the prick-puncture method to peanut, tree nuts, fish, and shellfish and followed by IgE testing for any positive results. Amoxicillin testing can be performed with skin-prick and intradermal testing if reagents are available and specific IgE testing if they are not. If testing is equivocal, the diagnosis requires a physician-supervised provocation challenge.

#3: Large local reactions and diffuse urticaria in patients younger than 16 years do not indicate that the patient is at high risk for anaphylaxis from *Hymenoptera* venom in the future. Testing is not indicated at this time. If the patient had anaphylaxis or was older than 16, testing should be performed six weeks after the incident. □

References and Suggested Reading

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Caring for the adolescent and young adult patient: we can do better! *(continued)*

relatively easy procedures. It will give your patients a convenient option that the majority of them might prefer.

Second, I feel the need to say a word about transition. A great resource is available at www.gottransition.org. Transitioning is more than finding an adult provider who will see your adolescent patient or sending them to an OB/GYN. Transition is a process that enables an adolescent to start taking charge of their own health care. It involves time alone with the provider starting with pubertal age kids - for ALL kids, not just those that you think need a private conversation. It means involving them in their care plan and reaffirming to parents that we will; 1) continue to encourage their young adults to involve them, and 2) be respectful of their values, while providing

their adolescents the best care possible.

Finally, I can't end without mentioning vaccines. We have made an amazing dent in infectious diseases in children in the last 50 years. I hope that you make sure to include adolescent vaccines in your recommendations. Every teen deserves a shot at being meningococcus free, HPV free, and Hep A free. There exists good documentation of the effectiveness of HPV vaccine already (<http://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2015-10/hpv-05-mar-kowitz.pdf>) and absolutely no evidence that administering the vaccine causes increased sexual activity. (<http://pediatrics.aappublications.org/content/pediatrics/early/2012/10/10/peds.2012-1516.full.pdf>). For the parents who refuse HPV vaccination (my kid will only have sex

with their spouse); how about asking: "If breast/prostate cancer were caused by a virus, would you risk it? How is this any different?" A strong provider recommendation is the most powerful tool in promoting child vaccination. Let's work together to increase Nebraska's HPV vaccination rates!

For those already doing all of this: keep up the work. Your efforts will be noticed by your patients, their parents, your peers, and eventually, with any luck, our payers. Namaste.

** The age of majority in Nebraska is 19. However, providers can counsel for and treat STIs confidentially at any age. Abuse must be reported. And EPT (expedited partner therapy) can be provided to patients to treat their partners for GC and Chlamydia.* □

 Make it a weekend as the Huskers take on the Oregon Ducks Saturday, Sept. 17!

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Childhood obesity (*continued*)

direct and indirect costs. Direct medical costs may include preventive, diagnostic, and treatment services related to obesity. Indirect costs relate to morbidity and mortality costs including productivity. The medical care costs of obesity in the United States are high. In 2008 dollars, these costs were estimated to be \$147 billion. The annual nationwide productive costs of obesity obesity-related absenteeism range between \$3.38 billion (\$79 per obese individual) and \$6.38 billion (\$132 per obese individual).

5) CURRENT APPROACH AND THE FUTURE

Weight loss interventions and programs that involve a combination of behavior modification, diet, and exercise have been shown to be the most effective intervention for patients with obesity.

The HEROES at Children's Hospital and Medical Center in Omaha and Lincoln - Healthy Eating with Resources, Options and Everyday Strategies - practices medical management of obesity through nutrition counseling, exercise, and behavior therapy/modification and is the only medical program in the region. The HEROES team offers care

for the obese patient as a systemic disease with the collaboration of a large team. The HEROES team is able to explore the patient's needs and those of his/her family including bariatric surgery for super obese patients with chronic long terminal end damage disease. The results of the HEROES efforts are measured as improvement of patient quality of life, decreasing comorbidities, changes in their long-term behaviors, maintaining BMI, and decreasing the growth weight velocity in the first few years in the program. For bariatric surgery the efforts are targeted to decrease or resolve long-term comorbidities and reduce BMI by 15 to 17 points from the original pre-surgery BMI.

There are other wonderful local efforts to support the community and their families such as the YMCA health programs, Healthy Families, Families in Action, boys and girls clubs, Teach a Kid to Fish and others.

6) ADVICE

Obesity requires interdisciplinary teams of researchers focused on developing innovative cross-system approaches to create sustainable change. The long-term goal is to develop and implement innova-

tive strategies to reduce obesity and obesity-related diseases through multi-systemic (home-school-media-environment-medicine) intervention.

One of the most important practice processes is to establish a regular, accurate, and efficient BMI screening for all patients during health management visits. To establish a therapeutic relationship and enhance effectiveness, the communication between the patient and the physician should be supportive and non-blaming. It should focus on treating the family as a whole. Long-term changes in behaviors that are related to obesity risks should be placed at high importance. There is limited data on how weight loss treatments for youth have been delivered and received. These treatments should be explored due to the extreme importance of the issue.

Thus, it is of utmost importance to have a long-term proposal to reverse this trend of obesity and improve the weight related comorbidities and quality of life aspects involved.

Timely intervention is the key for success. □

Ron Klutman, former NMA president, passes away at age 68

Ron Klutman, MD, of Columbus, passed away on Saturday, May 14. Dr. Klutman attended Columbus High School before attending the University of Nebraska-Lincoln and graduating from the University of Nebraska Medicine Center with his doctor of medicine degree. He practiced briefly in Rushville before returning to Columbus where he practiced for the remainder of his career.

Dr. Klutman was actively involved in organized medicine for many years. He served as president of the NMA from 1998-99

and dedicated his time to many NMA committees and commissions including the political action committee, Medicaid, maternal and child health, professional liability, legislation and governmental affairs, mental health, and the task force on health care coverage for all Nebraskans, among others. He also served as president of the Nebraska Academy of Family Physicians from 1994-1995. In his community he was instrumental in the start of the East Central Public Health Department and their Federally Qualified Health Center and served on multiple committees at the Columbus Community Hospital in addition to Secretary/Treasurer, Vice-President and President in the 1980s. In 2012, he received the Public Health Association of Nebraska Lifetime Award for Contributions to Public Health.

Dr. Klutman was known at the AMA

as a very effective speaker who everyone liked and respected. Many times he opened his remarks saying, "I am a poor country doctor."

Dr. Klutman served the NMA at great personal and financial cost. He served during his forties and fifties—a time when



most physicians realize some degree of financial success after many years of hard work. He frequently logged 10-20 hours of work every week in service to his fellow Nebraska physicians. He was dedicated to all three Nebraska caucuses, working tirelessly for all physicians.

Dr. Klutman received the NMA's Distinguished Service to Medicine award in 2014. In his nomination form, his peers described him as unforgettable, funny, and colorful, but also reliable and always there when he was needed.

Ron was a shining example as a physician involved in organized medicine. He taught his fellow physicians the importance of being involved locally in their communities, and politically in county, state, and national organizations.

Dr. Klutman is survived by his wife of 42 years, Suzanne; sons, Erik and wife Cassie of Columbus; Andrew and wife Laura of Denver, and daughter, Libby and husband Matt Hornibrook of Minneapolis.

The NMA is incredibly fortunate and thankful to be the beneficiary of Dr. Klutman's wisdom and leadership. We will miss our "poor country doc." □

New Members

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Daniel T. Harkins, MD

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TJ Holmes, MD

5/31/2016

Omaha

Ronald W. Klutman, MD

5/14/2016

Columbus

John H. Tinker, MD

2/17/2016

Omaha

Ask a Lawyer

Billing for services to transgender patients

How should I address billing for services provided to a transgender patient when there's a conflict with the individual's insurance card? Is it okay to simply ask the patient what gender should we use for your insurance claims?



From the guidance I have found, it appears that the best approach for insurance billing purposes is to use the patient's gender designation as stated on the patient's insurance card or legal ID.

In *Creating Equal Access to Quality Health Care for Transgender Patients: Transgender-Affirming Hospital Policies* (hereinafter *Equal Access*), a publication of Lambda Legal, the New York City Bar, and the Human Rights Campaign, the authors advise that hospitals ensure that the patient's gender captured in the "Gender" field in admitting/registration records match the gender marker in the patient's health insurance. This is recommended to avoid possible insurance mismatches and denials for necessary care in the future. For example, a transgender male may require a hysterectomy at some point in his life. This document further advises that admitting/registration records be designed so that an individual's current gender can be captured without regard to the patient's legal identity documents or insurance records. *Equal Access*

at 9. The guidance provided to hospitals by this document should also apply to physician practices.

Some electronic health records allow for additional documentation about the patient's sexual orientation or gender identity. The Joint Commission and California Endowment's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, Transgender (LGBT) Community: A Field Guide* (2011), notes in a sidebar how some providers add gender identification data to EHRs. Information reflected in the patient's legal ID or insurance card is entered into the record with a flagged option allowing for additional information to be documented about the patient's birth sex or the gender with which the patient currently identifies. Additional fields allow for documentation of the patient's preferred personal name and pronouns to be used in addressing the patient.

According to a May 2014 publication from the National Center for Transgender Equality, Medicare has approved the use of a special billing code (condition code 45) to remedy potential gender mismatches that may occur in the billing process of claims for care provided to transgender persons. Per the Medicare Claims Processing Manual, § 240.1, "Institutional providers are to report

condition code 45 on any inpatient or outpatient claim related to transgender, ambiguous genitalia, or hermaphrodite issues."

For physicians and non-physician practitioners, the Medicare Claims Processing Manual states, "The KX modifier is to be billed on the detail line only with the procedure code(s) that is gender specific for transgender, ambiguous genitalia, and hermaphrodite beneficiaries." Medicare Claims Processing Manual, § 240.2. The Manual further notes that the KX modifier is a multipurpose international modifier and may be used in conjunction with other medical policies. Billing personnel will want to ensure that appropriate modifiers are used to limit delays in receipt of payment. If uncertainties arise, it may be worthwhile asking for advice from a particular health care payor. □

Ask a Lawyer is a feature of the Nebraska Medical Association newsletter. If you have a legal question of general interest, please write the Nebraska Medical Association. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline Williams Wright Johnson & Oldfather, L.L.P., 1900 U.S. Bank, 233 South 13th Street, Lincoln, Nebraska 68508-2095. The answer in this issue was provided by Jill Jensen. Questions relating to specific situations should continue to be referred to your own counsel.

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Improving diagnosis in health care

IOM Report Examines The Issue of Diagnostic Errors

By COPIC's Patient Safety and Risk Management Department

Last year, the Institute of Medicine (IOM), now known as the National Academy of Medicine, weighed in on the issue of diagnostic errors with a landmark report called *Improving Diagnosis in Health Care*. This report is a continuation of Institute of Medicine reports *To Err is Human* (1999) and *Crossing the Quality Chasm* (2001), studies that launched the patient safety movement.

The report calls diagnostic errors “a blind spot” in health care delivery and offered a “conservative estimate” that 5 percent of U.S. adults who seek outpatient care experience a diagnostic error. It also noted that one in every ten diagnoses is wrong, and one in every thousand ambulatory diagnostic encounters result in harm.

Getting the right diagnosis is a key aspect of health care—it provides an explanation of a patient's health problem and informs subsequent health care decisions. The report defines a diagnostic error as “the failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or (b) communicate that explanation to the patient.” This definition is encouraging because it suggests that correct diagnosis isn't just limited to naming the disease, but also making the patient central to that process.

“The data on diagnostic error are sparse, few reliable measures exist, and often the error is identified only in retrospect,” says John R. Ball, MD, chair of IOM's Committee on Diagnostic Error in Health Care, in a preface to the report. “The stereotype of a single physician con-

templating a patient case and discerning a diagnosis is not always true; the diagnostic process often involves intra- and interprofessional teamwork. Nor is diagnostic error always due to human error; often, it occurs because of errors in the health care system. The complexity of health and disease and the increasing complexity of health care demands, collaboration and teamwork among and between health care professionals, as well as with patients and their families.”

The report's summary states that “Improving the diagnostic process is not only possible, but it also represents a moral, professional, and public health imperative. Achieving that goal will require a significant re-envisioning of the diagnostic process and a widespread commitment to change among health care professionals, health care organizations, patients and their families, researchers, and policymakers.”

From the available evidence, the report committee determined that diagnostic errors stem from a wide variety of causes that include:

- Inadequate collaboration and communication among clinicians, patients, and their families.
- A health care work system ill-designed to support the diagnostic process.
- Limited feedback to clinicians about the accuracy of diagnoses.
- A culture that discourages transparency and disclosure of diagnostic errors, which impedes attempts to learn and improve.

The report offers several suggestions to address diagnostic errors. It highlights the importance of involving patients in improving the diagnostic process and rec-

ommends engaging patients by providing opportunities to learn about the diagnostic process as well as improved access to electronic health records, including clinical notes and test results. Another recommendation is that

health care organizations and medical



professionals should create environments where patients feel comfortable to openly share feedback about the questions and concerns they may have related to diagnostic errors.

Related to medical liability, it suggests reforms to the current system that encourage transparency and disclosure of diagnostic errors, and a legal environment that facilitates the timely identification and learning from diagnostic errors. Additionally, the committee recommended that health care professional education and training emphasize clinical reasoning, teamwork, communication, and diagnostic testing. The committee also urged better alignment of health information technology with the diagnostic process.

Several COPIC physicians were acknowledged for their contributions to this report. This report is available free online at <https://iom.nationalacademies.org/Reports/2015/Improving-Diagnosis-in-Healthcare.aspx>.

To help address diagnostic errors, COPIC offers online courses such as “How Doctors Think—Errors and Cognition in Medicine” and “Difficult Interactions in the Office Setting.”

Visit www.callcopic.com/education for more information. □



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CONFRONTING A CRISIS: AN OPEN LETTER TO AMERICA'S PHYSICIANS ON THE OPIOID EPIDEMIC

The medical profession must play a lead role in reversing the opioid epidemic that, far too often, has started from a prescription pad.

For the past 20 years, public policies—well-intended but now known to be flawed—compelled doctors to treat pain more aggressively for the comfort of our patients. But today's crisis plainly tells us we must be much more cautious with how we prescribe opioids.

At present, nearly 2 million Americans—people across the economic spectrum, in small towns and big cities—suffer from an opioid use disorder. As a result, tens of thousands of Americans are dying every year and more still will die because of a tragic resurgence in the use of heroin.

As a profession that places patient well-being as our highest priority, we must accept responsibility to re-examine prescribing practices. We must begin by preventing our patients from becoming addicted to opioids in the first place. We must work with federal and private health insurers to enable access to multi-disciplinary treatment programs for patients with pain and expand access for medication-assisted treatment for those with opioid use disorders. We must do these things with compassion and attention to the needs of our patients despite conflicting public policies that continue to assert unreasonable expectations for pain control.

As a practicing emergency physician and AMA President, I call on all physicians to take the following steps—immediately—to reverse the nation's opioid overdose and death epidemic:

- **Avoid initiating opioids** for new patients with chronic non-cancer pain unless the expected benefits are anticipated to outweigh the risks. Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred.
- **Limit the amount of opioids** prescribed for post-operative care and acutely-injured patients. Physicians should prescribe the lowest effective dose for the shortest possible duration for pain severe enough to require opioids, being careful not to prescribe merely for the possible convenience of prescriber or patient. Physician professional judgment and discretion is important in this determination.
- **Register for and use your state Prescription Drug Monitoring Program (PDMP)** to assist in the care of patients when considering the use of any controlled substances.
- **Reduce stigma** to enable effective and compassionate care.
- **Work compassionately** to reduce opioid exposure in patients who are already on chronic opioid therapy when risks exceed benefits.
- **Identify and assist patients** with opioid use disorder in obtaining evidence-based treatment.
- **Co-prescribe naloxone** to patients who are at risk for overdose.

As physicians, we are on the front lines of an opioid epidemic that is crippling communities across the country. We must accept and embrace our professional responsibility to treat our patients' pain without worsening the current crisis. These are actions we must take as physicians individually and collectively to do our part to end this epidemic.

Together we can make a difference.

Yearly stock market declines – not even half the story

by Kent Kramer

Provided by the Foster Group

Investors, like gamblers, have always been faced with the question, “What potential loss are you willing to endure in pursuit of longer-term gain?” Unlike gamblers, who, as a group, have a long-term history of losing to the house, stock market investors, as a group, have a long-term history of positive total returns.

The year 2016 started out with stock market declines around the globe. There are many explanations being offered, including these:

- A) Collapsing oil and commodity prices (which can be net positives for most consumers and many companies),
- B) The Fed raising interest rates by one quarter of one percent (which had been anticipated for over 12 months),
- C) China’s economic slowdown (GDP growth still over 6% annualized if you trust their calculations), or
- D) The Iowa Hawkeyes’ disappointing Rose Bowl performance on January 1st (OK, that’s a stretch, but for those who proudly wear the black and gold, it was painful.)

No matter what story or stories you subscribe to, the result of these opening weeks of 2016 have been eye-catching, in a negative way, for stock market investors. However, what has made this year’s decline feel particularly bad may not be due as much to the actual percentage decline (less than 6% for the U.S. stock market at the date of this writing, February 24, 2016), but the timing of the loss occurring at the very beginning of the year.

In years when the U.S. stock market has either seen a period of gains or more modest declines in the first part of the year, investors have some mental cushioning to help buffer declines occurring later in the year. Think of it this way; in 1998, the S&P 500 had risen 16.46% by the end of July. In August of 2008, the S&P 500 declined 14.46% due, in part, to a Russian financial crisis and debt default. Certainly, that kind of decline was nerve rattling. But investors had already banked 16.46% and so were still showing a positive return for the year. For those investors who stayed invested for the entire 12-month period, the S&P 500 returned an historic 28.58%, rising 26.82% from August 1st through December 31st.

The graph “Some Perspective” reveals that **every year** U.S. stock investors have endured periods of decline during a portion of the year in pursuit of what, hopefully, will be a positive year overall. When we think about this, of course, we know

it is true, because the U.S. stock market has **never** gone up every single day over the course of an entire calendar year.

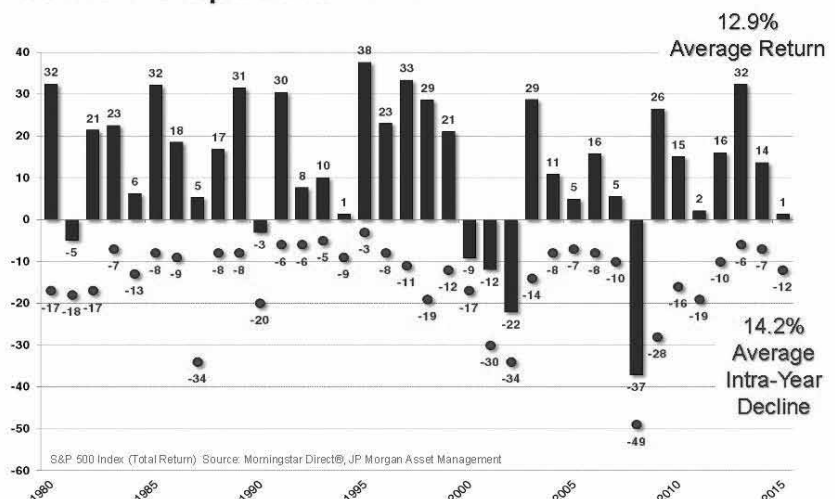
There have been, and investors should expect there always will be, some relative declines, whether it be for a day, week, month or even longer.

The actual historical data shows us that since 1980 the S&P 500 has averaged an intra-calendar-year decline of 14.2%. However, the average annual return for an entire calendar year was 12.9%. So even though the U.S. stock market, as measured by the S&P500, was down by as much as 11.44% from January 1 of 2016, that still qualifies as a lower-than-average “intra-year” decline and, based on history, would certainly not preclude an “average” overall stock market experience for 2016 which, since 1980, has been a positive return to the investor of 12.9%.

(continued on Page 24)



Some Perspective



PAST PERFORMANCE IS NO GUARANTEE OF FUTURE RESULTS.
Please see specific disclaimer that follows regarding index returns.

Yearly stock market declines – not even half the story (continued)

PLEASE NOTE: Past performance may not be indicative of future results. Therefore, no current or prospective client should assume that future performance of his/her account will be profitable, or equal any corresponding historical index/benchmark referenced above. The historical performance results for the comparative indices reflect reinvested dividends, but do not reflect the deduction of an investment management fee, which would have the effect of decreasing indicated historical index performance results. The historical performance results are provided exclusively for comparison purposes, to provide general comparative information to assist an individual client or prospective client in determining whether a certain type of asset allocation meets, or continues to meet, his/her investment objective(s).

PLEASE ALSO NOTE: (1) a description of each of the comparative indices is available upon request; (2) performance results do not reflect the impact of taxes; (3) It should not be assumed that a client's account holdings will correspond directly to any such comparative benchmark index; and, (4) comparative indices may be more or less volatile than a client's Foster Group account.

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The information and material provided in this article is for informational purposes and is intended to be educational in nature. We recommend that individuals consult with a professional advisor familiar with their particular situation for advice concerning specific investment, accounting, tax, and legal matters before taking any action. ☐



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VECTOR: SMALL CHANGES MAKE A BIG DIFFERENCE



Kate Juelfs
Associate Adviser Lead

Today's question:

Is it time for you to do some spring cleaning on your finances?

As a part of our relationship with the Nebraska Medical Association, we would like to offer you a complimentary Second Opinion. This \$1,500 service is yours at no charge. We invite you to participate in this unique opportunity to acquaint yourself with Foster Group and bring clarity, reduce complexity and increase your probability of financial success.

One of the fundamentals of financial planning is having an organized record of what you have and, equally important, what you don't have.

This can be as simple as having a full statement for each bank account, credit card, investment, insurance and debt that you have. It's most helpful if it shows the account holdings and the overall balance.

It's important to know what you have so that you can have an accurate picture of your overall financial condition. This can be as complex as understanding your allocation over multiple accounts and insurance coverages and as simple as knowing your net worth (cash, investments and other assets, less liabilities).

What do you do next?

Financial organization can help you identify big gaps in your plan and small changes that may make a big impact. Engaging a financial planner to review your overall financial condition can help ensure that you're on-track for the future you envision.

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Concussion

Recognition & Management Training Modules

Because research frequently sheds new light on concussion care, these training modules are provided to Nebraska licensed health care professionals as a comprehensive overview and guide for best practices in concussion recognition and management to ensure that every child sustaining a concussion in Nebraska is managed according to current best practices. **Continuing Medical Education Credit is offered by Children's Hospital & Medical Center.**

As a responsible licensed health care professional, it's important for you to be familiar with the requirements of the **Nebraska Concussion Awareness Act**, as well as understand how to assess and manage concussions.

Nebraska's Concussion Awareness Act. It's the law. (Effective Date July 1, 2012)

Contains the Three Tenets of Model Legislation

1. Education - Coaches, Parents and Student Athletes
2. Removal from Play - if a concussion is reasonably suspected
3. Clearance by a licensed Health Care Provider: licensed health care professional: physician or licensed practitioner under the direct supervision of a physician, a certified athletic trainer, a neuropsychologist; or other qualified individual who (a) is registered, licensed, certified or otherwise statutorily recognized by the state of Nebraska to provide health care services and (b) is trained in the evaluation and management of traumatic brain injuries among a pediatric population. Also, requires clearance from the athlete's parents.
4. PLUS...Requires schools to have a return to learn protocol in place. (Concussion Awareness Act Amendment, July 2014)

Topics include:

- Module 1 - Concussion Awareness Act (.5 CME)**
- Module 2 - Characteristics & Epidemiology (.5 CME)**
- Module 3 - Concussion Signs & Symptoms (.5 CME)**
- Module 4 - Assessment (.5 CME)**
- Module 5 - Management (.5 CME)**
- Module 6 - Delayed Recovery (.5 CME)**



Find training modules here: <http://dhhs.ne.gov/ConcussionManage>

Content for this site was developed by the Nebraska Concussion Coalition, the Nebraska Department of Health and Human Services Nebraska Injury Prevention Program, and medical professionals. Supported, in part, by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under H21MC26915, Traumatic Brain Injury State Implementation Partnership Program for \$1,000,000, 0% financed with nongovernmental sources.



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