Happy Spring!

The SOAPM-Executive Committee had a busy and productive meeting at AAP Headquarters in Elk Grove Village this past March. We had a terrific meeting with our new CEO, Dr Karen Remley, who was kind enough to spend some time with us discussing the opportunities and challenges for the AAP. The EC is busy working on a number of projects and we are always glad to have more involvement from our general membership. We are making outreach to our younger members a point of emphasis. Many of our projects can be worked on when you have time in between patients or after the kids are in bed (who needs TV when you have SOAPM?).

Please join me in thanking Dr. Herschel Lessin and

continued on page 2
MESSAGE FROM THE CHAIR

Dr. Budd Shenkin who are both rotating off of the SOAPM EC after the NCE this October. Our SOAPM list mates know that they have deep and wide pediatric practice management expertise but they have been deeply involved in advocacy for our issues behind the scenes and richly deserve our thanks.

I am delighted to welcome Dr Suzanne Berman and Dr Jesse Hackell to the Executive Committee as we continue to build on our successes as a section.

I deeply appreciate the trust you have all placed in me by re-electing me as Chair of the most amazing Section of the AAP and look forward to moving our good work forward.

We hope to see you all at the NCE and SOAPM cocktail party this October. Please join us! As always, please feel free to email me off list if I can help - Cdiasio@gmail.com.

Christoph

Letter From the Editor

By Jerald L. Zarin, MD, MBA, FAAP

Welcome to the Spring issue of soapmnews!

Our NCE Section H presenters have written summaries of their talks which you will find valuable: Common Legal Issues in Practice Management, Dr. Jess Hackell; Energizing the Disengaged – How to Motivate Your Office Staff, Susan Kressly; and, Going From Good to Great with Community Support, Dr. Gail Schonfeld. Also from 2015 NCE is an article by Dr. Hasan Merali, our 2015 SOAPM Scholarship Fellow Awardee. He discusses pediatric urgent care facilities.

Brenda S. Campbell, a practice manager and member of the PPMA talks about managing employees in the office. I know you will find this of interest especially when written by one of our practice managers. This article compliments Dr. Kressly’s motivating staff article. Richard Oken, MD, FAAP, a member of the Committee on Medical Liability and Risk Management (COMLRM) and an active SOAPM member writes about HIPAA and Risk Management. Vaccine storage is very important and we provide the results of a survey about the equipment our members are using for storage. Thanks to Robin Warner, MD, FAAP, Graham Barden, MD, FAAP and Chip Hart for providing this information for us.

In this issue you will also find a list of new members, information about our listserv to include “interesting posts” and etiquette, and SOAPM and AAP activities of interest. NCE 2016 is introduced and information about the SOAPM Social and Fund Raiser Dinner is included.

Enjoy!
Lynn Cramer Pediatric Practice Manager Award

Lynn Cramer, RN was a locally and nationally recognized pediatric practice administrator, as well as a friend to many of us! Lynn was devoted to improving healthcare for children in her practice and far beyond. Her vibrant personality and inherent ability to teach and mentor has helped so any pediatric practice over the years to become more successful, improve efficiency and stay relevant in the ever changing healthcare environment.

Lynn was also one who would not compromise when she felt strongly about standards that had to be met. She was not only an administrator, but a nurse as well, and used her management and clinical knowledge every day in her work. Many of Lynn's contributions have improved pediatric practices bottom line and therefore pediatricians and managers/administrators will experience her contributions for years to come.

In honor and tribute to all of Lynn's contributions, the Pediatric Practice Managers Alliance (PPMA) and the Section on Administration and Practice Management (SOAPM) are proud to announce the prestigious "Lynn Cramer Pediatric Practice Manger Award".

This award will recognize a pediatric practice manager/administrator who has exemplified excellence in his/her role in practice management within a pediatric practice. This annual scholarship will be awarded to a practice manager/administrator has also demonstrated a desire and willingness to share in the success of other pediatric practices through mentoring and sharing their knowledge and expertise. Traits that Lynn Cramer exemplified through PPMA and SOAPM every day!

This year's first annual award will be given at the 2016 National Conference & Exhibition (NCE) in San Francisco, CA. Nominations are now being taken. If you are interested in nominating an extraordinary Practice Manager/Administrator, please contact Elisha Ferguson at eferguson@aap.org.

In addition, donations for this award can be directed through the online AAP Friends of Children Fund here: Donations for Lynn Cramer Practice Manager Award. When making an online donation, please be sure to enter “Lynn Cramer Practice Manager Award” in the Gift Payment Notes section. If you have any questions, please contact Elisha Ferguson at eferguson@aap.org.

Project ECHO

Children and youth are one of the fastest growing populations affected by many chronic health conditions (Ridel & Gilbert, 2010). However, many do not have access to pediatric specialists for high-quality coordinated care provided in a medical home, especially in rural and medically underserved areas. This is further exacerbated by a national shortage of pediatric subspecialists and primary care providers who treat common and complex diseases resulting in many families having to travel several hours from rural areas or endure lengthy waiting times for clinic appointments. To help remediate appointment wait times and increase access to pediatric subspecialty care, the American Academy of Pediatrics (AAP) has adapted the national Project ECHO (Extension for Community Healthcare Outcomes) model to improve the health of children.

The ECHO model links expert specialist teams at the academic 'hub' with primary care clinicians in local communities 'spokes' using state-of-the-art video-conferencing technology. This partnership helps patients get the right care, in the right place, at the right time, standardize treatment and referral patterns and promote medical home goals. The Academy piloted Children and Youth with Epilepsy (CYE) Project ECHO in New Mexico, Colorado, Kansas, Missouri, New York, and Illinois with support from a Maternal and Child Health Bureau cooperative agreement and has expanded into addressing another health condition, endocrinology with support from Novo Nordisk. The AAP is honored to serve as a Project ECHO Superhub. In this capacity, the AAP can conduct trainings, assist with curriculum development, provide technical assistance, create/expand partnerships, address complex, medical conditions within the quality framework and empower providers. Visit www.aap.org/projectecho for more information.
Welcome to the New SOAPM and PPMA Members

(December 1, 2015 - March 31, 2016)

<table>
<thead>
<tr>
<th>MEMBER</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Candidate Member</strong></td>
<td></td>
</tr>
<tr>
<td>Adrian Goldman, MD, FAAP</td>
<td>CA</td>
</tr>
<tr>
<td>Priya Patel, MD, FAAP</td>
<td>PA</td>
</tr>
<tr>
<td><strong>Fellow Member</strong></td>
<td></td>
</tr>
<tr>
<td>Nadia Day, MD, FAAP</td>
<td>AZ</td>
</tr>
<tr>
<td>Rei Tosu, MD, FAAP</td>
<td>CA</td>
</tr>
<tr>
<td>Barton Schmitt, MD, FAAP</td>
<td>CO</td>
</tr>
<tr>
<td>Madhu Mathur, MD, MPH, FAAP</td>
<td>CT</td>
</tr>
<tr>
<td>Christine Booth, MD, FAAP</td>
<td>FL</td>
</tr>
<tr>
<td>Prabhu Parimi, MD, MBA, CPE, FAAP</td>
<td>FL</td>
</tr>
<tr>
<td>Erin Schutte, MD, FAAP</td>
<td>IL</td>
</tr>
<tr>
<td>Shelley Nelson, MD, FAAP</td>
<td>IN</td>
</tr>
<tr>
<td>Albert Richert Jr, MD, FAAP</td>
<td>LA</td>
</tr>
<tr>
<td>Olusoji Olatunjo, MD, FAAP</td>
<td>MA</td>
</tr>
<tr>
<td>Diana Fertsch, MD, FAAP</td>
<td>MD</td>
</tr>
<tr>
<td>Rochelle Kushner, MD, FAAP</td>
<td>MD</td>
</tr>
<tr>
<td>Sharon McFayden-Eyo, MD, MBA, FAAP</td>
<td>MD</td>
</tr>
<tr>
<td>Liliana Simon, MD, FAAP</td>
<td>MD</td>
</tr>
<tr>
<td>Archna Calfee, MD, FAAP</td>
<td>MO</td>
</tr>
<tr>
<td>Karla Keabey, MD, FAAP</td>
<td>MO</td>
</tr>
<tr>
<td>Adam Wheeler, MD, FAAP</td>
<td>MO</td>
</tr>
<tr>
<td>Joanna Storey, MD, FAAP</td>
<td>MS</td>
</tr>
<tr>
<td>Ernesto Villareal, MD, FAAP</td>
<td>NC</td>
</tr>
<tr>
<td>Stacey Houston, MD, FAAP</td>
<td>NE</td>
</tr>
<tr>
<td>Tricia Schmit, MD, FAAP</td>
<td>NE</td>
</tr>
<tr>
<td>Alla Erlichman, MD, FAAP</td>
<td>NJ</td>
</tr>
<tr>
<td>Niranjana Rajan-Mohandas, MD, FAAP</td>
<td>NJ</td>
</tr>
<tr>
<td>Bradlee Drabant, MD, FAAP</td>
<td>NV</td>
</tr>
<tr>
<td>Lynn Dunham, MD, FAAP</td>
<td>NY</td>
</tr>
<tr>
<td>Amy Deibel, MD, FAAP</td>
<td>OH</td>
</tr>
<tr>
<td>Akaber ElKhamra, MD, FAAP</td>
<td>OH</td>
</tr>
<tr>
<td>Shelly Senders, MD, FAAP</td>
<td>OH</td>
</tr>
<tr>
<td>Alka Sood, MD, FAAP</td>
<td>OK</td>
</tr>
<tr>
<td>Cindy West, DO, FAAP</td>
<td>OK</td>
</tr>
<tr>
<td>Ashley Yates, MD, FAAP</td>
<td>OK</td>
</tr>
<tr>
<td>Steven McSwain, MD, FAAP</td>
<td>SC</td>
</tr>
<tr>
<td>Eliza Varadi, MD, IBCLC, FAAP</td>
<td>SC</td>
</tr>
<tr>
<td>Kathryn Carlson, MD, FAAP</td>
<td>TN</td>
</tr>
<tr>
<td>Wendy Markowitz, MD, FAAP</td>
<td>TX</td>
</tr>
<tr>
<td>Alethea Allen, MD, FAAP</td>
<td>VA</td>
</tr>
<tr>
<td>Kyon Hood, MD, FAAP</td>
<td>VA</td>
</tr>
<tr>
<td>C. Isabel Jander, MD, FAAP</td>
<td>VA</td>
</tr>
<tr>
<td>Jessica Roberson, MD, FAAP</td>
<td>VA</td>
</tr>
<tr>
<td><strong>Post Residency Training Member</strong></td>
<td></td>
</tr>
<tr>
<td>Bracha Goldsweig</td>
<td>CT</td>
</tr>
<tr>
<td>Hasan Merali, MD</td>
<td>MD</td>
</tr>
<tr>
<td><strong>Resident Member</strong></td>
<td></td>
</tr>
<tr>
<td>Yagnaram Ravichandran, MBBS</td>
<td>NY</td>
</tr>
<tr>
<td>Danielle Maholitz, DO</td>
<td>OH</td>
</tr>
<tr>
<td>Elizabeth Marston, MD</td>
<td>TN</td>
</tr>
<tr>
<td><strong>Medical Student</strong></td>
<td></td>
</tr>
<tr>
<td>Amy PatelCA</td>
<td></td>
</tr>
<tr>
<td>Matthew Nelligan</td>
<td>IL</td>
</tr>
<tr>
<td>Sydur Rahman</td>
<td>NY</td>
</tr>
<tr>
<td>Simone Glichstein</td>
<td>PA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEMBER</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section Affiliate Member (PPMA)</strong></td>
<td></td>
</tr>
<tr>
<td>Javier Salazar</td>
<td>FL</td>
</tr>
<tr>
<td>Emily Lowe</td>
<td>GA</td>
</tr>
<tr>
<td>Elizabeth Parizo, MHSA</td>
<td>GA</td>
</tr>
<tr>
<td>Maureen Kelly, MHA</td>
<td>IN</td>
</tr>
<tr>
<td>Jessica Chapman, RN, BSN</td>
<td>MA</td>
</tr>
<tr>
<td>Shari Moore</td>
<td>PA</td>
</tr>
<tr>
<td>Laurie Serafine</td>
<td>TX</td>
</tr>
<tr>
<td>Elicia Wright</td>
<td>VA</td>
</tr>
<tr>
<td>Stacy Ladd</td>
<td>VT</td>
</tr>
<tr>
<td>Karly Port, BSED</td>
<td>WA</td>
</tr>
<tr>
<td><strong>National Affiliate Member</strong></td>
<td></td>
</tr>
<tr>
<td>Cassie Roberts, DNP, CPNP, IBCLC</td>
<td>MD</td>
</tr>
<tr>
<td>Nicole Eteo-High, CPNP</td>
<td>NC</td>
</tr>
<tr>
<td>Lacy Burkes, RN, CPNP-PC</td>
<td>TX</td>
</tr>
</tbody>
</table>

WE NEED YOUR HELP!

WE ARE LOOKING FOR YOUNG PHYSICIANS WHO ARE INTERESTED IN BECOMING PART OF THE CORE WORKING GROUP OF SOAPM.

If you have an interest in any part of practice advocacy or would like to learn more about becoming involved, we would be grateful to hear from you.

There are many options available from remote volunteering with minimal time commitment, to some that involves travel with meetings twice a year at the AAP Headquarters and NCE. Some of our sub-committees include the soapm news newsletter, technology, education, communication, nominations, membership, academic practice, private practice, solo practice, super-group and more. For more information please email Recruitment Subcommittee Chair Jeanne Marconi, MD, FAAP at jmarconi@aap.net. We look forward to your help!
Vaccine Storage Survey

We are all familiar with the story, Goldilocks and the Three Bears. And, more specifically, with her trying the porridge, going from “too hot,” to “too cold,” to “just right.”

Vaccine storage is much like Goldilock’s porridge. The temperature needs to be “just right.” The best way to achieve this is to have a medical or pharmaceutical grade refrigerator. But, how many physicians actually have one? Last year, the AAP hosted its first “Vaccine Storage and Handling” booth at the NCE. Afterwards, Graham Barden and I, with the help of Chip Hart, decided to conduct a survey, to see who had what kind of storage, and handling, technology.

The results were:

Type of Refrigerator: 60% medical grade; 40% commercial/domestic
Percent of Medical Grade refrigerator with digital thermometer: 90%
ALL fridges with at least one digital min/max thermometer: 75%
ALL fridges with a data logger: 65%
ALL fridges with some type of communication monitor: 55%

There was no correlation between size of practice and whether or not a practice had a “better” vaccine storage program. Participation in a VFC program also had no correlation.

Most respondents worked with some kind of GPO to purchase private stock vaccine. 20% said they were able to get better pricing on medical fridges through their GPO.

Many state VFC programs are increasing their storage requirements, in order to continue to participate as a VFC provider. At this time, I am unaware of any commercial insurer doing the same. But, this really shouldn’t matter. Vaccine cost accounts for a large percentage of our overhead. And, the decrease in vaccine preventable disease is undeniable. As pediatricians, we owe it to not only ourselves, from a business standpoint, but more importantly, to our patients, to make sure we store our vaccines at the temperature which is “just right.”

For any assistance in choosing a medical grade refrigerator, feel free to email Graham at gbarden@coastalchildrens.com, or myself at robinwarner@yahoo.com. We hope to be able to host an encore appearance at this year’s NCE. I personally hope to focus some on the handling aspect, by having a 2D barcoding demonstration set up, since this topic has, once again, been brought to the forefront by the CDC. If there is anything else we didn’t cover, that you would like to see, let us know!

Robin Warner, MD, FAAP, is a pediatrician at Union Pediatrics, in Union KY.
Graham Barden, MD, FAAP, is a pediatrician at Coastal Children’s Clinic, in New Bern, NC.
Chip Hart is the Director of Pediatric Solutions at PCC.
SOAPM Membership

As of May 2, 2016, SOAPM has a total of 1,358 members, of these members, 242 are affiliate members, who are part of the Pediatric Practice Management Alliance (PPMA). Please be sure to keep your memberships current to continue to receive the benefits of SOAPM membership.

As a reminder, membership includes access to members-only content throughout the AAP Web site, SOAPM Listserv®, newsletters, webinars, educational programs, and subscription to AAP News.

SOAPM-PPMA Practice Management Webinars

One of the many benefits of being a SOAPM member are the FREE practice management webinars. There are a wide range of topics covered; from social media and vaccine storage and handling to addressing oral health in your practice are NCQA certification. As an added member benefit, all practice management-related presentations sponsored by SOAPM and PPMA are archived. To view past webinars, slides and/or handouts, simply visit the Practice Management Archived Webinars on both the SOAPM home page (Member log in is required for access).

SOAPM is always looking for new and cutting edge practice management-related information to share with its members. Should you have any suggestions for future webinar topics and/or would like to be a presenter, please contact Elisha Ferguson at eferguson@aap.org.

AAP Resources

The AAP has a number of other resources to assist you.

• The SOAPM-PPMA Listserv online archive includes instructions on how to view the SOAPM & PPMA Listserv postings online and search by topic: http://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-Administration-Practice-Management/Pages/Listserv.aspx.

• The AAP Coding Hotline can assist you with coding questions: http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Coding-Inquiry-Form.aspx.

• The Hassle Factor Form can be used to report insurance administrative and claims processing concerns: http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Hassle-Factor-Form-Concerns-with-Payers.aspx.

• The Webinars page is a listing of all AAP webinars by topic: http://www.aap.org/en-us/professional-resources/webinars/Pages/Webinars.aspx.


Listserv Netiquette & Helpful Tips

The SOAPM Listserv® is a very active communication forum. Here are some tips to help you manage the number of emails that are sent through the Listserv®:

LISTSERV - Is a discussion list; type of mailing list in which each subscriber to the list may send messages to all other subscribers by
posting or replying to a specific email address, and may receive all messages posted to that address by other subscribers. By using the SOAPM LISTSERV, members agree to the terms of use.

**Netiquette** – Derived from the words “network” and “etiquette” - is a set of social conventions designed to facilitate interpersonal interactions in a variety of electronic forums where people may exchange ideas and information. In the context of this Discussion List, employing “good netiquette” is simply trying to adhere to a number of suggestions which, if followed, will make reading the list more enjoyable for all.

**Helpful Hints** - The SOAPM Listserv® is an active communication forum. Here are some tips to help you manage the emails that are sent through the Listserv®:

- Set up a separate email address and use it only for SOAPM related emails. Many members use a Gmail account, which easily groups the emails together by subject line.
- If your email account has the option to set-up one or more folders, consider doing so. This can automatically send all SOAPM related emails to that folder and not into your regular in-box.
- Be considerate. A reply to the group that doesn't add anything may not be necessary. These include messages such as: “me too,” “thanks,” “send me a copy” etc. These type of comments can clutter the listserv and add no additional value.
- It is a good idea to verify the “To:” address in your replying email, to insure that it really is going where you intend it to go. (Postings to the SOAPM list should be addressed to: soapm@listserv.aap.org).
- Utilize the Listserv Online Archive to search through previous postings, self-manage your Listserv settings (change your email address, vacation holds, etc.), or view the postings online rather than receiving individual emails.
- Change the subject in the subject heading if you are substantially changing the topic of discussion to reflect the new thread.
- Questions or comments to specific individuals should be sent to them directly, not to the entire Listserv.
- Be Courteous and Constructive, directing feedback to issues not individuals. Do not post content that is offensive, libelous, defamatory, indecent, harmful, harassing, intimidating, threatening, hateful, abusive, vulgar, obscene, pornographic, sexually explicit, or offensive in a sexual, racial, cultural, or ethnic context. In short, treat others as you would like to be treated.

For other changes including digest synopsis of messages, please contact Elisha Ferguson at eferguson@aap.org.

**SOAPM Channels**

The SOAPM listserv will soon be instituting the "channel feature". This will allow posters to choose a general topic for their post, and will enable all subscribers to opt in and out of four main topic groups:

- Clinical (CLIN)
- Practice Management (PM)
- Referrals (REF)
- Social (SOC)

Please stay tuned for updates, as this new feature is currently being tested.
New SOAPM Executive Members

Thank you to everyone who voted in the 2016 Council & Section Elections! Please join us in congratulating Suzanne Berman, MD, FAAP and Jesse Hackell, MD, FAAP who were elected as Voting Members of the SOAPM Executive Committee. Their 3 year terms as a Voting Members will begin on November 1, 2016.

There are many ways to be involved with the Section’s activities such as webinars, newsletter articles, membership drives, subcommittee activities, etc. If you are interested please contact the Manager, Practice Management and primary staff to SOAPM, Elisha Ferguson at eferguson@aap.org. Thank you!

2016 SOAPM Chapter-District Practice Management Grant

SOAPM is pleased to provide the third Annual Chapter-District Grant in the amount of $5,000 to conduct local practice management educational programs or to support a project that addresses a relevant practice management issue. The grant funding will be used to help offset the costs of the Chapter’s to hold a local practice management-related educational program.

Thank you to all 12 applicants that applied for the 2015-16 grant! The 2016-17 SOAPM Chapter-District Practice Management Grant application materials will be distributed later this year. We ask that you encourage your Chapter and/or District to apply!

Section on Telehealth Care (SOTC)

Be on the cutting edge of how technology can increase access to care. Help establish the standards to define quality pediatric telehealth care! Membership in the SOTC will provide you with a connection to a network of over 360 telehealth professionals and help inspire the embracement of telehealth. The Section offers a mentoring program, educational and collaborative opportunities, as well as, tools and resources to help participate in advocacy actions.

Join now to be an integral part of the telehealth movement and innovative technology!
Managing Employee Behaviors

By Brenda S. Campbell
PPMA Member

One of the most challenging aspects of practice management is managing the people within the business. It can feel overwhelming to manage employee attitude, behavior and performance, especially if confrontation doesn't come naturally. I have had the privilege of working for an amazing pediatrician for the last fifteen years. He's been in practice for decades and has taught me so much about practice management, especially the “people” part. He has helped me understand that it is possible to manage any employee behavior and expectations using a simple strategy.

When confronted with unsatisfactory employee behavior and performance, it is important to focus on three questions:

**You send a message to the rest of the staff no matter how you handle the issue. What's the message you want to send?**

If you choose to overlook the behavior, the message to your staff is that it is okay to continue this behavior and that it is acceptable. If you address a behavior, it sends a message to everyone that the behavior is NOT okay and will not be tolerated. Often times, even though they may not say it, the staff appreciate that you address negative behavior.

For example, we had a telephone triage nurse who had a lot of experience, worked for us for several years and was solid in the advice she would give. Her customer service skills, however, were lacking. I had to make a decision about the message I wanted to send to the rest of the staff.

**What you allow is what will continue. Are you going to allow it to continue?**

Make the decision to address the behavior and do it. Don't put it off. Ask, “May I give you some feedback?” Let them know the problem with their behavior, set expectations and move on. They’ll either choose to correct their behavior or they won't.

We've found that employees generally receive feedback in one of two ways. Some are completely unaware that their behavior was being perceived in a negative manner and are quick to ask how they can fix it. The others become defensive and refuse to take ownership of the behavior often blaming external factors.

With our triage nurse, I knew that I needed to address her customer service problem, particularly her tone which could be perceived as condescending and snarky at times. Her response fell in the defensive category and she said “somehow I get all the nasty parents on the phone.” I explained to her that she was the common denominator in each complaint and that her tone was the problem. “Ma’am” is not necessarily respectful if delivered in a sarcastic manner. It was her behavior that made the parents become, in her eyes, “nasty”.

**Are you better off with them or without them? Is it time to let them go?**

If, after you've given the feedback and they have not changed their behavior, it's time to make the decision about the employee's future. As you may have guessed, it didn't take long for another parent to complain about the triage nurse and, at that point, we decided that even though we'd be down a phone triage nurse in a busy sick season, it wasn't worth allowing negative behavior to continue thereby sending the wrong message to the staff. We have found that when it comes to working with someone who behaves poorly or working short-staffed most employees would rather work a little harder until we find someone who is a good fit for our practice.

It's certainly easier in the short term to ignore problematic employee behavior but it's always costly in the end. Allowing negative employee behavior to continue can hurt your employee morale, productivity and retention as well as cause you to lose patients. When we reflect on the occasions where we’ve had to let someone go after asking these three questions, we have yet to regret a single one.
SAVE THE DATE
5th Annual SOAPM Social Fundraiser & Dinner

Jade Studios

TICKETS GO ON SALE SOON!!!

$85 (June 1st – August 31st)
$100 (September 1st – October 23rd)

WHEN
October 23, 2016
7pm - 11pm

WHERE
Jade Studios
Treasure Island
30 Avenue G
San Francisco, CA

BENEFITING
Friends of Children fund
A charitable fund of the American Academy of Pediatrics

FEATURING
• SOAPM Entertainment
• DJ & Karaoke
• Razzie Awards
• Food & Fun

Sponsored by: PCC, PedsOne, The Verden Group, & Remedy Connect
The AAP 2015 National Conference & Exhibition (NCE) took place in Washington, DC and set the largest attendance record by far. This year's NCE set a record high totaling 10,053 professionals in attendance...that is 1,000 more than in 2014! Thanks to all who made these great sessions possible by bringing in dynamic speakers or cutting edge topics that contributed to making this such a successful National Conference!

The Pediatrics for the 21st Century (Peds-21) Symposium Series is an American Academy of Pediatrics initiative designed to address emerging issues that will impact the practice of pediatrics and pediatric care in the 21st century. Below are links to the plenary sessions from the 2015 NCE. The "Kid President" video that was played at the start of the opening plenary session on Saturday as well as the videos of the Peds 21 program. Watch the videos of the speakers at the 2015 National Conference & Exhibition Peds 21 program by clicking the link below.

Plenary Sessions: http://2015.aapexperience.org/educational-highlights/plenary-sessions/
Kid President: https://www.youtube.com/watch?v=L5-EwrhsMzY
Peds 21 Video: http://aapexperience.org/peds21videos

continued on page 12
4th Annual SOAPM Friends of Children Fund Social Fundraiser & Dinner

The 2015 SOAPM event was held at Carmine’s Restaurant in Washington, DC and was nothing short of entertaining. From the Razzie Awards to karaoke, the party was an ultimate success and raised $6,710 during the event for the AAP Friends of Children Fund!

One of the highlights of the evening, came from a special live musical performance by Drs Rob and Suzanne Berman. In addition, Dr Sonia Khan provided a little “ditty” that was also absolutely great. If you were unable to attend, the lyrics are listed below for your convenience.

On a California highway, cool wind in the trees,
Coming home from my daughter’s chemotherapy.
Up ahead in the distance, saw a sign for The Mouse
My daughter wanted to stop there on the way to our house.

As we stood at the entrance, beside Tinkerbell
I was thinking to myself,
“This could be heaven or this could be hell.”
Then we heard of the outbreak and the sick people there,
Told my daughter we must leave, ‘cause she’s immune impaired.

Welcome to measles in California,
Such an ugly place for exemption rates
Preventable illnesses grow in California
Bring your tiny tots, they’ll get Koplik spots!

I called up Paul Offitt and asked what should be done.
He said, “We haven’t seen outbreaks this bad since 1991.”
At the big health department they’ll make measles deceased,
Jab it with a steely needle when exemption rates decrease.

Giving quality health care could leave you depressed.
We are all just victims now of vaccine success.
But the tide there is turning, thanks to doc Richard Pan.

Philosophical exemptions, headed to the trash can.

Welcome back to a safer California,
Now a bit more free from SSPE**
The kids can all go to school now in California
With the nice demise of Andrew Wakefield’s lies…

Dr’s Robert & Suzanne Berman sung the tune of the Eagles’
“Hotel California”.

continued on page 13
The Bardener
By Sonia Khan, MD, FAAP

You’ve got to know when to cold them.
Know when to warm.
Know when to caulk away.
Know when to run.
You never count your vaccines,
when your sitting with the patient.
There’ll be time enough for counting,
When the clinic’s done!”

Dr Sonia Khan and her Razzie Award “Wrath of Khan”

www.aapexperience.org

The American Academy of Pediatrics (AAP) invites you to join us for the 2016 National Conference & Exhibition October 22–25 (pre-conference sessions and events begin on Friday, October 21) in San Francisco. Experience over 350 educational sessions including practical hands-on learning and networking in addition to the largest pediatric technical exhibit of its kind.

NCE 2016 - San Francisco, CA

<table>
<thead>
<tr>
<th>PPMA Education Program</th>
<th>SOAPM Section H Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friday, October 21, 2016</td>
<td>Saturday, October 22, 2016</td>
</tr>
<tr>
<td>8am – 12pm (Pacific)</td>
<td>8am – 12pm (Pacific)</td>
</tr>
</tbody>
</table>
In 1982 I started a practice in East Hampton in a community that had not had a pediatrician for two years. I spent my first decade learning pediatrics and the basics of running a practice. One day I received a phone call from a patient that changed how I looked at my practice, my community, and my own role in both. The patient called for a referral to a dentist who took their Medicaid Insurance. I was well aware from my decade of experience running my practice that many of my Medicaid patients had marked dental decay. There were no dentists that participated in Medicaid within a 50 mile radius. As usual, I thought to myself that someone should do something about that, but for the first time I realized that that someone was me.

Implementing new initiatives can be a daunting process, but it does not have to be. By structuring my project using a series of basic questions and focusing on my own interests, talents, and strengths, I was able to positively impact my patients and my community. I began with the most basic question, by identifying a unique need and then asking “what needs to change?”

From a simple question about a referral — in this case, a patient bringing attention to a need in my community — I then faced the issue of expenses, both in terms of time and money. So I asked myself “How much time will it take to fix this problem? Will my solution fulfill a need by the time it has been completed? How much will it cost, and how will I pay not only the initial costs, but any on-going costs?” The option of creating a new dental facility, while appealing, would have been impossible in terms of budgeting, and the need might not still exist once the facility was completed. My patients needed a dentist who would accept their Medicaid immediately, not months or years down the road.

The other option was to support existing dentists so they could accept my patients. This would speed up the timeline and allowed me to use other resources. I asked myself “what skills can I use? What resources do I have? Who do I need to involve?” For this initiative, I found that my most valuable resources were relationships I had already cultivated in the community. I received a call from a local radiologist who knew someone in the community who was in search of a charity for children to partner with him so that he could host a polo match on his horse farm. I founded that charity with an initial $25 filing fee. I knew that I had a patient whose mother was a licensed fundraiser, a patient whose father was a vice president at Colgate and other parents who would agree to be sponsors. Thus, I was able to hold a fund-raiser which would, within a few months, provide the funds so Medicaid patients could be seen by our local dentists. These symbiotic relationships, or what I call the “win-win,” were a way for me to align myself with members of the community and build something from which we all benefitted.

From getting buy-in and cooperation from your staff and colleagues, to seeking out community partners, your new initiative should not be yours alone. Building upon the alliances that I had formed through networking during my previous decade in practice, I was able to create the Pediatric Dental Fund of the Hamptons and raise money by hosting an annual summer event for children underwritten by tax deductible donations from large and small corporations and individual donors.

But a new initiative is not solely about the creation of a single new plan or change. Systems need to adapt and change, and The Dental Fund was no exception. As state mandated care and insurance companies changed over the years, I had to ask myself, “How will I adapt?” I stayed up-to-date on industry news and found ways to stay informed, whether by talking to colleagues, attending meetings, or by reading list serves (there is none better than SOAPM), newsfeeds, bulletins, journals, and blogs. As the need decreased, I decreased my involvement. To this day, however, I am still President of the Pediatric Dental Fund of the Hamptons, and our organization continues to positively impact many of my patients, as well as other children in the surrounding area.

The Dental Fund fulfilled a specific need. From that one phone call, I had to define the need, outline a course of action, create a timeline, assess my resources, and reach out to the people whose goals were aligned with mine and who could help most. I taught myself new skills, from networking to the basics of running a non-for-profit; as the need changed, I adapted and scaled back as appropriate.

Not all initiatives will begin with a phone call. You must choose to make it your task to seek out these opportunities for improvement and set yourself up to be the person who initiates that change. Starting small with your first initiative and remaining realistic about money and time commitments can help you succeed in creating positive changes both in your own practice as well as in the community in which you practice.

Deciding to take that first step can sometimes be the hardest. But the next time you recognize a need, instead of asking yourself “Who is going to fix this”, realize that person can be you.
Energizing the Disengaged: How to Motivate Your Office Staff

By Susan Kressly, MD, FAAP
SOAPM Member

Our practices cannot be successful without effective engagement of our employees. Employee engagement can be defined as “the extent to which a person chooses to apply their energy, talent and care toward any effort.” Organizations that have truly engaged employees outperform their competitors by over 200%. Employee turnover is incredibly expensive.

Why does this matter? Engaged employees outperform their peers, stay/are more loyal to the organization and bring more creativity to their position. In general, employees can be divided into 3 groups: engaged, not engaged and actively disengaged. Do you know where your employees fit? Take the time to work down your payroll and categorize your staff. While you are at it, what about your physicians, NPs and PAs?

Engaged employees work with passion and feel a profound connection to the company. They drive innovation and move the organization forward.

Actively disengaged employees are very toxic to your practice. They are not just unhappy at work. They are busy acting out their unhappiness and every day they undermine what their engaged coworkers accomplish. 26% of workers in the US are in this category. Identify them early and get rid of them.

Not engaged employees are essentially “checked out.” They are sleepwalking through their workday putting in time, but not energy or passion into their work. This represents about 45% of employees. Here's where to focus your attention. How can you engage them and improve your practice?

In order to do this well, practice leaders must understand what makes people happy, motivated, productive and creative at work. There is science behind the most effective ways to proactively impact engagement. (I encourage you to explore the resources listed below.) The steps to success include:

1. Pay people enough to take money off the table. You may think this is unrealistic, but if the staff is only showing up to cash a paycheck, you will never get the best from them. Consider taking all the money you lose every time you have to replace and retrain staff and pay the right people enough to follow this principle. If money is off the table, how do you incentivize them? Pay them in the currency that is important to them. This may be different for different staff members but may include things such as: time off, sharing of practice profits (the practice is financially successful, they got a portion), promotion, 401K, recognition, or a new role. Autonomy, mastery and purpose are demonstrated factors that lead to better performance and personal satisfaction.

2. Share your mission and vision. If you don't have this explicitly written down and shared, you can't expect full employee engagement. This can help employees find their purpose, and can facilitate autonomy. If they know what you stand for, they can do the 'right thing' without asking for permission.

3. Be a leader worth following. Set a good example, bring a positive attitude, display confident humility, and acknowledge team members. Are all of your practice leaders setting good examples? Do they show up on time with a good attitude and a commitment to promote the practice mission and vision?

4. Empower your entire team. This requires recognition of the strengths and weakness of team members. Give them responsibility and encourage them to problem solve. Set appropriate expectations and then support and advocate for them.

continued on page 16
Energizing the Disengaged: How to Motivate Your Office Staff

Inner work life matters more than you think. It is influenced by perceptions (making sense of workday events), motivation (what to do, whether/how/when to do it) and emotions (reactions to workday events). It’s not intuitive, but studies have shown that the single thing that affects inner work life the most is: the feeling of forward progress. How do you promote forward progress? Set clear goals, allow autonomy, provide resources, provide sufficient time, help with the work, learn from problems/successes and allow ideas to flow. If employees leave every day feeling like they were fighting to keep up an unrealistic pace, they won’t be energized to return tomorrow. If they leave feeling like they accomplished something meaningful, they will want to repeat the process.

So where do you start? Hire great employees. Give them a reason to come to work every day. Foster an environment where everyone feels like they are accomplishing something meaningful and making progress.

How do you nourish them? Respect and encourage them (give immediate positive feedback). Give them emotional support and a sense of affiliation: make them know that they are part of a bigger purpose.

Resources:
- The Puzzle of Motivation: TED talk by Dan Pink
- The Progress Principle by Teresa Amabile and Steven Kramer
- Drive by Dan Pink
- Leading Outside the Lines by Jon Katzenback and Zia Khan

Susan Kressly, MD, FAAP is founder and CEO of Kressly Pediatrics in Warrington, PA and the Medical Director at Connexin Software, Inc.

Ignorance of the Law is No Excuse: Common Legal Issues in Practice Management

By Jesse Hackell, MD, FAAP

SOAPM Member

Medical school and pediatric training programs generally include little, if any, instruction in the legal aspects involved with practice management, despite the fact that issues involving legal questions may surface in practice on a regular basis. Evidence for this can be seen repeatedly on the SOAPM list serve, where members regularly post questions which deal with these legal matters, seeking guidance from their practice management-savvy colleagues. This article, developed from a talk given at the SOAPM Section H session at the 2015 NCE in Washington, DC, will attempt to address some of the more recently seen questions from the list serve. Please note that I am not a lawyer, and, therefore, am giving only a general

continued on page 16
Ignorance of the Law is No Excuse: Common Legal Issues in Practice Management

overview of these questions and their impact on practice. For specific legal advice, it is imperative that you consult with a qualified attorney.

EMPLOYMENT ISSUES

Confusion often arises in regard to a practice (employer) when it comes time to hire new employees. It is helpful to remember that your employees are generally classified into two groups. Professional employees include employed physicians and possibly nurse practitioners, as well as administrators, if your practice is large enough to require the services of an administrator with an advanced degree and many years of experience. These employees are generally given an employment contract, usually drawn up by an attorney with labor law experience, which specifies the terms of the employment arrangement. These terms include salary, working hours and locations, performance expectations and, critically, termination clauses spelling out grounds for termination and restrictions on terminated employees, such as non-solicitation and non-compete agreements. While termination of employment may be specified either with cause (such as loss of medical license or hospital privileges) or without cause, the former is usually immediate while the latter may give the employee a specific time frame following the notice of termination in which to wind up his or her business affairs. Generally, however, upon termination, the employee should immediately lose access to the practice and its patients and records, lest a potentially hostile atmosphere develop and have a negative effect on the running of the office. Severance pay may be included in this clause, as an inducement for the terminated employee to leave the office promptly. A covenant not to compete is also usually a part of the contract with a professional employee; these covenants are governed by state law, and vary from one locale to another. This makes it even more important that such a contract is drawn up by an attorney who is familiar with the state employment statutes.

The other class of employee includes everyone else in the office--clerical and clinical staff. These employees are generally not hired with an employment contract, and are considered to be employees "at will." This concept exists in all fifty states, and basically means that the employee is under no restrictions in terms of his or her ability to leave the job at any time, while the employer has the ability to terminate the employment for any reason and without any notice. The terms of employment are governed by the office’s “Employee Manual,” which should be detailed and current. It must be noted, however, that the employer is still obligated by the terms of federal and state wage and hour laws, and is prohibited from harassment of the employee and from creating a hostile work environment, situations which should be addressed in the Employee Manual. Above all, the employer must not fire an employee on either a retaliatory or a discriminatory basis--someone cannot be fired “at will” if the employer has learned that the employee is planning to file a wage and hour complaint, nor can one be fired in violation of federal, state or local anti-discrimination statutes. It is important that the local statutes are understood, as the definition of “protected classes” of employees can vary from one locale to another.

INSURANCE CONTRACTING

A contract to participate with an insurance company is an enforceable agreement, which obligates both parties to the terms spelled out in the contract. These contracts are usually drawn up by lawyers for the insurance company, and, as such, will have the insurance company’s interests placed far above the interests of the contracting physician. The time to negotiate a contract is before you sign; after signing, the terms have been agreed to and are enforceable. Read and understand any contracts before signing them, and seek your own legal advice if you have any questions.

There are several common things in insurance contracts of which you should particularly be aware. Many contracts include language referencing a fee schedule specified in an attachment to the contract. Unfortunately, in many cases the attachment page is blank, with no fees listed. Similarly, terms involving risk-sharing or other compensation models also often reference a blank page. These blanks should be a red flag—if you sign such a contract, you are basically agreeing to whatever fees the insurer decides to pay you, and you have no recourse because the contract does not specify any fees. It is difficult to argue that a payment received is incorrect if there is nothing in writing to show what the correct amount should be. Beware as well of the so-called “evergreen clause” where the contract is automatically renewed unless either party gives notice of non-renewal. This clause puts the burden on the physician to monitor contracts for changes and for renewal dates, including the required advance notice time, in order to begin negotiation for a contract with better terms. Finally, watch out for the “most favored payer” clause. This insidious clause is an attempt by the insurer to force you to offer it the lowest fee schedule which you have ever agreed to accept from any other payer. Just remember the first contract you ever signed when you opened your office, and decided that a poorly-paying patient was better than no patient at all. Do not allow new contracts to get tied to the unfavorable older ones.

In the case of violation of the terms of the contract, the consequences of violation by the physician are generally clearly spelled out, and may range from financial penalties to exclusion from the insurer’s contracts and panels. But violations by the insurer are usually not addressed, so it is

continued on page 18
incumbent on the physician to be on the lookout for things such as improper payment amounts (seldom in the physician's favor, of course.) In order to be aware of these discrepancies, the physician needs to review the payments and their EOBs, and, again, you must know what fees you are expecting to be paid, so that you may spot any deviations. If using an automatic payment posting program, make sure that the most current fee schedule is referenced by the autopost system, and that it flags any discrepancies. When these are found, gather the data and protest promptly, to a provider representative, the medical director or the insurance commissioner in your state. If prompt resolution does not occur, consider suing the insurance company, which can often be done for limited dollar amounts in small claims court, which allows an expedited process at limited cost of time and money.

LEGAL PAPERS YOU MIGHT ENCOUNTER

It is not unusual for a physician to be served with legal papers such as subpoenas during the course of practice. While "being served" has a long history in popular media as something to be avoided, in reality most subpoenas are not threatening. Additionally, it is virtually impossible to actually avoid being served, even if by mail. Subpoenas usually come with a check of the amount in small claims court, which allows an expedited process at limited cost of time and money.

- Affidavit regarding medical condition of a patient. While not technically a subpoena (which carries a penalty for non-response), this simply requests that you complete a form asking specific questions about a patient. You will likely have to get the completed form notarized--it is a good idea for all offices of any size to have a staff member who takes the test to become a notary in your state.

- Subpoena *duces tecum*. The name comes from the Latin, "you will bring with you under penalty of punishment". It is a court order to produce evidence, and failure to comply may be construed and punished as contempt of court.

- Subpoena *ad testificandum*. This is another court order, compelling the subpoenaed individual to testify, under penalty of contempt of court for failure to appear. It is important to note that a physician may be subpoenaed as either a "fact" witness or an "expert" witness. The former handles input, so you can be aware of any charting which does not reflect what you saw and did at a given visit. Finally, be transparent in charting and dealing with patients and families. Don’t be afraid to discuss adverse outcomes, particularly in view of the increasing trend for states to introduce the so-called "Apology Laws." These laws, which are becoming

prevention of adverse outcomes, insofar as it is possible, is the key part of preparation for a malpractice suit. There are certain lawsuits which just simply should NEVER occur. In pediatrics, these include failure to diagnose lead poisoning, congenital hearing loss, critical congenital heart disease and inherited errors or metabolism. These should not occur because the screening tests to rule out these conditions are mandated by state law, and a violation of those laws, even if they may not be medically-sound laws, constitutes a departure from the standard of care which is very hard to defend. Know what screenings are required in your state, do them and DOCUMENT the screenings and the response to any abnormal results, and you can go a long way towards insulating yourself from being sued by the rare patient who is missed by screening. EHR issues are another area rife with pitfalls. Avoid cloning notes and copy-and-pasting notes from visit to visit, since it may be alleged that the work documented was not in fact performed, and if all notes read the same, the chart may look suspicious. Know the way your particular EHR handles input, so you can be aware of any charting which does not reflect what you saw and did at a given visit. Finally, be transparent in charting and dealing with patients and families. Don’t be afraid to discuss adverse outcomes, particularly in view of the increasing trend for states to introduce the so-called "Apology Laws." These laws, which are becoming
more widespread each year, provide for protection from a lawsuit for a physician who is open about discussing errors and apologizing to an injured patient and family. This is an evolving concept, so make sure to be aware of your local and state laws on this topic.

Finally, remember that the medical malpractice system can also be used for the physician’s benefit. Every malpractice lawsuit needs an expert opinion in order to determine adherence to the standard of care. Pediatricians are in the best position of any specialty to study and critique the care rendered to a child, and to express an opinion as to whether or not the care met that standard. Reviewing cases and testifying can benefit the physician in many ways. First, it is lucrative, and can provide a supplement to one’s practice income. To avoid looking like a “professional witness”, however, make it clear that the PRACTICE of medicine occupies the great majority of one’s time. More than the financial rewards, however, are the educational and practice improvement opportunities presented by this work. Reviewing a case gives one the impetus to review facts about conditions which one might seldom encounter, and can serve as a lifelong stimulus to learning. Additionally, every case reviewed is instructive in demonstrating ways that physicians may err; each error can lead a physician reviewer to recognize ways in which one’s own practice can be improved.

In summary, then, knowledge of the law is usually a good thing, for many practice management situations and reasons. Knowledge of one’s rights, responsibilities, and potential pitfalls is a good place to begin. Access to skilled lawyers is always a good thing, but with knowledge, skill, and a bit of luck, you may never need to call on them.

Jesse Hackell, MD, FAAP is the Vice President at Pomona Pediatrics, PC in Pomona, NY.
Response to the defective Auvi-Q recall and the erroneous comment by CVS that the Epipens had been recalled: “They should recall CVS as defective.” – Gail Schonfeld, MD, FAAP

The statement of the obvious by Sue Kressly in response to how to let your patient’s know where you have gone when you leave another practice: “This is why my practice name is “Kressly Pediatrics. It allowed patients to easily find me when I left my old practice after 15 years.” – Sue Kressly, MD, FAAP

Responses to Jon Caine’s quote to the ACA narrow networks: “Don’t let the Perfect be the enemy of the Bad”

Still on the topic of the ACA and Toxic stress a quote from the incredible rational Mark Helm:
“We already do ration. What we fail to do is ration rationally…”
Mark Helm, MD, FAAP

Screening Lab Tests:
“vit d — it is a finding without a disease” - Mark D. Moncino, MD, FAAP

Sports Physicals:
“I had always been of the belief that one person could not make a difference. That may still be true. But one person and an AAP staffer—that’s a different story.” – Gail Schonfeld, MD, FAAP

Smile for the Day:
“My adorable two year old patient was diagnosed with T1DM at 21 months. It’s been a rough go for them, but recently they got her stabilized on a pump. (Before that, Mom was making jokes about being a “full time pancreas.”
Mary Kathleen W. DiTursi, MD, FAAP

“Anyway, the baby had the cat on her lap and the cat was purring. My patient flipped the cat over to look for the cat’s pump, because it was buzzing. Made MY day”
Mary Kathleen W. DiTursi, MD, FAAP

Please accept with no obligation, implied or implicit, my best wishes for an environmentally conscious, socially responsible, low stress, non-addictive, gender neutral celebration of the winter solstice holiday, practiced with the most enjoyable traditions of religious persuasion or secular practices of your choice with respect for the religious/ secular persuasions and/or traditions of others, or their choice not to practice religious or secular traditions at all.

I also wish you a fiscally successful, personally fulfilling and medically uncomplicated recognition of the onset of the generally accepted calendar year 2016, but not without due respect for the calendars of choice of other cultures whose contributions to society have helped make our country great (not to imply that our country is necessarily greater than any other country) and without regard to the race, creed, color, age, physical ability, religious faith or sexual preference of the wishes.”

By accepting this greeting, you are accepting these terms:

This greeting is subject to clarification or withdrawal. It is freely transferable with no alteration to the original greeting. It implies no promise by the wisher to actually implement any of the wishes for her/himself or others and is void where prohibited by law, and is revocable at the sole discretion of the wisher. This wish is warranted to perform as expected within the usual application of good tidings for a period of one year or until the issuance of a subsequent holiday greeting, whichever comes first, and warranty is limited to replacement of this wish or issuance of a new wish at the sole discretion of the wisher.”

Disclaimer: No trees were harmed in the sending of this message; however, a significant number of electrons were slightly inconvenienced…” – Russell Clark Libby, MD, FAAP

continued on page 21
"I've never understood why a physician who made a conscious choice to never care for penises would be the ones to circumcise babies." - Michael Sachs, MD, FAAP

Correct Coding and BIG Data Banking:
There is a wonderful quote by Dan Ariery from Duke in a talk he gave back in 2013.

"Big Data is like teenage sex: everyone talks about it, nobody really knows how to do it. Everyone thinks everyone else is doing it so everyone claims they’re doing it."

I think we’ve only just begun to see the degree to which data banking work is offloaded to skilled healthcare providers.

If Google can scan my emails to know how to target sidebar advertising with 78% accuracy, then big data dogs should be able to develop programs to scan my EMR notes for their needs. - Gayle Schrier Smith, MD, FAAP

Staff Bonuses:
When does a bonus stop becoming a bonus? When the staff expects it? When they don't say thank you? - Jeffery M. Bienstock, MD, FAAP

Anyone Using EPIC?:
“It's very robust... Like trying to cut a steak with a deluxe Swiss Army knife in which every attachment is open.” - Phil Boucher, MD, FAAP

So help me God, I do not exaggerate:

I had a mom who brought her daughter in 265 times in one year and her son in 178 times!! State employee, not Medicaid. She was like an annuity! - Herschel Lessin, MD, FAAP

ICD-10:
We just received our first ICD-10 denial from one of our Medicaid HMO's. Date of service was October 1. ICD-10 Code was B97.89. Denial reason…….inappropriate ICD-9 code!!!

When we called, the gentleman told my staff that it was not an appropriate ICD-9 code. She told him that we should now be using ICD-10. His reply.…….oh yeah…..I will send it back for reprocessing! Duh!!!” - Ted Solari, MD, FAAP

To help with the ICD-10 madness…. Augmentin” - Mark D Moncino, MD, FAAP

Best Vaccine Company Excuse Ever!
Told us today that our vaccines ordered last Wed and due in Thursday are delayed due to the Pope. Gotta love it. Maybe he is why my baby flu and flu mist aren't in either. Powerful guy! - Katherine Frederick (Galarza), MD, FAAP

HEDIS means never having to say, “I'm flexible”. - Erich Segal, MD, FAAP
HIPAA and Risk Management

By Richard Oken, MD, FAAP
COMLRM & SOAPM Member

The Health Insurance Portability and Accountability Act (HIPAA) is a Federal law that is much talked about, but poorly understood. Most of us have learned about it in a nontraditional manner since it was enacted well after our time of formal medical education. HIPAA has evolved since its inception. Unless you’ve updated your compliance program in the past 3 years, it may be inadequate and leaving your office vulnerable to HIPAA violations.

The HIPAA legislation was passed in 1996 and the regulations went into effect in 2001 (privacy rule) and 2003 (security rule). This sweeping legislation had many purposes: to provide patients with health insurance portability, combat health care fraud and abuse, establish administrative simplification and standardization in health information and transactions, and other important goals. The foundation for the privacy and security regulations is found in Title II of HIPAA which covers Administrative Simplification. In January 2013 the US Department of Health and Human Services (HHS) issued a final Omnibus Rule to modify and expand aspects of the original HIPAA bill. The new Final Rule implemented changes that define and limit the circumstances in which individually identifiable health information can be used or disclosed by physicians, hospitals or other covered entities. It also established new required actions covered entities must take when protected health information is breached and added enforcement provisions for HIPAA violations.

A major concern for physicians is keeping patient protected health information private and secure. This information and material includes any information created or received by a covered entity relating to the physical or mental health of an individual. It includes oral or recorded matter in any form, written materials, and most importantly electronic data. Although it appears that enforcement and sanctions have been primarily directed against hospitals, health systems, and insurance providers, with increased enforcement tools available to investigators, all covered entities including physicians who violate the law are at increased risk of being detected and subjected to significant fines and penalties.

As in many medical arenas, liability prevention is the best policy to protect your patients from breaches in the medical records and your practice from fines and penalties incurred by HIPAA violations.

Some suggestions to follow that might be both practical and prudent:

**See No Evil**

1. Conduct an annual HIPAA office seminar to reeducate both the new and the old staff about the requirements of the law.
2. Have your staff and visiting students read and sign your office HIPAA policy.
3. Provide an annual financial policy and notice of privacy practices and the rules regarding release of information to families.
4. Provide business associate agreements to vendors who have access to patient protected health information and patient identifiable information (eg, name, address, city county zip code fingerprint, fax number, medical record, insurance number telephone number, photograph, etc).
5. Do not fax medical information to a non-secure fax location. Confirm that the receiving physician, school or health facility has a secure location.

*continued on page 23*
6. Do not fax medical records or forms to patient’s homes.
7. Be aware of the special laws pertaining to minors regarding disclosure of certain conditions – even to their parents.
8. Do not allow daily patient schedules to be viewed by other patients/parents.
9. Do not use email to communicate medical information to a family or a patient, except through an encrypted server.
10. Never release medical information on an answering machine, unless consent has been obtained.
11. Psychological and STD related medical information requires special consent for release.

Hear No Evil

1. Be careful not to discuss confidential medical information or patient names in a public area where others may overhear.
2. Remind staff that their conversations might be overheard in the waiting area or the exam room.
3. Evaluate your office premises to keep confidential patient information, both written and spoken, private.
4. Set up office safeguards (e.g., glass windows at the reception desk, white noise in the hallways, etc) to prevent staff conversations from being overheard in the waiting area.
5. In discussing medical information by phone, make certain that the individual has authorization to receive that information.

Do No Evil

1. Protect the confidentiality of your electronic health records. Use all security features provided and adapt them to your practice infrastructure.
2. Log off your computer when leaving the office.
3. Do not leave your computer screen opened to be viewed by other parties.
4. Change your password on a regular basis.
5. Make sure laptops, tablets, and thumb drives are encrypted and password protected. These are vulnerable to theft. Do not leave these devices in your car or unsecured in your office.
6. Be certain that your office portal is secure, and consider a method to protect the confidentiality of adolescent patients.
7. Confer with your insurance carrier regarding coverage for HIPAA violations.
8. Establish and enforce security policies on staff use of thumb drives, tablets, and laptops when taking devices offsite.

Prevention is the best policy.

continued on page 24
FREE HIPAA Resources

*HIPAA Privacy and Security Manuals* (including template policies and forms) on the AAP website. These were updated to comply with the 2013 requirements. They are downloadable and free to AAP members!

**AAP News Articles on HIPAA**

Data breaches: a wake-up call for physician offices
http://www.aappublications.org/content/36/1/22

What to do if your patient’s health information is breached
http://www.aappublications.org/content/34/12/1.2

New HIPAA Privacy, Security Rules take effect September 23, 2013
http://www.aappublications.org/content/34/8/31

*Dr. Oken, Clinical Professor of Pediatrics, UCSF, serves on the AAP Committee on Medical Liability and Risk Management. He is a previous member of the SOAPM Executive Committee and a past member of the Private Payer Advocacy Advisory Committee.*
President-Elect Candidates: Essay Question #1

How would you enhance engagement and leadership training for early career physicians in all areas of AAP?

Michael Brady, MD, FAAP

For early career pediatricians, engagement with AAP should begin during their pediatric residencies by providing tangible evidence that AAP offers value to them and to children's health. All pediatric residents should receive hard copies of valuable resources such as Bright Futures, Red Book and Guidelines for Perinatal Care. These concrete resources will be used frequently during training and will serve as a constant reminder of benefits of AAP membership.

AAP must recognize that the new generation of pediatricians has different priorities, including heightened social consciousness. Providing opportunities in AAP that address their passions can be a foundation for life-long engagement.

Chapters need to clearly and regularly promote their interest in having early career pediatricians participate in chapter activities. They should be specific about roles, responsibilities, time commitment and, most importantly, the value associated with participation. In deference to work-life balance, chapters and national AAP may need to restructure time commitments for AAP activities to be more attractive for pediatricians at all career stages to participate.

Leadership training programs should be developed within chapters to prepare members to participate in AAP activities at the chapter, district and national levels. The AAP NCE should host a pre-conference meeting to highlight the AAP structure, AAP leadership opportunities, networking skills and leadership competencies. Individuals interested in becoming leaders in their chapters should be assigned capable mentors to encourage their leadership development.

Life-long engagement and leadership training go hand-in-hand. Ensuring early career members have leadership opportunities is itself an effective way to maintain life-long engagement.

Colleen Kraft, MD, FAAP

Early Career Physicians are individuals with different and unique needs, interests, and goals; the American Academy of Pediatrics has a place for everyone. Real engagement of our newer colleagues happens less at an institutional level, more at a personal level. As members, we do this best through our interactions with these pediatricians.

Recall your own mentors within the AAP, and how they promoted your interest and informally developed your leadership skills. I started in practice as a part-time pediatrician with three young children. Having first-hand knowledge of struggles with quality child care, I found the guidance of Dr. Susan Aronson both pragmatic and inspiring. Two practice mentors, Drs. David Arkin and Harry Gewanter, helped me understand the academic, medical, and systems issues with school problems. Dr. Thomas Sullivan first approached me to lead the Child Care Committee of the Virginia Chapter AAP. Each one of us is a mentor and can impact engagement and leadership through recognizing interest and talent in our early career colleagues.

Two suggestions for the AAP at a national level include improving the navigation on AAP.org, and offering the Pediatric Leadership Alliance (PLA) course on a semiannual basis. The PLA is a terrific leadership training experience with lifelong rewards; I still use the principles in my day-to-day career. Resources for part-time pediatricians, starting in practice, physician well-being, relocation and discounts on other programs are additional member benefits. The ability to easily find these on AAP.org will enhance engagement of all our members. The link is: https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-young-physicians/Pages/Resources.aspx.
Considering Pediatric Urgent Care?

By Hasan Merali, MD
2015 SOAPM Scholarship Fellow Awardee

Introduction

Urgent care facilities continue to grow and expand in the US. Currently, there are approximately 4500 urgent care centers across the country where more than 150 million adult and pediatric visits occur annually. As an adjunct to primary care, providing pediatric urgent care services can help patients and families tremendously. It allows them to receive care when most facilities are closed, and avoid lengthy and costly ER visits. This can certainly be done as part of expanding your primary care practice, or creating a freestanding urgent care center, but there are important factors to consider.

Considerations

The main focus of urgent care facilities is to provide rapid treatment to moderately ill or injured children. As such, you will need to consider what is currently available in your practice or facility, and what you may need to invest in. You may also want to consider partnering with a larger facility so that you can have access to additional equipment. For example, because of the nature of childhood injuries, your facility should be prepared for musculoskeletal injuries which means you need to have access to plain radiography, as well splinting materials. You will also need materials and tools to manage uncomplicated lacerations, and nasal or otic foreign bodies. Simple laboratory testing is also useful. Next, consider if you are willing to work evenings and weekends or are able to recruit other physicians to do so. You will also need at least one receptionist and one nurse to work during those hours. Consider if you would be willing to take appointments, as some practices do. A few urgent care practices even provide routine services such as immunizations.

Once you have decided to take the next step and start an urgent care practice, you will need to decide whether you are going to expand your primary care practice to have urgent care hours, or are you looking for a new location? Based on the demographics of the population around your current location, you may want to be in a higher visibility area such as near schools or a shopping center. The design of your clinic is important, but equally or more important is how you brand it. Improving the patient experience is a way to expand your practice beyond your current patient load, and a means to get repeat patients and referrals. Having an easy to use website with accurate waiting times is also often used for urgent care. Some centers even allow parents to make appointments online making the process that much more convenient.

Keep in mind also that by the nature of being an urgent care center with extended hours, you may be more likely to see children who are acutely ill as parents either cannot tell if their child needs urgent care versus emergency care, or they may be confused about the scope of practice of an urgent care center. With this being the case, it is important that your providers are comfortable starting resuscitations. Having mock codes can be helpful to build confidence and prepare your staff.

Example Practice

To illustrate a successful practice, I will use the example of a pediatric urgent care facility in Toronto, Kid-E-Care. This urgent care center was built as an adjunct to a multidisciplinary pediatric practice. The daytime practice which operates during regular business hours has 6 pediatricians, 7 specialists, nursing, occupational therapy, speech language pathology, and dietary services. The urgent care practice operates 6 pm -10 pm Monday-Friday and 10 am – 4 pm on Saturday and Sunday. There is 1 pediatrician present at all times, and 2 at the busiest times. They are supported by one nurse and one receptionist. Wait times are provided for patients live, on their website. X-ray services are available onsite and all uncomplicated fractures and lacerations are managed in the clinic. 15-25 patients are seen on average during a weeknight shift, and on the weekends it is 30-50 patients. New patients seen in the urgent care center can easily be referred to pediatricians or specialists within the practice.

continued on page 27
Considering Pediatric Urgent Care?

**Conclusion**

Complementing a patient's medical home, urgent care facilities offer convenient care often when patients need it the most. With proper considerations and business planning, urgent care services can be an excellent way to increase your volume whether you want to expand your existing practice or start a freestanding facility. For providers who enjoy office based procedures and management of acute injuries and illness, this is an excellent way to do more of what you love and build those skills.

For additional information and to get more involved, the AAP Section on Emergency Medicine recently launched a subcommittee on Pediatric Urgent Care. This subcommittee provides support and resources for practice management, strategic planning, education, and quality measures for processes and outcomes. There is also a national Society for Pediatric Urgent Care which holds an annual conference and has continuing education cases and resources on their website.

**References and Useful Websites**

American Academy of Pediatrics, Section on Emergency Medicine, Subcommittee on Urgent Care: [https://www2.aap.org/sections/pem/PEM-UrgentCareSubcommittee.htm](https://www2.aap.org/sections/pem/PEM-UrgentCareSubcommittee.htm)


Society for Pediatric Urgent Care: [http://www.urgentcarepeds.org/](http://www.urgentcarepeds.org/)

---

*2015 SOAPM Scholarship recipients at the Edward J. Saltzman Luncheon (left to right: Adele Goodloe, MD, Christoph Diasio, MD, FAAP (SOAPM Chair), Miki Nishitani, and Hasan Merali, MD)*
Opinions expressed are those of the authors and not necessarily those of the American Academy of Pediatrics. The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Copyright © 2016 American Academy of Pediatrics. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher. Printed in the United States of America.