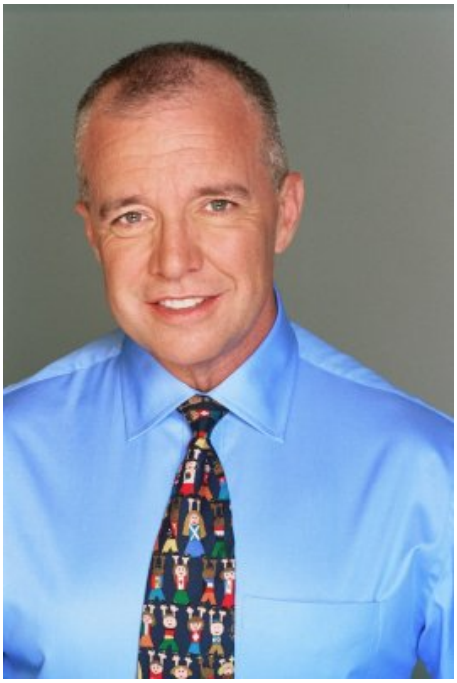
PEDSLINES

Missouri Chapter of the American Academy of Pediatrics

A LETTER FROM OUR PRESIDENT

Ken Haller, MD, FAAP



As I'm sure you know, our chapter has been busy with advocacy for kids these past few months. Much of that is detailed in the Legislative Report elsewhere in this PedsLines. I want to thank each and every one of you who wrote or called the office of your state senators and representatives to let them know what's best for the health and well being of Missouri's children and teenagers. Your advocacy was especially important in persuading some legislators not to pursue bills that might hurt kids and families.

We must now turn our advocacy efforts to the federal level and the American Health Care Act (AHCA). We have been asked by the AAP to engage in **two Days of Action to protect Medicaid on June 15th and June 22nd** (the next two Thursday's). The Senate is considering a health care bill as we speak that could be introduced any day and passed by the fourth of July recess. Since the process has not been transparent, we don't yet know the final bill they're proposing, but what we do know is that Medicaid is at risk, and now is the time to speak out.

Please **join me in these two days of action** to call your U.S. senators and urge them to vote "no" on any proposal that cuts or caps Medicaid funding in any way. Doing so would jeopardize the way the program works now to effectively cover 37 million children, and would leave children and families worse off.

Senator Roy Blunt - (202) 224-5721
Senator Claire McCaskill - (202) 224-6154

A sample script for your phone call is is included by clicking here.

MOAAP board members are meeting with district staff for both Senator Blunt and Senator McCaskill this week and next week to share the message that we need to protect Medicaid for kids.

This is a critical time for children's healthcare coverage in our country. Thank you again for all you do to advocate for Missouri's kids. Don't ever doubt how much the voice of the pediatrician is respected in policy and legislative circles.

IN THIS ISSUE

MOAAP Legislative Update

By Thuylinh Pham, MD FAAP
Chair, Chapter Legislative Committee

The 2017 legislative session adjourned on Friday, May 12th, with only 75 bills and resolutions sent to the governor for his signature. This is a relatively low number compared to recent years.

Advocacy Day on April 13 was a success! We had record numbers of participation with over 90 attendees. Participants met with both chambers to discuss vaccine safety, prescription drug monitoring and the importance of continued funding for the Medicaid and CHIP programs. Throughout session, we were also able advocate for several bills that impact the lives of Missouri kids. Following are a few highlights.

During floor debate on SB 50, both neonatal and maternal levels of care (HB 58) and expansion of the newborn screening to include SMA and Hunter's Syndrome (HB 66) were added and passed by both chambers. MOAAP supported both bills this session. SB 50 currently is awaiting the governor's signature.

Block funding for MO Medicaid (SB 28) was placed on the informal calendar and ultimately expired after the regular session ended. However, at the federal level there has been much movement with passage of the AHCA. We will continue to track this issue and update you as we work to protect healthcare access for children.

Multiple anti-vaccination bills were introduced this session. Thankfully none of them passed. SB 538, which prohibits the use of vaccines that contain mercury, was given a hearing in a Senate committee. Dr. Adam Massey from Columbia was able to provide testimony on the safety of vaccinations and evidence-based medicine on our behalf. The bill ultimately died in

committee with a split vote.
As pediatricians, it is critical that we continue to speak out to the public that vaccines are safe, effective and ultimately save lives.

A statewide Prescription Drug Monitoring Program continues to inch its way closer to the finish line. HB 90 was passed by both chambers. However, compromises could not be agreed upon during conference committee and it did not pass. We will continue to advocate for an encompassing PDMP to help Missouri fight the opioid battle.

The work in Jefferson City is far from done this year, as legislators have already been back to Jefferson City for one special session and will be back again this week. As we move into the summer months, MOAAP legislative committee will continue to work advocating for the health of all children at both the state and federal levels. If you are interesting in joining the committee or would like more information, please contact Kelsey Thompson at kthompson@moaap.org.

AAP Legislative Conference Reflections

By Christina Moellering, MD, FAAP
Vice Chair, Chapter Legislative Committee

L to R: Katie Blount, Carly Berg, Emma Kenyon (staffer for Sen. McCaskill), Jennifer Ikle,Chris Moellering and Jessica Simkins

I had the privilege of attending the 2017 Legislative Conference in Washington DC on behalf of Missouri AAP. This year was a legislative conference like no other. There was a palpable intensity and urgency among the attendees and the leaders of the conference that now, more than ever, advocacy on behalf of vulnerable children is of critical importance. The conference itself more than doubled its normal attendance with over 220 pediatricians representing 40 states across the country. The conference touched on issues such as protecting immigrant children and promoting the safety and efficacy of vaccines. The main topic of discussion we took to Capitol Hill was protecting children's access to healthcare by protecting Medicaid and renewing CHIP. I had the opportunity to meet with staff members for Sens. Roy Blunt and Claire McCaskill, as well as staff for Rep. Billy Long. The staff members I spoke with appreciated the insight I was able to provide as someone who had knowledge and experience working with children.

It was energizing to be at the conference surrounded by so many other individuals with the same goal: promoting the health and safety of children. It is time now to bring that energy home. Now is the time to let our elected officials know why we feel Medicaid and CHIP are important. Let them know what the consequences of block grants for Medicaid and cuts to Medicaid funding could do to children. The AAP has just released their "Protecting Children's Coverage" federal advocacy toolkit to help pediatricians to do just that. Go to federaladvocacy.aap.org and arm yourself with facts on why cuts to Medicaid and SNAP are bad for children. Our elected officials need to hear from you what harm may be done by cutting the programs many children depend on!

News from Washington, DC

According to the AAP Washington, DC office, AAP CEO/Executive Vice President Karen Remley, MD, MBA, MPH, FAAP, and Jennifer Lowry, MD, FAAP, chair of the AAP Council on Environmental Health, met with EPA Administrator Scott Pruitt to discuss the importance of the agency's work to child health. Drs. Remley and Lowry shared with Administrator Pruitt the evidence-based expertise of the Academy and its environmental health pediatricians. Also in attendance was the head of EPA's Office of Children's Health Protection, Ruth Etzel, MD, PhD, FAAP, editor of the Green Book.

The members of the COEH Executive Committee were also in town, urging Congress to protect EPA funding in FY 2018.

IN THE NEWS

- Dr. Ken Haller discusses the recent measles outbreak in Minnesota
- AAP statement on fruit juice for children under 1
- AAP statement opposing President Trump's FY2018 budget
- Dr. Jennifer Lowry is quoted in the New York Times regarding the FDA warning on lead tests
- Dr. Laura Waters discusses the HPV vaccine
- Healio article on vaccines, "Clinicians push back against vaccine myths"
- Dr. Kristin Sohl discusses the ECHO Autism program
- Pediatric Environmental Health Web Toolkit for Providers
- Dr. Kayce Morton discusses child abuse and neglect prevention

Residency Spotlight: St. Louis Children's Hospital

By Erin Orf, PGY-2

What I love most about pediatrics is the resilience of children. They are able to overcome many challenges with appropriate supports in place. Learning about the effects of toxic stress on child neurodevelopment, it became clear to me that there is a neurochemical explanation for this phenomenon. Some children face stressors and overcome, while others fall behind and are left with lifelong physical and mental health effects.

Through my advocacy project, I wanted to try to help the latter group and hopefully prevent some of these consequences. In Jennings, Missouri, some of Missouri's most vulnerable children experience toxic stress and trauma. Significant stressors include poverty, violence, parental mental illness and abuse. When exposed to these stressors in the absence of a caring adult, these children exhibit signs of toxic stress and often re-experience these traumatic events when triggered by everyday occurrences.

The school system provides a structured framework for traumatized children to learn essential skills to cope with these experiences. My project is to establish comfort spaces within each school in the Jennings School District. These comfort spaces will be calming environments and designated safe spaces where children re-experiencing trauma can go to self-regulate. The spaces will be composed of neutral color schemes and sensory materials to promote self-soothing (soft carpet, bean bag chairs, fidget toys). The goal is to de-escalate the stress response and promote a return to homeostasis. Students may self-refer to a comfort space, or be referred by a faculty member.

We plan to track use of the spaces as well as student perceived benefits from using the spaces. Our hope is to promote student self-awareness and self-regulation to allow them to cope more effectively and return to the classroom more engaged and ready to learn.

Let Teens Sleep In: A Statement in Support of Later School Start Times for Adolescents

By Njideka L Osuala, DNP, APRN, FNP-BC
and David G Ingram, MD, FAAP

What if there was a new treatment that improved student academic performance, decreased student disciplinary action, decreased student-involved car accidents, improved daytime alertness, decreased teen substance abuse, and decreased signs of teen depression? Would you recommend this to your patients?

Around the age of puberty, adolescents develop a tendency to go to bed and wake up later due to a normal physiologic shift in their circadian clocks. In addition, many teens are increasing their social, athletic, and scholastic commitments. At the same time, high schools are starting earlier, with the inevitable result being that teens wake up before they have had enough sleep.

According to a poll conducted by the National Sleep Foundation, 87% of high school students in the United States are getting less than the 8-10 hours of sleep recommended for teens by the American Academy of Sleep Medicine. Negative health related consequences of insufficient sleep include behavioral and mood problems, increased risk of cardiovascular disease, poor academic performance, and increased use of stimulants such as caffeine.

Early high school start times are a public health issue. School districts that have adopted later school start times have seen many benefits including improved student academic performance, decreased disciplinary action, decreased student-involved car accidents, less daytime sleepiness, less substance abuse, and decreased signs of depression. As a result, the AAP, CDC, APA, and AASM have all published statements supporting school start times no earlier than 8:30am.

The overarching goal of parents, pediatricians, and educators is to help children become the healthiest, happiest that they can be. Therefore, pediatric providers in Missouri need to educate patients, parents, and educators regarding the health benefits of adequate sleep, and advocate for middle and high school start times no earlier than 8:30am.

References

American Academy of Pediatrics. (2014). School Start Times for Adolescents. Adolescent Sleep Working Group, Committee on Adolescence, and Council on School Health. Pediatrics, 134, 642-649. Retrieved May 20, 2017, from http://pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-1697.

Davison, C. M., Newton, L., Brown, R. S., Freeman, J., Ufholz, L. A.,& Smith, J. D. (2012). *Systematic Review Protocol: Later School Start Times for Supporting the Education, Health and Well-being of High School Students.* The Campbell Collaboration.

Mindell, J. A., & Owens, J. A. (2015). *A clinical guide to pediatric sleep: diagnosis and management of sleep problems.* Philadelphia: Wolters Kluwer.

Overcoming Barriers to Implementation of Oral Health Services in Primary Care

By Abiye Okah, MD, FAAP
Chapter Oral Health Advocate

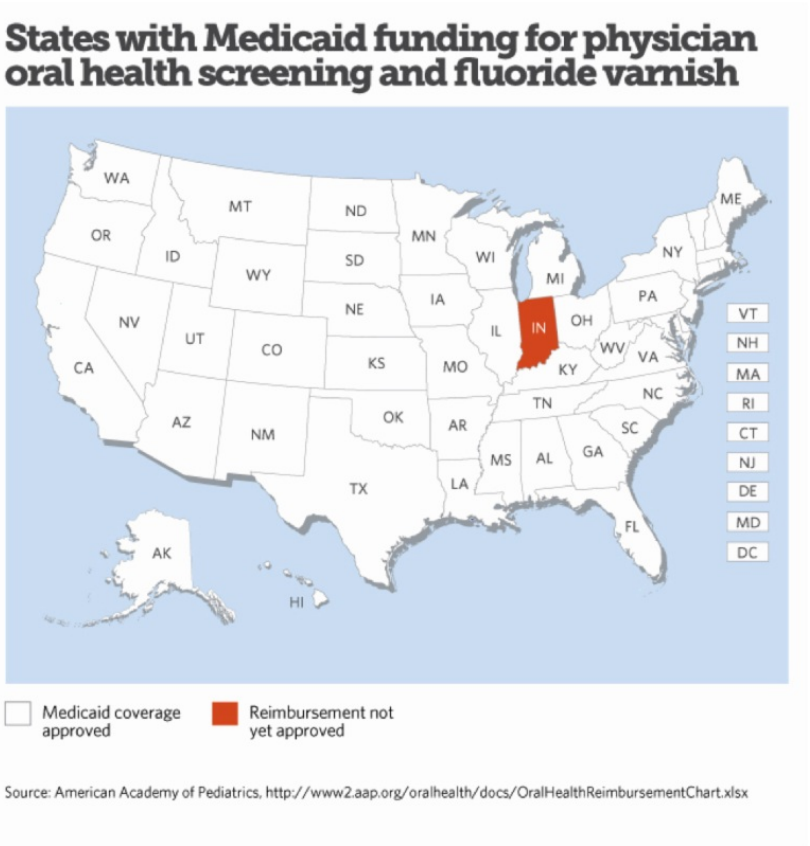
Early Childhood Caries (ECC) is a chronic infectious childhood disease that is preventable and potentially reversible if treated early (1). Preventive oral health services in the primary care setting which include oral health risk assessment, screening, counseling and application of fluoride varnish(FV) is recommended to improve outcomes (2). Despite these recommendations barriers exist in the adoption and implementation of these recommendations. A significant barrier is integrating preventive dental services into the daily practice routine (3). Others include time restraints, difficulty with dental referral, ordering fluoride varnish and

resistance from colleagues and staff (3). Factors that may promote fluoride varnish application in the office include strong provider and staff cooperation, establishing relationships with local dentists for referrals and Medicaid eligibility (4). Successful implementation of these services can be achieved by the following:

Identify a champion to lead the effort. Use quality improvement methods and tools to address the specific quality gap in your practice. Identify interventions for rapid plan-do-study-act cycles and adopt those, leading to positive outcomes. Provide families with lists of local dentists who accept their insurance and liaise with these practices for referral of those at high risk for ECC. These are some of the steps we have taken at Children's Mercy Kansas City to increase our rates of fluoride varnish application to 85% of eligible patients.

The AAP EQIPP Oral health course is free to members facilitates implementation in the office setting as well as 25 MOC credits. FV is easy to order and apply. Medicaid reimbursement for FV application is available in 49 states and insurance coverage is now required by the Affordable Care Act. It can be delegated to nursing staff. For further information please contact Dr. Okah at aokah@cmh.edu.

1. U.S. Department of Health and Human Services. Oral health in America: A report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000. NIH publication 00-4713.
2. American Academy of Pediatrics. Policy Statement. Maintaining and Improving the Oral Health of Young Children. pediatrics.aappublications.org
3. Integrating Oral Health Into Overall Health Care to Prevent Early Childhood Caries: Need, Evidence, and Solutions. Douglass JM, Clark MB. Pediatr Dent. 2015 May-Jun; 37(3):266-74
4. Bonetti D, Clarkson JE. Fluoride Varnish for Caries Prevention: Efficacy and Implementation. Caries Res. 2016; 50 Suppl 1:45-9. Epub 2016 Apr 22.



Physician reimbursement for fluoride

*CDT code: Kansas

D1203 Topical Application of Fluoride
MD, PA, NP
$17 --3x/year, no age limit
Delegated to LPN, RN

*CDT code: Missouri
D1206 Topical Application of Fluoride
MD, NP
$13.65--2x/year, <6 yr
Can be delegated to LPN/RN
***CDT code: Universal- 99218 Effective 2015**

Purchasing fluoride

Duraflor (5%NaF in a natural colophonium resin)
Company name: Medicom
(800) 361-2862
www.medicom.com/home.ch2
Company name: Henry Schein
(800) 372-4346
www.henryschein.com
Duraphat / Prevident (5%NaF in a natural colophonium resin)
Company name: Colgate Oral Pharmaceuticals
(800) 2-colgate 2654283
www.colgateprofessional.com

Fluoride varnish dosing

* Fluoride Varnish Treatment doses. NaF 22.6mg per ml
*Permanent dentition 0.5 ml (11.3 mg F)
*Mixed dentition 0.4 ml (9.04 mg F)
*Primary dentition 0.25 ml (5.65 mg F)
Infants 0.1 ml (2.26 mg F)
* The Use and Efficacy Professional Topical Fluorides; Seale et al, 9/201010

A Chemotherapeutic Option for Caries Management

By Craig S. Hollander, DDS, MS

When dental decay occurs in young, pre-cooperative children, the options to treat them in the past were either wait until the young child becomes more cooperative and hope the lesion does not get larger in the mean-time, scoop out as much decay as possible without local anesthesia and place a therapeutic interim restoration, or take the child an out-patient surgery center or hospital, and treat them under general anesthesia.

Now there is another option. Silver Diamine Fluoride (SDF) was originally approved in Japan over 45 years ago, and was created to reduce tooth sensitivity without any reported adverse reactions. When SDF is brushed onto a tooth's decayed surface, the silver ions react with the strep Mutans bacteria and dentin collagen to create a sclerotic silver-protein layer that will turn the cavity black and become resistant to degradation. This colorless and odorless product can stain clothing, countertops, flooring and instruments permanently, and gingival tissues and skin temporarily (like a henna tattoo) if not used judiciously.

Once the SDF has turned the dentin black, it will become more resistant to hot and cold temperature sensitivity, and the arrested cavity will not grow in size, assuming that good eating habits and proper oral hygiene regimens are followed. Multiple applications of SDF at 6 month intervals have been scientifically shown to be more successful at keeping the decay arrested over time. At the very least, visible decay in an infant or toddler can be nurtured until the child is old enough to cooperate in the dental chair to have it filled later, or the primary tooth exfoliates if the patient has special needs or disabilities that would be contraindicate having the child placed under general anesthesia except as a last resort.

2017 AAP Pediatric Acute Care Policy

by Gregory P. Conners, MD, MPH, MBA, FAAP

One of the great privileges that I had as a member of the AAP's National Committee on Pediatric Emergency Medicine (COPEM) was leading the 2014 publication of an updated AAP / COPEM policy statement on freestanding pediatric urgent care. The AAP had previously published a statement regarding retail-based clinics for children. AAP leadership recently assembled a small team of lead authors, including me, to replace these with an updated, overarching policy regarding acute care for children. We focused on freestanding urgent care, retail-based clinics, and acute care telemedicine, while creating broad principles covering other forms of acute care pediatrics that might emerge over time. We did not address acute care provided in the medical home or in an emergency department. Following its approval by the AAP Board, the policy statement, "Nonemergency acute care: When it's not the medical home", was published in Pediatrics in May, 2017.

This statement emphasizes the primary role of the medical home, while introducing acute care settings as potential members of a broader "medical neighborhood". Acute care providers are encouraged to collaborate with, rather than attempt to replace, the medical home, while payers are encouraged to avoid incentives directing children to acute care providers over the medical home. The policy emphasizes seamless, timely sharing of documentation between acute care providers and the medical home. Acute care should be evidence-based, with pre-determined limits on the scope of care and attention to quality improvement. Acute care providers should be prepared for emergencies and requests for care extending beyond their scope or hours of operation. Appropriate training and experience is necessary to provide acute care for children, with special expertise necessary when managing the youngest children. Finally, the policy recommends improving acute care services to children through research and education. The policy statement is worth reading in its entirety by pediatricians whose patients are seen in acute care settings.

PROS Update

By Alan Grimes, MD

PROS (Pediatric Research in Office Settings) celebrates its 30th year this year, with many accomplishments and plans. Given space requirements, I will only touch on highlights in this article, but please reach out to me (agrimes@pcpeds.com) with any questions or for additional information regarding any of the projects. PROS now has 715 practices in 49 different states, encompassing 1700 practitioners and 2.7 million pediatric patients. 80 published studies have come through the network, including over the past year updates on CEASE (smoking cessation), ADHD dx and guidelines usage, underdiagnosis of hypertension (factoid: using EHR data demonstrates that 75-80% isn't diagnosed even though it's documented as abnormal), obesity intervention, teen driving safety, and a novel way of automated identification of implausible growth data entry.

One major plan of the network is to start distribution of the PROS Brief--a study twice per year of (eventually) all PROS practices--one focusing on a pertinent topic requiring faster data accumulation than in a typical study, and one focusing on practice demographic updates. Major studies which have been funded and which will be enrolling practitioners soon are on parental expectations of antibiotic use (Dialogue Around Respiratory Illness), a further refined obesity intervention study (BMI 2+), reminder system for second influenza vaccine for those needing two in a season (Flu2Text), marijuana use (Helping Eliminate Marijuana use through Pediatric Practices), and HPV vaccination (STOP-HPV). Another factoid: With current vaccination rates (missed opportunities, vaccine refusal, etc.) 90 girls/day in the US will eventually get genital warts, and 14 girls/day will eventually get cervical cancer. As you can see, the network is dynamic and active. If you are interested in any of these projects, please feel free to reach out to me (agrimes@pcpeds.com) or contact PROS Central directly at PROSops@aap.org.

Providing mental health care: A case for an on-staff clinical psychologist

By Heidi Sallee, M.D. and Debra H. Zand, Ph.D.

Any practicing pediatrician will tell you that mental health conditions are a significant burden for our patients and their families. Many will also tell you that residency training did not adequately prepare them in the treatment of mental health problems. At the Danis Pediatric Center at SSM Health Cardinal Glennon Children's Center, we are actively changing that narrative. Staffed by faculty in General Academic Pediatrics from Saint Louis University School of Medicine, the Danis Pediatric Center is the primary care medical home for over 10,000 patients and serves as the main pediatric training site for over 50 residents and 170 medical students. With a full time licensed clinical psychologist on our medical faculty we have been able to:

- Co-locate a range of mental health services, resulting in:
  - Quicker and easier access for our patients
  - Immediate, brief consultation and real time discussion with providers
  - Shared documentation
  - Referral facilitation
  - Co-managed care of mental health issues.
- Provide resident education by a psychologist who understands primary care.
- Implement evidence-based mental health practices.
- Provide research opportunities for faculty around mental health conditions in primary care.

Funding to pay for psychological services has been through a combination of third party insurers and extramural grant support.

Our experiences lend support to growing evidence that it is both beneficial and feasible to have a clinical psychologist as an integrated member of the medical team. Doing so has enabled us to provide effective mental health care to our patients and their families, while simultaneously training our residents and creating generalizable knowledge.

Featured Event: Meet and Greet with AAP President-Elect Kraft

Join MOAAP in St. Louis!

Network with fellow chapter members and get an update on chapter activities.
We look forward to seeing you!

June 28 from 6:00 to 7:30 p.m.
Meet and Greet with
AAP President-Elect Colleen Kraft

Home of MOAAP President Ken Haller
4146 Flora Place, St. Louis

RSVP by June 23

Upcoming events

Be sure to visit the events calendar at moaap.org to see what's happening this summer!

MOAAP is sponsoring the Early Childhood Mental Health: Tips & Strategies Conference again this year on August 25. Registrations are limited. Sign-up today!

Calling all #Tweetiatricians! Join in on getting the word out!

By Kayce Morton, DO, FAAP
Chair, Chapter Communications Committee

We hope our last article encouraged more #MOAAP #Tweetiatricians to sign-up! Our Twitter account has had more activity for sure!

Every day the next two weeks, but especially on **Days of Action (June 15th & June 22 nd)**, consider sharing messages on social media to urge the Senate to keep Medicaid strong. The main hashtag AAP and our partners are using for this effort is **#DontCapMyCare**, and **#KeepKidsCovered** is another hashtag to incorporate into messages. You can tag our two US Senators by using @RoyBlunt and @clairecmc in your tweets. Following are a couple sample tweets. Be sure to incorporate the Twitter handles for Senator Blunt and Senator McCaskill.

- .@_____: Medicaid gives {Your state abbreviation} kids a better chance for a healthy future. #DontCapMyCare
- .@_____: I'm a pediatrician & my patients have one message: #DontCapMyCare. Keep Medicaid strong & #KeepKidsCovered!

Out of concerns with the travel bans and for immigrant kids around the world, AAP developed a toolkit for pediatricians and partners around International Children's Day on June 1st. The toolkit includes social media messages that you can use anytime. These messages will likely carry over into Father's Day efforts, which will work to amplify the needs of immigrant families impacted by deportation of fathers. Use notable hashtags: #CareNotCárceles , #PutKids1st

National Gun Violence Awareness Day was June 2, 2017 and this campaign asks everyone who believes we can do more to save American lives from gun violence to do one simple thing: Wear Orange. AAP shared gun violence prevention information throughout the day. This can be done throughout the month so consider sharing a photo of yourself wearing orange with the hashtag #WearOrange or make your own #WearOrange photo for social media. Use Notable Hashtags: #WearOrange

Last major upcoming campaign is #FAMILYROADTRIP Twitter Chat on June 27 at 2pm EST with @HealthyChildren. This will be with National Children Passenger Safety Board that will address family road trip safety, car seat safety, and more. Use Notable Hashtags: #FamilyRoadTrip.

Look to our Twitter or Facebook for more upcoming campaigns. July will be addressing Fireworks Safety and National Safety Month.

Looking for CME? Check out these events in St. Louis and Kansas City!

PEDIATRIC CODING CONFERENCE

WHEN: Friday, July 14, 2017 from 8 am – 12:15 pm

WHERE: Eric P. Newman Education Center (EPNEC)
320 S. Euclid Avenue St. Louis, MO 63110

SPONSORED BY: Washington University School of Medicine in St. Louis, Continuing Medical Education Office and St. Louis Children's Hospital, Continuing Nursing Education

PRESENTED BY: St Louis Children's Hospital

AGENDA

7:30 am	Registration & continental breakfast (provided)
8:00 am	CPT 2017 Updates
9:00 am	Breaking Down That Level of Care: A thorough understanding of what documentation is needed for each level of care
10:00 am	Break
10:15 am	ICD-10 Updates & Review
11:00 am	Procedures
11:20 am	Q & A – Bring your problems and questions and get some answers!
12:15 pm	Adjourn

Children's Hospital • St. Louis BJC HealthCare

Washington University in St. Louis School of Medicine

OBJECTIVES: The intended result of this activity is increased knowledge and competence in applying current health information management strategies in office practice. This program is designed to enhance physicians', nurses' and office coders' knowledge on correct documentation for pediatric services. At the conclusion of this program participants should be able to:

- Recognize the newest CPT codes and how to apply them in your office
- Develop a better understanding of what documentation is in each level of care
- Identify how to better use the ICD-10 codes

PRESENTER: Donelle S. Holle, RN – President and Chief Executive Officer, Peds Coding, INC.

Ms. Holle brings over 30 years of expertise in pediatric practice management, billing and coding services to her coding and reimbursement seminars for primary care physicians and staff throughout the United States. She also provides on-site chart audits with educational sessions with physicians and staff and off-site chart audits with educational written summaries.

CME PROVIDED BY: Washington University School of Medicine in St. Louis, Continuing Medical Education

ACCREDITATION: In support of improving patient care, Washington University School of Medicine in St. Louis is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

CREDIT: Washington University School of Medicine in St. Louis designates this live activity for a maximum of 4 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Washington University School of Medicine in St. Louis designates this live activity for a maximum of 4 contact hours for nurses. Nurses should claim only the credit commensurate with the extent of their participation in the activity.

This program is approved for AAPC 4 continuing education hours. Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor.

It is the policy of Washington University School of Medicine in St. Louis, Continuing Medical Education, that planners, faculty and other persons who may influence content of this CME activity disclose all relevant financial relationships with commercial interests in order for CME staff to identify and resolve any potential conflicts of interest prior to the educational activity. Faculty must also disclose any planned discussion of unlabeled/unapproved uses of drugs or devices during their presentation. Detailed disclosures will be made in activity handout materials.

JOINT ACCREDITATION

REGISTRATION FEE: $60 To register, choose an option:

- On-Line: StLouisChildrens.org/Med_Ed
  Select the link for "Pediatric Coding Conference"
- Call 800.678.4357 and pay by credit card

REGISTRATION DEADLINE IS: JULY 10, 2017
Fee includes enrollment, educational materials, refreshments and parking. Registration fee, less $25 service charge, is refundable if cancellation is received before July 10, 2017.

QUESTIONS: 800.678.HELP (4357)

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www.moaap.org

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