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Teaming Up to Shape Our Region: A Pathway to Baby-**Friendly™**

In a year, 10 "Baby-Friendly Coalition" hospitals have changed the landscape of breastfeeding support in NJ from prenatal through postpartum.

Commissioner Mary O'Dowd, MPH, NJDHSS & Laurence Grummer-Strawn, PhD, MPA, MA, CDC

Hospital leadership teams from 40 NJ delivery hospitals came together with public health leaders from New York, Connecticut and Pennsylvania on December 1, 2011 at the National Conference Center in East Windsor, NJ. NJ Department of Health, Shaping NJ, the American Academy of Pediatrics/ NJ Chapter (AAP/ NJ) & the NJ Pediatric Council on Research and Education (PCORE) partnered to sponsor a 2nd Annual Breastfeeding Summit: Teaming Up to Shape Our Region: A Pathway to Baby Friendly. The Summit is part of an important initiative for promoting a healthier NJ, by supporting exclusive breastfeeding.

National and State dignitaries participated in the daylong event. Key note speaker Laurence Grummer-Strawn, PhD, MPA, MA, Chief of the Nutrition Branch at the CDC spoke about the Critical Role of Hospitals in Supporting Breastfeeding. NJ DHSS Commissioner Mary O'Dowd, MPH challenged all NJ hospitals to achieve Baby Friendly status. The Commissioner awarded Certificates of Commendation to the ten NJ hospitals that received mini grants through the NJ BFHI in January 2011 to help them become Baby-Friendly certified, a designation earned by implementing the World Health Organization's Ten Steps to Successful Breastfeeding. Hospital teams from NJ along with regional partners shared strategies and lessons learned to increase exclusive breastfeeding rates to prevent obesity and improve health outcomes.

In a year, 10 "Baby-Friendly Coalition" hospitals have changed the landscape of breastfeeding support in NJ from prenatal through postpartum. NJ BFHI Medical Champion Lori Feldman-Winter, MD, MPH, FAAP shared the successes achieved to date. Coalition hospitals have exceeded expectations with the pace of change to support breastfeeding such that now:

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How are Maintenance of Certificate programs improving the quality of care in NJ?

PCORE Pediatric Council on Research & Education

Strengthening Pediatric Partners a Maintenance of Certification (MOC) Part 4 program, offered by AAP/NJ, is a program that is designed to help physicians improve healthcare outcomes for patients, develop better practice systems, and demonstrate a commitment to lifelong learning. There are six general competencies identified through the program's evaluation: patient care, medical knowledge, practice-based learning & improvement, interpersonal & communications skills, professionalism, and system-based practice. This American Board of Pediatrics-approved project uses established collaborative quality improvement methods providing practices with the necessary training, tools, and support to help parents and other caregivers circumvent four critical child abuse and neglect triggers: Crying, Maternal Depression, Toilet Training, and Discipline. One practice observed "quality process doesn't just happen, you make it happen; you need to work at it. It is a worthwhile endeavor." All physicians received 25 points towards Part 4 of their MOC process.

Physicians will benefit from MOC projects by identifying individual practice needs in efforts to prevent child abuse and neglect. Patients benefit from MOC by being provided with increased/better communication and quality clinical outcomes. At NJPCORE, the Child Abuse and Neglect (CAN) Team recently wrapped up the first Maintenance of Certification (MOC) project with a successful closing session in November. Nine physicians from seven practices statewide gathered to discuss lessons learned and barriers overcome, as well as share resources and accomplishments.

On a monthly basis, practices collected and electronically submitted data on 20 medical records (10 from 2-month well visits and 10 from 24-month well visits). The practices chose the quality improvements to implement and were connected to assessment, educational resources, anticipatory guidance, and/or referral organizations and DYFS on the four trigger topics. The participating practices identified positive outcomes throughout the project. One physician remarked "there is

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American Academy of Pediatrics

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In This Issue . . .

Keep Ideas fresh by sending in new ideas and articles. Let us know what you would like to see featured in this publication. If interested in submitting a new idea or article, please contact Cortney Mott, Newsletter Editor at 609.842.0014 or at cmott@AAPNJ.org

President's Message

Stephen Rice, MD, PhD, MPH, FAAP

As we approach the holiday season and year's end, it is a time to reflect, celebrate and look forward. 2010 has been a busy and successful year for our Chapter as we continue to grow and improve.

The fall season is always rich with various annual meetings: Resident Career Day in September, ably organized again by Dr. Michelle Tuck, with ever-increasing participation by more pediatric residency programs; these second-year residents were enlightened about the future opportunities and challenges that await them after residency. The 20th School and Community Health Meeting in October, was chaired for the final time by Dr. Wayne Yankus – who is passing the mantle and responsibility to Dr. Polly Thomas & Dr. Elliot Rubin. The 7th Vaccine for Children Conference (VFC) in November, which featured the always informative and entertaining Drs. Meg Fisher and Jeffrey Boscamp, was another successful educational program. With the NCE in Boston this October, many Chapter members availed themselves of the opportunity to attend the meeting, enjoy the beautiful new Convention Center and hear outstanding lectures.

Last year at this time, I wrote that "meetings between pediatric mental health professionals and AAP/NJ pediatricians and staff are paving the way toward improving access to child psychiatrist consultations and services for the patients we serve. A white paper has been produced and lively discussions have begun in an attempt to tackle this chronic issue. Dr. Gary Rosenberg has been the champion on this issue." Just this past week, it has been announced that this project has received both a grant and additional infrastructure funding. As improving mental health for children is one of our Chapter priorities as well as a priority for AAP at the national level, this is an achievement to celebrate. Congratulations to Dr. Rosenberg for his efforts.

The process of merging AAP/NJ and PCORE is hopefully in its final stages. Our amended and restated Certificate of Incorporation and revised By-laws have been forwarded to the appropriate agencies- and we await their response. When the merger is finalized, the operations of the merged entity will be consolidated and simplified.

Another important administrative decision has been to focus our attention on membership in its many facets: providing value to our members for their dues, such as representation, advocacy, education and benefits to help in their professional and personal lives. Through the efforts of Bert Mulder, the benefits available to our members continues to expand and improve. As the Chapter concentrated on membership retention and recruiting new members, we recognized that we could be better served by controlling the process internally rather than having AAP National solicit and collect our dues each year. The Chapter is in the process of that transition now and members will be receiving dues notices in a different fashion than in past years. Further, the Chapter has expanded the concept of Affiliate Membership to include those health professionals who are not pediatricians but who are interested in the health and well-being of infants, children and adolescents to join as affiliates (non-voting members). Corporate affiliation is also being considered as we appreciate the importance of building a community of those committed to improving child health.

The most significant change in 2010, in my opinion, was the decision to redirect the manner in which the Chapter approached advocacy and governmental affairs. Under the bold leadership of Drs. Jeanne Craft and Pierre Coant and the energy of our Executive Director Fran Gallagher, a thorough search for a new outside advocacy representative was undertaken. Our decision to engage Public Strategies Impact (PSI) through two of its partners, Joseph Simonetta and Tracy DeSarno, has been richly rewarded. The degree of our footprint and impact in Trenton has been dramatically enhanced by our collaboration. The Chapter was able to play an important role as the Pulse Oximetry law went through the legislature, into the regulatory phase and

President's Message cont.

finally into implantation.

Looking ahead to 2012 and my final six months as Chapter President, I want to concentrate our efforts to engage, encourage and nourish our younger members to feel comfortable and fulfilled by becoming active in Chapter activities. We are reaching out to these members and planning several regional social gatherings during the first quarter of 2011. There are several committees that would be enriched by the new energy of young members; opportunities for leadership are available.

In early May 2012 on the 5th, the Chapter will be holding its 2nd Annual Children's Gala at The Manor in West Orange, NJ. This will provide the opportunity to celebrate and honor champions of pediatrics and child health.

I want to close by updating our membership on concussion management. The new concussion legislation took effect in September 2011 (N.J.S.A. 18A:40-41.3) and requires schools that participate in interscholastic athletics to adopt a policy concerning the prevention and treatment of sports-related concussion and other head injuries among student-athletes. The New Jersey Department of Education (NJDOE) issued a model policy and guidance document for school boards in April 2011. The responsibility for clearing athletes to return to activity has been expressly given to physicians; at this time, only a physician can write the required note. The legislation stipulates that the physician must be knowledgeable and current in the management and treatment of concussion. All school district or team physicians must complete an educational program. In October 2011, the Center for Disease Control and Prevention (CDC) rolled out it free on-line 20 minute educational course for physicians on the management and treatment of concussion – complete with a post-test and a certificate. The opportunity to become educated and to verify your training is as close as your computer! The three moments that call for physician clearance to reintegrate into normal activity are: (1) readiness to return to school; (2) readiness to begin the graduated return to play protocol (when all symptoms have resolved); and (3) readiness to engage in full contact practices and then into games (presuming symptoms did not recur during the initial steps of the return to play protocol). I have been writing articles and giving lectures throughout 2011 at various venues in New Jersey. You can also check our AAP/NJ website for resource support materials.

Enjoy the holidays. Celebrate with your family, friends and colleagues. Come back in 2012 refreshed, re-energized and re-focused. 2012 will be an exciting and wonderful year for our Chapter; be a part of it!

AAP NJ & PCORE Working Together

minimal increase to total amount [of time] spent on each visit even with the implementation of screening and anticipatory guidance."

In fact, assessment for crying and maternal depression increased by at least 45% and distribution of resources for toilet training and discipline increased by 38% and 42%. However, average time spent on a well-visit only increased by one minute. On several occasions, practices referred families to community partners or DYFS even though the parent did not express concerns but the practice staff felt what they had observed warranted referral. That indicates a heightening of awareness among participating practices to respond to assessment criteria and observations to refer families for further assistance. Physicians and office staff agreed, "Making changes to improve patient care and prevent abuse is not as hard as anticipated." At least 621 families received interventions during the project to reduce the risk factors for child abuse and neglect with some families receiving more than one type of intervention.

As part of the technical assistance offered by the CAN team, conference calls were conducted on topics related to child abuse and neglect. Speakers included Dr. Jeanne Craft, a CAN trainer and PCORE Medical Champion who discussed categories of medical neglect, Dr. Margaret Thompsett, an experienced trainer on maternal depression, and Dr. Steven Kairys, PCORE Medical Director, CAN Medical Champion, and Strengthening Pediatric Partners Principal Investigator, who discussed discipline and how to raise responsible children.

If you or someone in your practice needs MOC Part 4 points, contact the CAN team today to be a part of this quality improvement collaborative provided at no additional cost to the physician.

Strengthening Pediatric Partners is part of the Educating Practices in Their Communities Child Abuse and Neglect Training Program (EPIC CAN) funded by the New Jersey Department of Children and Families at
NJPCORE Quality Improvement Project Leader: Dr. Steven Kairys, MD, MPH, FAAP
For information, contact Marilyn Dunning (mdunning@njpcore.org) or
Michael Weinstein (mweinstein@njpcore.org)

New Jersey Immunization Information System (NJIIS)
Interface Process Flow Sheet
For Healthcare Providers and Electronic Health Record (EHR) And Practice Management (PM) Systems Vendors

Healthcare Provider

Contact EHR/PM software vendor and determine feasibility for practice to submit immunization data electronically to NJIIS.
If the vendor has already established an interface with NJIIS for other practices, your practice will be added to this interface and the vendor will be notified by NJIIS Support. Otherwise, NJIIS Support will work with the vendor on interface development, testing and implementation.
To obtain NJIIS Interface Specifications and the NJIIS Interface Enrollment form, visit NJIIS home page http://njiis.nj.gov. Click on **"NJIIS Forms and Documents"** link on the left navigation bar and scroll to **"NJIIS Documents."**

Provider

1. Print and complete **"NJIIS Interface Enrollment Form"** and fax it to NJIIS at Fax # (609) 341-5098
2. Identify practice contact and team
3. Define data elements to be sent via interface
4. Discuss how the data will be sent
5. Determine who will submit data to NJIIS (provider or vendor)
6. Follow through on information needed

Vendor

Obtain and review NJIIS Interface Specification documents
Discuss with Provider data elements that can be sent via interface, interface message format and which file transfer protocol will be used

Draft Provider/Vendor Agreement to include:

1. Data elements to be submitted …i.e. VFC eligibility, lot numbers and historical shot data
2. Specified file format & transfer protocol
3. Define frequency of submission
4. Responsibilities for data submission (provider or vendor)
5. Training for data submission, if needed
6. Timeframe/milestones from vendor
7. Cost
8. Execute provider/vendor agreement

Design interface according to NJIIS specifications and as specified in provider's agreement.

For technical questions, contact NJIIS Support

Develop Interface test file

Submit test file to NJIIS Support

NJIIS Support notifies vendor of test file errors

Correct errors and resubmit test file

NJIIS Support notifies vendor test file successful

Work with NJIIS Support to establish file transfer protocol. Interface established

Monitor timeframe/milestones (i.e., status of test files)

Interface Established

1. Responsible provider or vendor staff person submits data to NJIIS according to established frequency
2. Identify staff and request NJIIS Training from Regional Trainer (Regional Trainer's contact information listed on back)

Technical Questions: Contact vendor or call OITS helpdesk at 1-800-883-0059

20th Annual AAP/NJ School Health Conference

The Committee on School Health of the AAP/NJ celebrated the Twentieth Annual School Health Conference "Back to Basics: Challenges for the next Decade" at The Palace in Somerset, NJ this October with over 350 participants: pediatricians, physicians, school nurses, and public health officials. The day began with a presentation from Eric Bartky, MD on Red Flags in Mental Health. Dr. Bartky addressed a variety of mental health disorders such as anxiety, depression, eating disorders, schizophrenia and many more as well as the effects that it has on a child and the triggers and causes. Robert Murray, MD, FAAP (national spokesperson for the American Dairy Council and Dairy Association) followed Dr. Bartky and spoke on Coordinated School Health Programs and Nutrition in Schools. During the presentation, Dr. Murray spoke about the impact of snack foods and drinks on a child's nutrition, the role school food programs have in a child's diet, remaking a healthy school environment and the many ways that school nurses can lead the effort. The day concluded with a presentation from Margaret 'Meg' Fisher, MD, FAAP discussing Infectious Disease - What's New?. During her presentation, Dr. Fisher addressed the recommendations for influenza vaccines, vaccines available to prevent human papillomavirus, and the recent measles outbreak and how to prevent the spread of the infection.

Throughout the day, conference participants attended various workshops that included: Sports Disqualifiers - Who Can't Play? And Post Concussion and the new NJ Law presented by Stephen Rice, MD, PhD, MPH, FAAP; School Rules and Regs for 2011 - Issues for School Nurses presented by Christene DeWitt-Parker, MSN, CSN, RN; Legal Issues for Physicians in Practice & Schools presented by Jayne Wesler, Esq. and David Rubin, Esq.; The Great Outdoors - Bugs, Bites and Beyond presented by Kristina Feja, MD and Sam Kim, MD; Demystifying the Asthma Action Plan presented by Gary Pien, MD, PhD, FAAP and Laurie Rufolo, MSN, RN, CSN-NJ; and All Things Dairy presented by Robert Murray, MD, FAAP.

Thank you to the School Health Planning Committee; Wayne Yankus, MD, FAAP, Committee Co-Chair; Polly Thomas, MD, FAAP, Committee Co-Chair, Allyson Agathis, MD, FAAP, Thomas Bejgrowicz, MD, FAAP; Christene DeWitt; Mary Ditri, MA; Marie Peppas, RN, MPH, CSN; Thomas Potter, MD, FAAP; Elliot Rubin, MD, FAAP; Albert Sanz, MD, FAAP; Michael Segarra, MD, FAAP; Kristen Walsh, MD, FAAP; Fran Gallagher, MEd; Cortney Mott MEd; and Bert Mulder.. The AAP/NJ & Planning Committee would like to extend a special thank you to Wayne Yankus, MD, FAAP for dedicated his time over the last 20-years to the School Health Conference.

Left to Right: Margaret 'Meg' Fisher, MD, FAAP, AAP/NJ Vice President; Fran Gallagher, MEd, AAP/NJ Executive Director; Stephen Rice, MD, PhD, MPH, FAAP, AAP/NJ President; Wayne Yankus, MD, FAAP, School Health Committee Co-Chair; Robert Murray, MD, FAAP

Stephen Rice, MD, PhD, MPH, FAAP, AAP/NJ President and Wayne Yankus, MD, FAAP, School Health Committee Co-Chair

Teaming Up to Shape Our Region: A Pathway to Baby-**Friendly™ cont.**

- Mothers delivering at Coalition hospitals receive information about the benefits and management of breastfeeding, and are supported to breastfeed exclusively,
- Mothers and families come to the hospital prepared for skin-to-skin care in the delivery room and continuous rooming-in, where they are with their babies during the entire hospital stay,
- NJ clinicians - mostly nurses, obstetricians, and pediatricians, have been newly trained in breastfeeding management,
- All 10 hospitals have discontinued the practice of handing out industry sponsored formula sample packs,
- All 10 hospitals have moved close to achieving Baby-Friendly status, and
- By January 2012, most will be paying for infant formula at fair market value, instead of taking it for free from formula companies, a practice many consider unethical, and which is not in compliance with the International Code of Marketing of Breastmilk Substitutes.

AAP NJ and PCORE have partnered with the NJ DHSS and hospital teams to create system-wide changes to support more mothers to exclusively breastfeed, leading to lower rates of obesity, and a healthier NJ. This quality improvement initiative is made possible through funding to the NJ Department of Health and Senior Services from the US Centers for Disease Control and Prevention (CDC) CPPW-STI (Communities Putting Prevention to Work - State and Territory Initiative).

Speaker presentations from the NJ BFHI Summit and additional Baby-Friendly resources can be accessed on the AAP NJ/PCORE website at http://www.njpcore.org/base/Programs/BabyFriendlyHospitalInitiative/tabid/168/Default.aspx.

Laurence Grummer-Strawn, PhD, MPA, MA, CDC And Lori Feldman-Winter, MD, MPOH, FAAP

Lorraine Boyd, MD, MPH - NYCDOHMH

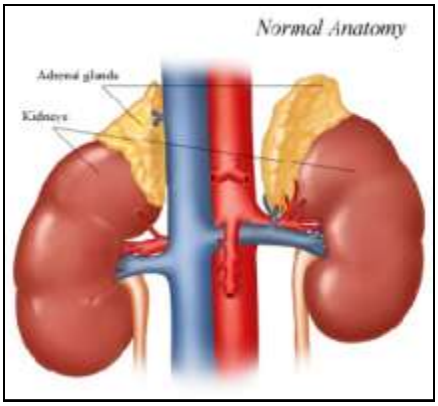
Exhibit Room

Capital Health Systems Exhibit

St. Barnabas Neonatologists Shyan Sun, MD & Kamtorn Vangvanichyakorn, MD, FAAP along with Anne Merewood, PhD, MPH, IBCLC and Lori Feldman-Winter, MD, MPH, FAAP

Commissioner Mary O'Dowd, MPH, NJDHSS, Laurence Grummer-Strawn, PhD, MPOA, MA, CDC, Anne Merewood, PhD, MPH, IBCLC and Lori Feldman-Winter, MD, MPH, FAAP presented certificates of accommodation to hospital teams (left to right: CentraState, Jersey Shore University Medical Center, and Capital Health). These 3 hospitals have or are in the process of scheduling their Baby-Friendly USA assessment visits.

Failure to Diagnose Addison's Disease - Wrongful Death of a 14-Year-Old Boy



THE CASE:

Robbie Armand, a 14-year-old boy, had been seen by Dr. Parker, for routine pediatric care since he was 5-years-old. Robbie had been diagnosed with attention deficit hyperactivity disorder (ADHD) and obsessive-compulsive disorder (OCD), but both were well-controlled by medications. He had some behavioral difficulties at school, but he routinely received A's and B's in all subjects, and was an otherwise healthy child. Dr. Parker also was the pediatrician for Robbie's two younger sisters.

In late June of 2007, at a routine annual pediatric visit, Mrs. Armand brought Dr. Parker's attention to a darkening of Robbie's skin. Dr. Parker did not think the darkening was significant and attributed it to recent sun exposure. Mrs. Armand also expressed concern about Robbie's "skinniness" and failure to gain weight after a recent growth spurt, but Dr. Parker did not think this was cause for concern.

When discussing the case with his partners a few days later, one of them raised the possibility of Addison's disease. As a result, Dr. Parker contacted Mrs. Armand and told her that he'd like Robbie to have some screening blood work to investigate the possibility of Addison's disease. The July 2007 lab results demonstrated a slightly low cortisol level, normal electrolytes, and an aldosterone of 5.3 ng/dl. However, it was Dr. Parker's opinion that Robbie's 2.0 cortisol level was not *significantly* below the normal range of 2.4 to 20 mcg/dL, despite the fact that it was not drawn in a fasting state, as it should have been. Because Dr. Parker felt the boy had no other symptoms indicative of Addison's, the diagnosis was not pursued further through more specific blood tests or referral to a pediatric endocrinologist. In fact, Dr. Parker reassured Mrs. Armand that the lab results were "fine" and specifically told her that Robbie did not have Addison's disease.

Over the next eight months, Dr. Parker did not see Robbie, but did see his mother on several occasions when she was in his office during appointments for her two daughters, who were also patients of Dr. Parker. At one of the visits, Mrs. Armand brought along a package insert for one of Robbie's ADHD medications and asked Dr. Parker if that drug could be causing the skin darkening. Dr. Parker reviewed it and told her that skin darkening was not a known side-effect of the drug. At another appointment for one of her daughters in the fall of 2007, Mrs. Armand again mentioned to Dr. Parker that Robbie's skin was still darkening, even in areas of the body that were not exposed to the sun. She also mentioned that Robbie had been taken off his ADHD medications, which tended to suppress his appetite, but that he was still not gaining weight. Dr. Parker told the mother that while he was not certain what was causing Robbie's problem, he was confident that it was not Addison's. He did tell her that a referral to a pediatric endocrinologist may have to be considered "in the future."

On March 10, 2008, Robbie was again seen in the office by Dr. Parker. His symptoms included vomiting, abdominal pain, diarrhea and general malaise for two days. These symptoms were consistent with an Addison's crisis, but Dr. Parker diagnosed a stomach virus that was "going around" and instructed Mrs. Armand to take Robbie home, give him lots of fluids and keep him out of school for another two days. Mrs. Armand again brought up the issue of her son's darkening skin tone, but the physician told her that they needed to deal with Robbie's acute situation first.

Mrs. Armand called the office the next day and asked to speak to Dr. Parker because Robbie was still unable to tolerate food. Unfortunately, Dr. Parker was out sick himself, and Mrs. Armand talked to an unidentified "secretary or nurse." That person asked Mrs. Armand if Robbie was still producing urine. When told that he was, the "secretary or nurse" determined he was not dehydrated and told Mrs. Armand to keep up the fluids and bed rest.

The next morning, March 12, 2008, Robbie was found unresponsive in bed by his father. 9-1-1 was called. Paramedics were on the scene promptly and the boy was taken by ambulance to a nearby hospital. However, Robbie was pronounced dead a short time later in the emergency department (ED).

Dr. Parker's partner, Dr. Wilson, called him from the hospital and told him that the Armand boy had just died in the ED. Dr. Parker went immediately to the hospital to speak with the child's parents. At this point, he was considering the possibility that the boy actually did have Addison's disease after all. In such patients, even an ordinary stomach flu can trigger a fatal Addison's crisis. Dr. Parker felt an Addison's crisis had occurred and had been the cause of Robbie's death, but he told the Armands that he could not tell them exactly why Robbie died at that point in time.

However, Dr. Parker continued to think about the most likely cause of this tragedy and the next day, Dr. Parker and Dr. Wilson went to the Armand home to talk to Mr. and Mrs. Armand. Only Mr. Armand was present, but Dr. Parker told him that it was his

opinion that his son died due to Addison's disease or from some type of Addison's crisis, although they would have to wait for the autopsy report to be 100% certain. Dr. Parker told Mr. Armand that Robbie's death was "all my fault." He later spoke to Mrs. Armand and told her the same thing.

Dr. Parker also attended the child's wake and had a similar conversation with the parents there.
Autopsy results later confirmed the presence of Addison's disease and the likelihood that the death was due to this undiagnosed but treatable condition.

ALLEGATIONS:
Failure to diagnose and treat Addison's disease resulting in an unrecognized Addison's crisis and the wrongful death of a 14-year-old boy.

PLAINTIFFS' DEPOSITION:
Both parents were deposed and related that over the period of time from June 2007 until just before Robbie's death, Dr. Parker repeatedly assured them that Robbie did not have Addison's disease. They appeared to be very caring parents, very much involved in all aspects of the lives of each of their three children. Dr. Parker was the family pediatrician for all three of the Armand children. Both parents noted that, despite their family's long relationship with Dr. Parker, he did not share their level of concern and anxiety over Robbie's darkening skin in the year prior to his death. Mr. and Mrs. Armand testified that during that time, Dr. Parker continued to attribute Robbie's increasing hyperpigmentation to sun exposure or other unknown causes for which he could offer them no explanation. In fact, Mrs. Armand expressed some degree of personal guilt for failing to persist in her complaints that "something is wrong" and repeatedly accepting the doctor's assurance there was "nothing to worry about." The Armands testified that the entire family has had a very difficult time dealing with Robbie's death and have all been undergoing grief therapy to some degree.

DEFENDANT'S DEPOSITION:
At Dr. Parker's deposition, he admitted several times that he failed to diagnose Robbie's Addison's disease and this led to the boy's death. He admitted that he did not suggest or recommend to Mrs. Armand that she take Robbie to be seen by a pediatric endocrinologist in July 2007 following the abnormal screening blood test, nor in September of 2007 when she mentioned to him that the hyperpigmentation was still present and had in fact increased, although he may have mentioned that a consult was something they may want to consider "at some time in the future." Dr. Parker stated that, at that point in time, he had not ruled out the possibility that medications Robbie was taking for ADHD (e.g., Focalin) were responsible for the skin darkening. Both Mr. and Mrs. Armand were present at the deposition and afterwards Dr. Parker tearfully apologized to both of them. Despite Dr. Parker's statements to both parents prior to the litigation, they seemed surprised he would repeat them under oath to their attorney. However, this occasion actually allowed Dr. Parker to express some measure of his own grief and remorse over this tragedy directly to the parents at a time when they could process and accept it. It also allowed both parents, especially the mother, to relieve themselves of some of the guilt they had been experiencing over their son's death. This appeared to be their primary objective in the litigation, as the family was already financially comfortable.

PLAINTIFF EXPERT'S POSITION:
The plaintiff's pediatric endocrinology expert stated that, in her opinion, Robbie's presentation, including his age, was "classic" for Addison's disease and that Dr. Parker's care deviated from the accepted standards of medical practice in the following ways:

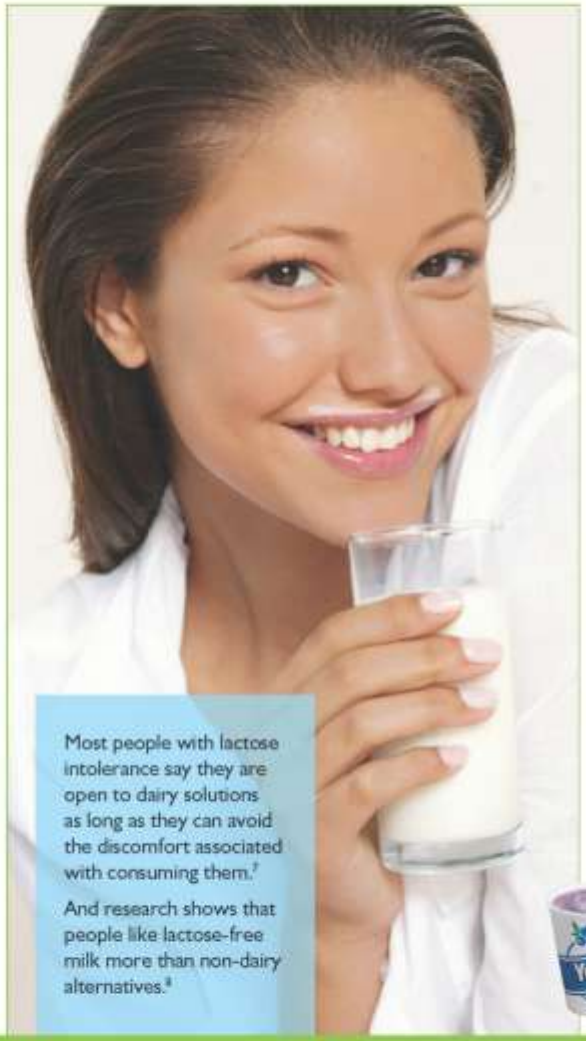
- He failed to interpret the low cortisol level in association with hyperpigmentation as consistent with Addison's disease in July 2007;
- He failed to refer to a pediatric endocrinologist for confirmatory blood tests and treatment at any time; and
- He failed to recognize the symptoms of an adrenal crisis in March 2008, a life-threatening but easily reversible condition if treated in a timely fashion.

The expert stated, with "a reasonable degree of medical certainty," that had Dr. Parker met accepted standards of care, Robbie Armand would have been successfully treated for Addison's disease and would be alive today.

DEFENSE EXPERT POSITIONS:
The case was reviewed by a pediatric expert who found Dr. Parker's treatment to be indefensible and recommended that the case be resolved quickly. He agreed that in light of the unexplained skin darkening and abnormal initial blood tests, the standard of care required immediate referral to a pediatric endocrinologist to rule in or rule out Addison's disease. Had that been done in July 2007 or even in March 2008 it was very likely the diagnosis would have been made and timely treatment would have allowed the

A NEW CONVERSATION ABOUT LACTOSE INTOLERANCE

Help Your Patients Enjoy Dairy Again



Most people with lactose intolerance say they are open to dairy solutions as long as they can avoid the discomfort associated with consuming them.[7]

And research shows that people like lactose-free milk more than non-dairy alternatives.[8]

Many health authorities agree that low-fat and fat-free milk and milk products are an important and practical source of key nutrients for all people – including those who are lactose intolerant.[1,2,3,4,5,6]

In fact, the 2010 Dietary Guidelines for Americans (DGA) recognizes dairy foods as an important source of nutrients for those with lactose intolerance.[7] Milk is the #1 food source of three of the four nutrients the DGA identified as lacking in the diets of Americans – vitamin D, calcium and potassium – and the DGA recommends increasing intakes of low-fat or fat-free milk and milk products to help fill these nutrient gaps.

A Solutions-Focused Approach

People who are lactose intolerant should know that when it comes to dairy foods, practical solutions can help them enjoy the recommended three servings of low-fat and fat-free dairy foods every day*, without experiencing discomfort or embarrassment:

- *Gradually reintroduce milk back into the diet by drinking smaller amounts of milk at a time, trying small amounts of milk with food, or cooking with milk.*
- *Drink low-lactose or lactose-free milk products, which are real milk just with lower amounts or zero lactose, taste great and have all the nutrients you'd expect from milk.*
- *Eat natural cheeses, which are generally low in lactose, and yogurt with live and active cultures, which can help the body digest lactose.*

Visit *nationaldairycouncil.org* for more information, management strategies and patient education materials.

NATIONAL DAIRY COUNCIL

These health and nutrition organizations support 3-Every-Day™ of Dairy, a science-based education program encouraging Americans to consume the recommended three daily servings of nutrient-rich low-fat or fat-free milk and milk products, to help improve overall health.

AMERICAN ACADEMY OF FAMILY PHYSICIANS · American Academy of Pediatrics · eat right. American Dietetic Association · NHMA · National Medical Association · SCHOOL NUTRITION ASSOCIATION

1. U.S. Department of Health and Human Services and U.S. Department of Agriculture. Dietary Guidelines for Americans, 2010. 7th Edition, Washington, DC: U.S Government Printing Office, January 2011
2. National Institutes of Health Consensus Development Conference Statement. NIH Consensus Development Conference: Lactose Intolerance and Health. Draft statement, issued at 7:47 p.m. ET on February 24, 2010. http://consensus.nih.gov/2010/images/lactose/lactose_draftstatement.pdf
3. American Academy of Pediatrics. Lactose intolerance in infants, children, and adolescents. Pediatrics. 2006; 118 (3): 1279–1286.
4. USDA, FNS. Special Supplemental Nutrition Program for Women, Infants and Children: Revisions in the WIC Food Package. Interim Rule. 7 CFR, Part 246.
5. National Medical Association. Lactose Intolerance and African Americans: Implications for the Consumption of Appropriate Intake Levels of Key Nutrients. Journal of the National Medical Association. Supplement to October 2009; Volume 101, No. 10.
6. Wooten, WJ and Price, W. Consensus Report of the National Medical Association: The Role of Dairy and Dairy Nutrients in the Diet of African Americans. Journal of the National Medical Association 2004; 96:15-315.
7. J N Keith et al. The prevalence of self-reported lactose intolerance and the consumption of dairy foods among African American adults are less than expected. J Natl Med Assoc. 2001;103:36-45.
8. Palacios OM, et al. Consumer Acceptance of Cow's Milk Versus Soy Beverages: Impact of Ethnicity, Lactose Tolerance And Sensory Preference Segmentation. Journal of Sensory Studies. 2009; 24:5.

* The 2010 Dietary Guidelines for Americans recommends 3 daily servings of low-fat or fat-free milk and milk products for those ages 9 and older, 2.5 cups for children ages 4 to 8 years, and 2 cups for children ages 2 to 3 years.

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boy to live a relatively normal life.

DAMAGES:
The wrongful death of a 14-year-old boy with the resultant loss of companionship, advice, and guidance and future financial support for his parents and two younger sisters.

OUTCOME:
Because of Dr. Parker's deviation from the standard of care and the obvious causal connection to the boy's untimely death, this case was always considered one to settle out of court. In addition, Dr. Parker had freely conceded his liability in this case from the day after the death and had admitted to the parents on several occasions that Robbie's death was his fault. Following the depositions of the distraught parents and doctor, the case was settled during a mediation session involving the parties, their counsel, MDAdvantage representatives and a retired judge. The amount of the settlement was confidential pursuant to a "non-disclosure" clause which is routinely included in settlement agreements involving MDAdvantage insureds. Virtually all MDAdvantage settlement agreements also include a clause stating there is no admission of fault on behalf of the settling defendant doctor(s). However, in light of Dr. Parker's repeated admissions of fault, that clause was not included in this particular settlement agreement as it would have contradicted the very statements the family needed to hear in order to end the litigation.

MEDICAL-LEGAL DISCUSSION: *Apology/Disclosure Issue*
Physicians are often very conflicted about whether they should talk to a patient or their family members after an adverse event or, as in the case under discussion, after the death of a patient. Obviously, such conversations are inherently difficult for all concerned. Physicians are concerned about incriminating themselves or saying anything that may jeopardize their defense in the event of a lawsuit arising out of the incident, a concern that is often reinforced by admonitions from their professional liability insurers, defense attorneys and colleagues. [In fact, some insurers deny coverage if an admission of fault is made. Contact your malpractice insurer and counsel before making disclosure to avoid denial of coverage and to utilize all available resources.] Saying anything to a patient or patient's family after an adverse event that may be interpreted as an apology, then, would seem absolutely out of the question. But that's not always the case.

In the case under discussion, then, how could Dr. Parker's immediate disclosure, including his full admission of fault and acceptance of responsibility for Robbie's death to the parents, be anything but the worst possible thing he could have done? Because of the particular facts of this case, it is difficult to say whether Dr. Parker's admission resulted in an outcome dramatically different from what would have occurred if he had not openly admitted responsibility and apologized for causing Robbie's death. In all likelihood, Dr. Parker's candor may have been beneficial in that it may have caused the parents to be less angry with him and less intent on making him suffer in return for the suffering he had caused them. In addition, it may also have alleviated Mrs. Armand's guilt over not challenging Dr. Parker's continued reassurances that Robbie's hyperpigmentation was not Addison's disease and was "nothing to worry about."

Obviously the disclosure in this case did not prevent the inevitable lawsuit. However, in the opinion of the defense counsel for Dr. Parker, it may have helped both the family and the doctor to achieve whatever degree of "closure" they have been able to reach in this tragedy at a much earlier time than would otherwise have been the case. It may have even resulted in the parents accepting a lesser amount in settlement than would otherwise have been the case, but that is something that can never be proven definitively. Nonetheless, once the doctor admitted his fault under oath and the parents recognized the doctor was also suffering over this tragedy, it seemed the parents' anger subsided. It appeared they realized there was nothing more to be gained from prolonging the litigation and the case was later resolved through mediation.

Can I say "I'm sorry"?
Yes, but in the event of an unanticipated or adverse outcome, be specific in stating what you are sorry about. There is a difference between expressing empathy, e.g., "I'm sorry to see that you are in pain," and apologizing (admitting fault), e.g., "I'm sorry that my error has caused you pain." "Sorry" is one of the most powerful words in our language. When offered sincerely, it carries considerable power to heal. In contrast, the withholding of a deserved apology may create its own "wound" and generate anger. Empathy is always appropriate. An apology may be unwarranted with respect to the medical care rendered, but may be owed with respect to delays or errors in communication with the patient or family members. By being specific, a doctor's attempt to offer empathy for suffering or an apology for communication problems is less likely to be misinterpreted by the patient as an admission of fault for the injury sustained. In some circumstances, however, an apology for a medical error may be appropriate.

You may be surprised to learn that some patient attorneys confess they don't want a jury to learn that the doctor involved apolo-

gized to the patient. Remember that the goal of a patient's attorney is to portray the defendant-physician as a villain, one who committed malpractice on an unsuspecting patient, and in some cases compounded it by trying to conceal the wrongdoing, thus confirming the injury was not an explainable complication. Villains don't empathize or apologize. Some patients say that if the doctor had only apologized to them, they would not have sued him or her. For these reasons, some patient attorneys don't want you to empathize or apologize to your patients -- their potential clients.

Still, caution is advised when communicating any adverse event. Some doctors say "I'm sorry" too quickly. They feel responsible as the "Captain of the Ship," even where no apology was owed by them or others. If you do say, "I'm sorry," be specific about what it is you are sorry for, instead of offering a "blanket" apology for events that are not your fault. Expressions of empathy for the patient's suffering are always appropriate and generally appreciated. Acceptance of responsibility for that suffering, however, may be unwarranted. The occurrence of an adverse event may be devastating to both patient and physician. Utilize all available resources to help all parties through this ordeal.

Risk Management Caveats[1]:

- Develop a practice policy or guideline on disclosure of unanticipated adverse events that outlines procedures to follow so that each situation is handled promptly and consistently by all. Have the policy reviewed by your practice attorney and/or your professional liability insurer. Your practice may already have such a policy and a team to assist with disclosure of an adverse event. Get acquainted with the policy and procedures now, before any event occurs.
- Educate your staff about what to do when an adverse outcome occurs (e.g., contact the office manager or a designated physician immediately, etc.).

If the adverse event occurred in a hospital, ambulatory surgical center, nursing home or other facility licensed by the state of New Jersey, the facility may require you to notify its risk manager. This will allow the facility to begin an investigation and, in certain circumstances, to assure that the patient and State are notified of "serious preventable adverse events" or adverse events related to an allergic reaction, as required under New Jersey law.[2] If you are the attending physician, you may be required by the facility's policy to participate in the notification of the patient and/or patient's family regarding the adverse event, accompanied by the risk manager. Some facilities have personnel trained to assist the doctor in making an appropriate disclosure of an adverse event to a patient or their family.

- Once appropriate provisions have been made for patient care after an adverse event, there are others who should be notified in order to assist you through the ordeal, to try to reduce the chances of a lawsuit, and to increase your chances of prevailing if a lawsuit occurs. Notify your insurance company immediately. Your insurance company will retain counsel who can guide you on the legal obligations of disclosure, what you can safely say to your patient and/or the patient's spouse or family members, and the protections that may be available for your benefit. Counsel may also offer guidance on the preservation of evidence that may be needed in the event a lawsuit is filed years later.
- Keep in mind that there's a difference between disclosing an adverse event and admitting liability. "I'm sorry" is not necessarily the same as "I'm guilty." Choose your words carefully and prepare for your discussion with the patient and/or patient's family.
- Don't disclose and run. Emphasize to the patient and/or patient's family that "This is what I think happened based on what I know *today*." In many cases it is appropriate to follow-up with the patient as more information becomes known, provided your facility or other concerned parties approve release of information obtained through internal reviews, as this process is generally considered confidential. This is another important topic which should be discussed with your counsel before disclosure is made.
- Document the fact that the adverse event was disclosed to the patient and/or family in the medical record. Discuss with counsel whether to include in the medical record the objective facts which led to the adverse event. It may be wiser to record those facts in a separate document sent only to counsel, protected from disclosure to others under the attorney-client privilege for safekeeping in the event of future litigation.
- If appropriate, review the circumstances and evaluate to determine why the adverse event occurred and what patient safety measures can be put in place to prevent its recurrence.

The foregoing is not to be construed as legal advice. Healthcare providers should familiarize themselves with the policies, procedures and requirements of their healthcare facilities for reporting and disclosing such events to their facility and patients. Healthcare providers are advised to consult a qualified attorney and their insurance company on the issues discussed herein and any related matters prior to making disclosure(s) of any adverse event to a patient, family member, guardian, government agency or other person or entity.

[1] *From Your Vantage Point (October 2010).* Disclosure after Adverse Events, by *Scott T. Heller, Esq., Reiseman, Rosenberg, Jacobs and Heller, P.C. in Morris Plains, NJ.*

[2] Patient Safety Act, N.J.S.A. 26:2H-12.25 *et seq.*

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NIH Consensus: In Most Cases Lactose Intolerance Shouldn't Limit Dairy Consumption When Managed Appropriately

Courtesy of the American Dairy Council and Dairy Association

In February 2010, the National Institutes of Health (NIH) convened an independent expert panel for a Consensus Development Conference on Lactose Intolerance and Health. The NIH panel reviewed the latest research on lactose intolerance, strategies to manage the condition and health outcomes of diets that exclude dairy foods. After a thorough review of the scientific evidence, the panel created a consensus statement that addresses some of the common misperceptions about lactose intolerance, including the belief that dairy foods need to be excluded from the diet.

Why Health Professionals Should Address Lactose Intolerance

While lactose intolerance may seem like a minor annoyance or disturbance that can easily be solved by recommending dairy avoidance, this approach may not only deprive your patients of a food group they'd like to consume, but may also lead to nutrient shortfalls and contribute to bigger health problems in the long-run. According to the NIH Consensus Development Conference Statement, "Many individuals with real or perceived lactose intolerance avoid dairy and ingest inadequate amounts of calcium and vitamin D, which may predispose them to decreased bone accrual, osteoporosis, and other adverse health outcomes."[i] Additionally, the NIH Consensus Development Conference expert panel concluded that it is unnecessary to eliminate dairy completely to manage most cases of lactose intolerance and consuming small amounts of milk, yogurt, natural cheeses, and lactose-reduced foods may be effective management approaches.[i]

Why Dairy Matters

The 2010 *Dietary Guidelines for Americans* recommends that adults and children ages 9 and older consume three cups of low-fat or fat-free milk or equivalent milk products every day. Milk and milk products are such an accessible source of important nutrients that it's difficult for most people to meet recommendations for key nutrients – calcium, potassium, magnesium and more – without consuming at least three servings daily.[ii,,] Higher dairy intake as part of a healthy diet leads to higher nutrient intake, better diet quality and bone health, may help maintain a healthy weight and has been associated with reduced risk of several diseases and conditions: osteoporosis, hypertension, metabolic syndrome, type 2 diabetes[iii,] and colon cancer.

What You Can Do

- Encourage formal diagnosis. To help prevent nutrient shortfalls that can result from avoidance of dairy foods, encour-

age formal diagnosis and personalized nutritional counseling.[i]

- Recognize there are individual variations in the amount of lactose that can be comfortably consumed. Research shows that people with lactose malabsorption can generally consume at least 12 grams of lactose (equivalent to the lactose content found in 1 cup of milk) in one serving with no or little discomfort.[i] People can generally tolerate larger amounts of lactose if consumed with meals and distributed throughout the day.
- Talk to your patients about the health benefits of dairy foods. Counsel patients with lactose intolerance on strategies for including dairy foods in the diet and/or finding other dietary sources for the many nutrients found in dairy foods.

Managing Lactose Intolerance

The NIH's expert panel on lactose intolerance suggests health professionals counsel patients with lactose intolerance or lactose malabsorption on strategies for including dairy foods (and other dietary sources of the many nutrients found in dairy foods) to prevent nutrient shortfalls due to dairy avoidance.[1] Patients who are lactose intolerant should know that when it comes to milk, there are practical solutions that may help them enjoy the recommended three servings of low-fat and fat-free dairy foods every day - without experiencing discomfort or embarrassment. Here are a few:

- Gradually reintroduce milk back into the diet by trying small amounts of it with food or cooking with it.
- Drink lactose-free milk, which is real milk, tastes great and has all the nutrients in regular milk.
- Eat natural cheeses, which are generally low in lactose; and yogurt with live and active cultures, which can help the body digest lactose.

To read the National Institutes of Health Consensus Development Conference Statement on Lactose Intolerance and Health click here: http://consensus.nih.gov/2010/images/lactose/lactose_finalstatement.pdf.

[i] National Institutes of Health Consensus Development Conference Statement NIH Consensus Development Conference: Lactose Intolerance and Health February 22-24, 2010. Available at: http://consensus.nih.gov/2010/images/lactose/lactose_finalstatement.pdf

[ii] U.S. Department of Health and Human Services and U.S. Department of Agriculture. Dietary Guidelines for Americans, 2005. 6th Edition, Washington, DC: U.S. Government Printing Office, January 2005.

Note: The 2005 Dietary Guidelines for Americans recommend 3 servings of low-fat or fat-free milk or milk products per day for individuals 9 years and older and 2 servings per day for children 2-8 years old.

[iii] Huth PJ, Fulgoni VL, DiRienzo DB, Miller GD. Role of dairy foods in the dietary guidelines. *Nutrition Today* 2008; 43(6):226-234.

[iv] Nicklas TA, O'Neil CE, Fulgoni VL. The role of dairy in meeting the recommandations for shortfall nutrients in the American diet. *J Am Coll Nutr*. 2009;28: 73S-81S.

[v] Supplement to the *Journal of the American College of Nutrition*. Evidence for the Role of Dairy Foods in Nutrient Adequacy and Chronic Disease Risk Reduction. 2009. 28: 69S-129S.

[vi] Huncharek M, Muscat J, Kupelnick B. Colorectal cancer risk and dietary intake of calcium, vitamin D and dairy products: A meta-analysis of 26,335 cases from 60 observational studies. *Nutr and Canc* 2009;61:47-69.

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Are You Ready for the New ICD-10 and Electronic Version 5010? Changes Start Taking Effect in January of 2012...

By: Robert J. Conroy, Esq., Denise Sanders, Esq., Matthew R. Streger, Esq., and Peter D. Espey, Esq.

The International Classification of Diseases (10th edition) (ICD-10) codes will take effect on October 1, 2013. While this may seem far off, according to the Centers for Medicare and Medicaid Services (CMS), physicians should begin preparing for the changes immediately. In addition, the CMS will require use of the new Version 5010 for the electronic submission of claims beginning at the outset of 2012. Although the Version 5010 represents less of a structural transformation than ICD-10, its impact will come in just a few months. Failure to prepare for either change can (and most likely will) result in unpaid claims.

ICD-10 - The ICD code change affects all healthcare providers subject to HIPAA. Even providers who do not handle Medicare or Medicaid claims must make the transition. In describing the magnitude of this change, the American Academy of Family Physicians observed that, while ICD-9 contains 14,000 diagnosis codes containing 3-5 digits each, ICD-10 contains 69,000 diagnosis codes with 3-7 digits. The purpose behind this change is to improve the structure and specificity of the coding system. In addition, since the ICD-9 was originally developed by the World Health Organization and is over thirty years old, an update is needed. Current Procedural Terminology (CPT) codes for outpatient procedures will remain unaffected; although with time, it can be expected that the CPT codes will reflect the greater specificity of the ICD-10.

The change was enacted through federal regulation, 45 CFR § 162.1002, and will require the use of two types of ICD-10 codes. The first code type is the ICD-10-CM (ICD-10) and it applies broadly to healthcare treatment settings. It must be used for diseases, injuries, impairments, other health problems and their manifestations, and causes of injury, disease, impairment, or other health problems. See 45 CFR § 162.1002. The second code is the ICD-10-PS which applies only to the inpatient hospital setting. It applies to inpatient procedures and other services relating to prevention, diagnosis, treatment, and management. Id.

In order to prepare for the conversion, a physician should consider the effect of the conversion on staff, budget, and future revenues. Staff will require instruction on the workings of ICD-10 and its many changes from ICD-9. Care will need to be taken to assure that sufficient resources are available to be allocated to training and compliance. Now is the time to lay a good foundation and make sure your staff has the tools to "get it right." You do not want to suffer any loss in revenue because you were unable to timely implement the ICD-10 codes. This is particularly important because, from October 1, 2013 onwards, you may only use the ICD-10 codes. With this much lead time, governmental and other payors are not likely to be too sympathetic to coding errors.

In addition, physicians might want to consider the use of software aids and the provider may want to contact their practice management or billing software vendors for assistance. CMS provides General Equivalence Mappings (GEMs) to translate ICD-9 codes into ICD-10. However, GEMs cannot substitute for learning the new system, and practices will be held responsible for errors.

Furthermore, physicians should consider whether ICD-10 could affect their agreements with payors. Employment productivity bonuses relying on the ICD-9 codes could also be affected. In order to prepare, agreements using the old terms should be reexamined and updated. The bottom line with these changes is the sooner the preparations begin the better. For a suggested timeline on preparing for the new system, including the electronic claims submissions, please see https://www.cms.gov/ICD10/03_ICD-10andVersion5010ComplianceTimelines.asp.

Electronic Claims & Version 5010

Less monumental, but more immediate, is the change to electronic claims submissions. CMS is requiring that, for electronic health care claims, Version 4010/4010A needs to be upgraded to Version 5010 by January 1, 2012. This requirement applies to all healthcare providers who are regulated by HIPAA, and transmit health care claims electronically. According to CMS, 99% of Medicare Part A claims and 96% of Medicare Part B claims are electronically received.

If after January 1, 2012 a covered provider submits an electronic claim without using Version 5010, it cannot, and will not, be paid. CMS began accepting Version 5010 claims on January 1, 2011. Therefore it is not too early to begin using Version 5010 or at least making the transition to it. Version 5010 will allow for the usage of ICD-10 codes and is intended to standardize business information about a transaction. In addition, Version 5010 includes updates for all HIPAA transaction standards.

Given the rapidly approaching deadline, confusion can be expected. Much of this confusion will find its origin in the difficulties faced by busy physicians in trying to keep up with the numerous changes instituted by CMS. Nevertheless, physicians should begin their preparations soon.

Cont. on page 17

In order to prepare for Version 5010, providers should determine what impact the new electronic claims version will have on their practice. An analysis should include a realistic determination of how much staff time and effort will be required to make the necessary changes by January 1, 2012. Physicians who use third parties or receive assistance in submitting claims from an outside entity should contact those third-parties or outside entities to make sure that they are prepared for these changes.

By December 31, 2011, physicians and their practices should have run external tests to verify the functionality of their Version 5010 electronic filing system. On January 1, 2012 Version 5010 takes over and no claims will be paid using the old versions.

ICD-11 (Not Until After 2015)

Updates to ICD-10 will begin on October 1, 2014 according to CMS. Yes, WHO has already begun work on ICD-11. Fortunately, ICD-11 is not due to be issued by the WHO until 2015. For more information on the forthcoming ICD-11, please visit http://www.who.int/classifications/icd/revision/en/index.html.

Summing Up

Time is of the essence in preparing for changes brought by ICD-10 and Version 5010. Physicians need to develop strategies, meet with staff, and learn all they can about these new requirements and systems. The physician who begins preparations now will have a competitive advantage and be in the best position to adjust while continuing to care for their patients and getting paid to do so.

For more information visit: https://www.cms.gov/ICD10/05a_ProviderResources.asp#TopOfPage

This article is intended for informational purposes only. It is not intended to constitute legal or other professional advice.

Kern Augustine Conroy & Schoppmann, P.C., Attorneys to Health Professionals, www.DrLaw.com has offices in New York, New Jersey, Pennsylvania and Illinois. The firm's practice is solely devoted to the representation of health care professionals. The authors of this article may be contacted at 1-800-445-0954 or via email - info@drlaw.com.

Having a Medical Home Helps Physicians Bridge the Transition "Gap"

One of the key elements of the Medical Home Initiative in NJ is the series of 3 Learning Collaborative Sessions spaced over the timeline of practice participation. These sessions provide a valuable opportunity for all participating practice teams in a given "Learning Collaborative" county to share successes, challenges, and lesions learned with their colleagues. Each Learning Session is focused on one or more of the 6 Core Outcomes of the Integrated Systems Grant.

- Families of children with special health care needs will partner in decision making at all levels, and will be satisfied with the services they receive.
- All children with special health care needs will receive coordinated ongoing comprehensive care within a medical home.
- All families of children with special health care needs will have adequate private and/or public insurance to pay for the services they need.
- All children will be screened early and continuously for special health care needs.
- Services for children with special health care needs and their families will be organized in ways that families can use them easily.
- All youth with special health care needs will receive the services necessary to make appropriate transitions to adult health care, work, and independence.

Learning Session I focuses on Developmental and ASD Screening; Learning Session II provides information on Cultural Competency and Insurance and Learning Session III covers issues around Transitioning the Children and Youth with Special Needs within the practice to adult providers of care. Learning Session III for the Southern NJ Practices (Camden, Cumberland and Salem Counties) was held on September 14, 2011, at Continuum Health Alliances offices in Marlton, NJ. All ten of the participating practices attended: Advocare Atrium Pediatrics, Advocare Gloucester Pediatrics, Advocare Haddon Pediatrics (2 sites), Advocare Haddonfield Pediatrics, Advocare Marlton Pediatrics, Advocare West Deptford Pediatrics and 3 sites of Cooper Family Medicine – Sewell, Leap Academy and Cramer Hill locations. The practice teams were provided with many resources covering Transition – including the "Six Core Elements of Health Care Transition" – which outlines the creation of a transition policy for the practice, transition planning, and finally, the transfer of care to a new adult care location. All of the practices in attendance expressed a need within their practices for these transition materials; many are in the process of creating "Transitioning Youth Registries" to have coordinated lists of the youth in their practice approaching transition age. Too often, transition planning is a missing piece of office protocol. Participation in the Medical Home Initiative has given these participating practices the tools, resources and materials needed to address a growing need within their practice. Each practice became aware of the need for their Medical Home in-house team to be a resource for each transferred patient and to provide contact with that patients' new "adult care team" for at least 3 months post transfer to guarantee success and continuity of care. The goal is to maximize the well being for all transitioning youth, including those with special needs by providing seamless transition and uninterrupted health care services.

One of the activities of the session was for the practices to work with their Medical Home team – usually consisting of an MD Champion, a Service/Care Coordinator and a parent partner, on crafting an AIM statement/PDSA (Plan, Do, Study, Act) Cycle around the concept of Transition – a goal for their office to address any issues they are having with transitioning their Special Needs patients to Adult Systems of Care. After having a half hour or so to work with their teams, the practices were asked to report out on what they had accomplished. Advocare Haddon volunteered to go first. Their office was in need of finding Adult Care/Family practices, that accepted Medicaid and were willing to take on their Special Needs patients – they crafted an Aim statement that read: "By October 31, 2011, we will secure 4 Family Practices that accept Medicaid that we can refer our transitioning patients to".

Upon finishing, one of the doctors in attendance from the Cooper Family Medicine sites, stood up, walked over to Advocare Haddon's staff, handed them her business card, and said "We accept Medicaid, we will wel- *Cont. on page 20*

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Having a Medical Home Helps Physicians Bridge the Transition "Gap" cont.

come your transitioning patients, and we have more than one location to serve them". I truly wanted to applaud at that very moment. A Medical Home neighborhood was born. We couldn't have planned or scripted any better than how that all came together and we could not have asked for more from our participating practices in the South. They have set the bar very high for our following County expansions. The concept of a Medical Home – though it's been in the pediatric world for 30 years, is still difficult for pediatricians to wrap their arms around..working with parents from within their practice on quality improvements is somewhat foreign feeling.. As this being the Southern practices' last Learning Session, the team was comfortable knowing that these pediatricians got it, they really got it!

7th Annual Vaccines for Children Conference

The 7th Annual Vaccines for Children Conference was organized by NJ Pediatric Council on Research & Education a charitable trust of the American Academy of Pediatrics, NJ Chapter and the New Jersey Department of Health and Senior Services. The conference was held on November 30, 2011 at The Conference Center at Mercer County Community College. The conference aimed to discuss and find solutions to improve health policies and practices, providing vaccines for children and aimed to educate parents and primary care providers on preventive health topics within the context of a Medical Home framework. The 7th Annual New Jersey Vaccines for Children Program Conference gathers its local and state experts to assist with the education of current immunization information and understanding the impact on clinical and practice management; current resources and strategies to enhance practice and community partnerships; defining social media tools and strategies for online immunization exchange; and identifying the NJ Immunization Network as an advocate for children.

The conference kicked-off with a keynote presentation from Bill Smith, PhD addressing The Storytelling Key to Effective Vaccine Communication. Within in the presentation Smith addressed three ways storytelling can be used to improve communication with parents concerning vaccine importance and safety, examples of missed opportunities for using storytelling, and type of behavioral modeling storytelling that may be particularly useful in overcoming vaccine doubt and fears. Along with the keynote, the conference offered two plenary presentation: Travelers Bring Back Bugs Which Vaccines Could Prevent presented by Margaret 'Meg' Fisher, MD, FAAP & Jeffrey Boscamp, MD, FAAP and What's New: Vaccine Preventable Disease & NJIIS Update presented by Celeste Andriot-Wood, MA.

Bill Smith, PhD; Meg Fisher, MD, FAAP; Stephen Rice, MD, PhD, MPH, FAAP; and Jeffrey Boscamp, MD, FAAP

The conference offered participants two workshop sessions where with four options that included: Tools for Building a Healthy Community a New Jersey Immunization Network presentation; Immunization Techniques: Best Practices for Infants, Children, and Adolescents presented by Patti Lucarelli, RN, MSN, CPNP, APN & Ellen Donovan, RN, MSN, FNP, CPM; Urban Evaluation of Immunization Coverage Using NJIIS presented by Peter Wenger, MD; and Talking to Parents About Vaccinations: Addressing Questions & Concerns presented by Charles Scott, MD, FAAP (sponsored by MERCK).

New Jersey Department of Health & Senior Services - Vaccine Preventable Disease Program Exhibit Booth

Lactation Lounge at Cooper benefits nursing mothers

Courtesy of the Asbury Park Press

A downtown lounge has opened here for an exclusive clientele — breastfeeding mothers who work at Cooper University Hospital.

The Lactation Lounge gives nursing moms a comfortable site to pump breast milk while on the job.

It offers two curtained stations with electric pumps, as well as rocking chairs, foot rests "and an ambient-noise fountain to create a peaceful, private environment," say Cooper officials.

More importantly, advocates say, facilities like the Lactation Lounge provide valuable support for mothers who otherwise might find it hard to keep nursing.

"It makes a big difference," said Peggy Stedman, a leader of La Leche League in Haddonfield.

She said a mother's ability to nurse can suffer if the woman does not express her milk on a regular schedule.
"If you keep putting it off, you end up lowering your supply," Stedman said. "This gives mothers a private place that's clean and quiet. Not all (nursing) mothers have private offices. A lot of them work in factories or Walmarts."

Statistics show the challenge that nursing mothers face. At the lounge's official debut on Thursday, Cooper administrator Robyn Harvey noted 74 percent of mothers in the United States initiate breastfeeding with newborns, but only 43.5 percent continue to do so at six months.

"The American Academy of Pediatrics recommends exclusive breastfeeding for the first six months of life, and thereafter as desired," said Harvey, Cooper's senior director for patient care.

Among other benefits, proponents say, breastfed babies are more resistant to infections and have lower incidences of serious illness. As a result, nursing mothers miss work less often due to sick infants, said Stedman at La Leche League.
"This is definitely good for the baby because it keeps the mother's supply up," she observed of workplace pumping stations. "But it's good for the business, too."

She noted a provision of the nation's health care reform law requires employers of 50 people or more to provide a private place where nursing mothers can pump.

"Lactation support in the workplace is one of our strategies as well," said Lisa Asare, a representative of the state's Department of Health and Senior Services. "This is really the wave of the future."

"We have a lactation room (at the Department of Health and Senior Services)," she added. "I wish I could call it a lounge."

Cooper's facility is behind a locked door near the third-floor maternity unit. Nursing mothers receive a code to enter the room, where they're to be undisturbed during pumping sessions that can last 15 to 20 minutes.

"You want to keep the stress down (to maximize milk production)," said Nancy Cornett, a Cooper worker who regularly pumps at the lounge.

"You're supposed to do it every three hours to keep up your supply," said Cornett, who has a 6-month-old son, Colm. The Willow Grove, Pa., woman noted she previously pumped at work under more difficult circumstances while nursing Colm's older brother, Liam, now 2½.

Lactation Lounge at Cooper benefits nursing mothers cont.

"I did it in an office with a locked door, but people were knocking on it all the time. This is much better."
Cooper's lounge was prepared with a $5,000 donation from an employee-funded charity, noted Cooper spokeswoman Melissa Maycott.

She said more than 140 female employees have taken maternity leave at Cooper so far this year.

The lounge also has a small refrigerator that holds bottled water for visiting moms. It will not be used to store breast milk, however.

"We are asking women … to bring their own coolers with them to the lounge," said Maycott. "Since employees are coming to use the lounge from all areas of the hospital, we want to make this a comfortable yet safe process so there is no confusion among breast milk."

From Darkness to Light - Sexual Abuse Prevention Information

We Can End Child Sexual Abuse
The ultimate mission of D2L, to end childhood sexual abuse, can only be accomplished by sharing the solution of prevention, awareness and education with more and more people. This, in turn, builds momentum and over time, changes the way our nation and culture cares for, protects and nurtures our children. Being an active participant in the mission to end childhood sexual abuse is one of the most rewarding things we will ever do – and we cannot do it without you.

We believe that learning the facts about childhood sexual abuse helps prevent it. Talking about it helps prevent it. Getting involved helps prevent it. The truth is, if childhood sexual abuse can be prevented, it can be stopped. That's why D2L exists – to empower adults through awareness and educational programs to prevent, recognize and react responsibly to childhood sexual abuse.

A Brief History
In 2000, Darkness to Light was created as a nonprofit with the mission of reducing the incidence of child sexual abuse through public awareness and education. With tremendous community support, over $100,000 was raised and an award-winning media campaign was developed and launched in June of 2001.

In 2002 *"7 Steps to Protecting our Children: A Guide for Responsible Adults"* was created and Time, Inc agreed to place ads in various magazines they publish. In 2003 the documentary Childhood Stories was produced by the award-winning team of Breslin-Dunn. The documentary details the stories of four adult survivors of sexual abuse from various backgrounds and life experiences.

In 2004 we began work on an interactive sexual abuse prevention training program, called *Stewards of Children,* a 2 1/2 hour training program for adults. And, CNN began running Darkness to Light public service announcements nationally. These pro-bono ads were designed to increase awareness of the prevalence and consequences of child sexual abuse and to drive viewers to educational materials. CNN is still a significant supporter today and countless organizations and individuals have found us because of an ad they saw on CNN.

In 2006, *Stewards of Children ONLINE* was released as a web based version of the "live" or facilitated version of the training program.

Today we have more than 2,500 Facilitators who teach the program in 48 states and 10 additional countries and more than 200,000 copies of the *Stewards of Children* curriculum have been distributed and the program is also available in Spanish and Icelandic. For more information about Darkness to Light, visit www.d2l.org

CATCH

Community Access To Child Health

CALL FOR PROPOSALS

2012 Implementation and Cycle 2 Resident Funds Programs
November 1, 2011—January 31, 2012—Award Notifications June 2012

Grants available in the 2012 cycle

- **Medical home access**
- **Access to health services not otherwise available**
- **Connecting uninsured/underinsured with available programs**
- **Initiatives to address community barriers to immunizations**
  CATCH is seeking innovative community-based projects to improve access to immunizations for children who are most likely to experience barriers. Eligible initiatives reach out to the community at large; activities to increase immunization rates for existing patients within practices or clinics would not qualify for this funding.
- **Native American Child Health**
  The AAP Committee on Native American Child Health has partnered with CATCH in the funding of its Native American child health grants for projects that benefit American Indian/Alaska Native (AI/AN) children. Indian Health Service (IHS) family physicians and community family physicians serving AI/AN children may apply in partnership with a pediatrician. According to the IHS manual, IHS physicians may accept grants less than $100,000 and no approval is required from Area or Headquarters.

The American Academy of Pediatrics is pleased to announce that CATCH will be accepting applications for its Implementation and Resident Funds programs beginning November 1, 2011. The Implementation Funds program supports the initial and/or pilot stage of developing and implementing a community-based child health initiative. Grants of up to $12,000 are awarded to pediatricians who will work collaboratively with local community partners to ensure that all children have medical homes and access to needed health care services. Priority is given to projects that will serve a population known to be underserved or with demonstrated health disparities. All projects must be sustainable. *A pediatrician must lead the project and be significantly involved in the grant proposal development and project activities.*

Grants of up to $3,000 are awarded to residents to plan and/or implement community-based initiatives that increase access to medical homes or health care services not otherwise available. Projects must include planning activities or demonstrate completed planning activities. *A pediatric resident must develop the proposal, lead the project and be significantly involved in project activities.* To ensure project completion, residents who are in their 1st or 2nd year of residency on the submission due date of January 31, 2012, are eligible to apply; 3rd-year residents may apply if they will be chief resident in their 4th year.

More information is at www.aap.org/catch; e-mail catch@aap.org; call 847/434-4916.

Join more than 1,200 pediatricians who, through their CATCH projects, have learned that local child health problems can be solved locally, often using local resources.

One pediatrician *can* make a difference!

Congratulations to Dr. Barbara Snyder and her colleagues in the Department of Pediatrics at the University of Medicine & Dentistry of New Jersey- Robert Wood Johnson Medical School. As part of an AAP CATCH grant, she will be investigating pediatricians' practices with adolescent patients, particularly in discussing questions about sexuality, sexual identity and risk taking behaviors.

A separate part of the research will involve surveying the experiences and barriers experienced by Gay, Lesbian, Bisexual and Transgender (GLBT) adolescents in accessing medical care. As part of this project, the investigators are asking members of AAP/NJ to participate in the research by completing a brief, anonymous online survey. Please visit the following link: http://kwiksurveys.com/online-survey.php?surveyID=OJIKFM_6912f9ca

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