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President’s Column

Jeffrey Beinstock, MD, FAAP
President, NJAAP

Change is in the air.

By the time you read this issue of New Jersey Pediatrics, the summer season will be coming to a close and another school year will be getting under way. Similarly, transition to the new NJAAP Executive Council has already taken place and the election campaign for the next AAP President is in full swing, as is the campaign for President of the United States.

As I assume the presidency at NJAAP, I want to pledge my expertise, guidance and support to the over 1,700 pediatricians and other pediatric healthcare professionals located in every county throughout New Jersey, while simultaneously remaining a stout advocate for the patients and families for whom we care each and every day. Building on the successful accomplishments of my predecessors requires a robust effort, so I am asking each of you to get involved in our Chapter and stay involved. Fortunately, our Chapter is supported by a dynamic, well informed staff that is dedicated to assisting our efforts to advance the Chapter’s mission. Looking for ways to get involved? Reach out for suggestions and ideas from members and staff alike.

I have been practicing general pediatrics in a group practice, with its main office in Fair Lawn, since 1988. My involvement in AAP began while I was a medical student. I have been involved both locally through the state chapter as well as nationally, serving on numerous committees ever since. In addition, I am currently President of the Northern New Jersey Pediatric Society, Chairman of Pediatrics at The Valley Hospital and Medical Director for Healing the Children, New Jersey.

Engagement will be a word you will hear me reference often. As President, I hope each of you will commit to becoming and staying engaged with NJAAP, so that together, we can further our Chapter’s mission.

Now that I have your attention and you are engaged, let me fill you in on some of what the Chapter has been doing and what else you can expect.

• NJAAP continues to expand its educational outreach—working closely with the NJ Department of Health on Zika educational outreach, and a variety of CME offerings.
• We have ongoing webinars on a variety of topics: the recent measles outbreak, Human Trafficking, and our Mental Health Pediatric Partnership Initiative. Currently we are registering for the Fetal Alcohol Spectrum Disorder webinar series and offering a webinar on The Identification & Management of Lead Poisoning and Asthma.

For additional information on member benefits and other education and advocacy initiatives, check out www.njaap.org.

• This fall, watch for huge savings on the NJAAP Malpractice Insurance offerings from A-rated companies and other savings as the Chapter strives to lower the ongoing costs of practicing pediatricians. Thanks to Drs. Canzoniero, Leva, Segarra, and Tuck, our Purchasing Alliance Officers.
• NJAAP has numerous MOC Part 4 and Part 2 opportunities in Mental Health, Child Abuse and Neglect Prevention, HPV, and Bright Futures/Developmental Screening. All programs are provided to members at no additional cost.

In closing I want to personally thank the previous officers who have held the position of President of the NJAAP: Drs. Fisher, Graff, Lander, Lilienfeld, Patel, Prontnicki, Rice, Rubin, Scott, Segarra, and Yankus. They have all demonstrated what a leader should provide for the membership and have all helped to further our mission.

Engagement of All! This is the vision of our new President, Jeff Bienstock, MD, FAAP. I am excited about his vision and its possibilities. If you are already engaged with the Chapter, thank you, if not, contact us today and connect with our leaders or staff/team members and discuss how your passions and expertise can benefit your colleagues and children and families throughout New Jersey. We will work with you to make it happen.

In mid-September, an expanded leadership group is strategically planning for how and where the Chapter will invests its time, energy and resources over the next three years. The planning session will culminate in the development of a dashboard. The priority topics in our developing dashboard: Advocacy/NJAAP Agenda for Children; Practice Management / Pediatric Council; PCORE Programs/Initiatives; Communications; and Organizational Development. Please weigh in… what’s important to you? Reach out to members of your Executive Council or our staff to let us know. Contact information is available at www.njaap.org. Completion Deadline for our 2017—2020 NJAAP Dashboard is December 14th.

In this issue, read about the Chapter’s work in partnership with Meridian, Cooper, and the NJ Department of Children and Families (NJ DCF) to bring mental/behavioral resources to pediatricians in 11 counties via the Pediatric Psychiatry Collaborative Hubs. These Hubs provide participating pediatricians with real-time psychiatric phone consultations and connections to expertise provided by psychiatrists, psychologists and social workers. If you are signed up with the Hub in your region, you already know the benefits, if not, sign up today to participate. See page18 for more information.

We continue working with partners on the Pre-K Our Way Campaign, because like you, we understand the role that high quality healthcare and pre-school education play in ensuring the optimal development in children, especially those children most vulnerable or considered “at-risk.” Linking Pre-K to Medical Homes has value; it provides information important to pediatric efforts to identify developmental delay or disability early—and connecting families to appropriate services. Speaking of education, be sure to read the primer for pediatricians on IEPs (Individualized Education Plans), 504 Plans and Private Assessments on page 14.

Join NJAAP on October 18th for the 25th Anniversary School Health Conference at The Palace in Somerset, NJ. Spend time with colleagues, link with school nurses, hear exceptional presentations and register for the MOC program. Good 4 Growth to earn 20 Part 2 points without leaving NJ! More information can be found on page 23. Looking for something in November? Meet up with colleagues at our Immunization Conference on November 30th at the Renaissance Hotel in Woodbridge. Look forward to seeing you at one or both! Check our website for additional information.

I would like to conclude with this thought; NJAAP leadership and staff are interested in hearing from you about your passions, your challenges and your thoughts on how we can support you. Over the past decade we have built Chapter capacity to help design custom opportunities and solutions through marketing, educational outreach, building partnerships and more. Want to explore the possibilities of partnering? Contact us, we will come to you and begin the conversation!

Kind Regards,
Medical Director’s Column

Steven Kairys, MD, MPH, FAAP
Chairman, Department of Pediatrics
Jersey Shore University Medical Center
Medical Director, K. Hovnanian Children’s Hospital

September marks the end of summer, the beginning of football season and for most children, the start of an amazing new school year. For many, but not all children, this annual ritual is filled with great excitement and soaring expectations. For others, the return to school highlights some of the social and economic issues that are powerful impediments to academic success. Foremost among them are food insecurity and housing insecurity.

Food insecurity is defined as having limited access to or uncertain availability of nutritionally adequate and safe foods. Data show that close to 24% of households with young children meet this definition. In a sample of 5000 families with children under age four, there was a 77% increase in the proportion of food-insecure families in the US between the years 2006 and 2012.

Food insecurity is a marker for poor health. Children in food insecure families are twice as likely to experience poor health than their well-fed counterparts. The effects are both short and long term and its impact on academic success is far reaching, including: an inability to concentrate, memory impairment and diminished social functioning. One study reported these children as having greater difficulty getting along with peers, poorer reading and math skills and being more likely to have to repeat a grade. Federal Supplemental Nutrition Assistance Program (SNAP) and school lunch programs help, however, legislative funding for these programs is eroding and the ongoing lackluster support in the House suggests further cuts could be on the horizon.

Housing insecurity also plays a leading role in academic fragility. A history of multiple moves or an overall lack of housing stability can negatively impact a child’s mental and behavioral health by triggering risky practices including: smoking, drug and alcohol abuse and sexual promiscuity, all of which contribute to poorer school performance.

While homeless children are certainly the most severely affected, there are large numbers of children with less visible housing and food insecurities. Many families, even those already living in a home, are spending over 50% of their income on housing alone. These families are forced into making difficult decisions daily on where to cut back in order to remain in a home.

Pediatricians are well positioned to play a meaningful role in helping to identify children and families suffering from food and housing insecurity early on and then linking them to services that will help them avoid crisis. Drs. Erin Hager and Anna Quigg and the Children’s HealthWatch team developed the Hunger Vital Sign, a 2-question screening tool based on the US Household Food Security Scale to identify young children in households at risk of food insecurity.

Pediatricians can be proactive and start asking all families two simple questions to help identify families in need.

- Within the past 12 months were you worried whether your food would run out?
- Within the past 12 months was the food you bought not enough to last till there was more money to purchase more?

Support for food insecure families can be found through New Jersey’s WIC program and at NJ211 (NJ211.org). Feeding America is another resource available state-wide. Go to feedingamerica.org and click on the tab “find your local food bank”. You can then enter the family’s zip code for more information.

In addition to these nutritional resources, New Jersey has a state-wide system for addressing many more family challenges and concerns. Central Intake provides referrals and services for early intervention, housing and food assistance, transportation and employment, home visitation and parent education. See page 34 to learn more about Central Intake.

1. USDA Survey Dec. 2011
A growing national crisis in access to child mental health services is particularly impacting the state of New Jersey. This crisis is leading many children to forgo needed mental health services and putting pressure on pediatricians to serve children in need with very limited clinical and consultative resources. The Pediatric Psychiatry Collaborative (PPC) care model is increasingly being recognized as an important response to this crisis. This article reports on the development of a collaborative care model program in the state of New Jersey, as well as on case examples, to illustrate how this program supports primary care pediatricians and their patients and leverages their skills to identify and serve children in need.

1. Introduction/Background

Up to 13 percent of children in the U.S. are estimated to have significant mental health problems. However, approximately two-thirds of children and adolescents with mental health and substance use disorders will not receive the necessary and appropriate treatment services. At the same time, there are only 8,500 child and adolescent psychiatrists in the U.S., while the need is estimated to be approximately 30,000, a gap that has remained over the last 35 years. There is a similar shortage of non-medical child mental health professionals, particularly those who will serve children covered under Medicaid. This state of affairs has led to a national crisis where increasingly larger number of children and youth wait in emergency rooms for access to child psychiatric beds, and longer wait lists for outpatient services. Research suggests that children and adolescents who are living in urban areas will be more likely to receive mental health care while those who live in rural areas have even greater challenges.

During Fiscal Year 2014, approximately 24,500 children and adolescents in the state of New Jersey received community mental health services, which represents a 7.7% rate of access to any care. Out of that total, 9,318 met the Federal definition for Seriously and Emotionally Disturbed (SED). Additionally, 3.8% of the children and adolescents who received behavioral health services through the state mental health authority (SMHA) had a co-occurring mental health and an Alcohol or Other Drug (AOD) disorder; and 5.4% met the Federal definitions of SED as well as a substance abuse disorder. Depression remains one of the more common mental health disorders among children and adolescents. In New Jersey, approximately 47,000 adolescents (6.8% of all adolescents) per year in 2009–2013 had at least one major depressive episode within the year prior to being surveyed and 58.2% did not receive treatment for this. Concurrently, the number of children and adolescents who do not receive treatment for substance use disorders during this same time period is estimated at around 77%. Although preventable, suicide, which is the main serious morbidity resulting from depression, continues to be the third leading cause of death for all people between the ages of 10 and 24 in New Jersey.

There are even greater challenges in certain parts of New Jersey, such as in the southernmost five counties of the state. For example, according to data we have collected, only 7 child psychiatrists practice in this region and only 3 actively see children and youth. Much-needed child and adolescent behavioral health services within these counties are lacking on a scale not dissimilar to some of the poorest geographic regions in the country. A chief factor that contributes to this problem is the critical shortage of qualified behavioral health professionals, which leaves pediatric practices in those counties to serve as the de facto mental health provider for their young patients. Although pediatric primary care providers (PCPs) are ideally positioned to address mental health problems and most pediatricians (94%) agree that they should inquire about a child’s mental health status, over two thirds do not feel comfortable or competent to conduct mental health assessments. Pediatricians generally lack the prerequisite training and clinical experience in pediatric behavioral health, and lack the time to assess and treat all but the simplest mental health disorders. Even in those children where mental health issues are identified, pediatricians are often placed in the difficult position of finding appropriate and qualified referral resources. In spite of these challenges, many families of children with complex and serious psychiatric disorders come to pediatricians seeking behavioral health services. These range from requests for diagnostic and treatment services to step-down and continuity of care after children are treated in intensive treatment programs (inpatient, partial hospital, or residential), often with complex medication regimens. Additionally, PCPs do not have systems in place for...
to track and follow children with mental health problems. Current child mental health services are oversubscribed, of brief duration, fragmented, and lacking in community-based coordination for effective treatment and to increase access for newly identified children.

Several major gaps in the current system that present challenges to PCPs and families include: 1) Limited care management services to provide access to existing services, and coordination between these services and other child caring entities and professionals. 2) Screening services that incorporate screening for mental health needs (along the lines of the Early Periodic Screening, Detection and Treatment services mandated under Medicaid) and connect screening to early intervention and treatment services. Such screenings are ideally performed in PCP offices and in schools. 3) Significant lack of access to treatment services for children, particularly those covered by Medicaid, often poor minority children, and children living in urban areas or in more rural regions (all frequently highly stressed and traumatized).

II. New Jersey Pediatric Psychiatry Collaborative (PPC): Origins and Organization

The state of Massachusetts developed a promising statewide program, the Massachusetts Child Psychiatry Access Project (MCPAP), that provides pediatric PCPs with timely access to child psychiatric and mental health consultation, assistance to families in accessing local behavioral health, and transitional services for patients.12, 13 There have been numerous replications of the MCPAP model with adaptations for regional needs, with a total of over 40 such programs now organized under the National Network of Child Psychiatry Access Programs (NNCPAP).14 The integrative behavioral health model, promoted for primary care-psychiatric collaborative care for adults is a promising evidence-based model,15 but its application in pediatric primary care settings is challenging given the shortage of available professionals for on-site services, and the added complexity of collaborating with families.

The New Jersey PPC program came together as a collaboration between the Departments of Psychiatry and Pediatrics of the Hackensack-Meridian Health System, the Departments of Psychiatry and Pediatrics at Cooper Health System, and the New Jersey Chapter, American Academy of Pediatrics (NJAAP). The program, funded by a competitive grant by the New Jersey Department of Children and Families, is based largely on the Massachusetts model. Initially it comprised two collaborative Hubs: one serving Ocean and Monmouth County and the other Burlington and Camden Counties. Initially, 160 pediatricians participated in the collaborative, with each Hub serving up to 20 pediatric practices. The following table provides preliminary data illustrating our experience with various reasons for consultations during the pilot year.

<table>
<thead>
<tr>
<th>Table 1. Pediatric Psychiatry Collaborative Reason for Contact: July 2015 – June 2016</th>
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<tr>
<td>Behavioral health</td>
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<td>Treatment consult</td>
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<tr>
<td>Medication consult</td>
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<td>Community referral</td>
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<td>Diagnosis</td>
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<td>Parent guidance</td>
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<td>School guidance</td>
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<td>Second MH opinion</td>
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<td>Crisis</td>
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<td>Screening question</td>
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<td>Other</td>
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<td>Note: Consults may be initiated for multiple reasons.</td>
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The key programmatic components of the collaborative include: 1) Capacity for routine and urgent child mental health telephonic and live consultations. These are initiated by a pediatrician’s request, based on either systematic screening or indicated concerns about a child. 2) A learning collaborative model with Maintenance of Certification (MOC) credits for pediatricians engaged in the project (managed by NJAAP), 3) Support of standardized, systematic and standardized mental health screening using the Survey of Wellbeing of Young Children (SWYC) for ages 0–5 and Pediatric Symptom Checklist (PSC) for ages 6 to 18.

4) Care management/navigation services by Hub social workers and psychologists to ensure linkage from PCPs to community mental health resources appropriate for each child. 5) Outreach to pediatric community mental health providers, especially those associated with the NJ Children’s System of Care program (including the county Case Management Organizations and the Family Service Organization). 6) Training and educational sessions for pediatricians related to the management of common pediatric behavioral health problems (such as ADHD, anxiety, depression, substance use and suicidality). 7) Collaboration with state and managed care companies on methodologies to improve reimbursement. 8) A tracking system for children consulted on by each Hub for care management purposes. 9) A formal program outcome evaluation process provided by an outside evaluation firm (Kelley Analytics), with 3 and 9 month follow-ups.

Case consultation services follow a step-wise process, including: 1) Pediatricians call in or fax
consultative requests, based either on positive screen results or more immediate presenting problems by a child or family. 2) The Hub’s social worker or psychologist performs an intake obtaining information from the PCP on demographics, mental health concerns about the child, consultation questions, all background medical information, and available developmental information. 3) The family is then contacted and they participate in completing the intake, including background history, developmental and psychosocial history, family history, and prior mental health treatment. Primary screening instruments (i.e. PSC or SWYC, if not obtained) and secondary screening instruments (such as depression, anxiety, ADHD, and bipolar disorder screens) are obtained from the family and youth to help guide the diagnostic assessment, treatment planning and medication management. 4) Based on the intake information, the social worker or psychologist completes the Child and Adolescent Service Intensity Instrument (CASII) to derive a recommended level of care intensity. Efforts are made to collect relevant records from previous mental health or mental health-related services (schools, primary care, specialty medical, etc.). 5) The Child and Adolescent Psychiatrist (CAP) reviews the collected information, and the social worker or psychologist will either a) schedule a telephone consult with the PCP and the CAP and/or, b) the LCSW will schedule a live in-person evaluation by the CAP with the patient and family. 6) The CAP provides feedback to the PCP on treatment recommendations, with options for a) the PCP continuing to treat the child using CAP recommendations (with the CAP being continuously available for informal consultation), b) the CAP provides intermittently following-up along with the PCP, or c) referral for CAP management with PCP input. In cases of referral, the CAP will provide “bridge” child mental health services until child can reach the receiving child mental health service. 7) Referral for outpatient services with referral to existing specialty child mental health services (typically outpatient psychotherapy, but higher level of care intensity if warranted), with Hub staff providing information and support for referrals.

III. Case Examples

Below, we report on two cases of children that illustrate the stepwise Hub collaborative consultative process, as well as some of the behavioral health problems presented by children referred:

Case 1: Medication Management, Case Management, and Parent Psychoeducation

In the early months of the Cooper Hub, we received a consultation about a 13-year-old male with ongoing obsessive compulsive disorder (OCD) symptoms. The patient presented to his pediatrician for a refill of sertraline, but the patient was experiencing a gradual increase in symptoms. The pediatrician contacted the collaborative program to request consultation from a CAP about whether to continue prescribing the sertraline. Additionally, the patient’s insurance was changing at the end of the month, and sertraline might not be covered under the new plan. The mother was contacted and confirmed the pediatrician’s report that the OCD symptoms were becoming worse, making it difficult for the child to study and adversely affecting his school performance at the end of the previous school year. There was also an added report of reading difficulties. The family noticed the return of compulsions, including clearing his throat often, touching his hair to the point where parts were falling out, and others. The patient described obsessive thinking about bad things happening to family members when they were not present, as well as being poisoned by his food, and feeling that these compulsions were making him “visible and miserable at the same time”.

Past clinical history was significant for the patient, having experienced frequent sore throats around age 7, and also being diagnosed with recurrent streptococcal pharyngitis (strep throat). At that time, the patient began having difficulty in math, his handwriting became messy and unreadable, he lost some coordination ability, and he became easily emotional. The mother also noticed the patient started to express a need to write and re-write his homework until it felt just right. The patient was later diagnosed with pediatric autoimmune neuropsychiatric disorder (PANDAS), which is associated with the rapid onset of OCD and/or tics caused by group A beta-hemolytic streptococcal (GABHS) infections.17 The family sought treatment from two specialists in the treatment of PANDAS, and one of them prescribed sertraline, which the pediatrician continued to prescribe. The patient also had his tonsils and adenoids removed and the patient’s symptoms improved significantly. The medication was effective in controlling OCD symptoms for some time, until two months prior to the recent consultation.

The pediatrician had the family complete the PSC (parent and adolescent report) as well as the Patient Health Questionnaire (PHQ-9), a measure for depression. The patient’s self-report results were subclinical for depression and anxiety symptoms. However, his mother’s results suggested significant emotional distress. The consulting CAP reviewed the screening results and spoke with the pediatrician. Due to concerns about the change in insurance, it was suggested that the patient be transitioned from sertraline to fluoxetine (40mg) daily, which the new insurance, or most $4 pharmacy formularies, would cover. The CAP also recommended the patient be tested for strep throat in order to determine if a new bout of infection might be contributing to the recurrence of symptoms. If positive, he recommended treatment with a 10-to-14-day course of penicillin along with the fluoxetine. The staff psychologist contacted the mother to discuss psychotherapy options to optimize treatment of the OCD symptoms, providing a list of psychotherapy providers in close proximity who accepted the patient’s insurance.

Three months after the original consult, the patient’s family was contacted by the Hub to determine follow through with treatment recommendations and their effectiveness, and if continued on next page
further assistance was needed. The medication regimen had been effective in relieving anxiety and reducing OCD symptoms, but psychotherapy services had not been pursued. The psychologist explained that ongoing therapy services would further improve treatment outcome. A list of referrals for psychotherapy was again sent to the family, and they began the process of scheduling an appointment. Additionally, the staff psychologist educated the mother on accessing academic supports for her son’s learning problems, including pursuing Section 504 accommodations, and a visit with a developmental optometrist to evaluate an identified vision problem.

Case 2: Direct Evaluation, Medication Management, and Case Management

The pediatrician of a 10-year old African-American male living in foster care sought psychiatric consultation from the Cooper Hub due to his being physically aggressive and violent at home and school, exhibiting oppositional behaviors towards his foster mother, stealing in the home, and getting suspended from school. This patient also had a long history of aggression, especially towards his brother. The patient had been recently separated from his biological mother due to alleged neglect and substance abuse. Prior to his foster care placement, the patient required a period of acute psychiatric hospitalization for his aggression and suicidal ideation. At discharge, he was diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD) and Major Depressive Disorder. Discharge medications consisted of sertraline 25 mg and methylphenidate extended release (ER) 27 mg daily, which was left for his pediatrician to manage.

At his first post-discharge outpatient visit, the pediatrician increased the methylphenidate to 36 mg daily due to continued problems with impulse control. In spite of this increase, there was no appreciable improvement in these symptoms, and the patient was admitted to a psychiatric partial hospital program. The attending psychiatrist in the partial hospital program added olanzapine dissolving tablet 10 mg daily to his medication regimen, which was effective in decreasing aggressive behaviors but was discontinued for unknown reasons prior to discharge. The patient continued on methylphenidate ER 36 mg and sertraline 25 mg daily. Additionally, the patient received in-home and outpatient psychotherapy services, but began to gradually decompensate over the next two months. The foster mother, feeling increasingly overwhelmed, contacted the pediatrician for assistance. The pediatrician also wondered if the patient needed to be back on an atypical antipsychotic, and if he suffered from bipolar disorder.

The pediatrician requested that the foster mother complete the PSC-35 in the office. The results reflected clinically significant elevations on the attention, internalizing and (especially) externalizing subscales. A Hub psychologist contacted the foster mother, obtained additional collateral history and arranged for the completion of additional secondary screeners, which included the Vanderbilt ADHD Scale, Mood Disorders Questionnaire (MDQ), and the Depression Self-Rating Scale for Children. The patient screened positively for ADHD and depression. The MDQ, completed by the patient’s foster mother, also screened positively, and given the concern that patient may have a serious mood disorder, the Hub scheduled a 90-minute face-to-face psychiatric evaluation for this patient.

Hospitalization records and collateral history obtained from the patient’s case worker revealed that the patient was exposed to benzodiazepines and alcohol in utero during the first trimester with no reported complications during pregnancy or delivery. He was delayed in speech production, but other developmental milestones were reportedly normal. During his evaluation with the Hub CAP, the patient self-reported nightmares of past abuse experiences, flashbacks, and hyper-arousal when he felt others were intruding into his space. He did not endorse any symptoms suggestive of manic or hypomanic episodes. The patient also expressed feelings of guilt and sadness, but denied any disturbances in his sleep and appetite. He showed some hyperactivity, impaired concentration, monotonous speech, and guarded and anxious affect. There was no indication that the patient had a learning disorder.

The consulting CAP diagnosed the patient with Post-Traumatic Stress Disorder (PTSD) and ADHD (Combined Type), with a rule out of Depressive Disorder. He recommended increasing sertraline initially to 50 mg daily, and restarting methylphenidate at 36 mg daily, with room for subsequent increase. In addition, the consulting CAP strongly recommended trauma-focused cognitive-behavioral therapy (CBT) for the patient, and psychoeducation classes for the foster mother to help her better understand and manage the patient’s behavioral and emotional problems arising from PTSD and re-experience of traumatic memories. The referring pediatrician concurred with the recommendations and agreed to continue the medications. The Hub psychologist and the patient’s child welfare case worker collaborated to identify community programs to provide the recommended psychosocial treatments.

Discussion and Conclusions

These cases present good examples of the types of practice challenges faced by pediatricians in managing patients who present with serious emotional, behavioral, and developmental disturbances, as well as the types of consultative and supportive assistance provided by the New Jersey PPC. The first case presented a complex diagnostic and treatment challenge that at first, focused on pharmacological management, but later expanded into specialty psychotherapy and educational services. Both of these are needed by children with PANDAS, a condition that affects midbrain regions with behavioral/emotional as well as neurodevelopmental impact. The second case, presented with a frequent form of racial/ethnic disparity associated with misdiagnosis, with a focus on the disruptive behavioral symptoms presented by the child.

continued on page 10
(with a presumptive diagnosis of bipolar disorder), but less attention on the underlying internalizing disorder (PTSD) and the need for pharmacological, psychotherapeutic, and specialized parent training for its effective management.

Lack of specialized psychiatric training of pediatricians, limited community psychiatric treatment resources, and time restrictions imposed during routine visits increases the probability that such children can experience poorer treatment outcomes for these issues. As demonstrated by these case examples, programs such as the PPC not only assist pediatricians with identifying children and adolescents who are at-risk for experiencing behavioral health and substance use disorders through universal screening, but also provide them with ready access to psychiatric and psychological professionals who are able to provide skilled consultation and guidance in assessment, diagnosis, and treatment planning without unnecessarily interrupting the treatment relationship between primary care physician and patient.

The NJ PPC has now expanded to two additional counties in Central New Jersey (Mercer and Middlesex Counties), and the five southernmost counties in New Jersey (Gloucester, Cumberland, Salem, Atlantic and Cape, under a second Hub staffed by Cooper Health). This was facilitated by a second competitive grant by the New Jersey Department of Children and Families. We are actively recruiting practices in those counties and reaching out to additional practices in our existing counties. In addition to this expansion, other priorities for the program include: 1) Initiation of televideo capabilities for live distance psychiatric and psychological consultations and family support services. 2) Expanding systematic behavioral health screening for children seen in participating practices in order to fulfill the promise of a truly preventive approach with early access to care, which should help to reduce higher emergency level care. 3) Pursuing models of payment for screening and PCP behavioral health services with both private third party payors and NJ Medicaid. Additionally, we are looking into future funding both for long term sustainability of these services as well as expansion of these critical services into the remainder of the state.

References
1) Which of these factors is not cited as a major problem contributing to lack of access to pediatric psychiatric and mental health services?
   a. Shortage of child and adolescent psychiatrists
   b. Shortage of non-psychiatric child and adolescent mental health professionals
   c. Lack of coordination in the mental health sector
   d. Families do not seek care for their children’s mental health problems
   e. Rise in need for mental health services amongst children and adolescents

2) Depression and substance use are two of the more prevalent mental health disorders among children in New Jersey.
   a. True
   b. False

3) Pediatricians’ challenges in handling mental health concerns of their patients include:
   a. Lack of time
   b. Discomfort in the area of psychiatric/psychological concerns
   c. Lack of knowing the resources for psychosocial and mental health concerns
   d. All of the above

4) Collaborative primary care-mental health models can provide:
   a. Consultative services to the PCP
   b. Medication management assistance
   c. Additional psychological secondary screenings
   d. Educational and treatment guidance and resources to families of the children
   e. All of the above

5) Over 9000 children and adolescents in New Jersey met the Federal definition for seriously and emotionally disturbed.
   a. True
   b. False

6) Approximately two-thirds of children and adolescents with mental health and substance use disorders will not receive the necessary treatment services.
   a. True
   b. False

7) In New Jersey, the number of children and adolescents who do not receive treatment for substance use disorders is estimated to be around 77%.
   a. True
   b. False

8) Some of the gaps in mental health care include:
   a. Limited care management services to provide access to existing services
   b. Services that incorporate mental health screenings and connecting such to early intervention and treatment
   c. Significant gaps in access to treatment for children, especially those covered by Medicaid
   d. All of the above

9) The mental health screenings conducted in the New Jersey Collaborative include all except:
   a. SWYC
   b. PSC
   c. MMPI-2
   d. CASII (on consultations)

10) The PPC will be covering 11 of the 21 counties in New Jersey.
    a. True
    b. False

CME Instructions
Read the CME-designated article and answer the Fall issue, quiz questions above. Print your name and phone number and mail or fax this form within six months from the date of issue to: NJAAP CME Quiz, 3836 Quakerbridge Road, Suite 106, Hamilton, NJ 08619 • Fax: 609.842.0015

NAME __________________________ PHONE __________________________
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Submitter must answer 8 of the 10 questions correctly to qualify for CME credit

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This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Medical Society of New Jersey through the joint providership of Atlantic Health System and the American Academy of Pediatrics, New Jersey Chapter. Atlantic Health System is accredited by the Medical Society of New Jersey to provide continuing medical education for physicians. Atlantic Health System designates this live activity for a maximum of 1.0 MA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Introduction

The term “vaping” is used to describe the action of inhaling vaporized nicotine-laced liquid through an electronic cigarette, as opposed to inhaling nicotine and other carcinogens by smoking a standard tobacco cigarette. Since its introduction, there has been significant increase in the popularity of vaping, largely due to it being touted as an effective method for helping individuals to quit smoking. However, recent studies indicate that vaping increases co-habit forming with actual smoking in young people.1 The popularity of “vaping” has grown exponentially among adolescents since its introduction to the market. Over 70% of high school age children have been exposed to advertising for e-cigarettes.11 There are currently over 450 brands of e-cigarettes available in the United States.

While the adverse health effects of nicotine vapor are still under study, the safety of the actual device itself is now being brought to light. This report describes the incidences of two teenagers admitted to a burn unit after being injured by exploding e-cigarettes, one with serious oral injuries.

Case Report

Case 1: A 16–year old female vaping on an e-cigarette, which exploded upon contact with the mouth. Patient with multiple injuries to the face was transported by EMS. Upon arrival, patient was alert, responsive and in moderate distress due to pain. No significant past medical or surgical history.

Examination: Patient presented GCS 15, hair and scalp with no injuries evident. Mental status—oriented to place person and time. Ears—tympanic membrane clear, no injuries to external pinna. Eyes—vision gross normal, eyelashes intact. Conjunctiva Injected bilaterally, cornea clear no hyphema. Eyelids show evidence of 1st degree burns. Fluorescein staining of eye show uptake in the sclera none in the conjunctiva. Face—2nd degree burns to the face involving the perioral area, nasal folds, bridge of the nose and between the eyebrows. Nose hair not singed, no nasal discharge or bleeding. Mouth—Both upper and lower lips crusting of blood and mild swelling noted. Gums both upper and lower show swelling and mild discoloration. Teeth upper central incisors avulsed and missing, lateral incisors upper fractured, lower incisors central and lateral fractured horizontally with half the teeth missing. Throat—no airway compromise, denies pain to throat. Neck trachea midline no neck pain. Chest—no external injuries noted, lungs clear no wheezes, heart regular sinus rhythm. The remaining portion of the exam showed no significant findings. IV access obtained. Bolus of normal saline started, pain relief provided. Because of the location and extent of the burns, patient was transferred to the Burn unit and remained in the unit for 48 hours, thereafter requiring extensive dental work.

Case 2: A 17-year old male was sitting alongside a 16-year old female who was “vaping” when the e-cigarette she was using exploded in her face. Both the male and female patients were transported by EMS in the same ambulance. On arrival, the male patient was in moderate distress from pain. He stated that he had showered immediately after exposure. No significant past medical or surgical history. Social history denied alcohol or opioid use; has used marijuana on a recreational basis.

Examination: 17-year old male was alert, responsive, but with moderate distress from pain. Mental evaluation oriented to time place and person. Head, scalp and hair showed no evidence of injury or burn. Eyes—pupils equal reactive, gross vision normal left periorbital area shows erythema and tenderness, suggestive of 1st degree burns. Oral cavity—no injury.

Rest of the face—ears, nose with no injury. Skin in addition to burns to the periorbital area, the anterior chest wall and upper abdomen are involved with blistering 2nd degree burns described as being painful. IV access obtained and bolus with normal saline started. IV morphine given for pain relief. With significant involvement of almost 10% BSA with second degree burns, patient was transported to the burn unit at the pediatric tertiary care center.

Discussion

The incidence of burns resulting from electronic cigarette explosions, either in adult or adolescent populations, is unknown. However, it is known that electronic cigarettes present a risk for injury from sudden and unexpected ignition and explosion. According to a 2014 report by FEMA, there were 25 separate media reports of fires attributed to electronic cigarettes between 2009 and 2014. FEMA stated that this total is not all-inclusive, as there were likely numerous other incidents that went unreported to the media or fire departments.2 Additionally, the known issue with lithium ion batteries suffering from thermal runaway, a positive feedback loop wherein an increase in temperature precipitates an exothermic reaction that in turn increases flammability and ultimately an explosion.3

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The damage from e-cigarette explosions can be more severe than those from the lithium ion batteries used in other commercial devices, largely because of the design of e-cigarettes: the cylindrical device is weakest at the ends, allowing for the e-cigarette chamber to be propelled. The batteries used in laptops and other tools are encased in a strong rigid container that can confine a fire, batteries in cellphones are flat and more flexible leading to less pressure buildup and therefore less explosive potential.4

The vaporizers in electronic cigarettes are powered by a lithium ion battery. The cigarette itself consists of a battery chamber, a chamber to atomize or vaporize the chemicals and the chamber that holds the chemicals or liquid that is vaporized.

The discussion of whether vaping is safer than smoking is still raging and far from being determined. Although the adverse effects from tobacco smoke are well known, and understood to be related to the burning of tar and other tobacco constituents, the effects of ingesting nicotine in vapor form are still under study. In either form, nicotine is recognized as the primary contributor responsible for the addictive and pleasurable experience of smoking or vaping.5

Until recently the sales of e-cigarettes to teenagers and children had been largely unregulated with sporadic regulation locally to prevent sales to underage children. Recently, the FDA approved regulation that prohibits the sale of e-cigarettes to persons under the age of 18, both in person and online.6

Research is suggesting that e-cigarettes may be a gateway to the use of traditional tobacco products and other drugs.7 And, the popularity of vaping products is not in question. In a 2014 survey, it was estimated that 16% of 10th graders and about 17% of seniors in high school had used e-cigarettes.8,9,10 It is important to note that statistics on e-cigarette use is hard to come by as the market to date is not well regulated. Never the less, use is trending up with annual sales now estimated to be approximately 1.7 billion dollars per year and growing.

Summary/conclusion

As discussed, burns resulting from exploding e-cigarettes are both serious and predictable. The snowballing popularity of vaping necessitates more study examining the potential dangers of e-cigarettes on two fronts: their role in leading to a significant crossover to more traditional tobacco products, and the potential for injuries from explosion. Recent FDA regulations banning sales to persons under the age of 18 both at retail and online mark a first step toward regulating this device, but more needs to be done.12

This case report highlights some of the injuries that can occur when using a vaping device. Pediatricians are well positioned to educate teenagers, and caregivers, about the potential hazards of these devices. If you are hesitant to initiate the conversation at a well visit, consider the impact of past efforts to alert children and families to the potential of hover boards hazards.

References

9.  Frequency of Tobacco Use Among Middle and High School Students—United States, 2014 Weekly October 2, 2015 / 64(38);1061-1065
12.  http://www.fda.gov/TobaccoProducts/Labeling/ProductsIngredientsComponents/ucm456610.htm#regulation
Pediatricians are increasingly asked to offer guidance and pass judgment on school-based concerns, many of which may not be in the physician’s area of expertise. There are common questions that pediatricians are asked to address. Should my child have a special education assessment or should I go the private route? If I go privately, is the school obligated to pay for the testing? Why is my child struggling so greatly in reading, spelling and writing? Can medication address these learning issues? Just because a child scores high on the Vanderbilt or Connor’s Scale, does it mean he’s ADHD or are there other factors? What about a 504 Plan or an IEP—how can I get those? Why is my child having so much trouble getting along with other children? Is he really impulsive or just being a boy?

Parents concerned about their child’s educational progress are in need of professionals who are well-versed enough to help the parent navigate challenging waters. Many pediatricians will tell parents something like, “I will take care of the medical issues and the school will take care of the school concerns.” However, the issues can be quite complex and it may not be that the school will readily take care of school issues in such a manner that many assume.

Additionally, before considering whether a child should be placed on medication to address inattentiveness or distractibility, many pediatricians prefer (rightly so) to seek more diagnostic information in the form of an assessment. Understanding the difference between a special education assessment compared to a private assessment is important, as there is a great deal of misunderstanding as to their purpose and how these are obtained.

Within this article we will discuss:

- Special education assessment vs. private testing
- IEPs & 504 Plans
- Pediatrician’s role in relation to these issues

A Few Statistics

The vast majority of school referrals for special education are grounded in the child’s difficulty with reading (along with spelling and writing, as a cluster with reading). In fact, approximately 80% of referrals for special education testing are related to this concern. In lower socioeconomic areas expectation is that approximately 60% of the children entering first grade will have trouble with reading, while in more affluent areas, the expectation is that around 30% of entering first graders will show mild, moderate or severe difficulty learning to read, spell and write. While not all of these children will be viewed as “learning disabled” or “dyslexic,” a good percentage will.

Compounding these statistics is the common concern of “distractibility” or “inattentiveness.” A simple fact is that when a child struggles with tasks such as reading, spelling and writing, he or she will probably veer off task and show considerable inattentiveness simply trying to keep up with his peers. Imagine what it is like to have others around you performing tasks competently, while your skills are significantly lacking. At a minimum, avoidance becomes a strategy. Such children will likely score significantly high on inattentiveness or distractibility on the Vanderbilt or Connor’s Rating Scales. Yet, many children are diagnosed as ADHD or “ADD” primarily based on the rating scale along with the child’s history, without adequately considering the full contribution of the skill deficits contributing to the distractibility.

Special Education Assessment

Obtaining a special education assessment has become increasingly more complex over the years. There was an era where a teacher, parent or outside professionals could make a request for an evaluation and this would be granted. This is no longer the case. Even when a pediatrician makes such a request, the process is not straightforward. “Ask, and you shall receive,” is simply a mythology when it comes to generating a special education assessment. It is important that pediatricians help educate parents on the realities of the process.

To put this in concrete terms, let’s take a scenario whereby the mother of an 8 year old raises concerns to her child’s pediatrician about lack of progress in reading and is at a loss as to what direction to go. Trying to be helpful, the pediatrician writes on a prescription pad, “Request for special education evaluation.” The mom takes the prescription written by the pediatrician and is disappointed when the representative from the school’s Child Study Team denies the request.

At a minimum, requests from a pediatrician need to be on the physician’s letterhead, ideally with a preliminary diagnosis and a few statements of the nature of the problem and the physician’s concerns that help justify the request for an assessment. While a lengthy letter is not necessary (in fact a solid paragraph will probably do), the odds of this request being honored are far greater than the prescription pad approach.

Step One: Intervention & Referral Service

In the State of New Jersey, the first step toward receiving an assessment involves the Intervention & Referral Service (I&RS). The I&RS is a school-based committee comprised of different disciplines from within the school setting, likely including at least one representative from the Child Study Team (CST). The primary purpose of the I&RS team is to review requests for special education assessment, such as the one described above from the pediatrician and to determine an appropriate course of action.

The I&RS team is not necessarily a direct route to special education or special education assessment, as often assumed. A special education director interviewed for this article emphasized that the team exists to address concerns, not necessarily direct the child toward special education.

continued on next page
While special education assessment may ultimately be recommended, other approaches may be considered and the I&RS team reviews a variety of factors in determining whether to proceed with assessment.

For example, if the child is obtaining passing classroom grades, the I&RS committee may not deem it necessary to proceed forward with an assessment. However, if it is agreed that the child is struggling to a significant degree (and not receiving adequate grades) the I&RS committee will first make recommendations as to what steps can possibly be implemented to see if improvements can be made, prior to any decision to proceed ahead with a special education assessment. Specific classroom strategies are determined to see whether improvements can occur. Referred to as Response to Intervention (RTI), this represents approximately a three month process that is the first stage in determining whether to proceed ahead with an assessment.

Theoretically, RTI helps to lessen the burden that special education places on school districts in terms of number of referrals and is designed to effectively implement lower impact and less-costly strategies (almost always in the regular classroom) that may have the result of preventing bigger problems from arising.

After approximately a 90 day period, the I&RS committee reconvenes with the parents to determine whether the child is making sufficient progress with the implemented strategies from the initial meeting. If the progress has been deemed to be sufficient, then no further testing will be offered. If insufficient, then the Child Study Team makes the determination to proceed ahead with a special education evaluation. From that point forward, the CST team has another 90 days with which to complete the assessment and determine eligibility.

Classification/Eligibility

The overriding purpose and central role of the CST is governed by one central question, “Is the child being evaluated eligible for special education services or not?” Eligibility is not diagnosis and it is imperative that pediatricians understand the special education team’s mission is eligibility and not a diagnosis. This eligibility role of the CST may create a certain level of frustration for parents. A common situation is where a child has been identified as struggling with reading, spelling and writing by the CST, yet not found to be sufficiently, “eligible for service.” If the child is not found to be eligible then there are no services offered to the child under special education beyond those given for a typical child in the regular class.

Individual Education Plan (IEP)

If the child has been found by the team to be eligible for services, this certifies that the child qualifies for one of a variety of special education categories. The vast majority of children are classified under the category of “specific learning disability” or “SLD.” In New Jersey a discrepancy formula is utilized to determine eligibility. That is, there needs to be a statistical discrepancy between the child’s overall, Full Scale IQ (FSIQ) and his overall score in reading or mathematics.

While many states have abandoned the discrepancy model for SLD identification due to a variety of methodological concerns (too numerous to discuss under the scope of this article), NJ continues with this approach, although at the writing of this article there is talk that the Department of Education may be seeking alternatives to this model.

While ADHD is not a special education category, if there is enough outside support to have medically supported concerns related to ADHD, an ADHD child may be classified under the category, “Other Health Impaired (OHI)”, an umbrella term that encompasses numerous medical concerns. The assumption in the classification of OHI is that the medical issues are having an adverse impact on the child’s educational functioning.

Once classified, an Individual Education Plan (IEP) is generated. Specifying areas of need, goals for the child and the delivery of services, the IEP is the document where these are developed. The IEP is revisited annually to determine whether goals have been reached and to draft goals for the coming year. The IEP is a legally binding document and one that may be a source of contention between parents and school districts.

Parents may feel (rightly or wrongly) that the IEP is not being properly followed or is not adequately meeting the child’s needs. It is at this point where the two parties may be at such odds when outside professionals such as special education attorneys or professional advocates are brought in to the meetings to attempt to resolve their differences. If differences cannot be resolved then the case is sent to mediation, and then if not resolved to due process, often a lengthy and costly process.

Under special education guidelines, a parent may request a second opinion to the special education assessment that was conducted at the expense of the school district. It is only in this situation of the second opinion to the special education assessment where a school has an obligation to pay for the services of an outside evaluation. Otherwise, outside assessment is the parent’s responsibility to pay for the assessment, which is often not covered by insurance.

Private Assessment

Private testing is typically conducted by a psychologist or neuropsychologist specializing in learning and school-related issues. Whereas the special education team’s focus is eligibility, a private assessment is primarily concerned with answering the referral question. Typical questions, include, does my child have a learning disability (dyslexia), what are the factors contributing and what are appropriate next steps? Private assessments are more consultative in nature than school district assessments. Effectively the private practitioner becomes the professional that the parents turn to for advice on how to handle the school, the child and related concerns. By its nature, a private practitioner can discuss the issues more candidly, whereas a school district needs to be more circumspect due to school regulation, special education law and the culture of a particular school or district.

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The report that is generated from a private assessment may or may not be accepted by the school district. There is no requirement or regulation that states an outside evaluation must be utilized by a school district. If the practitioner conducting the assessment has the necessary credentials, then school districts usually accept the report and factor the assessment information into their own findings as to what a child should receive in terms of service.

This last point can be frustrating to parents and lead to a certain level of consternation. For example, an outside evaluation may clearly state that a child has a learning disability or “dyslexia,” where the school may look at the quantitative data and the child’s grades in school and feel that classification in special education is not warranted.

It is important to understand that private assessments can be costly and may not be covered by insurance. As a general rule, if the presenting problem to the insurance company is anything school-related such as a learning disability, dyslexia, ADHD or any other school concern, they will likely reject the pre-certification approval, leaving the parents to pay for such services out of pocket.

504 Plan

A 504 plan (Section 504 of the Rehabilitation Act of 1973) is grounded in ADA legislation (Americans with Disability Act). Originally, the law provided workplace accommodations to those with disability to, “level the playing field.” Since the mid-1990s 504 legislation found its way into the schools. The notion of the 504 is that the child identified by an outside professional as having a handicapping condition (even if temporary, such as symptoms related to a concussion) necessitates developing reasonable accommodations so that the child with an identified disability can function as free of handicapping barriers as possible in the mainstream setting.

Obtaining a 504 Plan is a less stringent standard than generating an IEP and having a child classified, which represents a much higher standard. Typically, with a 504, a medical practitioner certifies that the child has some type of handicapping condition that necessitates the development of a 504 Plan. This letter of certification is brought to the 504 office of the school who presents it to the 504 team for review. The school is not required to conduct an evaluation in the implementation of a 504 Plan. A good example of this process would be a pediatric neurologist who has seen a child for a concussion. The neurologist can request a temporary 504 plan to provide basic accommodations while the child is adjusting back to school post-concussion. The vast majority of 504 plans are written for ADHD, as ADHD is not a classification in special education code. Typical accommodations include providing the child with extra time, preferential seating, and reduction of required amount of work, to name a few of the more common ones.

Once again, pediatricians and pediatric specialists need to understand that using the tried and true prescription pad and writing something like, “Concussion. Needs 504 Plan and reduced homework,” is 99% likely to be rejected. While the letter requesting the 504 does not have to be overly long, it does need to be on letterhead certifying that the child was seen for some type of office visit or medical assessment that resulted in the diagnosis being generated. Most schools would accept such a letter as medical testimony that carries considerable weight.

A 504 Plan may be short-term as in the case mentioned above of a child returning to school post-concussion, or for the entire school year, which is typically what is provided with a child diagnosed with ADHD. 504 Plans need to be annually revisited in order for them to be renewed. If the school district feels that the 504 Plan is unnecessary and the child can function adequately without special accommodations, then they will make their case in the annual 504 meeting with the parents. If there is sufficient compelling evidence to continue to keep the 504 Plan in place, then it is renewed for an additional year.

Takeaway Points

In closing, here are some of the top takeaway points for pediatricians to consider.

- Increasingly, parents will be coming to pediatricians and pediatric specialists with questions and concerns that are school related. It is not sufficient to state, “I will take care of the medical, and the school will address the learning.”
- There are very definite differences (pros and cons) between special education and private assessments. Understanding these differences will help in making better referrals.
- IEP and 504 Plans are very different. Understanding the differences is imperative for pediatric practitioners.
- Understanding the special education process and being able to communicate this to parents will help alleviate undue frustration.

Richard Selznick, Ph.D., is a psychologist, nationally certified school psychologist and assistant clinical professor of pediatrics. The author of “The Shut-Down Learner,” he is the director of the Cooper Learning Center, Department of Pediatrics, Cooper University Healthcare. He can be reached, Selznick-r@cooperhealth.edu
### Wrightslaw Advocacy Game Plan Checklist for Caregivers

Wrightslaw.com provides families with accurate, up-to-date information on special education law and advocacy. The organization is directed by **Pete Wright**, an attorney who represents children with special educational needs. Mr. Wright struggled with learning disabilities, including dyslexia, dysgraphia and ADHD. His determination to help children grew out of his own educational experiences. **Pam Wright** is a psychotherapist who has worked with children and families since the 1970's. Her training and experience in clinical psychology and clinical social work give her a unique perspective on parent-child-school dynamics, problems, and solutions. She has written extensively about raising, educating, and advocating for children with disabilities. For information about the organization visit www.wrightslaw.com.

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<td>2. <strong>Read</strong> From Emotions to Advocacy: The Parents' Journey to help you understand your emotions and how to use emotions as a source of energy and strength. <a href="http://www.wrightslaw.com/advoc/articles/Emotions.html">http://www.wrightslaw.com/advoc/articles/Emotions.html</a></td>
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<td>4. <strong>Review</strong> The Art of Writing Letters to learn how to write letters that get results, and how to avoid common pitfalls. <a href="http://www.wrightslaw.com/advoc/articles/letters.draft.htm">http://www.wrightslaw.com/advoc/articles/letters.draft.htm</a></td>
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<td>5. <strong>Read</strong> three times and <strong>highlight</strong>: Understanding Tests and Measurements for the Parent, Advocate and Attorney to learn how to measure your child’s progress in special education. <a href="http://www.wrightslaw.com/advoc/articles/tests_measurements.html">http://www.wrightslaw.com/advoc/articles/tests_measurements.html</a></td>
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<td><strong>Learn Your Rights and Responsibilities</strong></td>
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<td>7. <strong>Download</strong> IDEA 2004 (Statute and Pete’s Commentary) <a href="http://www.wrightslaw.com/statute.htm">http://www.wrightslaw.com/statute.htm</a></td>
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<td>8. <strong>Contact</strong> your State Department of Education. Ask them to send you ALL their publications about special education. <a href="http://www.yellowpagesforkids.com/help/seas.htm">http://www.yellowpagesforkids.com/help/seas.htm</a></td>
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<td>9. <strong>Contact</strong> your State Protection and Advocacy Agency. Ask them to send you ALL their publications about special education. <a href="http://www.ndrn.org/ndrn-member-agencies.html">http://www.ndrn.org/ndrn-member-agencies.html</a></td>
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<td>10. <strong>Contact</strong> your State Parent Training and Information Center or CPRC for help, information, and resources in your area. <a href="http://www.yellowpagesforkids.com/help/ptis.htm">http://www.yellowpagesforkids.com/help/ptis.htm</a></td>
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<td><strong>Comprehensive Evaluation</strong></td>
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<td>11. <strong>Get</strong> a private sector expert involved who can evaluate your child, test him to measure educational progress, and make recommendations about the services he needs. <a href="http://www.fetaweb.com/help/eval.expect.meyer.htm">http://www.fetaweb.com/help/eval.expect.meyer.htm</a></td>
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<td><strong>Read One Book a Month</strong></td>
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<td>12. <strong>Read</strong> One Book a Month: Find more information in the Advocate’s Bookstore. <a href="http://www.wrightslaw.com/bkstore/bks_index.htm">http://www.wrightslaw.com/bkstore/bks_index.htm</a></td>
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<td><strong>Join the Wrightslaw Online Community</strong></td>
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<td>15. <strong>Ask or Answer</strong> a question on the Community Helpline. <a href="http://www.wrightslaw.com/blog/?page_id=38">http://www.wrightslaw.com/blog/?page_id=38</a></td>
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Pediatric Psychiatry Collaborative
Available at hospital-based Hubs in your area

Attention Pediatric Providers in
Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Middlesex,
Monmouth, Ocean, and Salem Counties

What Practices
Are Saying About the Hub

“I love the Hub! It has really helped us provide immediate access to mental health services for our patients. Now our patients’ mental health issues are addressed in a timely manner. I was so impressed that the child psychiatrist called me for consults about my at-risk teens.”

J. Bautista, MD
Colts Neck Pediatrics

“We have found the Cooper Hub to be valuable to our Pediatric Care Center and hope to continue to work with them as they expand their services and resources for us in this area.”

P. Coant, MD
AdvoCare Gloucester

Why Pediatricians Participate in a Hub:
The Hub provides quick access to psychiatric consultation and facilitates referrals for accessing ongoing mental and behavioral health care. The program is available for pediatric providers serving children up to age 18 and requires that primary care providers (PCP) universally offer standardized mental and behavioral health screenings at each child’s well visit. PCPs can make a referral to a Hub for a child or family to access mental health services.

Hub benefits include:

- Child psychiatrist available for diagnostic & medication consultation for children in your practice
- An initial appointment with a child psychiatrist can be arranged for urgent cases, regardless of family’s insurance
- Licensed social workers and psychologists available to support care management and identify resources for children in your practice

Optional Benefit of Hub Participation: 25 MOC Part 4 Points

Participants may also opt to join NJAAP’s Collaborative Mental Health Program. This ABP-Approved Maintenance of Certification (MOC) Part 4 Program is aimed at helping pediatricians increase use of mental/behavioral health screening tools, anticipatory guidance, referrals and care coordination to support the early detection of mental health issues, and the improvement of mental health care in the primary care setting. You will receive:

- Training on mental/behavioral health screening
- An AAP Mental Health Toolkit, along with many other resources
- Hands-on technical assistance for implementing screening
- Opportunities to network with colleagues and experts
- 25 ABP Part 4 MOC points upon program completion

To participate in your local Hub / the MOC Program or for more information email MHC@njaap.org or call 609-842-0014.
The Pediatric Psychiatry Collaborative: Helping Pediatricians Help Families

Advocare Woodbury

How is the Hub benefitting your patients in terms of access, referrals, and timeliness of addressing their needs?

The Hub has expedited the timing for when our families have received services, and it has helped to bridge the gap that often exists when it comes to meeting the mental health needs of our patients. There just aren’t enough specialists for these services, making what the Hub offers invaluable. In the short-term, it helps us help kids in crisis, in that moment.

Is there one patient case that stands out as far as a positive outcome as a result of utilizing the Hub?

One of my patients is a young pre-teen boy who is being raised by his grandparents. He has significant ADHD and behavioral problems. Medically, he was well covered, so I was at a loss about how to help him further. I reached out to the Hub and they suggested a summer camp for children who need social skills training. And while he is at camp, the grandparents are also receiving services to help them manage their relationship with their grandson. This was all set up by the Hub, and it has been extremely helpful for the entire family.

What are your patients saying about services/care received through the Hub?

My patients are giving nothing but positive feedback. The attention the psychologists give to the patients has been very helpful and informative, and action is being taken which is the most important thing.

Based on your experience to date, what would be your recommendation as far as making this program available to pediatricians across the state?

I would absolutely recommend this program! I believe the program should be available to all pediatricians. We all know that mental health concerns are increasing, and there aren’t enough specialists to deal with the growing burden. For these reasons alone, access to this program should be available to everyone.

How has NJAAP’s MOC program enhanced mental/behavioral health screening in your practice?

The MOC program greatly enhanced our screening. We had a big gap in the age groups that were not being screened at all. Now, we’re screening every child who comes in for a well visit. Prior to the program, some of the providers in our practice were hesitant to prescribe meds, but because of this program they are more comfortable now.

Colts Neck Pediatrics

How is the Hub benefitting your patients in terms of access, referrals, and timeliness of addressing their needs?

Having access to clinical psychologists and pediatric psychiatrists has always been a problem for our office. Before the Hub, we often heard back from parents of patients we referred telling us they were unable to schedule an appointment because the psychologist does not accept insurance and that they could not afford to pay out of pocket. Since the Pediatric Psychiatry Collaborative, we are now able to refer our patients in need of immediate assistance with just a phone call and families come back happy because they’ve received the help they needed in a timely manner.

Is there one patient case that stands out as far as a positive outcome as a result of utilizing the Hub?

A college student who has been suffering from anxiety and who was able to talk to a psychiatrist (Dr. Schiff), who diagnosed her accurately and started her on the right medications. He immediately provided me with an update and gave me pointers for follow-up. It is because of this relationship with the clinicians and staff of the Hub that I am now more comfortable prescribing anxiolytics and antidepressants.

What are your patients saying about services/care received through the Hub?

I now receive call-backs saying “Thank you” for the way that their children’s issues were addressed in a timely manner as well as the overall satisfaction with Dr. Schiff and his staff. We are happy that we were able to help our patients and our relationship with them is not compromised.

Based on your experience to date, what would be your recommendation as far as making this program available to pediatricians across the state?

I believe this program should be available to all pediatricians. In fact, I have even talked to some school psychologists about the Hub and advised them to refer their students having issues back to their private pediatricians and have even volunteered to ask their pediatricians to call me if they need information or if they are not familiar with the Hub. I also have spoken with some of my colleagues and have encouraged them to use the Hub.

How has NJAAP’s MOC program enhanced mental/behavioral health screening in your practice?

I have always been up-to-date with all my developmental screenings in the office and have recently incorporated the use of ASQ-SE with the help of the MOC program. Even though it gave the parents more forms to complete during well visits, it gave us the satisfaction of monitoring their emotional and psychological well being aside from their physical health.
Dr. Finkel,

My name is Meredith Mayes, and I also happen to be located in NJ. Unfortunately, both my sister and I were repeatedly molested at a young age by different perpetrators. My parents are amazing, but they never discussed prevention with us, so like most victims, I kept the secret for many years.

Now as a mom of two young daughters, ages 8 and 5, I have made it a priority to openly discuss privacy and prevention with them on a regular basis. However, when I took my daughter to the pediatrician last year for her annual exam, something disturbing happened.

I told the pediatrician my background and ask her why she had NEVER brought up sexual abuse prevention during any of our visits. She looked in my eyes and said “I don’t think there’s anything we can do to stop it.” I told her that I completely disagreed and cited several examples in my personal circle where young children had been informed and actually came to their parents right away when something happened.

Time has passed, but the doctors response kept nagging at me. This brought me to you! I began searching to see what the American Academy of Pediatrics has to say about the topic and found your article, Child Sexual Abuse Prevention: Addressing Personal Space and Privacy in Pediatric Practice. What a powerful document!!

Oh how the world could change if every single pediatrician had this in their hands and used it. It would be even better if it was turned into a handout for parents that was given at every single physical. And it’s practically free.

And I know my pediatrician is not alone. Not one of my friends or family members with young children has been informed or even given a handout by their doctor to equip them to protect their children. As you know, the sexual abuse epidemic is just wreaking havoc on the physical, mental and emotional well-being of our country. Even though I’m passionate about nutrition, it just seems unbelievable to me that WAY more emphasis is placed on preventing obesity than preventing sexual abuse.

At any rate, I know you are extremely busy, but I was wondering if you had any additional information about the state of pediatrics. Are there any advances around this type of education during physicals? Is there any way that we can help get the word out?

A big thank you again for all of the work you do!

Parent Tips for Preventing and Identifying Child Sexual Abuse

Sexual abuse is a difficult subject for most people to discuss, and especially difficult for parents to discuss with their children. But as frightening as the topic may be, sexual abuse is a serious and, unfortunately, common problem that affects both boys and girls. In most cases, the person who sexually abuses a child is an adult or older child known to the victim, often an authority figure that the child knows, trusts or loves. The offender usually uses coercion and manipulation, not physical force, to engage the child. Visit http://bit.ly/2bY3GMG for information from AAP on What parents should know about child sexual abuse.
I write this for my pediatric colleagues.

We have seen the practice of pediatrics shift from a primary focus on the delivery of acute care to one which now focuses increasingly on the provision of anticipatory guidance and preventive care to assure optimal growth and development.

There is not one amongst us who doesn’t routinely address the importance of back-to-sleep, seat belt safety, bicycle safety, water safety and environmental hazards, believing that the time taken to deliver each of these messages helps to reduce risk to children and has proven value. So I ask why it has been so challenging for us to incorporate in our prevention repertoire a message that addresses personal space and privacy, an issue that presents considerable risk to children and has the potential for serious long term physical and mental health consequences. Our failure to do so is not because we are unaware of the issue of child sexual abuse (CSA) but maybe because we find the topic unpalatable, don’t have the language to address it or are unsure of what would be effective.

We know that we can't just tell kids to wear their seat belts one time and expect that we have successfully addressed car safety.

Since CSA affects approximately 1 in 4 girls and 1 in 7 boys it’s well overdue that we add this issue to our prevention repertoire. Even if we can’t “immunize” every child against the possibility of CSA we can likely help protect some from being abused.

Before we think about prevention, let’s reflect on some basic facts; most children who experience CSA do so at the hands of someone they know and trust. That person is most likely to be a family member or someone who knows and has easy access to the child.

Although it is appropriate to talk about “stranger danger” the reality is that only a relatively few children are molested by strangers or registered sex offenders.

Most perpetrators do not intend to physically harm the child while engaging them in sexually inappropriate activities and thus few children ever present with physical examination findings that confirm sexual contact. Very few children actually experience sexual contact that involves the use of force and restraint that we call rape. About 1/3 of perpetrators are juveniles and 40% of child victims are under 6 years old.

Most kids never disclose and those that do may not do so for some significant amount of time after the last sexual contact. There are many reasons for delayed or non disclosure which generally include fear of consequences, embarrassment, stigmatization, shame and thinking that they may not be believed. The primary impact of sexual victimization is not physical but psychological with the potential for long term emotional and behavioral consequences. All children regardless of their race, ethnicity, education or socioeconomic status are at risk. No community or group is immune.

So you may be asking, if I were to deliver anticipatory guidance regarding personal space and privacy when do I start? How often do I need to deliver the message? And how do I deliver the message? We know that we can’t just tell kids to wear their seat belts one time and expect that we have successfully addressed car safety. We have to begin by delivering these messages early in childhood and continue to deliver these simple safety messages over and over again in a developmentally appropriate manner reinforcing the information. This same concept equally applies when delivering the message of personal space and privacy.

Let me suggest the following;

Begin talking to parents about delivering information on personal space and privacy by 3 years of age.

Tell parents that they should limit the individuals who provide genital, perianal and bathing care to those who they trust to reduce risk. Let them know that the more independence children have for their own genital/perianal care the better. Encourage parents to teach their children the appropriate names for their private parts so they have the language to communicate.

A mom taught her 5 year old daughter that her private parts were called her “diamonds” and to tell if anyone touched her diamonds. She told her teacher that someone touched her “diamonds” but the teacher thought that was silly and didn’t inquire further. As a result her disclosure and protection was further delayed. A 3 year old can say the word vagina or penis as easily as they can say “diamonds” or “ding-a-ling”.

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Discourage co-bathing with siblings and adults.

Introduce the concept of “OK and NOT OK” touching and the need to tell if anyone touches their “private” parts in a context other than providing care. A good time to have this discussion is right after completion of the non-genital components of the annual physical while the child is sitting in their underwear or a gown. Discussing OK and NOT OK touching provides an easy transition to the genital examination. In the context of the genital examination the child can learn the distinction between a doctor’s examination and inappropriate touching.

If you have heard about “good touch–bad touch” that is a phrase that was thought to be a way to communicate a prevention message. We have since learned that phrase is problematic because children do not anticipate being touched in a way that is “bad” by someone they know, love and trust. Touching in private parts can feel “good” and be confusing to children. If what the child experienced is perceived by them as being “bad” there is the possibility that may think that they are “bad”. We do not want children to have to make a judgment on the quality of the touch thus the simplified message about what’s OK and what’s NOT OK now is a standard approach to introducing this concept.

Parents should emphasize to their children that it is never OK to have a “secret” and if anyone tells them to keep a secret or they think they need to keep a secret they need to tell two adults. Explain how “surprises” can be fine because we find out but secrets are never okay. All of these messages should be delivered at every annual visit.

**Parents should explain (to children) that if anyone ever touches them or makes them touch someone else's private parts they need to tell two adults right away.**

If a child walks into a bedroom or bathroom and the parent needs privacy they should tell the child they need privacy. Wherever the message of privacy can be reinforced it should. Children should be taught to respect siblings need for privacy.

The pediatrician should deliver the above guidance annually at every health maintenance assessment and modify based on developmental age.

If these messages are routinely delivered to young children as they grow older they will not only expect this discussion but will accept it as well.

The parent has an ideal opportunity to reinforce the concept of a right to personal space and privacy starting with preschoolers when supervising their bathing.

The parent explains that the parts of their body that are covered by a bathing suit or their underwear are called private parts and the reason they are called that is because they belong to them and they are the only one that can see them or touch them. Reinforce that the only people who are allowed to touch their private parts are:

- The child themselves when washing or wiping themselves;
- Parents or caregivers, if they need help with washing or having a wiping problem;
- Doctors checking to be sure their body is okay during a physical or when there is a problem with their private parts—with Mom/Dad in the room.

Parents should explain that if anyone ever touches them or makes them touch someone else's private parts they should tell two adults right away. The reason for emphasizing two adults is that you want the child to tell someone who is a family member as well as someone who is not such as a teacher. When young children experience something inappropriate and then think about telling, they might be reluctant or afraid to tell a parent because they have processed the message from Mom/Dad as; Don't let anyone touch your private parts, I let someone touch my private parts, Mommy/Daddy is going to be mad at me. As a result the child might turn to a teacher or another adult because they think they won't get into trouble. The important message is not who they tell but that they tell. Parents should emphasize to the child that they will not get into trouble or be punished for telling, in fact they will be brave.

While supervising the bathing the following questions or statements can be made to reinforce the concept. Periodically say: “Don't forget to wash your vagina/penis and butt and when you're done let me know and I will help you with your hair, or Don't forget to wipe your private parts, Who is allowed to touch your private parts? And What do you do if someone touches your private parts?” Over time when these simple messages/questions are asked, the child will respond by saying, “Mommy/Daddy, I know that!”

Just because kids know what is OK and what is not doesn’t mean they aren’t vulnerable and they can stop someone from touching them inappropriately, but they may be more likely to recognize what they’re experiencing is inappropriate and may disclose sooner rather than later.
...children armed with information about personal safety are 6-7 times more likely to develop protective behaviors...

You might be asking, if I am going to add this message to the repertoire of anticipatory guidance, where is the science that it works. Unfortunately the “science” of prevention is still evolving and there is no body of literature that purports a single message/approach that can be used to simply supply the magic bullet of prevention. We know that children armed with information about personal safety are 6-7 times more likely to develop protective behaviors, enhance potential for disclosure and experience less self blame. As in the early development of every area of prevention “common sense” was used to build a foundation that was then tested and led to the science. There isn’t a parent who wouldn’t want to protect his or her child against a sexually abusive experience.

When we begin to give the parents the language to communicate these concepts, we educate children about this potential risk and empower them to help protect themselves.

It is the collective responsibility of parents, pediatricians and our institutions to deliver and reinforce children’s right to personal space and privacy.

Now, it’s time for pediatricians to integrate personal space/body safety into every annual health maintenance assessment.
As insurance companies continue efforts to reduce reimbursement rates and increase administrative burdens on their participating providers, more and more physicians are considering terminating their in-network contracts with private insurance payers and going out-of-network. If you or your practice are contemplating doing so, here are some issues you may want to consider when making that decision.

As an out-of-network physician, you are not limited in the fees that you can charge by either in-network negotiated rates (although you continue to be subject to the Medicare fee schedule for Medicare patients should you continue to accept Medicare); you are free to charge any rate that you believe is commensurate with your expertise and the quality of services you provide, subject to the regulations of the State Board of Medical Examiners prohibiting excessive fees. In this connection, private payers are increasingly attempting to challenge the fees charged by out-of-network physicians. Some insurance companies, such as Horizon, Aetna and United Healthcare are notorious for suing physicians, alleging “excessive” billing/”unconscionable” fees.

Recently, the New Jersey Appellate Division affirmed a trial court’s order and final judgment dismissing claims by Aetna against a cardiologist alleging excessive billing and insurance fraud, and awarding nearly $2 million to the doctor for unpaid claims. Although it is an unpublished opinion with limited formal precedential value, it does indicate that the Appellate Division is prepared to support a physician’s reasonable fee schedule in the face of insurance company challenges. Of particular note, the Appellate Division in this case recognized that the physicians were allowed to establish their own fee schedule, and declined to impose a “fair market value” standard, while noting that the fees of the physicians were subject to the oversight of the New Jersey State Board of Medical Examiners.

The New Jersey State Board of Medical Examiners is the governing body that not only issues physicians their medical licenses, but also promulgates and oversees compliance with its regulations governing the practice of medicine in New Jersey. The Board regulation prohibiting “excessive fees”, N.J.A.C. 13:35-6.11, provides in part that, “A fee is excessive when, after a review of the facts, a licensee of ordinary prudence would be left with a definite and firm conviction that the fee is so high as to be manifestly unconscionable or overreaching under the circumstances.”

Violation of this Board regulation may result in a finding of professional misconduct subjecting the physician to disciplinary action, including reprimand, suspension or revocation of one’s license.

One of the most common issues that arise in connection with an out-of-network practice is the extent to which an out-of-network physician is required to collect co-payments, co-insurance and deductibles. The answer is relatively clear when dealing with Medicare and Medicaid—a routine waiver of such payments can constitute a violation of the Anti-Kickback Act or the False Claims Act. Although those statutes do not generally apply to patients with private insurance, it is not advisable to maintain a policy that waives payment by all patients with out-of-network benefits of their co-payment, co-insurance and deductible obligations, and reasonable efforts to collect such obligations is strongly encouraged. While there is currently no specific law or regulation in New Jersey that prohibits an out-of-network physician from waiving such payments, such a practice can be grounds for claims of insurance fraud. Therefore, any outright waiver of a co-pay, co-insurance or deductible payment should be made on a case by case basis following a finding of financial hardship.

An exception to the requirement to balance-bill patients arises when services are rendered to an insured patient seeking emergency treatment. New Jersey prohibits physicians from balance-billing patients who receive such emergency services. Department of Banking and Insurance regulations require that, when a patient obtains emergency treatment at an in-network facility, the insurance company must reimburse the out-of-network physician enough to insure that the physician does not balance-bill the patient more than the patient would have been responsible for had such physician been an in-network provider.

On June 20, 2016, a state Assembly committee approved legislation that would prevent consumers in New Jersey from getting surprise out-of-network medical bills. The proposed Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act, sets out extensive requirements for hospitals and doctors to disclose to patients whether they are part of the patient’s insurance network before treatment occurs. For example, if the bill passes, as it is currently drafted, hospitals and healthcare facilities will be required to: disclose whether they are in the patient’s insurance network; advise patients to contact their insurance carriers and doctors for further information; list the names and contact information for all contracted physicians; publish on their websites a list of standard charges for services, the insurance they accept, and a statement saying: “doctors working in the facility may or may not accept the same insurance as the facility”. continued on next page
With regards to physicians, if the bill passes, physicians will be required to: disclose which benefits plans they accept and the hospital with which they are affiliated prior to non-emergency services and at the time of an appointment; inform patients about the specific price of out-of-network services, and provide the contact information for outside anesthesiologists, radiologists and other professionals they use. Of note, this bill would provide that waiver by an out-of-network provider of all or part of a patient’s co-payment, co-insurance or deductible would be considered a prohibited inducement to the patient to seek covered services from the physician.

Another very common questions that comes up when physicians are considering going out-of-network, is whether some, not all of the physicians, at the practice can go out-of-network. In that case, there are various additional elements to consider. For starters, the practice needs to review its contracts with insurance companies, as some may require that all physicians at the practice be participating providers. In addition, where some practitioners are out-of-network while others are in-network, treatment of any patient by the out-of-network physician may be considered an out-of-network referral by the group, which would be subject to any limitations or prohibitions in the participation agreement, including notice of the out-of-network status and advice regarding the availability of in-network providers.

Finally, where not all physicians in the group have the same participation status, they generally need to bill for their in-network and out-of-network services under separate billing/tax identification numbers. Depending on the proportions involved, this may run the risk of the group ceasing to qualify as a “group practice” within the meaning of the Federal Stark law, the Federal Anti-kickback safe harbors, and the New Jersey Codey law, resulting in practices and transactions which are legal only when conducted within a single group practice, suddenly becoming subject to rules governing transactions between or among separate group practices. Therefore, it is critical that a thorough legal analysis be conducted before any decision is made to include both in-network and out-of-network providers within a single group.

The decision to go out-of-network is not an easy decision, and the anticipated resistance from the insurance industry and the various pending bills in the New Jersey legislature make the future viability of such a decision all the more difficult to predict. However, with careful planning and legal and financial guidance, it is still possible under the right circumstances for physicians to successfully transition to out-of-network status.

References
2 In the Matter of Violations of the Laws of N.J. by Aetna Health Inc., DOBI Order No. A07-59 (July 23, 2007)

NJAAP Government Affairs
Making Things Happen on Your Behalf

On September 1, the Senate Health Committee announced its agenda for the September 8 committee meeting, and S2156—requiring health care professionals with prescribing authority to discuss the addiction potential of certain prescription medications prior to issuing a prescription—was scheduled to be heard. The NJAAP Government Affairs Committee, Chaired by Alan Weller, MD, MPH, FAAP, responded rapidly as there was less than a week to advocate, with Labor Day in the midst.

After a careful review of the legislation, the Committee determined that three amendments were needed:

1. The bill must be limited to Schedule II opioid medications only;
2. Documentation of the “risks” conversation with the family be noted in the patient’s chart and not separately in a form established by the Division of Consumer Affairs; and
3. The section authorizing the Division of Consumer Affairs to establish guidelines for scripting the risk conversation must be stricken from the bill entirely.

Matthew McDonald, MD, FAAP testified at the hearing, outlining the requested changes and the reasoning behind each. We are pleased to report that all three changes were accepted to the legislation.
Meeting the July 1st Constitutional deadline, Governor Christie signed the $34.5 billion budget and issued an executive order impounding millions of dollars—money, he said, that may be needed if labor unions for state workers and teachers can’t agree on how to trim health care costs.

The Governor vetoed close to $300 million in additional spending initiatives included in the budget bill passed by the Legislature. Their bill provided for a $34.8 billion budget, which closely mirrored the Governor’s budget proposal as delivered in February. Included in the Governor’s cuts was $2.4m for the Child Collaborative Mental Health Care Pilot Program, that AAP advocated be included in the budget, $25 million for charity care spending, $7.5 million in grants for family planning services, a $45 million increase for senior citizen property tax relief and $25 million towards pre-school aid expansion.

The Governor did leave in the budget, $4.8 million of the $10 million added by the Legislature to fund Child Advocacy Centers throughout the state. S972, legislation that establishes the Child Advocacy Center-Multidisciplinary Team Advisory Board, in but not of, the Department of Children and Families, was passed by the Legislature and awaits action by Governor Christie. The board will establish a certification program for the State’s child advocacy centers and multidisciplinary teams to ensure that certified centers and teams comply with the accreditation standards developed by the National Children’s Alliance, or its successor.

The Legislature also passed S816 which establishes a Personalized Handgun Authorization Commission which would be responsible for establishing performance standards for personalized handguns, also known as “smart guns” and “child proof guns.” The commission also would be responsible for approving and maintaining a roster of personalized handguns authorized for sale to the public. Governor Christie has not yet acted on it.

As is their custom, the Legislature met infrequently over the summer months. They are expected to resume a full calendar of meetings in September.

As there have been close to a dozen bills introduced that deal with the subject of opioid addiction we can expect the Legislature to pay particular attention to this issue.

On June 30, 2016 the Senate passed S2035 which provides that a practitioner may not issue an initial prescription for an opioid medication in a quantity exceeding a seven-day supply.

“Opioid medication” is defined to mean a Schedule II narcotic drug, available only with a prescription and generally prescribed for analgesic purposes, which binds to the body’s opioid receptor sites and produces opiate-like effects. The term would include, but not be limited to, hydrocodone, oxycodone, fentanyl, and any other similarly-acting prescription narcotic analgesic drug, whether or not such drug is combined with another drug substance to form a single drug product or dosage. Subsequent prescriptions for any such medication may be issued in any quantity that complies with applicable State and federal laws, provided that:

1. the prescription is not deemed to be an initial prescription;
2. the practitioner determines the prescription is necessary and appropriate to the patient’s treatment needs; and
3. the practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction, or diversion.

The bill will apply if a patient has never previously been issued a prescription for the opioid medication or its pharmaceutical equivalent, or if the current prescription is being issued more than one year after the date the patient last used or was administered the drug or its equivalent. In determining whether a prescription is an “initial prescription,” the practitioner will be required to consult with the patient and review the patient’s medical record and prescription monitoring information. The Senate bill passed by a vote of 24-13 and an identical Assembly bill, A4035 has been introduced.

The following bills have also been introduced, many as part of a package, and there will be significant efforts from the legislation’s proponents for the Legislature to consider them.

A3424 and S2156 require health care professionals with prescribing authority to discuss the addiction potential of certain prescription medications prior to issuing a prescription for the medication to a patient who is under 18 years of age. The prescriber is to have this discussion with the patient, if the patient is an emancipated minor and with the patient’s parent or guardian if the patient is not emancipated. The discussion will be required prior to issuing a prescription for any Schedule II controlled dangerous substance and any medication which is a prescription opioid. The prescriber will specifically be required to discuss the risks of developing a physical or psychological dependence on the medication and, if the prescriber deems it appropriate, any alternative treatments that may be available. The prescriber will be required to obtain a written acknowledgement of the discussion using a form to be developed by the Director of the Division of Consumer Affairs in the Department of Law and Public Safety and to include this written acknowledgement in the patient’s medical file.

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The director will additionally be required to develop, and make available to prescribers, guidelines for the discussion required under the bill.

S2188 and A3803 require health care practitioners prescribing opioid medications on a first-time basis, or to minor children, to limit amount of prescribed medication to seven-day supply, except in certain circumstances. The bills would specify, in particular, that the first time a health care practitioner prescribes an opioid medication to an adult patient, for outpatient use, and whenever a health care practitioner prescribes an opioid medication to a minor patient, the health care practitioner will be prohibited from prescribing more than a seven-day supply of the medication. They would also require a health care practitioner, before prescribing opioid medication under the bill's provisions, to discuss with the adult patient, or with the parent or guardian of the minor patient, as appropriate, the risks associated with opioid use, and the reasons why the opioid medication is necessary. The bills would specify, however, that if a prescribing health care practitioner determines, in the practitioner's professional medical judgment, that the prescription of more than a seven-day supply of opioid medication is necessary to treat an adult patient’s or minor patient’s acute medical condition, or is necessary to provide the patient with appropriate management of chronic pain, treatment of pain associated with a cancer diagnosis, or palliative care, the health care practitioner will be authorized to issue a prescription, consistent with all other applicable State and federal prescribing requirements, for the quantity of opioid medication that is needed to treat such acute medical condition, chronic pain, cancer-related pain, or pain experienced while in palliative care. The condition triggering the prescription of more than a seven-day supply of opioid medication would need to be documented in the patient’s medical record, and the health care practitioner would be required to indicate that a non-opioid alternative was not appropriate to address the medical condition.

A3980 requires certain health care professionals to meet continuing education requirements on topics related to prescription opioid drugs as a condition of renewal of a professional license, certification, or registration. Health care professionals with the authority to prescribe opioid medications, including physicians, physician assistants, and dentists, will be required to complete one continuing education credit on topics that include responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion. For advance practice nurses, who also have prescribing authority, their required six contact hours of continuing professional education in pharmacology related to controlled substances will include issues concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion.

Health care professionals who do not have prescribing authority but who frequently interact with patients who may be prescribed opioids, including pharmacists, professional nurses, and practical nurses, will be required to complete one continuing education credit on topics that include alternatives to opioids for managing and treating pain and the risks and signs of opioid abuse, addiction, and diversion. The continuing education credits required under the bill will be part of a professional’s regular continuing education credits and will not increase the total number of continuing education credits required.

A3982 requires that every prescription for a controlled dangerous substance, prescription legend drug, or other prescription item be transmitted electronically using an electronic health records system. This requirement will take effect one year after the date of enactment. The electronic prescription requirement will not apply to: a veterinarian; a practitioner administering a prescription drug or item directly to a patient; a practitioner prescribing a drug or item to be dispensed by an institutional pharmacy or to a patient in hospice care; a situation in which the electronic prescribing system is not operational or is temporarily inaccessible; a situation in which the patient requests the prescription be transmitted to a pharmacy that is unable to receive and process electronic prescriptions; or a practitioner who has been granted a waiver due to technological limitations or other exceptional circumstances. A prescription that is subject to an exception would be issued on a New Jersey Prescription Blank or in such other manner as may be authorized by the Director of the Division of Consumer Affairs in the Department of Law and Public Safety.

A3984 would add naloxone hydrochloride, and other opioid antidotes, to the list of prescription drugs that are to be monitored as part of the State’s Prescription Monitoring Program (PMP). Although the PMP focuses on monitoring the dispensation of controlled dangerous substances in the State, and although opioid antidotes are not considered to be controlled dangerous substances, information related to the dispensation of opioid antidotes is nonetheless relevant to determinations regarding the prescription and dispensation of controlled dangerous substances. The bill would additionally authorize hospitals, emergency medical services providers, and law enforcement agencies that are engaged in the administration of opioid antidotes pursuant to the “Overdose Prevention Act,” to provide the Director of the Division of Consumer Affairs (DCA) in the Department of Law and Public Safety with such information as the director may prescribe by regulation, for inclusion in a secondary electronic system that would be established by the DCA to monitor the administration of opioid antidotes in the State. The opioid antidote administration system established by the bill would be cross-referenced with the State PMP.

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A practitioner, pharmacist, or other person authorized to access the PMP would be required to review prescription monitoring information, as well as any linked opioid antidote administration information, when prescribing or dispensing a Schedule II controlled dangerous substance to a patient with acute or chronic pain.

A3992 would establish certain limitations and requirements to restrict the prescription and dispensation of opioid medications to student athletes, and to provide for the close monitoring of a student athlete’s use of such medications. The bill would define the term “student athlete” to mean: a student, enrolled in a public or nonpublic elementary or secondary school, who participates in an interscholastic athletic program governed by the rules of the New Jersey State Interscholastic Athletic Association, or who engages in any other school-sponsored athletic activity. Pursuant to the bill’s provisions, a prescriber—including a licensed physician, advanced practice nurse, or physician assistant — would be required to exercise extreme caution when determining whether to prescribe opioid medication in the course of treatment afforded to a student athlete. The prescriber would be required to make every reasonable effort to utilize non-narcotic drugs, including acetaminophen, non-steroidal anti-inflammatory medications, and salicylates, as well as non-medicine alternatives such as cryotherapy and transcutaneous nerve stimulation, as an alternative to opioid medication.

Whenever a prescriber determines that such alternative treatments are insufficient to address the student athlete’s medical needs, and prescribes an opioid medication for the treatment of the student athlete’s injury or pain, the prescriber would be required to:

- make every effort to ensure the student athlete’s safe use of the opioid medication;
- prescribe no more than a seven-day, non-refillable supply;
- indicate, on the face of the prescription blank, that the prescription is being issued for a student athlete, pursuant to the bill’s provisions;
- provide the completed prescription blank to the student athlete’s parent or guardian, as opposed to providing it directly to the student athlete;
- provide the student athlete’s parent or guardian with instructions as to how to administer the opioid medication and the ways in which the parent or guardian can engage in medication monitoring, on a daily basis, to determine the continued need for, and effectiveness of, the medication;
- provide the student athlete, and the student’s parent or guardian, with information or educational materials regarding the risks that are associated with the use of opioid medication, including information about drug tolerance, the possibility of developing physical and psychological dependence or addiction, and the warning signs of these conditions;
- emphasize to the student athlete, and the student’s parent or guardian, the importance of preventing the student athlete from engaging in the unsupervised self-administration of the opioid medication; indicate that the student will be required to engage only in the supervised administration of the drug supply while on school grounds or under the authority of school officials, as provided by section 2 of the bill; and strongly encourage the parent or guardian to continue to supervise the student athlete’s administration of the opioid drug supply when the student athlete is at home, or is otherwise not under the authority of school officials; and
- notify the school nurse of the fact that an opioid medication has been prescribed to the student athlete, and indicate the amount of medication prescribed, as well as the expected duration of the student’s opioid use.
What’s in your glass?

Choices are great, but they can be overwhelming. This at-a-glance chart can help you understand what’s in your 8-ounce glass of milk.

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Cow’s Milk</th>
<th>Soy</th>
<th>Almond</th>
<th>Coconut</th>
<th>Rice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calories</td>
<td>110</td>
<td>110</td>
<td>60</td>
<td>80</td>
<td>120</td>
</tr>
<tr>
<td>Protein</td>
<td>8g</td>
<td>8g</td>
<td>1g</td>
<td>&lt;1g</td>
<td>1g</td>
</tr>
<tr>
<td>Fat</td>
<td>2.5g</td>
<td>4.5g</td>
<td>2.5g</td>
<td>5g</td>
<td>2.5g</td>
</tr>
<tr>
<td>Carbohydrates</td>
<td>12g</td>
<td>9g</td>
<td>8g</td>
<td>7g</td>
<td>23g</td>
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</table>

VITAMINS AND MINERALS** (% Daily Value*)

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Cow’s Milk</th>
<th>Soy</th>
<th>Almond</th>
<th>Coconut</th>
<th>Rice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium</td>
<td>30%</td>
<td>45%</td>
<td>45%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Phosphorus</td>
<td>25%</td>
<td>25%</td>
<td>N/A***</td>
<td>N/A</td>
<td>15%</td>
</tr>
<tr>
<td>Potassium</td>
<td>10%</td>
<td>10%</td>
<td>1%</td>
<td>1%</td>
<td>15%</td>
</tr>
<tr>
<td>Riboflavin</td>
<td>25%</td>
<td>30%</td>
<td>30%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Vitamin B-12</td>
<td>20%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Vitamin A</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>25%</td>
<td>30%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
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</table>

- Naturally Occurring
- Good Source = 10%–19% DV
- Excellent Source = 20%+ DV

PRICE*

<table>
<thead>
<tr>
<th>Serving</th>
<th>Cow’s Milk</th>
<th>Soy</th>
<th>Almond</th>
<th>Coconut</th>
<th>Rice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per ½ Gallon</td>
<td>$2.05</td>
<td>$3.37</td>
<td>$3.28</td>
<td>$4.99</td>
<td>$3.46</td>
</tr>
<tr>
<td>Per 8oz. Serving</td>
<td>$0.26</td>
<td>$0.42</td>
<td>$0.41</td>
<td>$0.62</td>
<td>$0.43</td>
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</tbody>
</table>

2. Silk Original Soy Milk, Original Almond Milk, and Original Coconut Milk: Nutritional information per Silk® website www.silk.com
3. Rice Dream Enriched Refrigerated Original: Nutritional information per Rice Dream® website www.tastethedream.com
4. Based on gallon volume equivalents per IRI DMI Custom Database Data for 2014 (Jan-Dec) – National Average (Cow’s milk based on conventional white milk)
*The percent Daily Value (DV) provides nutrient information based on a caloric intake of 2,000 calories for adults and children four or more years of age.
**Nutrient information not listed here can be found on the product website
***Nutrient not listed on product website

paid advertisement
Voters’ Guide Advocacy

Voters’ Guide: President-elect candidates discuss evolving medical home

The 2016 national AAP election for president-elect and district officers will begin on Oct. 21 and conclude on Nov. 21. Look for an email message from the AAP election coordinator in October with your personalized link to the ballot. No other login information will be required.

Members will be asked to choose their next president-elect: Michael T. Brady, M.D., FAAP, or Colleen A. Kraft, M.D., FAAP. The winner will serve as the 2018 AAP president.

Voters also will elect district officers in six out of 10 districts: district chairpersons (who serve as AAP Board members), district vice chairpersons and National Nominating Committee representatives. Visit coverage of the candidates in District I, District II, District IV, District V, District VII and District IX. The new president-elect and newly elected district officers will take office on Jan. 1, 2017.


If you have any questions on the election procedures, contact Katie Friedman at 800-433-9016, ext. 4296, or kfriedman@aap.org.

All members are urged to vote.

The AAP president-elect candidates were asked, "As the medical home evolves in pediatrics, describe the role of the pediatrician in this context."

Colleen A. Kraft, M.D., FAAP
Cincinnati, Ohio

Here's a familiar sentence. "Dr. Kraft, someone else can see Jade if she's sick, but we must see you for her __________ (well visit, ADHD, school problems, behavior, etc.)."

Pediatricians span the milestones of childhood, from the delivery room to the newborn nursery; the first vaccines or the first fever at night; through temper tantrums, toilet training, the first day of kindergarten; learning disabilities and sports injuries; bullying and high school graduation. It is the pediatrician who fosters the relationship that builds the skills, competencies and confidence of our families and patients.

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Voters' Guide, Advocacy

As the pediatric medical home evolves, we have the opportunity to expand both access and quality of pediatric care. Team-based care includes roles for nurses, care coordinators, dietitians, pharmacists, social workers, legal partners, educators and home visitors. Nontraditional tools such as telehealth and virtual teams have potential to improve health care access for both primary and subspecialty care for children. The medical home could also evolve to include additional options for health care delivery, including school-based clinics, colleges, mobile clinics, patients’ homes, public housing projects, retail clinics and juvenile detention facilities.

The opportunity in this “broader” medical home lies in the design of clinical, operational, communication and administrative workflow that keeps children and families at the center. AAP leadership must address the challenges of poor quality disruptions to pediatric medical care as a threat to children’s health. Pediatric leadership is essential as we navigate the inter-connectivity of scope, complexity, cost, revenue and quality of this “broader” medical home.

Evolution of the medical home is essential as we move from a disease-focused health care delivery system to a wellness- and population-focused approach. Pediatricians need to drive this evolution, not just respond or acquiesce to it. No one better understands the potential benefits of the medical home than a pediatrician.

Pediatricians are uniquely qualified to champion health and wellness-focused care for children. Pediatricians have always been engaged in disease prevention and health maintenance through developmental screening, anticipatory guidance, vaccine administration, family-centered care and child health advocacy. The evolving medical home offers the possibility to enhance care delivery by expanding the array of services available.

Obesity, school-related problems, mental and behavioral health conditions - all would best be managed through these expanded services within the medical home. Families facing poverty, violence, domestic abuse and other stressful circumstances would benefit as well from the medical home’s family-centered care, since no child’s health exists in a vacuum. Nutritionists, developmental specialists, mental health providers, social workers and home visitation services could complement the pediatrician’s ability to address the usual health concerns and improve evaluation and prevention strategies. Pediatricians would serve as the head of a medical home team that can address all needs of patients and families.

Pediatricians and the AAP need to be the leaders in determining the best structure for the medical home and, crucially, establishing the most appropriate payment process to support the expansion of essential health and psychosocial services, assuring every child has the opportunity to achieve maximum health and well-being.

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Residents Voice: Certain Uncertainty

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Resident Voice: Certain Uncertainty

When I flipped the girl onto her back, she was squirming much less than she had been earlier. Her lips were purple, her skin was pale, but it was her eyes that I will never forget. She was looking right at me, eyes wide, almost bulging out.

As I flipped her back onto her stomach and delivered additional back thrusts, I realized that my worst fears were coming true. This little girl was going to die. Those words kept replaying on a loop in my head with each seemingly futile back thrust. Each second that went by, that statement seemed to be crystalizing into reality.

Then she coughed. Weak at first, and then more forceful. I have no idea how much time had passed. I gave her a few more back thrusts, probably more out of disbelief that the piece of food had been dislodged, and then sat her on the table. She was breathing, and her color was returning to her lips. She was crying. I looked around, and her family was crying too.

I checked her to make sure that she was otherwise okay. Other than being upset and frightened by everything that had just taken place, she seemed completely fine. “When the ambulance arrives, I requested that they look her over as well.” As multiple family members crowded around the little girl to console her, I quietly made my way back to my table. As I walked to the front of the restaurant, many of the restaurant patrons just stared at me. One man smiled and nodded in my direction. I could barely smile back.

I realized I was shaking.

While my family dissected the entire incident, and told me how proud they were of me, I didn't feel proud at all. Though I kept it to myself, at the time I was ashamed of my uncertainty and fear. Shouldn't I have felt more confident? After all, in one month, I would be a senior resident! Things like this could happen at any time. Would this be my reaction every time a patient became acutely ill?

Total strangers patted me on the shoulder as they walked past, and the waitress brought me the chocolate cake that I had ordered before the incident happened. The whole situation was surreal; how could I eat anything at this point? More than anything, I wanted to go home.

However, my family didn't pick up on just how uneasy I felt. One by one, they replayed the event from their own vantage points, while I sat and smiled.

After the EMTs departed, the little girl and her family walked past our table as they left restaurant. Her mom made eye contact with me, still with tears in her eyes, and I reflexively stood up and gave her a hug. “Thank you,” she whispered. I smiled at her, shook hands with a few more family members as they passed, and then they were gone.

Joe? Joe! They need a doctor!”

I felt sick. It really had been such a nice day. After all, it was Mother’s Day, and my one day off from the floor as an intern. I was out to dinner with my parents, my sister, and grandparents enjoying the quality family time that I had seemed to become less frequent over the past year. I just helped walk my grandpa to the bathroom and was standing in the alcove waiting for him. I saw my dad running up to me. “In the back of the restaurant!” he motioned. It was becoming clear that the day was taking a very different turn.

In the hospital, you’re never really alone, even at night. There are almost always knowledgeable people who are right there, or only a phone call away. Here and now, I was alone with no one to call. The first thought that ran through my mind was of an elderly man having a heart attack. What would I do? I’m a pediatrician!

As I barreled toward the back of the restaurant, past my family’s table, I heard someone say, “It’s a little girl!” In retrospect, this probably should have made me feel slightly better. It didn’t. Now I would be expected to know what to do. And honestly, I wasn’t sure that I would.

When I arrived at the table, there were two adults hunched over a little girl, probably around a year and a half old. The woman, I later learned, was the girl’s mom, and the older man was her grandfather. He was crouched down beside her with his finger in her mouth. Blood was dripping from her mouth. Her eyes were wide, her skin pale, and she looked terrified. It was clear she was unable to breathe. “I think she’s choking,” her mom said between tearful gasps.

“I’m a pediatrician,” I announced myself as being a pediatrician (even though I didn’t feel like one at the time). They stepped back, and I quickly glanced at the grandfather’s hand. It looked like he had been bitten. “What happened to you,” I inquired. He explained that when she started choking, he attempted to pull the food out of the back of her mouth and she reacted by biting him. As he spoke, I picked the girl up, flipped her over onto her stomach and used my knee to brace her weight. She squirmed as I delivered back thrusts. With each pound on her back, my sense of dread increased, as did the questions in my head. What am I going to do if this food doesn’t come out? What if she loses consciousness? In that moment, my instincts took hold. I turned to someone standing next to me and told them to “Make sure someone has called 911.”
Our Pediatric outpatient practice, which operates within the Children's Hospital of New Jersey at Newark Beth Israel Medical Center, had the opportunity to collaborate on a quality improvement program to increase use of evidence-based developmental screening tools and enhance linkages with community resources. With funding from SAMHSA (Substance Abuse and Mental Health Services Administration) to the NJ Department of Children and Families, and facilitation by the NJ Chapter, American Academy of Pediatrics (NJAAP), Project LAUNCH (Linking Actions with Unmet Needs in Children's Health) brings together all of the essential players in young children's lives to strengthen and expand the medical home neighborhood.

We know and understand that the best possible outcomes for patients experiencing developmental issues are achieved when children are identified as early as possible and effective interventions begun soon thereafter. We perceive every patient encounter as a valuable opportunity for conducting behavioral and mental health screenings, but unfortunately, sometimes these opportunities are missed.

The Project LAUNCH Learning Session provided us with an opportunity to meet the other practice teams participating in this collaborative. It also served to introduce us to the myriad of services available to families through Essex Pregnancy and Parenting Connection (EPPC). EPPC is part of the NJ Central Intake initiative that connects families before and during pregnancy, infancy and early childhood to services in the community. The goal of EPPC and the other central intake sites is to provide successful connections between families and the services they need to stay healthy and safe. (Editors Note: See page 34 for a listing of Central Intake sites in all 21 NJ counties.

At the Learning Session, Manuel Jimenez, MD, FAAP and Joseph Schwab, MD, FAAP provided an understanding of two evidence based developmental tools, namely the Survey of Wellbeing of Young Children (SWYC) and Ages and Stages (ASQ). We discussed each of these tools in detail, examining their benefits (simplicity, ease of use, sensitivity, etc…), their effectiveness and understanding how each tool is scored. We also discussed best practices for addressing the needs of those patients who fail or nearly fail either screening.

Our practice team elected to incorporate the SWYC screen into all nine-month well visits. Utilizing the model for improvement, introduced by the NJAAP QI team, our plan called for either the nurse or physician to provide each caregiver with the SWYC screener and request that they complete it prior to the well visit. Upon completion, the provider would then score the screen and afterwards, share the score with the caregiver and explain its significance. If the patient's score was below average, the provider would schedule a near-term follow up visit to reassess the patient. If no progress was reached, the patient would be referred to both Early Intervention and a developmental pediatrician.

Monthly data collection was a component of the Project LAUNCH initiative. The data charted the number of nine month olds seen in the outpatient practice and what percentage of these patients had been given the SWYC. This quantitative information helped us assess the success of our screening implementation. At the project’s conclusion, our practice determined that the SWYC would be incorporated into more than just the nine month visits. Presently, we are seeking less cumbersome way to input the SWYC into our EMR, other than scanning in paper copies. Determining such a process is preferred as it would save time and the results would be readily available for all our providers.

Participation in Project LAUNCH has been a rewarding experience for our practice; it made us more aware of the need to do a better job of implementing screening for developmental delays for all our patients. It also enabled us to collaborate with neighboring practices and community partners, which was both fun and educational. I look forward to future projects with the NJAAP, our fellow pediatric practices and community partners.
New Jersey now has a statewide network of central intake hubs encompassing all 21 counties. Central Intake provides pregnant women, families and providers with easy access to resource information and referrals to local community services that promote child and family wellness. The range of services include—prenatal care, infant/child health, family planning, nutrition/WIC, home visiting (Healthy Families, Parents As Teachers, Nurse-Family Partnership), Head Start/Early Head Start, child care services, preschool programs, Family Success Centers, early intervention, special child health services, behavioral health, domestic violence support, financial needs/public assistance services, substance use/addiction treatment and much more.

The primary focus of central intake is to facilitate linkages from pregnancy to age five. The county-level hub is a single point of entry that helps to simplify the referral process, improve care coordination, and ensure an integrated system of care. Local central intake staff remain up-to-date on the local array of available services, and works closely with families and provider partners to ensure that referrals best match a family’s needs based on program eligibility, language/culture and other considerations.

<table>
<thead>
<tr>
<th>#</th>
<th>County</th>
<th>Lead Agency</th>
<th>Name of County Central Intake</th>
<th>Central Intake #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Atlantic</td>
<td>Southern NJ Perinatal Consortium</td>
<td>The Connection</td>
<td>1-800-611-8326</td>
</tr>
<tr>
<td>2</td>
<td>Bergen</td>
<td>Partnership for Maternal &amp; Child Health of Northern NJ</td>
<td>Bergen Central Intake</td>
<td>973-942-3630 x11</td>
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<tr>
<td>4</td>
<td>Camden</td>
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<td>5</td>
<td>Cape May</td>
<td>Robins’ Nest</td>
<td>Cape Connect</td>
<td>609-407-0040</td>
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<td>6</td>
<td>Cumberland</td>
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<td>CGS Connect</td>
<td>856-431-4180</td>
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<tr>
<td>7</td>
<td>Essex</td>
<td>Prevent Child Abuse NJ</td>
<td>Essex Pregnancy and Parenting Connection</td>
<td>973-621-9157</td>
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<td>8</td>
<td>Gloucester</td>
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<td>9</td>
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<td>10</td>
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<td>12</td>
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<td>Morris Central Intake</td>
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<td>13</td>
<td>Middlesex</td>
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<tr>
<td>14</td>
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<td>CGS Connect</td>
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<td>18</td>
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<td>19</td>
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<td>21</td>
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<td>Project Family Connect</td>
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</tr>
</tbody>
</table>
The CDC estimates that each year over 24,000 cancers could be prevented with HPV vaccines.

Six things you can do to prevent cervical cancer and other devastating HPV-related diseases in your patients:

1. Know your numbers – Assess HPV vaccine coverage for each provider in your practice
2. Work as a team – Involve all members of your care team including receptionists, nurses, and providers in developing an office-wide strategy to improve HPV immunization rates
3. Make a strong, effective recommendation for HPV vaccination as cancer prevention
4. Use a reminder/recall system to make sure your patients get all 3 doses of HPV vaccine
5. Check out these great strategies for talking with parents about HPV and cancer prevention: http://goo.gl/A147YS http://goo.gl/xzC7ba
6. Learn more about HPV and cancer prevention at: http://www.cdc.gov/cancer/hpv/

Average number of cancers and genital warts per year in the U.S. attributed to HPV infections

<table>
<thead>
<tr>
<th></th>
<th>PENIS</th>
<th>VAGINA</th>
<th>JUVENILE-ONSET RRP*</th>
<th>VULVA</th>
<th>ANUS</th>
<th>OROPHARYNX</th>
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<td>2,900</td>
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<tr>
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<td>BOTH</td>
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</table>

Source: President's Cancer Panel Annual Report 2012-2013
*recurrent respiratory papillomatosis

Published by the New Jersey Immunization Network, a program of the New Jersey Chapter of the American Academy of Pediatrics: www.immunizenj.org.
I don’t want your patient to be my patient.

David Warshal, M.D.
Director of the Gynecologic Cancer Center

Immunize girls and boys with 3 doses of HPV vaccine by age 12.