Legal Update: Beades, 34

Legislative Update, PSI, 35

Case Report
Constricting Finger Injury from a Wire Mixing Ball, Mariano, Diah, 26
A Cry for Help - Evaluating and Managing Post-Traumatic Stress Disorder in Adolescents, Baiel, Pineda, Lim, Patel, Pelliccia, 28

Resident Voice
Evaluation of a Group-Based Standardized Patient Training, Pette, Shahidullah, Jaques, Kettlewell, DeHart, 30

CME Articles
Wired at Birth: The Importance of Infant Mental Health, Korn-Heilner, Lee, 6
Understanding the Age-Old Wisdom that Sleep is Important, Mandelbaum, 12
Eyes are Never Quiet, McKnight, 16

Special Project Report
The Digital Data Logger Project: Testing the Usability and Perceived Value of Advanced Features Beyond CDC Specifications, Craft, Cera, Sathmary, Van Vlijmen

Pediatric Guidance
Understanding the Age-Old Wisdom that Sleep is Important, Mandelbaum, 12
Eyes are Never Quiet, McKnight, 16
6  CME Activity
Wired at Birth: The Importance of Infant Mental Health
By Hannah Korn-Heilner, MSW
Lana Lee

12 Understanding the Age-Old Wisdom that Sleep is Important
By Bert Mandelbaum, M.D., FAAP

16 Eyes Are Never Quiet
By Michael McKnight, MA

20 The Digital Data Logger Project: Testing the Usability and Perceived Value of Advanced Features Beyond CDC Specifications
By Jeanne Craft, MD, FAAP
Peter Cera
Jake Sathmary
Sharleen Van Vlijmen

26 Case Report: Constricting Finger Injury From a Wire Mixing Ball
By MaryBeth Mariano, MSN, RN, APN, CPNP
Paulett Diab, MD, FAAP
Jennifer Romalin, MSN, RN, APN

28 Case Report: A Cry for Help – Evaluating and Managing Post-Traumatic
By Joshua Baiel, M.D.
Daphne Pineda, M.D.
Jin Whan Lim, D.O.
Zalak Patel, M.D.
Frances Pelliccia, M.D.

30 Resident Voice: Evaluation of a Group-Based Standardized Patient Training
By Rachel A. Petts, Ph.D.
Jeffrey D. Shahidullah, Ph.D.
Michelle Jaques, Ph.D.
Paul W. Kettlewell, Ph.D.
Kathryn Dehart, M.D.
President's Column

I dedicate this column to our CEO, Fran Gallagher.

In October, Fran Gallagher will be leaving the New Jersey Chapter, American Academy of Pediatrics, following her successful thirteen year-long run, first as Executive Director and then as its Chief Executive Officer. Fran’s tenure has been marked by her relentless commitment to excellence and extraordinary dedication to members. These indefatigable traits have led to NJAAP being awarded the coveted recognition of Outstanding Very Large Chapter by the National AAP. Additionally, innovations introduced as a result of Fran’s vision including: New Jersey Pediatrics, the Agenda for Children, and integrating the position of a Medical Director to oversee all Chapter programs, have resulted in our Chapter being regularly tapped as a go-to resource for other state AAP chapters. Also included among the Chapter’s many achievements, especially those that directly benefit our members, has been earning the designation as an ABP MOC Portfolio Provider and a recognized ECHO Hub. Each of these achievements, along with many other, have contributed mightily to improving the health and wellbeing of all children throughout New Jersey AND the pediatricians who care for them.

As co-chair of government affairs committee, Fran and I have worked in concert to advocate for children’s health issues at the legislative and regulatory levels. Topics we advocated for included - Medicaid payments, scope of practice concerns, immunizations and protecting and strengthening the pediatric medical home.

Fran Gallagher has been a tirelessly enthusiastic and dedicated advocate for children in the state of NJ. She has been an extraordinary ED/CEO for our Chapter and I personally want to thank her for all she has done to make the NJAAP what it is today.

“I cannot think of any other person who has more passion, enthusiasm and knowledge about NJAAP than Fran. Moreover, she communicates those qualities like no other. Fran has taken this organization not just to the next level; she took us all the way to the top. On a personal level I have learned so much from her over the past 10 years, and I will be forever grateful for the opportunity she offered me to be part of this organization.”

Bert Mulder

“I am very fortunate to have worked closely with Fran for the last 13 years. Her energy, vision and determination have transformed us from a team of three to an innovative and dynamic Chapter with unlimited potential.”

Harriet Lazarus
CEO's Column

Fran Gallagher, MEd
Chief Executive Officer
NJAAP

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Moving Forward – Leaving a Mark

Fran Gallagher will be leaving AAPNJ after 13 years as the Executive Director/CEO of the Chapter. Her legacy will last far longer.

When Fran first started in New Jersey, the Chapter was in its early childhood. There were a few projects and there was a small staff of two or three. Most pediatricians knew very little about the Chapter’s work and only a few pediatricians were active in the work. The Chapter paid a management company to handle the financial and operational aspects. Within that first year the chapter separated from the management company and set up its own administrative structure. It hired its own employees and found permanent office space. I remember so well Fran negotiating with the office management group for them to support our golf outing with a donation — and they did.

Fran has always worked five jobs at one time: 1) managing the office, office staff and the finances; 2) oversight of all current grants; networking with state government and foundations for new grants and contracts; 3) advocating for pediatricians in every venue be it the insurance company, state government, foundations; 4) working with membership around such issues as payment, vaccines, CME, MOC and; 5) representing the chapter at local, regional and national events. This usually entails an 18-hour day since program and grants are a 9 to 5 schedule and membership needs and event often take place in the evening.

The Chapter may now be the best chapter in the country. There is a staff of 22, over 2 million dollars in grants and improvement work, even two staff working solely on grant management and the budget. As a MOC Portfolio Provider, we can offer MOC for all our projects. There is the chapter’s quarterly journal, which is working toward becoming worthy of PubMed status. Even more importantly, there are over 50 pediatricians actively involved in improvement work and chapter affairs and I believe nearly every pediatrician in the state has some ties to a program or chapter event.

NJAAP stands for children and families and for improving the health of the population. It is recognized as the organization to go to for access to pediatricians and to children and adolescents. Moreover, its programs are evidence-based and also innovative, stretching the current definitions of pediatric health and health care. All of this remains and will be maintained by a very competent and professional staff and by very passionate pediatricians contributing their time and energy.

While it is vital to find a replacement that complements and perhaps supplements the chapter with some different expertise and vision, it is also so important to recognize what Fran has accomplished in such a short period of time.

It is amazing to have witnessed the capacity of one person to make such a positive impact to the chapter, to children’s health and that of the parents and families living in NJ.

We all thank Fran for her tireless years of dedicated, passionate, and leadership and wish you great success in all your future endeavors.

“Fran always seems to know someone, who knows someone, who knows someone who has the answer to my question. Sounds a bit like the Mafia “I know a guy who knows a guy” but in a good way.”

Jeanne Craft
This dilemma presents an opportunity for pediatricians and the healthcare community to advocate for improved access to infant mental health services. Together, we can shape the conversation, draw attention to this critical issue and help give young children the necessary supports for healthy development.

**How Pediatricians Can Support Infant Mental Health**

Danielle’s story may sound familiar to many pediatricians who have experienced first-hand how difficult it is for parents to find and access mental health services for their infant or toddler. Even prior to accessing services, there are barriers to addressing social-emotional issues at this age, especially because of the sensitivity of the topic and the confusion regarding what is typical development and behavior.

“It’s hard work being a child. We’re born and our brains are developing at a rapid speed. We have to learn to walk and talk and have control over our emotions. Kids are developing across all these different domains at the same time,” says Dr. Dayna Zatina Egan, Psy.D, director of the Youth Consultation Services (YCS) Institute for Infant and Preschool Mental Health. This can make it challenging to determine if some behavior is part of their natural development or if there is an underlying issue. “If a child is biting or hitting, sometimes it can come from frustration. They have big emotions but do not have the language to express how they feel yet,” explains Dr. Egan.

To aid in assessing mental health in young children, the American Academy of Pediatrics recommends developmental and behavioral screening at 9, 18, and 24, or 30 months of age. Standardized developmental screening tools that are helpful to monitor infant mental health are:

- Brief Infant Toddler Social Emotional Assessment (BITSEA)
- Carey Temperament Scales (CTS)
- Greenspan Social Growth Chart
- Temperament and Atypical Behavior Scale (TABS), TABS Screener

While these tools can be extremely helpful, North Jersey pediatrician Dr. Peter Cardiello adds that screening a family can be as simple as asking about what is happening in their lives. Observing child-parent interactions and having meaningful conversations can help identify the strengths and stresses in families, which affect an infant’s development. “You can raise things like, ‘You know, it seems like this situation isn’t going so well, can we talk about that? What would you like to talk about?’ I make sure I ask again and again, ‘Do you have any other questions?’ Eventually, you learn about the family stressors that make it more difficult to manage. You have a lot of stress—financial stress, housing stress, stressful relationships among the adults.”

Fostering a child’s emotional health starts at birth. At a time when a child’s brain is developing the most—between the ages of 0 to 3—the ability for babies to interact socially and regulate their emotions is critical to their overall health. During this time, a child learns how to relate to other people, how to begin exploring and how to feel safe and loved.

Pediatricians are often the first professionals parents will turn to for guidance when concerned with their child’s development. In fact, in a national survey of voters, nine out of ten parents who talked to their pediatricians about their child’s social-emotional development found it helpful. Therefore, it is critical that pediatricians have the tools necessary to inform families about social-emotional health as well as viable resources for parents to address their child’s social-emotional and/or behavioral needs. Unfortunately, the options are limited for families when it comes to accessing many infant mental health services, which may include social-emotional screenings, mental health consultation services in early care and education settings, parent-child mental health treatments and maternal depression screenings.
“The important thing is that it’s never too early to intervene. Sometimes, people will suggest to wait and see, but what if, by then, it’s too late, leaving gaps in services,” says Dr. Kaitlin Mulcahy, MA, LPC, associate director for the Center for Autism and Early Childhood Mental Health at Montclair State University.

Danielle remembers feeling dismissed when she first brought up Theo’s biting behavior at his routine checkup. Because her son was verbal, the doctor told her that this was normal development and they should wait and see. “I understand why doctors say wait and see,” says Danielle. “But watching and waiting is so painful, especially when I knew something wasn’t right all along.”

Because it can be difficult to parse out the different domains of development and where a behavior might be coming from, Dr. Egan suggests first referring families to Early Intervention (EI) for assessment. “Always start with EI. They’re the front lines. They have a system in place.” However, children will only qualify for EI if they have a physical or cognitive delay, and may not qualify for EI if they only have a social-emotional challenge, like in Theo’s case.

Danielle had tried to obtain services for her son for years, who had been screened and turned down for EI services twice. However, she persisted and finally obtained EI services when Theo was 2 and a half years old. However, EI services end at age 3. Although Danielle was grateful to finally receive support, she felt frustrated that the process took so long. She knew from an early age that Theo was in need of services and yet was continuously dismissed by a system that is not set up to help babies with social-emotional challenges. Waiting so long to care for his social-emotional development meant fewer opportunities to intervene early on. “He missed out on the most critical years of therapy,” says Danielle.

**Infant Mental Health: The Blueprint for Social-Emotional Wellness**

Research shows that the first few years of life are an important time period for physical and cognitive growth and also a crucial time for social-emotional development. This includes understanding feelings, regulating emotions, forming relationships, interpreting social roles and cues, and even learning to love. The infant brain is attuned to facial expressions, gestures, tone of voice and non-verbal interactions. The nature of these experiences and their interpersonal relationships form connections in their brains that lay the foundation for their emotional well-being.

“Development does not happen in a silo. Rather, it is enmeshed with the child’s relationships,” says Dr. Mulcahy. She refers to this as relational wellness. “Infant mental health is not just about the baby. It’s about the baby in the context of their relationships.” Babies are learning to form secure, trusting and caring relationships with the adults around them and those relationships are critical to support their growth and development.

“We’re wired for relationships from birth and our relationships give us a blueprint for how we approach the world around us and going forward as we grow up,” says Dr. Egan. She underscores the importance of cultivating those relationships between parent and child as they become the model for a child’s future relationships. This includes romantic relationships as well as relationships with their own children. “If we intervene with those earliest relationships, we’re going to make the biggest impact.”

**Stress, Trauma and ACEs**

Intervening early is especially important for babies and their families affected by stress and trauma. Parenting is not easy and having a new baby can be a challenging time for many families. The ability to parent is often reflected in the nature of their own lives. Stress and anxiety compounded with instability in our environment can affect a baby’s emotional well-being. Negative experiences can have a harmful impact on a baby’s growing brain and their emotional health. Children who experience traumatic events at an early age, known as adverse childhood experiences or ACEs, are exposed to stressors that can have more long-term consequences, including physical and mental health issues in adulthood.
Highly stressful early relationships may induce prolonged activation of stress response systems. This can be due to factors such as neglect, poverty, instability or violence. Even maternal depression can impact the mother-child relationship. “High levels of stress have a toll. Our body keeps score and our body remembers, even when we’re not consciously holding onto those negative memories,” says Dr. Egan. This puts children at greater risk for challenges in life, including social difficulties and behavioral problems, which could lead to learning difficulties in school.

Trauma can disrupt those earliest relationships critical to a child’s well-being, impacting the blueprint for how they approach life and their relationships. “For families dealing with intergenerational layers of trauma, we have to work through decades and generations of blueprints that reflected the nature of how they were parented and how their parents parented, and so forth.” With early assessment and intervention, this may be the most opportune time to engage families with the potential for improved outcomes. “In working with families, we often show parents how amazing they are with their child and also where their child and their relationship might need a little more support. I tell them you’re the expert on your child and I’m an expert on child development, so let’s work together,” says Dr. Egan.

**Infant Mental Health Services in New Jersey**

If addressing mental health in infants is critical to the development of a child, then why are infant mental health services so limited in New Jersey? A variety of factors impact the availability of infant mental health services, including inadequate insurance coverage for screenings and services, low insurance reimbursement rates, a lack of professionals trained in infant mental health and limited information about the infant mental health field in education settings.

New Jersey’s Medicaid plan has uneven or inconsistent coverage for critical infant mental health services for babies and their parents. According to a recent analysis of services covered under state Medicaid plans, New Jersey is one of eight states that does not cover social-emotional screening and one of 10 states that does not cover dyadic (parent-child) mental health treatment. New Jersey Medicaid also does not cover maternal depression screening under a child’s Medicaid or parenting services. Medicaid mandates health and developmental screenings and services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit to help ensure that children's healthy development is on track. However, even though these infant and maternal mental health services are allowable under EPSDT, they are not written into New Jersey’s state Medicaid plan. In addition, many private health insurance plans do not provide adequate coverage for infant mental health services. Even when screenings and services are covered under Medicaid or private insurance, the reimbursement rates are not adequate to cover the services.

“High levels of stress have a toll. Our body keeps score and our body remembers, even when we’re not consciously holding onto those negative memories,” says Dr. Egan. This puts children at greater risk for challenges in life, including social difficulties and behavioral problems, which could lead to learning difficulties in school.

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“There is currently no direct way to code an infant mental health diagnosis. Therefore, it is difficult for specialists to get reimbursed for services,” says Dr. Mulcahy. The New Jersey Think Babies Coalition recognizes the need for a stronger, comprehensive system to address infant mental health and expand access.

“Our state Medicaid plan needs to be revised to incorporate important infant and maternal mental health screenings and services, and to increase reimbursement rates,” says Cecilia Zalkind, CEO/president of Advocates for Children of New Jersey, which spearheads the coalition.

Furthermore, there is often a lack of understanding from insurance companies regarding infant mental health. “The insurance company will call for an authorization after two sessions because they don’t see why a 2-year-old would be in long-term service,” explains Dr. Mulcahy. “This is why it is important for our health care system to have a better understanding of infant mental health needs.”

Moreover, the availability of qualified, well-trained infant mental health professionals is in short supply. In New Jersey, professionals can obtain an Endorsement® from the New Jersey Association of Infant Mental Health (NJ-AIMH), which certifies that a professional has specific training in infant development and dyadic and family therapy. To learn more, visit http://nj-aimh.org/endorsement/.

“We only have about 20 infant mental health specialists in the state who are endorsed by NJ-AIMH to provide clinical services to the birth-to-three population,” explains Dr. Mulcahy. With limited job opportunities and inadequate insurance coverage for services, there is a disincentive to promote this specialized field in mental health. However, mental health programs need to do more to educate their students and promote the infant mental health field in higher education and continuing education programs.

Lastly, New Jersey is one of 15 states that does not cover mental health consultation services in early care and education settings, contributing to expulsions in child care settings, like what happened to Theo. The Center for American Progress, a Washington-based research and advocacy institute, estimated that in 2016, roughly 50,000 preschoolers were suspended at least once, and more than 17,000 were expelled. In addition, black children and boys were suspended at a disproportionately higher rate when compared to their peers, leading experts to attribute implicit racial bias among early educators as a factor. Nationwide, black children make up 18 percent of preschoolers, but account for nearly half of all out-of-school suspensions.

Studies show that early childhood mental health consultation can have a tremendous impact on reducing suspensions and expulsions due to challenging classroom behavior. Mental health consultation services support the whole setting, including teachers, families and parent-child relationships. Without the support to address their social and emotional needs, young children may miss out on the benefits of early childhood education and leave mental health issues unaddressed.

continued on next page
Pediatricians can support *Think Babies* efforts by:

- Sharing a story about a family who needed, but was unable to access infant mental health services.
- Becoming familiar with resources in your community and any professionals providing infant mental health services in the area. If you do not know where to start, contact YCS Center for Infant and Preschool Mental Health at info@ycs.org and MSU Center for Autism and Early Childhood Mental Health at caecmh@montclair.edu.
- Speaking with your state legislators about unmet needs for infant mental health services through writing a letter/email, calling or setting up a meeting.
- Testifying to the New Jersey Legislature about the need for and importance of infant mental health services.
- Inviting the Think Babies Coalition to your practice to learn more about infant mental health or sharing innovative practices and strategies that you have used to address infant mental health.
- Writing an op-ed or letter to the editor for local newspapers to spread the word about infant mental health.

**Types of Stress**

**Positive stress:** associated with moderate, short-lived physiological responses; necessary part of development; occurs in the context of stable and supportive relationships, which support the child in developing mastery and self-control.

**Tolerable stress:** associated with events that could result in physiological responses that could affect brain structure but are buffered by supportive relationships—promotes coping that restores heart rate and stress hormone levels to baseline (events can include death of a loved one, divorce, natural disaster, etc.).

**Toxic stress:** intense and prolonged activation of stress response systems—without adult protection and support. Stressors can include: child maltreatment, severe maternal depression, parental substance abuse, family violence, unaddressed separation, inconsistency in love and care.

**Source:**

References


4. Ibid.


CME Quiz on page 11
1. At what ages does the AAP recommend conducting developmental and behavioral screenings?
   A. 3, 6, and 12, or 24 months of age
   B. 8, 12, 24, and 30 months of age
   C. 9, 18, and 24, or 30 months of age
   D. 6, 9, 12, and 24 months of age

2. Which of the following are AAP recommended developmental and behavioral standardized screening tools?
   A. Greenspan Social Growth Chart
   B. Ages and Stages: Social-Emotional
   C. Brief Infant Toddler Social-Emotional Assessment
   D. All of the above

3. True or false, infant mental health includes the baby in the context of their relationships.
   A. True    B. False

4. True or false, experiencing ACEs at an early age does not have long-term consequences on children because they were too young to remember.
   A. True    B. False

5. Why are mental health services limited in New Jersey?
   A. Inadequate insurance coverage for screenings and services
   B. Low insurance reimbursement rates
   C. Lack of professionals trained in infant mental health
   D. All of the above

6. True or false, New Jersey is one of eight states in the country that does not cover social-emotional screenings under Medicaid.
   A. True    B. False

7. What type of stress is a necessary part of development?
   A. Good stress
   B. Positive stress
   C. Tolerable stress
   D. Manageable stress

8. True or false, babies are too young to understand facial expressions, gestures, and tone of voice.
   A. True    B. False

9. True or false, maternal depression can contribute to highly stressful early relationships for a baby.
   A. True    B. False

10. What does EPSDT stand for?
    A. Every Pediatrician Screens, Diagnoses, and Treats
    B. Early Practice Services, Development and Testing
    C. Easy Pediatrician Screenings to Diagnose and Treat
    D. Early and Periodic Screening, Diagnostic, and Treatment

80% Correct Response Rate Required to earn CME
Understanding the Age-Old Wisdom that Sleep is Important

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Princeton Nassau Pediatrics, PA.
Chairman, Department of Pediatrics
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Why All The Fuss About Changing School Start Times?

Over the past year or two, there’s been an increase in conversations related to school start times, most specifically, that of high school start times being too early. The topic is popping up in newspaper editorials, educational conferences and even backyard summer conversations. That begs the questions: why are people talking about this now? The majority of school districts in the United States start before 8:30am, has something changed to make us think that this is no longer acceptable?

To answer the second question first, the major change over the past decade is that we have gained a better understanding and awareness of two basic scientific concepts: the importance of sleep and the natural shift in circadian rhythms in adolescence.

Societal value on sleep has shifted over the years, but recently, there’s been an abundance of evidence to support the age-old wisdom that sleep is important. Lack of sleep has a direct effect on multiple short- and long-term outcomes. Short-term negative outcomes from lack of sleep include poorer academic performance, poorer athletic performance, riskier/impulsive behaviors and increased automobile accidents. Long-term negative outcomes from lack of sleep include obesity, heart disease and growth suppression. Luckily, the opposite is true and getting sufficient sleep helps to reduce all of the above-mentioned short- and long-term consequences. How much sleep is needed? As most pediatricians are aware, the CDC recommends 8–10 hours of sleep for adolescents and most sleep experts believe that 8.5–9 hours seems to be the correct amount. Eight hours seems to be a critical point for preventing much of the negative outcomes mentioned above.

The concept of circadian rhythm changes in adolescence is not new to anyone; in fact, almost all adults have experienced this during adolescence and should be able to relate. Pediatricians caring for adolescents know well that during the teen years, melatonin has its release shifted two to three hours later than it was in childhood. The result of this shift in melatonin release means that teens who had been able to fall asleep between 8 and 9pm previously now cannot fall asleep until 10:30 to 11pm. It also means that these teens have a hard time waking up before 7am, since the melatonin release is often continuing in teens through sunrise. This shift in melatonin release has been documented to occur worldwide and is not a new phenomenon. Once teens become young adults in their early to mid-twenties, the melatonin release often shifts back to follow a more typical adult sleep schedule.

Taken together, these two facts have changed much of our thinking about adolescence, sleep and school start times. If we know adolescents need a minimum of eight hours of sleep to prevent the consequences listed above and we know that they cannot fall asleep until 10:30–11pm, then we know we shouldn’t wake them up until 6:30–7am at the earliest. Working from there, we know that we should be giving them time to get up, eat breakfast, get ready for school and then time to commute to school, usually on the school bus. Those calculations result in the general recommendations for starting school for middle and high schoolers no earlier than 8:30 am.

In 2014, knowing the facts stated above, the American Academy of Pediatrics published its policy statement, entitled “School Start Times for Adolescence”, in which the authors expertly reviewed the data surrounding sleep and changes in adolescent circadian rhythms, and recommended that middle and high school start times not begin before 8:30 am. The Center for Disease Control, the American Academy of Sleep Medicine, and many other national health organizations have also made similar recommendations.

Educators have long recognized that in districts where high school starts early, many of the students are either late for school or are not paying attention during the first and second periods of the day. Parents have long recognized that their adolescents seem exhausted and are difficult to wake up in the morning, resulting in them rushing their teens to school. So how did we get here and why haven’t we changed anything?

First and foremost, it’s important to recognize that the science mentioned above is evidence-based and there are no real opposing viewpoints. There has not been any proposed educational rationale showing that adolescents receive better education when they start schools early. It should be noted that the school schedule historically has not always been like this. The big push to move high schools to an earlier start time began in the 1970s and 1980s. As towns grew, schools became larger and transportation needs increased. As a cost savings technique, towns turned to tiered busing systems—using less buses and bus drivers and having them repeat multiple loops with staggered start times. By convention, high schools often got shifted earlier and that process continued through the present day. Today, many towns have three staggered start times and often start the high school students earliest and the younger elementary school students latest.

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Though there is no benefit to starting school earlier for high school students, there has been a benefit to ending school earlier. Athletics typically benefits from earlier school end times, by allowing more time for practice and transportation to away games. Other benefits of ending school times earlier for adolescents include allowing more time to get to after school jobs, helping with childcare for younger siblings and allowing use of the school by other community organizations.

Now to answer the first question—why are people talking about this now? As we have become more aware of the importance of sleep and the changes in adolescent circadian rhythms, health care professionals, school administrators and boards of education have begun to re-think school policies to see if they can help solve these problems. Keeping student health, education and wellbeing as the driving principle, they have found solutions to the three common problems that most districts face when considering the issue of school start times: transportation, athletic schedules and resistance to change.

Small towns and big cities have both been successful in finding ways to make this change. In many towns, transportation has been the first hurdle. Schools have been successful in solving the transportation dilemma in multiple ways, including swapping schedules and having the younger children start school first and the older ones later, tightening bus routes or reducing tiers and finding the money to offset the increase in transportation costs.

Athletics, a priority for many parents and educators and often a seemingly huge hurdle, has been successfully managed by school districts as well. Rotating bell schedules, implementing Option 2 programs allowing HS sports to count in place of gym, eliminating waste from the schedule and creating as early a school end as possible have been some of the solutions. Athletic directors have also looked to create efficiencies in practices, limiting them to 90 minutes, game transportation and to create more serial game play with freshman, JV and varsity teams playing at the same time on separate fields.

Lastly, changing school start schedules, which families, teachers and the community base their home life schedule around is often difficult. Successful districts have accomplished this change though open communication, explaining the rationale, inviting input and allowing time to adjust people’s schedules.

More and more schools are successfully implementing this and leading this way for other schools. Data from these schools’ after the change in start times support the success of the program and help to dispel many of the myths that people mention when discussing the difficulty of changing school start times. The data shows that when you delay school start times, bed times do not change and that students gain an average of almost a minute of sleep for every minute of delayed school start times. Tardiness, absences and automobile accidents decrease and academic performance increases. Best of all, parents report that their teens are in better moods and are more pleasant to be around.

Legislators have been weighing in too. California currently has legislation being proposed that would mandate school start times for adolescents begin at 8:30am or later. New Jersey recently passed legislation to pilot a four-year study of later school start times in five districts. Things are starting to move in the right direction.

So what can pediatricians do now? Pediatricians can and should communicate this information to their patients and families, but can also take the next step and discuss this with school administrators and public officials. Public schools in New Jersey are required to have a school physician and often these physicians can advocate on behalf of the students to the local board of education and administration. Physician advocates can also help on the legislative level when opportunities present themselves.

There is clear evidence that policy change at the school board level can directly have an immediate positive impact on the adolescents in that district. The obstacles to making the change are known, but surmountable. This is a problem where science and common sense are on the same side and in most cases, bright committed adults can come together as a community to find solutions and create a healthier and better learning environment for our teens. As pediatricians, we can take the first steps and lead the charge to promote education surrounding this topic. Sometimes, a little push from us is all it takes to make a huge difference to a multitude of children in our community.

Bert Mandelbaum serves as the Chair of the newly launched NJAAP Task Force on Adolescent Sleep and School Start Times. For more information and to participate on the Task Force, please contact the NJAAP office.
References:

Let’s be healthy together.

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Children’s Specialized Hospital
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“Let us build communities and families in which our children and youth, especially those who are most troubled, can belong. Let us build a country in which our children and youth can learn to care for and respect others.”

—Nelson Mandela

Our children are not doing well.

“T.” is eight years old, although his lexicon is that of a streetwise nineteen year old. He is angry all the time. He is volatile, aggressive, and defiant beyond words. He feels deeply and is known to protect his younger sister at all costs. A few years ago, T. watched his mother murder his father. His mother is incarcerated, and his father is dead. He lives with his grandmother. Last week, he walked into Room 9 telling his teacher that gunshots went through the screen of his window, just missing everyone in the living room. They are looking to move. T. is on ADD medication, blood pressure medication, and medication for depression. Some mornings he walks into the classroom and just flops on the carpet and sleeps.

Amanda is a 16-year-old adolescent that has just flunked all her classes and will be held back. Amanda is not a behavior problem in school and is very bright. She often doesn’t get to school and when she is present, she does absolutely nothing. Often, she just puts her head down and can easily fade into the woodwork. She lives with both her parents and has been diagnosed with an anxiety disorder. She has panic attacks and it was recently discovered that she is cutting herself.

John is a 17-year-old adolescent that has been suspended from school too many times to count. He has failed almost every class he has taken since entering high school and is currently on homebound instruction waiting for an alternative education seat to open at his high school. John is quick to anger and is often suspended for physically assaulting peers. He is on homebound for his last offense of kicking over a desk in class and pushing a number of teachers on his way to leaving the school building. John is currently in foster care having lost his mother to a heroin overdose. John’s father has not been in his life since he was 5.

Even a cursory look at the state of children and youth in America can give any teacher, parent, youth worker, counselor or physician cause for concern. A recent report from the Children’s Defense Fund, for example, sheds some light on the current ways many children are growing up in the richest country on earth:

<table>
<thead>
<tr>
<th>Statistics</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 children are killed by abuse or neglect.</td>
<td>167</td>
</tr>
<tr>
<td>7 children or teens commit suicide.</td>
<td>566</td>
</tr>
<tr>
<td>8 children or teens are killed with a gun.</td>
<td>1,414</td>
</tr>
<tr>
<td>167 children are arrested for violent crimes.</td>
<td>1,759</td>
</tr>
<tr>
<td>311 children are arrested for drug crimes.</td>
<td>1,854</td>
</tr>
<tr>
<td>566 babies are born to teen mothers.</td>
<td>2,805</td>
</tr>
<tr>
<td>589 public school students are corporally punished.</td>
<td>2,857</td>
</tr>
<tr>
<td>1,414 babies are born without health insurance.</td>
<td>4,388</td>
</tr>
<tr>
<td>1,759 babies are born into poverty.</td>
<td>12,816</td>
</tr>
<tr>
<td>1,854 children are confirmed as abused or neglected.</td>
<td></td>
</tr>
<tr>
<td>2,805 children are arrested.</td>
<td></td>
</tr>
<tr>
<td>2,857 high school students drop out.</td>
<td></td>
</tr>
<tr>
<td>4,388 babies are born to unmarried mothers.</td>
<td></td>
</tr>
<tr>
<td>12,816 public school students are suspended.</td>
<td></td>
</tr>
</tbody>
</table>

In 2015, the U.S. Department of Health and Human Services reported that about 3 million teens ages 12 to 17 had at least one major depressive episode in the past year. More than 2 million teens report experiencing depression that impairs their daily function. About 30% of girls and 20% of boys—totaling 6.3 million teens—have had an anxiety disorder, according to the National Institute of Mental Health.

Adding to these frightening statistics, a 2015 report compiled by the New Jersey Department of Children and Families found the number of suicides among children and young adults in New Jersey has increased by 40 percent since 2002. And it’s not just New Jersey. Teen suicide is climbing across the U.S., peaking at a rate of 8.5 out of 100,000 children and teens nationally.

The first study on the effects of adverse childhood experiences (ACEs) on adult health outcomes was published in 2006 by Dr. Vincent Felitti and Dr. Robert Anda. In this landmark study, Drs. Felitti and Anda documented the frequency of traumatic experiences during childhood for over 17,000 adults enrolled in the Kaiser Permanente health care system. Defying conventional belief, the data revealed a powerful relationship between emotional experiences as children and physical and mental health.

ACEs include 10 types of adversity that people can experience prior to their 18th birthday:

continued on next page
The cumulative number of ACEs in a person’s life is that person’s ACE score, meaning that the highest possible ACE score a person can receive is 10.

The original adverse childhood experiences study found that ACEs are extremely common. Sixty-seven percent of study participants had at least 1 ACE, while 12.6% had 4 or more ACEs. This idea of a composite total ACE score is critical to our understanding of how adversity impacts children and youth. Put simply, the higher the ACE score, the more likely a person will experience challenges in their life.4

Dr. Wendy Ellis and Bill Dietz’s recent research explores community environments where our children grow up and expands the concept of adversity to consider effects of living in environments where ACEs are all too common. While it seems obvious that our children and youth experience adversity in their individual family situations, Ellis and Dietz argue that adversity can also manifest itself in our communities. In their framework, symptoms of Adverse Community Environments include: poverty, discrimination, community disruption, violence, lack of opportunity or economic mobility and social capital, poor housing quality, and unaffordable housing. The Pair of ACEs tree depicts the relationship between family and community adversity:

The Pair of ACEs provides a deeper context of the possible levels of toxic stress in the lives of youth and their families. It is critical that our agencies, physicians, childcare workers, educators and other adults positioned to provide support for children be aware of the connection between adversity, toxic stress and trauma.5

For the sake of clarity, we can categorize two broad types of trauma: acute trauma and complex developmental trauma. Both can affect the children and youth we work with and support.

Acute trauma results from a single incident that overwhelms a child’s ability to cope. These single incidents can include things like being a victim of a crime, involvement in a serious accident, or any other serious event that triggers a stress response.

Children and youth growing up in environments with toxic levels of stress often have symptoms of complex developmental trauma. This is different than other types of trauma, and is associated with ongoing and persistent adversity in their lives. In Dr. Bessel Van der Kolk’s words, complex developmental trauma occurs when a young person experiences “multiple, chronic, and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature...and with early life onset.” Children who experience complex developmental trauma exhibit a more pronounced deficit in developmental brain-aligned stress response systems.

An increased awareness of ACEs has led the field and many school districts to become “trauma informed.” After working with troubled and troubling children and youth for forty years, it is exciting to be a part of this positive and encouraging movement. This shift requires school districts, and the adults within them, to change long-held beliefs about how we handle, correct, and discipline children and youth in our schools and classrooms. To transform our current practices, we must be able to see, feel, and think differently about our most challenging students who carry toxic stress and adversity into our schools.

continued on page 18
A young person growing up surrounded by trauma, unpredictability and toxic levels of stress will only be able to develop neural systems and functional capabilities that reflect this disorganization. According to Dr. Bruce Perry, a leading expert in childhood trauma, repeated and overwhelming stress sensitizes the brain’s amygdala and it becomes hyper-alert to danger. Even when no external threat is present these young people will be in a persistent state of alarm. This lack of or loss of the ability to regulate emotions is a defining characteristic of the far-reaching effects of trauma.

Becoming a trauma informed school or organization is not an event; it is a process. If we are to create schools and organizations able to respond to the needs of all the students, becoming aware of the impact of adversity on our young people’s ability to focus, learn and grow is a critical first step toward creating a trauma responsive environment.

References

“Fran is ever the optimist, with an uncanny ability to foresee and build bridges between people and their soaring accomplishments. We wish her the best of luck in her new adventures where she will continue to ‘be in the room where it happens.’”

Elliot Rubin

“It was the best of times. Your willingness to be the furthest out on the limb in efforts supporting children, Chapter members and your staff says it all. Your vision, creativity and unique leadership skills have and will continue to mold NJAAP for years to come. Thank you, Fran.”

Michael Weinstein

“I met Fran eight years ago. I was a relative newbie to the NJAAP but I immediately recognized the drive that Fran puts forth to advocate for the children of New Jersey. I knew at that moment that NJAAP was going to be my new home for organized medicine. Thanks Fran for your guidance and inspiration.”

Elliot Rubin

“Fran Gallagher has more energy and enthusiasm than anyone I know. While she was energized by networking, I tried not to be drained! I think I did get her to stop using the term networking, at least for the years I was in office. We will truly miss her!”

Meg Fisher

“Fran, I’m in awe of your leadership as you have pushed our team to be exceptional, converted mistakes into valuable lessons, advocate, collaborate, innovate and influence while never leaving out your human side. Thank you. You are not just a leader but an inspiration.”

Bethany Kondavaty
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The Digital Data Logger Project: Testing the Usability and Perceived Value of Advanced Features Beyond CDC Specifications

Jeanne Craft, MD, FAAP
Peter Cera
Jake Sathmary
Sharleen Van Vlijmen

Abstract

The proper storage of vaccines ensures that the efficacy of the vaccine does not deteriorate between the time it is produced to the time it is administered. Although work is being done to try and improve the temperature stability of vaccines, today they remain vulnerable to temperature fluctuations. Maintaining an appropriate thermal environment for storage is dependent on both appropriate storage equipment and close monitoring to detect changes in environmental temperature before they become a threat to the integrity of the vaccine. Digital Data Loggers have improved the ability of vaccine providers to continuously monitor storage temperatures and previous models have also provided local alerts when preset thresholds are exceeded. Newer models have incorporated remote, real-time alerting for temperature fluctuations outside defined thresholds. We tested 2 Digital Data Loggers for usability, one offering real time alerting through an imbedded SD card and cellular phone network (Berlinger Fridge-tag 3), the other offering real time alerting through a Wi-Fi internet connection (LogTag UTRED 30). Eighty-two participating practices completed the study. Participants tested their assigned devices for 3–6 weeks and then reported on their satisfaction with their use. Overall satisfaction was high for both Digital Data Loggers with over 80 percent of respondents indicating Satisfied or Very Satisfied for the device tested. Cellular connection proved to be a challenge for several of the practices testing the Berlinger Fridge-tag 3 device, despite using a Cellular Service Provider (AT&T) with >99% coverage for the state of New Jersey.

Introduction

In 1993 the Centers for Disease Control and Prevention (CDC) the Vaccines for Children (VFC) Program was part of the measles epidemic in 1989–1991 where investigation revealed that many of the affected children were unvaccinated due to their family’s inability to pay for the measles vaccine. Vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are purchased by the CDC and distributed to grantees. The grantees, including the New Jersey Department of Health (NJ DOH) are then responsible for overseeing the distribution, storage and handling, and administration of the vaccines through participating private and public practices.1 Qualified adults benefit in a similar fashion through the 317-Funded Adult (317) Program.

Monitoring and maintaining the integrity of the vaccines is essential to ensuring that the patients who receive vaccines are adequately protected. The cold-chain process prevents loss of vaccine efficacy due to excess heat or cold exposure. It starts at the point of manufacturing and continues until the vaccine is administered to the patient. The nature of an individual vaccine determines its tolerance to low temperatures and its tolerance to high temperatures. Although the individual vaccines vary in tolerance, recommended storage temperatures provide suitable environments for 2 major groups of vaccines, those stored in freezers and those stored in refrigerators. Tracing “vaccine failure” back to historical storage temperature of the vaccine can be difficult, but there is some suggestion that storage failure can lead to loss of protection for vaccinated children. A review of the literature by Hanson et al in 2017 found a report of an increased incidence of Hepatitis B in Mongolian infants born in the winter months suggesting the possibility of exposure of vaccine to extremely cold temperatures, and a report that found a higher incidence of pertussis in health regions of the US that had a higher reporting of refrigerators with freezing temperatures.

During April and May of 2011, The U.S. Department of Health and Human Service Office of the Inspector General (OIG) assessed the vaccine storage practices of 45 providers in 5 states and cities and issued a report on their findings in 2012. Based on a threshold of 5 hours of exposure to out of range temperatures over a 2-week period, they identified at least one incident over threshold in 76% of offices assessed.3 In their response to the OIG report, the CDC noted that exposure to temperatures higher than threshold may decrease effectiveness but does not make them less safe. They also reflected that although national monitoring was indicative of the overall effectiveness of current vaccination practices, “The vaccines that protect children against serious and even deadly diseases should always be stored properly.”4

In January of 2018, the CDC recommendation for use of Digital Data Loggers (DDLs) for continuous temperature monitoring of stored vaccines became a requirement for participation in the VFC Program. The CDC further delineated specific features for qualified DDLs and their use in managing the federally-funded vaccine supply. The NJ VFC Program incorporated this information in the VFC/317 Provider manual.5

A survey conducted by the New Jersey Chapter of the American Academy of Pediatrics (NJAAP) in 2018 highlighted some of the challenges that VFC participants face in monitoring their storage refrigerator and freezer temperatures, including monitoring and responding to alerts when the staff is not physically present.

continued on next page
In March of 2019 the NJAAP partnered with NJ DOH’s VFC Program to test the usability and perceived value of DDL with remote alerting of temperature related events, an advanced feature beyond the CDC specifications. This report summarizes the methodology and results of the Digital Data Logger Project.

Methodology

Project Team

The core project team included members from the NJAAP (Peter Cerra, Jake Sathmary, Sharleen Van Vlijmen and Jeanne Craft) and from the NJ DOH VFC program (Faith Borradaile)

Selection of the DDLs

Resources available from a variety of VFC programs were reviewed. Three candidate DDLs were selected based on remote alert capability, estimated cost, published user experience information, and review of the product website. The 3 vendors demonstrated their product via teleconference and the final 2 products were selected based on the criteria listed above.

The Berlinger Fridge-tag 3 has the ability to remotely alert designated staff to an out of range temperature through a cellular phone connection. The LogTag UTRED 30 uses a Wi-Fi connection to send alerts remotely to designated staff. Pricing, including the cellular or web subscription, for the 2 selected devices for the 2 products including the cellular or web subscription for the 2 selected devices was similar and negotiated as part of the participation of the vendors in the project.

Enrollment of Participants

Information about the project, an invitation to all VFC and/or 317 providers, and contact information for enrollment was posted on the New Jersey Immunization Information System (NJIIS) and NJAAP websites. In addition, a direct email campaign was conducted with email invitations sent to NJAAP members, non-member pediatricians in the NJAAP database, and VFC/317 providers. Previous participants in other NJAAP programs were also invited in an additional recruiting effort. All interested practices were asked to complete a short questionnaire which enabled the project team to confirm current VFC/317 participation.

Baseline Survey

Each qualifying participant was welcomed to the project and asked to complete a baseline survey that allowed them to describe their current office VFC/317 vaccine management process as well as their experience with their current DDL selection and use. Participants who failed to complete the baseline survey were contacted individually to encourage/assist in completion of the baseline survey.

Assignment and Distribution of DDLs

Each participating practice site tested one of the 2 test DDLs. Any practice already using one of them was automatically assigned to test the other one. Assignment was made as the participants were confirmed as current VFC providers and an effort was made to distribute the 2 test DDLs evenly across practice types. The respective lists were provided to each vendor, and the DDLs were sent directly from vendor to participant along with enclosed instructions on installation, connection to remote alert system (cell phone subscription or Wi-Fi connection to website), and vendor support contact information. The vendors reviewed their respective tester list following distribution and participants who had not yet linked to cellular or Wi-Fi/website for remote alerting were personally contacted by core project team and vendor support to assist in completing their installation.

Participants completing the program were invited to keep their test DDL. Participants who chose to withdraw from the project were supplied with mailing labels to allow them to return their DDL to the NJ VFC Program.

Training and Support

In preparation for the teleconference training sessions for participants, each vendor was asked to provide an education session to the core project team and additional NJAAP staff and DOH VFC Program staff. The sessions were a combination of face-to-face and teleconferencing. These sessions served to address outstanding questions about the DDLs, review project logistics, and finally to refine the planned training sessions for the participants.

Each vendor presented their training session twice over 2 days. Once at 0800 hr and once at 1200hr to accommodate the schedules of the participants. The core project team participated in these training sessions along with the vendor educators.

An additional teleconference call was held for each of the DDL groups midway through the project to address unresolved challenges and to encourage information sharing.

continued on page 22
Throughout the project, support was available from the vendors and the core project team. Each training session included resource links to CDC, NJ DOH VFC Program and vendor specific information.

End of Project Survey

At the end of the anticipated 4-6-week testing period, participants were asked to complete the final evaluation survey which queried the participants about their experience with their test DDL and their experience with participation in the project. Participants who failed to complete the survey by the requested date were contacted individually to encourage and assist them in completing the final survey.

Data Collection and Analysis

All survey responses were collected using SurveyMonkey. Responses were then downloaded into Microsoft Excel for qualitative and quantitative analysis. Results are descriptive. All satisfaction related questions used a 5-increment scale: Very dissatisfied, dissatisfied, neutral, satisfied and very satisfied. An additional “not applicable” choice was available, responses in this category were eliminated from the denominator when calculating the combined percentage of “Satisfied” and “Very Satisfied” responses.

Results

Participants

Ninety-four interested practices, public and private, were confirmed as active VFC providers, completed the baseline survey and were sent one of the two test DDLs, either the Berlinger Fridge-tag 3 (48 practices) or the LogTag UTRED 30 (45 practices). The practices were distributed across the state (see map). 73% self-identified as private, and included 58 pediatric, 7 family medicine and 2 hospital-based practices. The 27% who identified as public included 8 Federally Qualified Health Centers (FQHCs), 14 Public Health Departments and one public hospital. Three practices identified as other. 16 practices participate in both VFC and 317 programs. Sixty-two percent of practices reported that VFC/317 vaccines accounted for half or more of the vaccines administered in their practice.

Baseline Survey Results

Practices reported that the top considerations in selecting their current digital data logger were meeting CDC criteria (88%), Price (68%) and Data storage capability (62%). Only 23% reported Remote Alerting as an important consideration.

Respondents were asked about satisfaction with several features of their current DDLs. The percentage of respondents reporting they were either satisfied or very satisfied is reflected in Chart 1 on the following page. Of note, only half of the practices that rated their current satisfaction with remote alerting described themselves as satisfied or very satisfied.

More than half of the participating practices are currently using pharmaceutical grade (purpose built) refrigerators and/or freezers. Eighty-two percent of practices had an identified back-up storage site and 27% had a back-up generator in the event of a power outage.

All participating practices reported having a readily available emergency plan for VFC vaccine management, and all 56% who reported having had an excursion since January 2018 when the new CDC requirements went into effect had executed their emergency management plan. Several practices commented that they had executed their emergency management plan in anticipation of a possible threat to vaccine integrity.

End of Test Period Survey results

Eighty-two participants completed the final survey. Free text comment boxes allowed participants to add additional information beyond the more structured survey questions. Forty-three respondents tested the Berlinger Fridge-tag 3, and 39 tested the LogTag UTRED 30. 60% were able to test the DDL for 3 or more weeks.

Participants were asked about specific DDL features and asked to rate them on a 5-increment scale from very dissatisfied to very satisfied. The majority ranked all elements in the satisfied or very satisfied category for both of the tested DDLs. Chart 2 on the following page, reflects the comparative responses.
The start of the testing period was delayed for many respondents due to several challenges, primarily related to activating the remote alerting features which disproportionately affected those practices testing the Berlinger Fridge-Tag 3 DDL. Additional stated reasons for delay included unrelated internal office issues, delay in internal IT support, and lack of an available electrical outlet close to the storage refrigerator. Some respondents were able to resolve these issues quickly, and some experienced significant delay. Forty percent of the practices received a remote alert during the testing period and were able to comment on that experience. Four of the 82 respondents reported an excursion during the project time period.

More than half of the respondents plan to continue to use their test DDL going forward (Chart 3). Reasons for not continuing or being unsure included preference for a dual probe device, concern about ongoing fees related to the remote alerting feature, and connection challenges.

Although only 23% of respondents reported that remote alerting was an important consideration in choosing their current DDL, 78% of those who tested the Berlinger Fridge-tag 3 and 89% who tested the LogTag UTRED 30 indicated that they would consider advanced features such as remote alerting as important or very important when considering their next DDL acquisition. (Chart 4 on the following page)

The majority of respondents reported that they were either satisfied or very satisfied specific elements of the project. The difference between the 2 DDLs tested likely reflects challenges with activating the remote alert function that disproportionately affected the users of the Berlinger Fridge-Tag 3 DDL.
Several of the study participants did not realize that an additional step was required to activate the remote alert messaging feature of both DDLs (cell service for Berlinger Fridge-Tag 3 or website registration for the LogTag UTRED 30. This delayed the beginning of the testing period until those practices who the vendors were able to identify as “not yet activated” were individually contacted and coached through the activation steps.

An additional challenge was the failure of AT&T cell service connection in the location of some of the vaccine storage refrigerators. The reason for this is unclear since AT&T is reported to provide over 99% cellular coverage in New Jersey. Although there are unserved geographic pockets that may coincide with the practice locations that had difficulty, there may also have been dead zones related to location of the storage refrigerator within the practice building. The vendor offered substitution of AT&T with T-Mobile as the cellular service provider for those practices that were unable to connect with ATT. Due to the time constraints of this project, we do not have follow-up to see if the issue has resolved with the alternative cellular provider for all of the affected practices.

Practices who withdrew from the project reported time constraints related to instillation and training of a new device, and difficulty activating the remote alerting feature as challenges to participation.

A longer study period would be required to fully explore the impact of the remote alert capability on the incidence of temperature excursions and the ability to react before there is significant vaccine loss.

Successes, Challenges and Opportunities

The majority of the participants found value in the ability to receive remote alerts and are either planning to or considering continued use of the DDL they tested and now consider the remote alert feature an important option to consider during their next DDL acquisition. A few of the participating practices also used this opportunity to update their alert management plan and at least one improved the positioning of the data logger probe within their vaccine storage refrigerator.

Due to unexpected challenges, the data was suited for descriptive but not rigorous statistical analysis.

References:
Dr. Karen Leibowitz and Health Coaching Team At KAREBoost HEALTH
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Case Report: Constricting finger injury from a wire mixing ball

MaryBeth Mariano, MSN, RN, APN, CPNP
Audrey Hepburn Children’s House

Paulett Diah, MD, FAAP
Jennifer Romalin, MSN, RN, APN
The Joseph M. Sanzari Children’s Hospital
Hackensack University Medical Center

Abstract

Finger injuries are a common occurrence in young children and finger entrapment in objects has been reported in the medical literature. We present a case report of a two-year-old female who presented to a local emergency department with a constricting finger injury involving a coiled, wire protein shake mixing ball. The medical personnel caring for the child became concerned about the possibility of non-accidental injury and referred the case to a child abuse team. The child was ultimately diagnosed with an accidental injury. This case points out a new mechanism for accidental injury and raises the concern for additional safety measures to be implemented in the use of protein shaker mixer balls.

Introduction

Young children are curious by nature and use their hands to explore their environment. As such, finger injuries can occur. Finger fractures and crush injuries are common in pediatric population. There are previous published reports of finger entrapment in metallic rings, including sink plugholes and a door latch.

Recently, shake mixing bottles have gained popularity in the general population. These bottles contain a coiled, spiral wire mixing ball that is used to blend powdered shakes. The ball is easily removed from its bottle container for cleaning. The easy accessibility of these balls pose a possible new mechanism for finger injury among young children.

Case presentation

A 2-year old female was brought into a Pediatric Emergency Department (Peds ED) by her parents with a metal, partial circumferential, foreign body embedded in the right index finger. Upon presentation, the parents provided a history of hearing the child crying in her crib. Upon checking the patient, they observed that a wire shake mixing ball had become lodged on her finger. Numerous attempts to remove the child’s finger from the ball proved unsuccessful, resulting in her being brought to the pediatric emergency department. An additional attempt to remove the ball made by medical staff was also unsuccessful.

An X-ray of the right hand revealed a curvilinear, metallic foreign body within the soft tissues of the second digit at the level of the proximal interpharyngeal (PIP) joint (Figure 1). A small underlying fracture could not be excluded. Concern was raised by the medical staff regarding the possibility of non-accidental injury.

Figure 1 Curvilinear, metallic foreign body within the soft tissues of the second digit at the level of the proximal interpharyngeal (PIP) joint.

Management and Outcome

Following consultation with a hand surgeon, the child was taken to the operating room for surgical removal of the foreign body. During the surgery, it was discovered that the circumferential placement of the wire ball was constricting the tendon, bones and blood vessels. A call to child protective services was made and consultation was provided by the hospital’s child abuse team. A skeletal survey x-ray was obtained, which revealed a mild bilateral hip dysplasia and no fractures.

The child abuse team concluded the injury was accidental. Post-operatively, the child was doing well and expected to recover without sequelae.

Discussion

To this author’s knowledge, injuries from wire shaker balls have not been previously reported in the medical literature. In our case, the limited history provided by the parents did not fully explain this injury, prompting consideration of non-accidental injury and subsequent referral to the child abuse team. Due to the small size and shape of the wire ball, children may mistake this object for a toy. This highlights the need for proper warning labels and increased public awareness of the dangers of wire shaker balls.

Conclusion

New products sometimes emerge on the market that may pose safety risks to young children. When injuries occur involving such products, the developmental stage of the child, the history provided, and the features of the product must carefully be considered to determine the etiology of the injury.

References:


Breakfast After the Bell: Fighting Food Insecurity

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Case Report: A Cry for Help – Evaluating and Managing Post-Traumatic Stress Disorder in Adolescents

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Abstract

Post-traumatic stress disorder (PTSD), originally identified in adults, is being increasingly reported in children and adolescents following traumatic events. While awareness of this disorder is improving, driven largely by the use of assistive tools such as the Adverse Childhood Experiences (ACEs) questionnaire, limited epidemiological studies and lack of evidence assessing response to therapy make diagnosing and treating the disorder challenging. In New Jersey, the Pediatric Psychiatry Collaborative (PPC) was established to improve access to mental and behavioral health care in this vulnerable population. Through proper utilization of this invaluable resource, more children with PTSD and other debilitating psychiatric diagnoses are receiving more appropriate and timely care.

Introduction

Post-traumatic stress disorder (PTSD) was first listed as a psychiatric diagnosis in the Diagnostic and Statistical Manual of Mental Disorders Third Edition (DSM-III) in response to symptoms identified in veterans of the Vietnam war. Similar symptoms have been identified in the pediatric population, with some studies citing incidence rates as high as 60% depending on the trauma suffered.1 Various community studies have cited prevalence rates between 2 to 9.2%.2 While no population-based epidemiological studies have focused on the prevalence in adolescents among the general population, these community studies suggest that PTSD is a diagnosis affecting a significant portion of youth. In a society where technology can allow traumatic exposures to occur at a moment’s notice, general practitioners and mental health professionals alike need to be aware of the symptoms of PTSD and the resources available for its management.

The Pediatric Psychiatry Collaborative (PPC) is a grant-funded program piloted in 2015 in New Jersey to improve access to mental health services for children and adolescents. Being a referral-based program, the PPC relies on general practitioners to screen for and identify mental health problems in their patients. Once identified, information regarding the patient and the results of the appropriate mental health screening tool is sent to a regional hub in the state. From there, a case manager reviews the information and contacts the guardians, conducting an intake and assisting with obtaining appropriate, timely psychiatric resources for the patient.

The following is a case presentation of a patient who obtained psychiatric services through referral to and utilization of the PPC in New Jersey.

Case Presentation

A 13-year-old female with previously diagnosed PTSD went to her pediatrician for her routine well-child care appointment. Her mother was concerned that her daughter was becoming increasingly withdrawn and that her performance at school was suffering. When questioned about why she was feeling this way, the patient asked her mother to share the details with the pediatrician.

The mother reported that the events leading to the patient’s current status began one year prior to the visit. At that time, the patient’s maternal aunt had just returned from a tour of duty in Iraq. The aunt’s job was to retrieve the dead bodies of soldiers and tag them for return to the United States. The aunt had difficulty coping with this assignment and when she arrived back in the United States, she resorted to drugs and alcohol and ultimately ended up homeless. Upon learning of this, the mother invited the aunt to stay in their home to help her get back on her feet.

While in the house with the mother and patient, the aunt continued to use drugs and alcohol, becoming increasingly more troubled and isolated. One afternoon, the patient heard the aunt’s dogs barking and she went into the aunt’s room to check on them. Upon entering the room, the patient discovered the aunt had committed suicide by strangulation.

Following the discovery, the daughter was diagnosed with PTSD and subsequently referred to counseling. However, she was not ready to share her feelings with her counselor and also needed other services. Additionally, she was not taking medication previously prescribed.

At the well-child visit, the patient was observed to be walking around the room aimlessly, touching the various equipment. She would stop and stare when asked a question, rarely responding to what was being said. She did say, however, that she remembered the events that took place but did not want to talk about them. The pediatrician recommended the patient begin journaling to express her feelings, a suggestion to which the patient responded positively.

The patient also completed the Pediatric Symptom Checklist–Youth screening form (PSC-Y) with a score of 37. Based on this score as well as the patient exam and parent’s concerns, she was referred to the PPC for assistance in obtaining psychiatric support and resources.

Discussion

In 2013, the DSM-V established new criteria for the diagnosis of PTSD. These include exposure to a stressor that is persistently re-experienced, avoiding stimuli associated with the stressor, negative alterations in mood and behavior, and functional impairment for greater than one month that cannot be attributed to substance abuse or other illness.3 Our patient previously met the criteria for the diagnosis of PTSD and presented following initial treatment failure.

Treatment for a child diagnosed with PTSD involves ensuring the safety of the child and limiting the exposure of the inciting event. It is crucial that treatment include:

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psychotherapy for the child, support for the caregivers, and support for the patient in other environments, including school and work. While pharmacotherapy was attempted in our patient, it is not necessarily a first-line treatment as more success has been shown with psychotherapy.

On initial intake, it was discovered that the family had previously sought help through their county’s care management organization and had exhausted nearly all their resources. Through the PPC, the patient obtained a referral to a community mental health center that could provide psychiatric resources, diagnostic clarification, and medication monitoring, all with a short waitlist.

In the interim, the patient was encouraged to continue journaling. The pediatrician asked the mother to get colored pencils and markers for the patient so she could draw when she did not want to write. The patient was asked to follow-up and leaf through the journal in front of the pediatrician to ensure she was journaling while maintaining her privacy.

**Conclusion**

One month following the referral, and accounting for some minor delays due to missed follow-up with the primary care provider, the patient started receiving outpatient psychiatric services. On follow-up with the mother regarding the patient’s status, the mother stated that the patient was ‘doing well’ and that through the PPC, the entire family was receiving services.

This case not only highlights the ability of the PPC to find timely psychiatric resources for patients in need, but also demonstrates how useful the PPC is for patients receiving counseling or other psychiatric services that are not meeting their specific needs. We are proud to be a part of this collaborative and hope that through sharing this case, many more children are able to find the help they need through the PPC.

**References**


**Additional PTSD resources**


The National Council for Behavioral Health: https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/?gclid=EAIaIQobChMI84Lrk9v94wIVi4zICh2ugQfIEAAYAiAAEgLXvD_BwE

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"Your leadership and words of encouragement mean a lot to me. I’m very grateful for the opportunities you have given me. Thank you once again for all your support! ”

Stacy Israil

"Fran has been a model in showing us how to build collaborative relationships and how to have faith in others. She has great confidence in her staff and always looks to inspire people, reminding us of the “why” in what we do. She shares her vision for the Chapter, inspiring staff to look ahead and see the bigger picture.”

Marcela Betzer

"I am infinitely grateful for Fran’s hard work at NJAAP for these past years. Fran has shown me strong leadership, supported me, and encouraged me to grow. At the end of the day, Fran has been a very positive and warm figure for me at NJAAP. I am very sorry to see her go, for she will be dearly missed”.

Irina Cherpnina

"Fran, Thank you for helping me to become mature in the role of Program Director for Oral Health. You have taught me a lot. Thank you.

Having worked under a great professional like you was a lifetime opportunity. On your farewell, I would like to tell you that you have left a legacy that would be cherished for years to come. May you succeed in your endeavors.”

Juliana David
Improving behavioral health and communication skills of pediatric residents remains an important focus in medical education. In this paper, we present a preliminary evaluation of two novel standardized patient (SP) training experiences in which PGY-1 residents observed and practiced behavioral health/communication skills within a group format, and facilitated by an interdisciplinary team. Two separate trainings (“Working with a Challenging Patient” and “Breaking Bad News”) were implemented at the beginning of the residency training year during intern orientation and retreat. Post-intervention surveys demonstrated that the trainings were received favorably by residents and were considered relevant and realistic learning opportunities. The outcomes from this pilot project suggest that group SP trainings for behavioral health and communication skills may be a promising option for pediatric residency training programs.

Keywords: standardized patients, behavioral health, medical education

1. Introduction

Training experiences in behavioral health/communication skills are generally considered inadequate by pediatric residents.1,2 Curriculum development in this area is essential to improve experiences on rotation and appropriately prepare residents to meet the needs of children and families.3,4 Given this need, the pediatric residency program at Geisinger Medical Center has prioritized continuous development of behavioral health training experiences for residents, particularly through partnership with pediatric psychology and medical education staff. The outcome of this collaboration is to promote feasible, acceptable, and effective training experiences in behavioral health and communication skills.

This paper describes a recent project that involved the use of three standardized patient (SP) encounters implemented within a group format (i.e., “fishbowl” method)5 and with an interdisciplinary team focused on behavioral health and communication skills. We assessed acceptability and other learner outcomes post-training and used these data to enhance the quality and content of our curriculum.

2. Method

The trainings described below were considered a part of the typical educational curriculum at our institution. IRB approval was obtained to deliver post-training surveys and to analyze the data.

2.1 Participants

PGY-1 pediatric, combined internal medicine/pediatric residents, and preliminary pediatric residents were invited to participate in this project. All trainings were conducted at the beginning of the training year, during intern orientation (n = 11 residents; Training One) and intern retreat (n = 16 residents; Training Two). While attendance at these trainings were required for those who were available, the completion of the post-intervention survey was voluntary. Most residents completed both trainings.

2.2 Trainings

Three scenarios (which were divided into two trainings) were developed based upon perceived needs of residents and relevance to practice: “Working with a Challenging Patient” (i.e., a teenager abusing marijuana) and “Breaking Bad News” (i.e., a potential Down Syndrome [Trisomy 21] diagnosis and a child’s death). The Standardized Patient Training Center created the script and recruited/trained actors to play their roles. The group-based approach was chosen in order to decrease resource and time burden, while also fostering a realistic experience that required active participation. Two of the scenarios were previously implemented with medical trainees with success.6 The current project represents an improvement in our previous methodology and post-assessment. Specifically, two different types of group-based trainings were piloted and assessed: one involving role plays with standardized patients (SPs) by content matter experts with resident feedback/participation and the other utilizing a typical fishbowl method of training,7 with residents briefly practicing skills and peer observation/feedback. Further, the trainings were conducted during intern orientation and intern retreat, which allowed for lengthier training sessions and the ability to utilize several members of the training team who were made available in advance of the trainings.

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The first training ("Working with a Challenging Patient") began with a lecture/discussion on basic Motivational Interviewing (MI) skills led by two pediatric psychology postdoctoral fellows and a general pediatrician. The didactic portion of the training lasted approximately 60 minutes and covered 4 key topics in MI/communication skills: open-ended questioning, responding to resistance via reflections, developing discrepancies, and evaluating commitment or willingness to change.

The active learning portion of the training lasted approximately 60 minutes and began with 2 role plays modeled by the psychology fellows. The first encounter modeled poor use of skills (e.g., providing solutions prematurely or unsolicited, expressing disappointment) while the second modeled more appropriate skills (e.g., taking a neutral stance, expressing empathy through reflective listening). Residents were encouraged to provide feedback during and after the role plays. Following this, they were given the opportunity to role play with their peers, choosing one of five predetermined topics (i.e., parent who is reluctant to vaccinate, teenager who struggles to take birth control, mother who refuses for psychology to see her child, or one's own behavior change). During this time, the psychology fellows and pediatrician provided feedback to residents on application of skills. The expert role plays and resident role plays lasted approximately 30 minutes each.

The second training ("Breaking Bad News") involved two SP scenarios focused on communicating bad news to parents (a Trisomy 21 diagnosis and child's death, respectively) and lasted a little over 2 hours. A brief discussion regarding breaking difficult news was led by a palliative care PICU physician prior to the SP encounters (~10 minutes). The residents were then randomly divided to complete each SP encounter in a small group setting (~8 residents per group). Each group completed both SP scenarios, lasting approximately 1 hour each.

In order to facilitate active learning, residents were asked to volunteer to interview the SP briefly (~2 minutes), then the group would pause to discuss and provide feedback to the resident or complete a "do over". Feedback by faculty was modeled using the ARTful approach ("Ask, Respond, Tell"). There was an attempt to give every resident a chance to briefly interact with the SP across the two encounters. Typically residents would pick up where their peer left off in order to reduce repetition and to allow the encounter to progress. Discussions/feedback was facilitated by a psychologist, general pediatrician, and PICU physician in the Trisomy 21 case and by a general pediatric hospitalist, a PICU palliative care physician, and a communication educator for the child death case.

2.3 Measures

An 11-item post-intervention survey was developed by the training team to assess acceptability of the trainings and preliminary learner outcomes (see Table 1 on the following page). Item 1 asked participants to indicate their level of training (in this particular project, all were PGY-1 residents). Items 2-8 assessed satisfaction with the training, real-world applicability, and confidence in using skills using a Likert-type response format (1 = strongly disagree to 6 = strongly agree). Items 9-11 assessed strengths, weaknesses, and future directions of the trainings in an open-ended format. The post-intervention survey was administered immediately following each training session. This survey was developed solely to evaluate the training and has not been empirically evaluated.

3. Procedure

3.1 Data collection

Data was collected at two group-based standardized patient trainings at the beginning of the residency training year. Survey administration occurred at the end of each training session. Prior to administering the post-intervention survey, training staff verbally informed residents that completion of the survey is a part of a research project and that their participation is voluntary. They were also told that results of the survey are anonymous and have no impact on their training. Completion of the survey served as the residents’ implied consent to participate in the evaluation portion of the training.

3.2 Data analysis

Basic descriptive statistics (i.e., mean, standard deviations, and range) were calculated for items 2-8 (see Table 1). A content analysis was completed by two members of the training team for items 9-11. Answers to these items were coded independently for themes and responses were compared and reviewed for concordance.

4. Results

Eleven residents completed the survey after the first training, while 16 completed after the second. Likert-type items suggested overall positive ratings for both trainings (see Table 1). With the exception of item 7 (confidence in utilizing skills), Training Two ("Breaking Bad News") appeared to have relatively higher ratings. However, there was more variability in response to the second training, particularly related to its perceived benefits and relevance (range 1-6).
The relatively lowest rated item for “Working with a Challenging Patient” (Training One) related to sufficient time to participate in the learning experience. This is not surprising, given that a large portion of the training was devoted to didactics (60 minutes) and observing role plays (30 minutes). In contrast, the relatively lowest item for “Breaking Bad News” (Training Two) was confidence in applying skills post-training. Again, this appears related to the content of the training in that the skill of breaking difficult news to a parent (particularly death or a noteworthy diagnosis) likely requires more training and experience to obtain mastery and confidence.

Themes from open-ended items are presented in Table 1. Pertinent to this project, several strengths appear related to the group experience (e.g., taking a collective approach, getting feedback from others). Residents also appreciated the ability to contrast two (good versus bad) encounters in the first training and the cooperative/incremental approach in the second. However, residents did report more role play time as an improvement for Training One (“Working with a Challenging Patient”). Further, having individual or smaller group formats and more individual feedback were given as improvements for Training Two (“Breaking Bad News”). Suggestions for future cases were varied including parents against vaccinations, abuse, upset patients, and chronic cases.

5. Discussion

Group standardized patient training sessions implemented with PGY-1 residents were received favorably. Despite the group format, residents generally reported that they could actively participate in the training and that the scenarios were realistic and relevant to their work. Of particular relevance is confidence in utilizing skills post-training. The relatively lower scores on this item across the trainings (and particularly in the “Breaking Bad News” scenario) suggest we may have been modestly helpful in this domain. A weakness of our data collection pertains to objective assessment of knowledge gained and generalizability of skills (i.e., training outcomes).

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Open-ended themes pointed out several strengths of the training, several of which are related to the group format. However, at the same time, several residents requested smaller group/individual training experiences as a way to improve our training suggesting that there were perceived weaknesses of this approach as well. Smaller learning groups may be preferable for more practice and individualized feedback.

From a medical educator’s point of view, we reflected that the time and resources involved were modest and appropriate for a busy training clinic, while not requiring an overhaul of the curriculum. The implementation during intern orientation and retreat allowed us to deliver a lengthier training with most residents available. It also allowed us to plan ahead to recruit an interdisciplinary faculty where appropriate (e.g., psychology, PICU). The interdisciplinary aspect of the training was particularly favorable, as residents learned skills from a range of professionals across the patient care spectrum.

6. Conclusion

This project assessed learner experiences from group standardized patient trainings as a first step in curriculum development. More rigorous methodology is needed to assess learner outcomes, among other variables of interest. However, given calls to promote behavioral health/communication training in residents1,3 and an increased emphasis on interdisciplinary training experiences,4,8 this project is an example of a feasible option which promotes active learning with diverse professional involvement.

References


“Thank you for all that you have done, not only to help New Jersey’s children and the agency, but for all that you have taught me over the past 2 years. You saw my potential and constantly pushed me to be better. On top of that, I have never felt so appreciated at a job. NJAAP feels more like a community and a family than a place of work and that all begins with your leadership. I could not have asked for a better mentor and friend!”

Kyle Shupp

“I will always be grateful to Fran for giving me the opportunity to enter the healthcare field and the times her vision inspired me to see my potential in new and surprising ways.”

Michael Stec

“Fran -- The impact you have had on this Chapter and the children of New Jersey is immeasurable. We are all so lucky to have had the opportunity to work with, learn from, and grow alongside you during your tenure as CEO. Thank you for tireless efforts to support our NJAAP team and always leading by example. You will be sincerely missed. Wishing you much success as you embark upon this new chapter!”

Brittany Johnson
Legal Update: New State Laws Highlight the Importance of Pediatric Mental Health

Guillermo J. Beades, Esq.
Frier Levit Attorneys at Law

This month, Governor Murphy signed two legislations that highlighting the importance of taking into consideration the mental well-being of children. The two legislations, S2861 and S3160, aim to create an environment where mental health is better understood and openly discussed, while launching a pilot program that would allow students to be well-rested to tackle demanding school days.

S2861 will require the State Board of Education to review and update the New Jersey Student Learning Standards in Comprehensive Health and Physical Education to ensure that mental health education is incorporated in curriculums for students aged K through 12. While the curriculums will be "age-appropriate," Gov. Murphy has stated that the goal is to ensure "that children in grades K through 12 learn about mental health [in order to] promote a healthier future for New Jersey."

Meanwhile, S3160 seeks to shift school start times so that students do not wake up as early as they currently do in an effort to improve their ability to learn. Gov. Murphy stated recently that "academic progress may be negatively impacted by starting school too early. By testing the viability of changing start times, we are exploring ways to improve learning outcomes for New Jersey students." The hurdle currently in place is that Boards of Education are unsure how the delayed start times will affect districts overall, including how extracurricular activities may be impacted and how transportation to and from school would be affected.

To learn more about the potential implementation issues, there is currently a Pilot Program in place to that will start this year. Commissioner of Education Lamont Repollet will select five school districts to participate in the pilot program. Those school districts must include urban, suburban, and rural areas of the state.

With a legislative focus on mental health, how should pediatricians respond and what legal issues are likely to arise? The American Academy of Pediatrics ("AAP") has stressed for years the importance of routine well-visits to ensure the physical well-being of patients. However, in recent years, there has been increased focus and attention to treating the "whole patient," which includes mental health. As mental health becomes a more openly discussed topic and no longer a "touchy issue" to discuss with patients and parents, pediatricians must adapt to these societal changes and be ready to address these issues head-on.

Legally, pediatricians are likely to be held accountable for failures to diagnose and/or failures to act in cases where a child exhibits mental health issues but no treatment is rendered and/or no referral is made to a specialist. Also, if a pediatrician starts performing mental health assessments/tests and begins using CPT Codes not historically used by pediatricians, it will likely result in scrutiny from payors (e.g., audits).

While no one can forecast the future, it is clear that pediatric mental health is an issue in New Jersey that is likely to gain more attention in the months and years to come.
This November, the Assembly is running for re-election, so we expect a slower than usual Legislature calendar until after the November election. We are pleased to report that the budget passed by the Legislature and signed by Governor Murphy contained $5 million in additional funding for the statewide expansion of the mental health collaborative which had been operating as a pilot program to address pediatric behavioral health issues and are optimistic that the Legislature’s budget bill will include this funding.

We reported in the previous issue that representatives of AAP testified at a hearing of the Assembly Women and Children’s Committee in support of A4218/S2691 which will appropriate $100,000 to the Commission on Human Trafficking, in the Division of Criminal Justice in the Department of Law and Public Safety. We are pleased to report that Governor Murphy signed this legislation on August 23, 2019.

Governor Murphy also signed legislation, S3160, that establishes a four-year pilot program in the Department of Education on later school start times for high school students. The purpose of the program is to implement later school start times for high school students in selected school districts and to study the issues, benefits, and options for instituting a later start time to the school day for high school students. The pilot program will: implement the recommendations of the American Academy of Pediatrics on the establishment of later school start times; include an assessment of the health, academic, and safety benefits associated with establishing later start times in high schools; and evaluate any potential negative impacts on school districts and families that may be associated with a later school start time, including issues related to transportation and after-school activities such as athletics, clubs, and other extracurricular activities, and consider strategies for addressing potential problems.

Last month we also reported on a package of bills moving through the Legislature, with the support of Governor Murphy, that will put into state law many of the health care reforms from the federal 2010 Affordable Care Act. They will also authorize the Department of Banking and Insurance to establish, operate, and fund a state-based exchange for Medicaid and other health benefits plans. Governor Murphy signed the legislation, A5499/S3807 authorizing DOBI to establish a State-based exchange for certain health benefits plans.

The remainder of the package, including S562/A5248 which preserves the requirement that health insurance plans cover essential health benefits, S626/A1733 which clarifies the prohibition on preexisting condition exclusions in health insurance policies, A5501/S3802 which requires continuation of health benefits dependent coverage until child turns 26 years of age, A5507/S3803 which requires health benefits coverage for certain preventive services and A5509/S3805 which requires health benefits coverage for breastfeeding support, will likely be considered in the Legislature’s lame duck session in November and December.

We also expect the Legislature to consider S484 which revises the State’s newborn screening program for congenital disorders by requiring the Commissioner of Health to establish a Newborn Screening Advisory Review Committee, consisting of medical, hospital, and public health professionals, scientific experts and consumer representatives, which would be authorized to make recommendations on the disorders to be screened for by the department, as well as on screening technologies, treatment options, and educational and follow-up procedures, to be used in the State’s newborn screening program. The bill requires that the committee meet annually to review and revise the list of disorders that are recommended for inclusion in the program. The bill also makes several other changes to the program, including formally designating it as the “Newborn Screening” program.

Finally, it is our goal to have the Legislature consider legislation, A3818, that will provide for solely medical exemptions to mandatory immunizations. Securing passage of this bill will require a significant grass roots effort on the part of NJAAP, its members and their patients, and continuation of efforts advocating for passage of this bill. Those who oppose the bill are vocal and have a sustained effort to persuade legislators that passage of the bill will violate their religious freedoms.
Manish Majithia CPA PC
Certified Public Accountants

Manish has been practicing accounting and taxation since 1994, 25 years now! His extensive experience affords him the ability of providing value added services to his clients. The wide range of clients that he serves include physicians, home healthcare agencies, ambulatory surgery centers, dialysis units, imaging centers, cancer centers, etc. He is also accountant to lots of non-profits and medical associations.

Manish assists clients with issues concerning operations of their practice, purchase or sale of practices, practice valuations, exit strategy formulation, cost reduction analysis for the clients, etc.

With the kind of experience and expertise that Manish has, with the kind of clientele that he caters, he has been able to truly contribute towards catering and streamlining the accounting and taxation needs for all his clients in a major way and has been able to help them save a lot of taxes, legitimately. With premium service, he exactly knows what they need to do not only for their taxes, but also with regards to their asset protection, estate planning, retirement planning etc. He also has extensive knowledge and experience with international accounting, foreign bank account reporting, foreign income and tax reporting, captive risk management strategies, etc.

After graduating with a major in Auditing and Financial Accounting, Manish went ahead to become a Cost Accountant. He was a Professor teaching Accounting, Auditing and Taxation to graduate students. He then pursued his career as a CPA.

He operates out of offices in Garden City (Long Island) and Brick (South New Jersey).
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PRESENTS

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Questions? Email: MHC@njaap.org or Call: (609) 842-0014

Funding for this program has been provided by the New Jersey Department of Children and Families
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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U4CMC32317 Pediatric Mental Health Care Access Program for an award amount of $445,000 with an additional 20% match provided by The Nicholson Foundation. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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