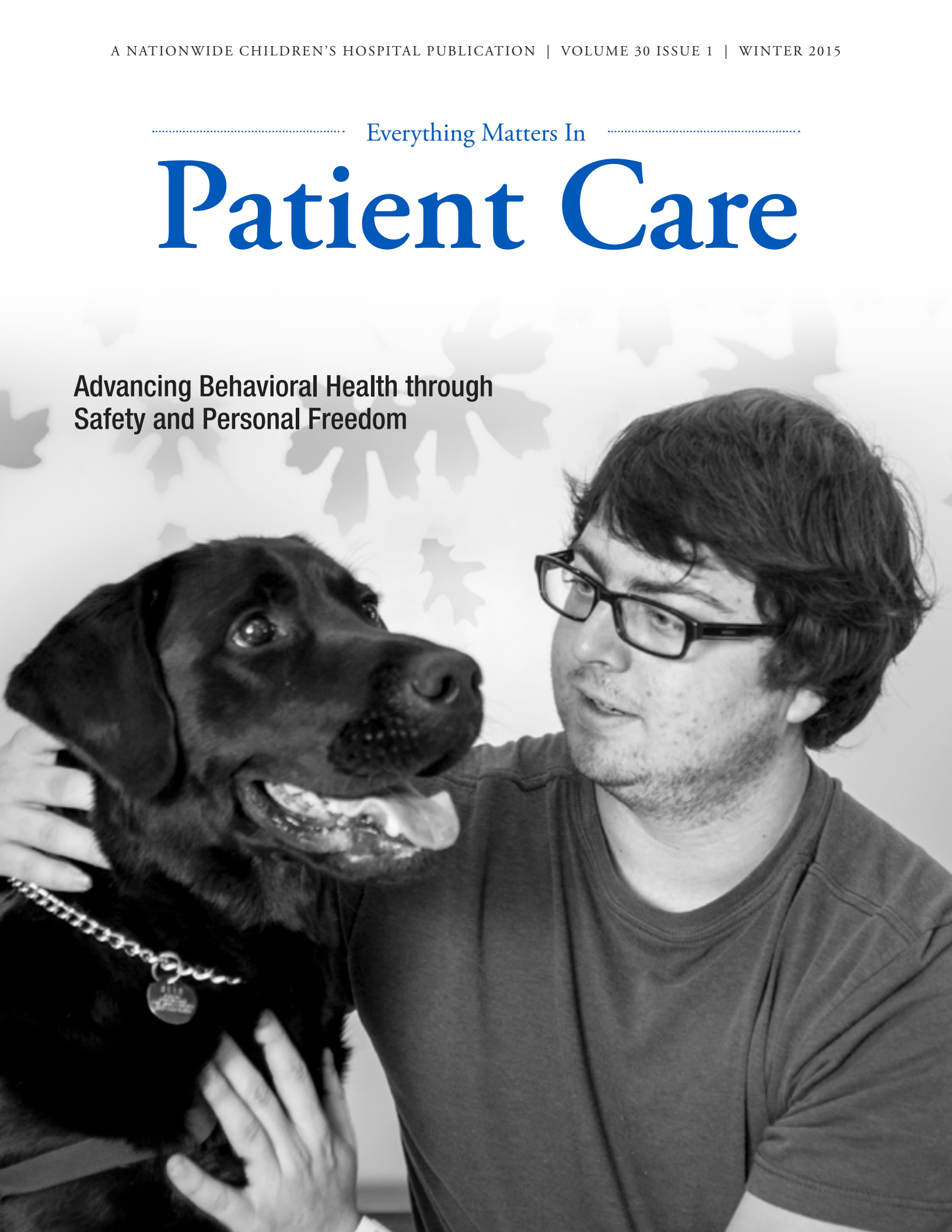
A NATIONWIDE CHILDREN'S HOSPITAL PUBLICATION | VOLUME 30 ISSUE 1 | WINTER 2015

Everything Matters In

Patient Care

Advancing Behavioral Health through Safety and Personal Freedom



Hud, a medical dog, is one of many therapies available to patients.

Contents

Feature

Articles

Editorial Staff:

Editor: Charline Catt | **Managing Editor**: Marcie Rehmar | **Editorial Board:** Adeline Cursio, Margaret Carey, Cindy Iske, Hollie Johnson, Jenna Merandi, Paul Seese, Nanette Spence, Sherri Watts, Danielle Worthington | **Editorial Assistant:** Nancy Denney | **Editorial Support:** Kim Dwyer
Photography: Brad Smith and Dan Smith | **Art Director and Designer:** Lindsey Tobin

Pictured left: Recreational Therapist Ashley Tuisku encourages a patient to work with Hud

2014 Journey to Best Outcomes

Linda Stoverock DNP, RN, NEA-BC,
Senior Vice President, Patient Care Services, Chief Nursing Officer

As 2014 comes to an end, we can look back and celebrate many milestones along the way on our Journey to Best Outcomes.

The year started with a huge team effort to complete our Magnet document by February 1. It was a joy to read the many improvements in care. Nurses changed practice and reduced hospital days for our very complex patients. Initiatives included better coordination of care for patients with gastrostomy tubes and tracheotomy tubes. Our Ambulatory nurses exemplified their efforts to standardize education, competencies and care through the work of their shared governance structure. Our BSN rate continues to climb toward our 2020 goal of 80%. We celebrated many colleagues completing their RN to BSN program along with advanced nursing and business degrees. This is important to continue our efforts to improve the use of evidence for practice.

As 2014 comes to an end, we can look back and celebrate many milestones along the way on our Journey to Best Outcomes.

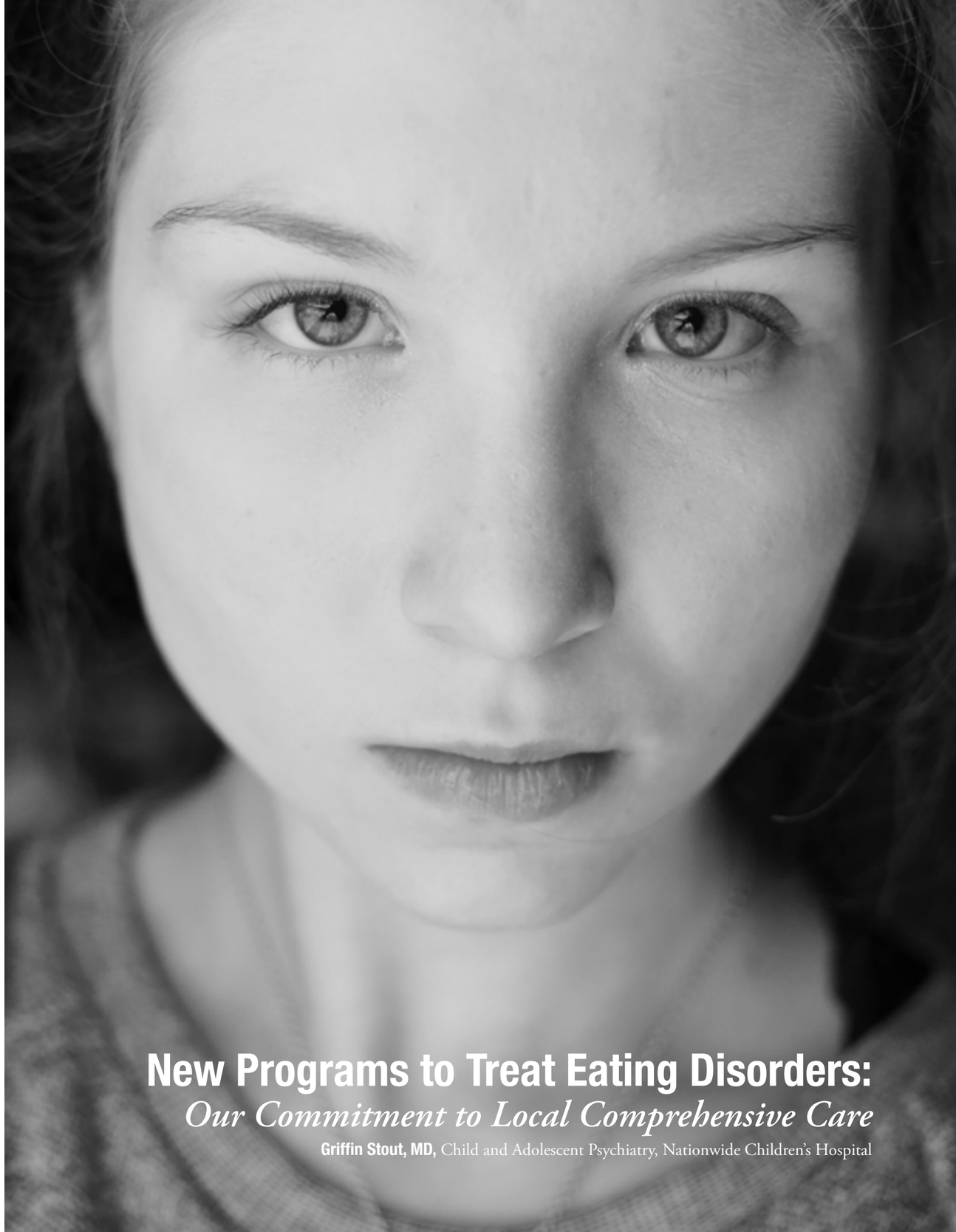
Leadership among our nursing staff improved neonatal care to include better care for micro preemies. Neonatal services have had a record year of infant admission across all campuses. We welcomed our colleagues at The Ohio State University Wexner Neonatal Intensive Care Unit to the Nationwide Children's Hospital family of neonatal units. Together, these units continue to strive for the best care with standardize practices through national collaboratives and regional conferences.

Together we continue our journey toward reducing preventable harm. The interdisciplinary team has improved compliance with our bundle of skin care. Our prevalence data show marked improvement for early detection and intervention in pressure injuries. The H8 Pediatric Intensive Care Unit celebrated a full year without a central line acquired blood stream infection. As we are working to reduce harm, we recognize the toll it takes on staff when harm does occur, so the You Matter second victim program was launched to recognize and help those who may be impacted negatively by an event. The program is successful because of the volunteers' willing to take on the role of peer mentor. Thanks to all.

In order to provide the best care, Nationwide Children's has recognized a need for more services to reduce harm for employees while providing care. Our training for employee safety was completed resulting in the establishment of teams of staff with foci on the reduction of needle sticks, back injuries, falls and injury from violent patients/families.

Recognizing the growing need for better acute mental health care for patients, Behavioral Health Services launched new teams of providers in the emergency department. In 2015, we still have to continue to strive to integrate mental health care with the physical health of our patients.

With so many teams working together for constant improvement, it is no wonder our Magnet surveyors had no trouble validating, verifying and amplifying nursing practice at Nationwide Children's for Magnet re-designation! The teams of care providers at Nationwide Children's are the best. I wish you and your family wellness and peace in the New Year.



New Programs to Treat Eating Disorders:

Our Commitment to Local Comprehensive Care

Griffin Stout, MD, Child and Adolescent Psychiatry, Nationwide Children's Hospital

Eating disorders are highly stigmatized and a poorly understood problem facing our adolescent population.

Quality of life has consistently been reported as very low among those with eating disorders and patients with anorexia nervosa have the highest mortality rate of any psychiatric disorder.

Eating disorders are highly stigmatized and a poorly understood problem facing our adolescent population. Symptoms often are hidden from parents, coaches, doctors and friends. The media sends messages that prioritize thinness above other measures of beauty and success. The general public does not understand the distress associated with struggling with an eating disorder. In comparison to depressed individuals, the general population is more likely to see clients struggling with eating disorders as "responsible" for their disorder and more attention seeking. Quality of life has consistently been reported as very low among those with eating disorders and patients with anorexia nervosa (AN) have the highest mortality rate of any psychiatric disorder. Risk of premature death is six to 12 times higher in this population versus the general population. Up to one-third of deaths in this population are due to suicide. However, recovery from an eating disorder is possible if the patient and parents are fully motivated. Nationwide Children's Hospital (NCH) has made a commitment to treat children and adolescents struggling with eating disorders.

Several years ago, treatment at NCH consisted of a medical doctor, nurse, nutritionist and therapist seeing patients in an outpatient clinic. Many families were successfully treated. However, it was common with severe cases to recommend out-of-state residential facilities because higher levels of care for eating disorders were not available locally. Adolescent Medicine and Behavioral Health spearheaded a plan to provide care for all children and adolescents struggling with an eating disorder. In January 2014, the Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) opened at 500 E. Main Street. New referrals are assessed, triaged and treated through all levels of care.

The multidisciplinary team includes therapists, medical doctors, nurses, nutritionists, psychiatrists, occupational therapists, massage therapists, an education coordinator and chefs who work collaboratively to ensure the highest probability of success. The PHP patients are present at the clinic for approximately 40 hours per week which includes six days per week for typically four to six weeks. Programming consists of therapeutic groups, meals and snacks based on the patient's individually developed meal plan, individual and family therapy sessions and medical and psychiatric appointments. During this time, the patient is removed from school, and one hour per day of school time is provided for patients to work with our education coordinator, a state of Ohio certified teacher. The main goals of PHP include weight restoration, teaching families the basics of Family Based Therapy (FBT) as well as addressing many of the distorted thoughts and behaviors associated with the eating disorder.

Once PHP is completed, patients step down to IOP, alternatively the team may recommend IOP directly from assessment. The IOP consists of approximately 20 hours per week, four days per week for six to eight weeks. Programming continues with psychotherapy groups, motor groups, nutrition groups and one meal per programming day. Outside of this programming, patients are seen for medical, nutrition and psychiatry appointments as well as family and individual therapy sessions. Main goals for IOP include further weight restoration, support of parents and challenging of eating disorder thoughts and behaviors as well as reintegration into school and home. Outpatient therapy consists of therapy, medical, psychiatric and nutritional follow up as needed. Once the patient is nutritionally restored and is able to identify and challenge the eating disorder thoughts, the therapist can then address other developmental stressors and issues with mood, depression and anxiety.

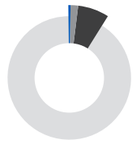
Several therapeutic techniques are used in all of the levels of care through this program. FBT is the most successful intervention with adolescent patients with anorexia. It is the only consistently proven treatment for anorexia of any age. The basic principle of FBT is that parents provide the full structure around a patient's meal plan. Therefore, parents must re-feed their child and take all control of eating choices away from the patient. Once the patient is deemed medically and psychologically ready, control is slowly returned to the patient. Cognitive Behavioral Therapy (CBT) has consistently shown improvement with patients with Bulimia and this is integrated into treatment of patients at all levels of care.

The longer the duration of illness is, prior to getting the treatments as described above, the poorer the prognosis becomes. Therefore, it is imperative to refer patients as soon as possible if there is a suspicion of an eating disorder. Symptoms are often hidden from those closest to the person struggling with an eating disorder and clinicians must remain vigilant. It is recommended that clinicians monitor patient's height and weight as well as screen for disordered eating patterns. However, adolescents may not present initially with loss of weight or changes in eating behaviors, rather teens can complain of medical complications including delayed or absent menstruation, bradycardia, syncope, mood changes, constipation or abdominal pain. An adolescent struggling with eating may not be bothered by his or her symptoms and parents may not be aware of any change. Risk factors that may increase suspicion of eating disorders include frequent dieting, family history of eating disorders, high levels of perfectionism along with negative self-esteem, obsessive-compulsive traits, bullying about weight and history of sexual, physical abuse or neglect.

From 1999 to 2006, hospitalizations for eating disorders increased 119 percent for children under the age of 12 years old, the steepest incline yet.

5-10% of eating disorder patients are males

The prevalence of eating disorders has increased steadily over the past several decades. Approximately five to 10 percent of eating disorder patients are males, but this population is growing as we have improved awareness and research in how males are affected by eating disorders. From 1999 to 2006, hospitalizations for eating disorders increased 119 percent for children under the age of 12 years old, the steepest incline yet. Overall prevalence of AN is currently 0.5 percent of adolescent girls in the United States. Prevalence is slightly higher with bulimia nervosa (BN), approximately one to two percent. There is a greater amount of patients (0.8 to 14 percent) who have sub-threshold symptoms, which would previously fall into Eating Disorder Not Otherwise Specified (ED-NOS), as diagnosed from the DSM-IV. With stricter criteria in the DSM-V, the prevalence of ED-NOS will likely decrease.



0.5% of adolescent girls have anorexia nervosa

1-2% of adolescent girls have bulimia nervosa

0.8-14% of adolescent girls have ED-NOS

For AN, the key criterion is restriction of energy intake leading to low body weight along with intense fear of gaining weight or behavior that interferes with weight gain. Patients feel they are overweight and over value their weight in terms of self-esteem. There are two subtypes, binge-eating/purging type where there are compensatory behaviors to get rid of food by vomiting, excessive exercise, use of laxatives, diuretics or enemas, and the restricting type where there are no compensatory behaviors present in the last three months.

Anorexia commonly presents during adolescence or young adulthood. Anorexia is a heritable illness; relatives of patients with anorexia have a ten times greater risk of having anorexia than those unaffected. With appropriate treatment, most patients experience remission within five years; however the mortality rate is approximately five percent per decade. There are many medical complications associated with AN. Virtually every organ system can be affected, most concerning is the cardiovascular system as it is a common cause of mortality. Bradycardia and QT prolongation is a common presenting symptom and cause of death. Clinicians must take bradycardia seriously, even if it is present with an athlete, and must assess eating habits, self-perception and fear of gaining weight. Laboratory tests are checked frequently to assess for any abnormalities, especially anemia and electrolyte imbalances. At times, patients may require inpatient medical hospitalization. Often these patients are at or below 75 percent of expected body weight, present with dehydration, electrolyte disturbances, cardiac dysrhythmia or vital sign instability.

For BN, there is presence of binge eating and inappropriate compensatory behaviors present for at least one time per week for three months. Binge eating is defined as eating within a two-hour period a larger amount of food than most individuals would consume along with a sense of lack of control. Patients are unduly influenced by body shape or weight and do not meet criteria for anorexia nervosa. For BN, the severity is measured by frequency of compensatory behaviors per week. Typically, these patients present in the normal or overweight range and will restrict caloric consumption throughout the day and the binge/purge cycle occurs in the evening.

Similar to anorexia, BN behaviors typically begin in adolescence to late adulthood. Bulimia often presents with multiple psychiatric comorbidities, including depression, mood disorders and physical or sexual abuse. Lifetime prevalence of substance abuse in individuals with bulimia is at least 30 percent. Although patients with bulimia present with less dramatic medical complaints, common complaints include abdominal pain/bloating, constipation, weakness, syncope and swollen cheeks. Medical hospitalization is required if a patient cannot eat without purging.

Although eating disorders are difficult to treat, NCH offers the most up to date, evidenced-based treatment with a multidisciplinary, collaborative team for children and adolescents struggling with disordered eating.

Self-image therapy activity used for patients

Legal Issues: Use of the Sensitive Note

Natasha Davis, JD, MBA, Legal Services Associate Counsel Corporate
Jonathan Pope, Legal Intern

An important aspect of providing quality health care to our patients is ensuring they have a complete and accurate medical record. As a health care provider, we have a duty to keep the patient's medical information private. There are times when certain information needs to be given an extra level of protection. This protection comes in the form of a "Sensitive Note." A Sensitive Note is a note that is part of the patient's medical record. The note is written by a clinician but is not readily viewable by most clinical staff accessing the patient's record. The information subject to Sensitive Note status may be related to the patient's medical treatment and could cause the patient or the patient's family harm or undue hardship if it were released to the wrong party. Limiting the note to the appropriate health care providers on a 'need to know' basis is designed to prevent disclosures of especially sensitive protected health information to unwanted parties. The health care providers with access to the Sensitive Note must always keep this in mind as they discuss issues with the patient/family AND as they authorize the release of the patient's medical record.

The Department of Behavioral Health developed and implemented the process and policies necessary to make a Sensitive Note useful for its families. Only certain parties within NCH have access to the Sensitive Note (social workers, Emergency Department physicians, and behavioral health). They are in a unique position to collect this information because of the services they provide. It is important to capture the information for other health care providers, but also to ensure the information is not disclosed without proper cause. When a request for a release of information is received for a record with a Sensitive Note, Health Information Management must determine if the requestor has the proper authority to receive such records and has properly completed the Release of Information forms. Behavioral Health then (1) receives a copy of the request form (2) reviews their stated purpose for requesting the release of the records, as well as, (3) reviews and authorizes requested medical information to be released. The clinician involved in the case makes the final decision if the Sensitive Note is to be released to the requestor.

A common example of a Sensitive Note being properly withheld from the requestor is domestic violence. A child could disclose throughout the course of treatment to a psychiatrist that his father is abusive towards his mother. This could be an important factor in providing proper care to the patient, so the psychiatrist will want to include this disclosure in their notes. However, there is a risk for potential significant negative consequences for the child and mother if the father were to exercise his right to view the medical record and see that this family secret was disclosed. Adding this to the record as a Sensitive Note would underscore the need for discretion in not disclosing the information to the father, while still making it available to other treating providers.

Process for the Release of a Record with a Sensitive Note

Health Information Management determines if the requestor has the proper authority to receive such records and completed necessary forms.

1. Behavioral Health receives a copy of the request form
2. Then reviews their stated purpose for requesting the release of the records
3. Then reviews and authorizes requested medical information to be released
4. The clinician involved in the cases decides if the Sensitive Note is to be released

Innovations in Behavioral Health

Shari Uncapher, MSW LISW-S, Clinical Director Outpatient Services, Behavioral Health Services

"It is an invigorating, challenging, stimulating time of innovation for behavioral health care."

Psychotherapy has its origins in the arts. As practitioners we are intrigued by the nature of the relationship we are developing with our client, we monitor the flow of communication and we anticipate (quietly wish for) a cathartic response. In more recent years, we have been able to add scientific elements to our practice. Evidence-based interventions are now readily available in mental health practices. Therapists are in the glory days of blending artistic expression and elements with logical and proven sequencing of interventions. It is an invigorating, challenging, stimulating time of innovation for behavioral health care.

Behavioral Health Services at Nationwide Children's has long appreciated innovation. We have provided diagnostic assessment and treatment in family homes for decades. Clinicians have been offering animal-assisted therapy to trauma patients for five years. We have been linking the parents of acute patients with parent partners (parents who have experienced similar situations with their own children) for three years. We also have spent the last 12 months streamlining our clinical triage process to improve access to care. All of these interventions, novel at the time of their inception, have been met with high patient family satisfaction and solid clinical outcomes. This year has been no different as we continue to seek fresh, family-centered treatment methods. Two such projects are a telemedicine initiative and the development of a smart phone application.

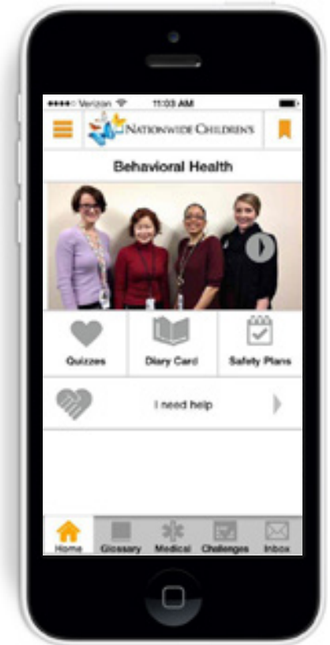
Telemedicine*

Telehealth Service was introduced in Ohio HB 123 as health care service delivered to a patient through the use of interactive audio, video, or other telecommunications or electronic technology from a site other than the site where the patient is located.

Behavioral Health Services has been providing psychiatric intervention and medication management via telehealth visits since 2012. In 2014, we added a therapist to the offering so that we can provide truly integrated care. Our process initiated with the selection of a pediatric medical practice that was interested in adding behavioral health care for its patients. After pre-work by operations coordinators, attorneys, information specialists and others, clinical programming development began.

The current Nationwide Children's treatment team consists of a psychiatrist, advance practice nurse (APN) and master's-trained therapist. These individuals coordinate care with the pediatrician and APN at the medical office. The practice identifies patients suspected of having a mental health issue. The patient and family members are scheduled at a Nationwide Children's location for a diagnostic assessment by one of our team members. If appropriate for care, future appointments are scheduled at the pediatrician's office. The psychiatric service, as well as the psychotherapy, is offered via a high quality computer monitor and electronic platform.

The communication of patient information and case consultation are critical to effective patient management. Prior to every psychiatric session, the medical practice sends the results of the vitals screening and any chart review updates to the Behavioral Health Services psychiatrist/APN. Further, the psychiatrist/APN and the therapist coordinate care through regular consultations. Lastly, the results of every behavioral health visit are provided in writing to the medical practice.



Smart Phone App*

One of the many services offered by Behavioral Health Services is a structured intervention called Dialectical Behavioral Therapy (DBT). This intervention was developed by Marsha Linehan, PhD, and treats patients struggling with severe emotional dysregulation and self-harm behaviors. The pediatric model consists of family skills group, individual and family therapies, and phone coaching. Due to the clinical presentation of patients served by this model, the attainment and practice of skills to manage unsafe thoughts and behaviors is heavily emphasized.

An innovative strategy that we have recently advanced is a skill-focused smart phone application for parents of patients in our DBT service. Some of the app is standardized, containing the skills that all patient families are taught and listing emergency phone numbers for our geographic region. However, much of the app is customized by the patient. Each unique patient's safety plan is loaded just for them. The app also contains a check-in questionnaire that monitors the individual's weekly responses. The parent can also make notes and send non-urgent messages to staff. We coach parents to use the app to practice skills, register and monitor the trends of their reactions across the weeks of treatment and to receive affirmations for utilizing therapeutic techniques.

The DBT clinicians' responsibilities are to embed the use of the app in treatment. That is, to review the parent completed questionnaires, highlight recently taught skills and encourage a constant focus on safety. We are able to monitor each parent's use of the app to evaluate usefulness for any given family. We are currently experiencing a 69 percent activation rate.

Telemedicine and the smart phone app are only two examples of the evolution of behavioral health care. For a field that is premised on spontaneity and individualization, innovation is an essential and valued concept.

** Both our telemedicine project and our app were in part made possible by the Center for Medicare and Medicaid's Health Care Innovation Award, Kelly Kelleher, MD, Principle Investigator.*

Early Childhood Mental Health: How to Identify Behavioral Health Issues at an Early Age

Rebecca Baum, MD, Clinical Assistant Professor of Pediatrics, Section of Developmental Behavioral Pediatrics, Department of Pediatrics

Why is Early Childhood Mental Health Important?

Promoting the emotional health and well-being of children has long been a goal of the field of pediatrics. Increasingly, breakthroughs in science have illustrated that this goal not only makes good sense, but also results in improved adult health, even affecting generations to come. Using a large database, Vincent J Felitti and colleagues determined that the number of Adverse Childhood Experiences (ACEs) directly correlated with adult risk behavior, health status and disease. ACEs included serious childhood events such as physical or sexual abuse, domestic violence and caregiver mental health issues. Adults exposed to four or more categories had higher rates of heart disease, chronic lung disease and cancer. Developments in neuroscience offer clues to the biologic basis for these adverse outcomes. Studies in rat models have demonstrated changes in neurotransmitter levels, brain structure, and ultimately behavior in rats exposed to a high stress environment. Interestingly, these changes crossed generations, with high stress environments resulting in changes in the genetic code that could be passed to offspring.

It is important to remember, however, that not all stress is "bad stress." Navigating stressful situations like the first day of school or arguing with your best friend helps children grow and develop. Higher and more chronic levels of stress, when buffered by positive relationships and other resiliency factors, can be tolerated. However, stress may become damaging, or toxic, as levels increase, persist or if buffers are not effective. The American Academy of Pediatrics summarized the effects of stress on a young child in its technical report, *Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science into Lifelong Health.*

What is Early Childhood Mental Health?

Early Childhood Mental Health (ECMH) is focused on the healthy social and emotional development of infants, toddlers and preschoolers. The three core concepts include promotion of healthy development, prevention of mental health problems and treatment of mental health problems in young children. Many providers may be surprised to learn that even young children are at risk for anxiety, depression and disruptive behavior disorders. While diagnosis may be more difficult in young children, these diagnoses can be made accurately with specialty evaluation, and early identification with timely intervention is important for best outcomes. Specialty ECMH clinicians often receive their training in the fields of social work, counseling, psychology, nursing or medicine, but nearly everyone involved in the health care of young children plays a role in promoting healthy social-emotional development.

Many providers may be surprised to learn that even young children are at risk for anxiety, depression and disruptive behavior disorders.

How Can We Identify Children at Risk?

Two concepts are important when considering early identification. **Surveillance** refers to the observation and monitoring for developmental concerns. Meeting milestones such as playing peek-a-boo by nine months of age, developing pretend play by age 2 and showing concern for others by age five is reassuring, but reliance on milestones alone may overlook children with delays or concerns. **Screening** refers to the use of a standardized tool at set intervals to better identify children at risk. Primary care practitioners are advised to administer a standardized developmental screening tool at ages nine, 18, and 24-30 months, as well as an autism-specific tool at 18 and 24-30 months. Environmental stressors such as poverty, abuse and neglect and parental mental illness also place children at increased risk. Protective factors are similarly important, including the presence of consistent and nurturing relationships with caregivers.

How Can We Intervene?

Some of the simplest interventions are likely the most powerful tools for prevention and promotion. Interactive play helps build strong bonds between children and their caregivers. This "serve and return" interaction results in the development of new brain circuits. Exposure to language, both by talking with young children and by reading, similarly helps strengthen relationships and build brain architecture. Parenting practices that are nurturing, consistent, protective and developmentally appropriate help children feel secure while being able to explore new experiences.

When concerns arise, prompt evaluation is recommended. Ohio's early intervention program, Help Me Grow, provides developmental assessment and intervention services to children birth to three years. Evidence-based treatment programs including the Triple P Positive Parenting Program, Incredible Years and Parent Child Interaction Therapy, have been shown to be effective at reducing symptoms of emotional and behavioral disorders in young children. These and other programs for young children are offered at Nationwide Children's Hospital and can be accessed through Behavioral Health Intake.

Referrals can be placed by calling **(614) 355-8080** or online at **NationwideChildrens.org/Behavioral-Health.**

Therapeutic Recreation: The Hidden Therapy in the Treatment of Behavioral Health Diagnosis

Melissa McMillen, CTRS, Clinical Lead Therapeutic Recreation, Therapeutic Recreation/Division of Clinical Therapies
Ashley Tuisku, CTRS, Therapeutic Recreation/Division of Clinical Therapies

Mental health challenges can interfere with normal cognitive, social, behavioral and physical development. Signs and symptoms of mental health illness often present in the early stages of development and can impact a person's ability to form relationships and develop healthy coping skills and self-esteem.

The goal of therapeutic recreation (TR) is to enhance the physical, cognitive, social and affective development of individuals, so that they may participate fully and independently in chosen life pursuits, regardless of physical or mental illness.

In children and teens, these life pursuits typically encompass age-appropriate leisure and recreation activities and peer relationships. TR interventions target the individual as well as the quality of his or her environment and support systems, in order to maximize physical, mental health and psychosocial well-being. Structured, guided activities target the reduction of specific symptoms or enhancement of specific functional skills in inpatient and outpatient settings.

Certified Therapeutic Recreation Specialists (CTRS) are key members of the mental health treatment team. They focus on individual and group treatments, animal-assisted therapy and family-centered interventions to not only promote quality of life for the patients, but also impact their overall function and developmental continuum. Each treatment provided by the CTRS is designed to enhance the individual's freedom of choice and expression through a variety of age-appropriate activities. A CTRS models, educates and endorses practices of appropriate social and coping skills learned through leisure and recreation.

Following a physician order, the CTRS completes a full evaluation to assess a patient's overall psycho-social history, living environment, daily schedule, social connections, leisure interest and participation level, barriers to participation, healthy coping and community-based resources. This information is used to develop personalized goals, based on the individual's needs, skill sets and diagnosis. Leisure education is provided to each patient and family to reinforce the importance of recreation in promoting a healthy lifestyle.

Each session involves an active leisure skill, self-expression, cognitive problem solving task or gross motor activity. This approach often camouflages the intended goal of therapy and puts the patient at ease which in turn improves their receptiveness to further interventions from the multidisciplinary staff. Following TR sessions, patients may be less guarded and more likely to trust others as a result of their positive experience in leisure participation.

Upon discharge, the CTRS connects patients and families with community resources. Individuals are encouraged to continue new tasks learned during their admission and to connect with community activities, groups, events and resources. Linkage in the community will help the patient and family improve quality of life and continue to promote the goals addressed during hospitalization. This approach helps a patient and family continue to progressively gain independence and improved functioning within their home and community setting.

The TR department at Nationwide Children's Hospital is an integral part of the mental health treatment process. TR promotes overall quality of life because of the understanding that mental health disturbances impact not only the patient, but all members of the household. This guided approach to treatment allows patients and families to purposefully play their way to greater independence and recovery.

I Am Going to Retire…

Margaret Carey, RN, MS, CPN, CNRN, Service Coordinator, Myelomeningocele Program

Someday. Well, I hope I can. I imagine the perfect picture of living in a house without a mortgage payment, my children being self-sufficient and having a little extra money in the bank to travel and do things I haven't had time to do while working full-time. Then I ask myself if that is realistic and if I am preparing adequately. I need to start planning more now or I will not get there successfully.

It is difficult to predict the future. Retirement for most people will depend on their Tax-Sheltered Annuity or 401(k) balance, cost of living, medical costs, food costs and Social Security benefits. One of the greatest retirement considerations is medical care and health insurance. Medicare coverage can start as early as the month a person turns age 65. I know I am not the only one concerned about retirement. There are advertisements on television and in the newspaper encouraging everyone to do something now and not wait until tomorrow. I even receive regular emails at work reminding me of opportunities for information and assistance with financial and retirement planning. I am very grateful to be working at an organization that offers this assistance, especially since this is not my area of expertise.

Employees of Nationwide Children's Hospital are able to access information about financial and retirement planning from our ANCHOR website and by contacting Human Resources. Contact TIAA CREF directly at 1-800-842-2776 for customer service. For onsite appointments, call 1-800-732-8353 to schedule.

ANCHOR Resources

- Human Resources Information
- Compensation and Benefits
- Savings and Investments
- Flexible Spending Accounts
- Pension Plan
- Matching Savings Plan
- Tax-Sheltered Annuities
- Nationwide Children's/TIAA-CREF Retirement Plans Video
- TIAA-CREF On-Site Counseling Schedule

I have witnessed the retirements of family, friends and co-workers and hear the plans of many others. I am learning some do's and don'ts, but I am still relying on the expert advice of financial planners. There are many different statistics quoted by multiple popular news and financial sources that can add to the overwhelming information about retirement. But I want to be in control of my financial future, so I will continue to save a little more money than I want to now to help me later. Good luck to you!

Neuropsychological and Psychoeducational Evaluations: Helping Children Succeed in the Classroom and Beyond

Kelly Wolfe, PhD and Kerry Monahan, PsyD, Post-Doctoral Fellows, Pediatric Neuropsychology Program, Department of Psychology

When a child is struggling in school, a neuropsychological or psychoeducational evaluation may help parents and teachers better understand the child's strengths and weaknesses and pave a path for intervention. However, understanding the different types of evaluations available and which would be more appropriate for a particular child can be confusing.

Neuropsychological Evaluation

A neuropsychological evaluation is most commonly indicated if a child has a history of illness, injury, insult or treatment affecting the brain or central nervous system. It is a specialized form of assessment that incorporates an understanding of the relationships between brain functioning and real-world functioning, namely behavior, learning, attention and mood. Tests are given in a one-to-one setting assessing different cognitive skills such as intelligence, language, visual-spatial skills, memory, executive functions (e.g., attention, planning, problem-solving), fine motor skills and academic tests (reading, spelling and math). Parents, teachers and children themselves may also fill out paper-and-pencil measures about the child's emotional and behavioral functioning. All measures are norm-based, comparing a child's performance to that of her same-age peers.

Neuropsychologists take the many "puzzle pieces" of a particular child, including medical history, present context, test results and emotional and behavioral functioning and fit them together to paint a picture of the child's strengths and weaknesses compared to other children of the same age. Whether a child meets criteria for a particular diagnosis such as attention deficit/hyperactivity disorder (ADHD) may also be considered. Based on the child's history, results of the evaluation and knowledge of the research literature a neuropsychologist can then make predictions about future risks. For example a child may struggle with completing assignments on time or with paying attention during lectures so recommendations can be made for school, home and community settings. These recommendations are made to optimize the "fit" between the child and environment, so the child can experience success. For some children, special educational services such as an Individual Education Program (IEP) might also be beneficial.

At Nationwide Children's, neuropsychological evaluations are completed at the Main Campus location. A typical evaluation involves an intake interview and three to five hours of one-to-one testing depending on the child's age and level of function. Families and referring providers receive a thorough written report including relevant patient and family history, testing results, conclusions and recommendations during a feedback session usually done about four weeks after testing is complete. This report can then be shared with school or community providers at the family's discretion.

Repeat neuropsychological evaluations may be recommended to monitor the child's function over time and update recommendations. Time between neuropsychological evaluations can vary depending on the particular child. Typically evaluations are done at least one year apart and when there is concern for a change in the child's ability to succeed in the environment such as a decline in grades, transition to high school, or a new illness or injury.

Psychoeducational Evaluation

If a child does not have a history of illness, insult, injury or treatment involving the brain or central nervous system and is struggling with learning, attention or behavior, a psychoeducational evaluation may be the right choice.

The process of a psychoeducational evaluation is similar to a neuropsychological evaluation with an intake session, one-to-one testing, and feedback session that allows for a discussion about the results and recommendations which are also outlined in a written report. Psychoeducational evaluations also utilize norm-based tests, comparing a child's performance to that of same-age peers.

A psychoeducational evaluation is a targeted assessment, typically focusing on IQ, academic skills (giving a wider variety of academic tests than a neuropsychological evaluation), attention, emotional and behavioral functioning, and sometimes memory. A psychologist then "puts the pieces together" to determine whether a diagnosis such as a learning disability or ADHD is appropriate, and whether the child may qualify for special educational services.

At Nationwide Children's, psychoeducational evaluations are primarily completed at our Dublin, Westerville and East Broad Close to Home℠ locations. A limited number are completed at the Main Campus location. The time between psychoeducational re-evaluations may vary depending on the child. Sometimes one evaluation is all that is needed to qualify for special education services and then the school can take over testing every few years to update school recommendations.

In general, it is beneficial to ask a psychologist, family physician or specialty doctor which type of evaluation may be best for a particular child. Then everyone can "put their heads together" to figure out the best path to help a child who is struggling in school.

Intensive Autism Spectrum Disorders Therapy Program

Jacqueline Wynn, PhD, BCBA-D, Director/Psychologist, Center for Autism Spectrum Disorders

In the waiting room you may see a 2-year-old pacing back and forth, a 15-year-old chatting loudly, a 13-year-old waiting patiently with mom, an 18-year-old reading, and a 10-year-old having a meltdown. At the Center for Autism Spectrum Disorders (CASD), patients of all ages with a broad range of needs are served with programs designed specifically to meet their needs and those of their caregivers.

Autism is a developmental disorder that affects a child's social functioning, language development and behavior patterns. These individuals often have repetitive behaviors, compulsive interests or rigid personality styles. Understanding social conventions, building friendships and communicating thoughts and feelings may pose significant difficulties. Because of this unique combination of challenges, it can be difficult for children with Autism Spectrum Disorder (ASD) to cope with everyday stressors, and problem behaviors such as aggression or self-injury may develop. They may experience difficulty at school, feelings of loneliness, depression and anxiety and challenges navigating the transition to adulthood. Children diagnosed with ASD may or may not have cognitive deficits, language delays and/or other syndromes — so this makes for a varied group of patients, with diverse clinical needs. In order to meet their needs, a full range of care is required.

In order to meet their needs, a full range of care is required.

In 2000, CASD opened with a handful of clients being served with the most intensive form of care, Intensive Behavioral Intervention (IBI). In this care model, young children receive up to 40 hours of 1:1 weekly intervention, provided by a team of clinicians and supervised by a psychologist. Family members are integrally involved, goals are comprehensive with a heavy focus on language and social development, children are served in their homes, community and school settings, and their intervention plan is implemented for three to five years.

A program is established that is uniquely suited to each child's skill profile, and learning activities are designed in the areas of language, socialization, play, coping/emotional regulation and self-help skills. A team of interventionists implement these activities across the week, taking data on the child's responses, in whatever natural setting the child is in including home, daycare, school or community. The parents are involved in setting the plan's goals and designing activities, and are trained to implement the activities. In this way, the child is maximally exposed to a learning environment that, over time, significantly changes his or her developmental trajectory. Each week the data are evaluated, patterns of progress and challenge are identified and the treatment plan is altered accordingly. Over several years, this on-going, weekly progress accumulates into extensive levels of change. It is the most effective form of care for ASD, but is labor intensive and demands energy and focus from the family.

Since inception, the CASD has provided more than 300,000 hours of care in this program to hundreds of children.

Since inception, the CASD has provided more than 300,000 hours of care in this program to hundreds of children. Approximately, 30 to 50 percent have reached best-outcome, meaning they no longer require services and function typically in the areas of cognitive skills, social functioning, daily living skills and academics. Other children receiving this treatment have made substantial gains in their level of functioning, allowing them to better cope with the demands of everyday life and become more integrated into family and community living. In addition, a byproduct of providing community intervention, we have brought new ideas and strategies to hundreds of school personnel and other providers.

A large number of IBI services are provided by CASD, but lower-intensity services also are available, such as group and individual parent training, school consultation and transition supports. This allows a family to access the care they need and want in a flexible way. The CASD offers specialized care to patients who have significant impairments and are engaging in severe problem behavior, such as aggression or self-injury. These patients require sophisticated interventions designed and implemented by specially-trained staff. The CASD also offers a full range of care to higher-functioning individuals with ASD who can benefit from individual and group interventions. These services are provided by a team of specially-trained therapists and services grow consistently to meet community need. In all of the programs offered at CASD, treating children in their home and community environments is emphasized. In 2013, CASD provided more than 24,000 hours of community-based care.

In 2013, CASD provided more than 24,000 hours of community-based care.

The Center for Autism Spectrum Disorders is unique. Not only are we partners with the Child Development Center (a unit of Behavioral Health/Developmental Behavioral Pediatrics that focuses on assessment, treatment planning, care coordination and medical follow-up care for individuals with disabilities), but we have also built a program that broadly addresses the needs faced by these patients and their families. There are few centers worldwide that offer this level of care to this many patients. CASD is very grateful that Nationwide Children's leadership has provided the support and resources that allowed us to care for these families.

Community-Based Programming in Nationwide Children's Behavioral Health

Glenn Thomas, PhD, Clinical Director of Community-Based Programs, Nationwide Children's Behavioral Health
Adjunct Clinical Assistant Professor, Department of Psychiatry and Behavioral Health, The Ohio State University

Sometimes the mental health needs of a child or adolescent are so significant that parents feel overwhelmed. Imagine, for example, the heartbreak and worry of a father whose daughter has struggled with depression and thoughts of suicide — and now she's returning home after an inpatient stay. Or a single mother whose teenage son has been expelled from school on several occasions and now faces felony charges in juvenile court.

When psychiatric and behavioral difficulties are severe or chronic and affect multiple areas of a child's life, they may not be sufficient to warrant an inpatient level of care, but something more intensive than outpatient therapy is needed. Nationwide Children's Behavioral Health offers a number of programs that deliver services in the community including in the home, at school, in the court system or wherever a child and their family is struggling.

Our Community Support Program (CSP) offers therapy for children with a wide range of ages and psychopathology and has recently expanded to two teams. In addition to cognitive-behavior therapy, CSP therapists are trained in family therapy models which are either IFAST (Integrated Family and Systems Treatment) or Intensive Home-Based Therapy. Depending on the needs of the patient and family, therapists will tailor treatment and employ a mix of individual and family therapy with the goal of maintaining the patient in the home and helping them to function as effectively as possible.

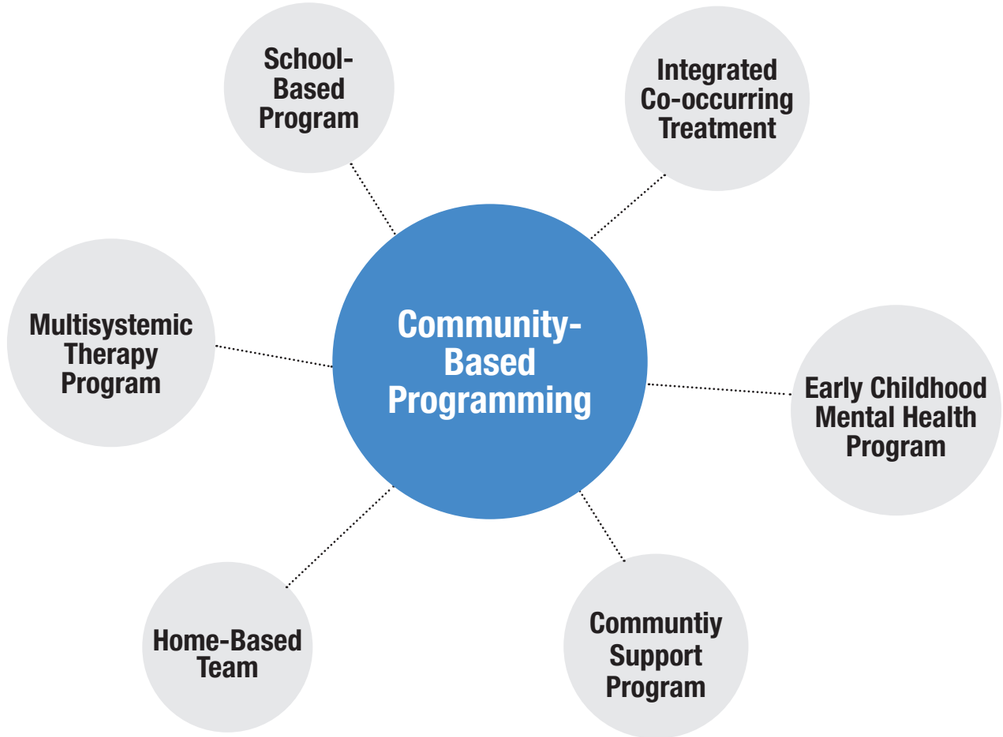
The Home-Based Team focuses on parent training when children (usually between the ages of three and 12) are at risk of out-of-home placement. Our therapists primarily work with parents whose discipline patterns may be inconsistent or harsh. Often these families have also experienced domestic violence.

Our Multisystemic Therapy (MST) Program delivers family-based services in the home that address severely disruptive behavior and delinquency in youth aged 11 to 17. These difficulties are severe enough that there is a risk of removal from the home and many of these youth are involved with juvenile court. Therapists meet with the patient and parents to help the parents more effectively manage their teen's behavior, address the causes of their acting out behavior and enhance family warmth. Nationwide Children's also offers an adaptation of MST, Multisystemic Therapy for Problem Sexual Behaviors (MST-PSB), to address inappropriate sexual behaviors of children in the community.

Integrated Co-occurring Treatment (ICT) is an intervention designed to meet the needs of adolescents with both mental health and substance use disorders. Again, these difficulties are substantial enough that multiple sessions a week are necessary and parents and caregivers are also engaged in the therapeutic process. A mix of individual and family therapy approaches is used.

Therapists in the School-Based Program provide services in approximately twenty Columbus City Schools and two Canal Winchester Schools. Their primary goal is to reduce non-academic barriers to academic success and much of their work occurs directly with students in the school, but family therapy is also provided in the home when indicated. More recently, the School-Based Program has also been involved in providing prevention interventions in the school by way of the PAX Good Behavior Game (part of the hospital's Healthy Neighborhoods Healthy Families initiative) and some suicide prevention efforts.

When problems occur with younger children up to the age of five, the Early Childhood Mental Health Program (ECMH) is available to consult in the home and provide more intensive services if they are warranted. Most of these children have displayed early disruptive



behavior; impacting how the parents interact with their children and can lead to significant improvements in the overall functioning of the child and the family. These services are also provided in an outpatient setting in the Behavioral Medicine Consult Clinic on a limited basis. The ECMH program also provides prevention services in the preschool setting as well as training and education to preschool providers (also part of the Healthy Neighborhoods Healthy Families initiative).

Psychiatry is integrated into all of these programs and therapists and psychiatrists communicate on a regular basis to provide the most effective care possible. Each program has a round-the-clock crisis component and on-call therapists are always available to take calls when families are struggling or in crisis. Depending on the needs of the family, therapists may even respond in person, going out to the home to provide assistance. All our therapists are master's level and have licenses in Clinical Counseling, Social Work or Marriage and Family Counseling. Some also have additional accreditation in substance abuse counseling.

All of these programs offer evidence-based interventions and, because they are frequently delivered in the home, allow the therapists to work intensively, sometimes several times a week, with the family in their natural environment building upon existing strengths.

For more information on these programs or to make a referral, please contact Behavioral Health Intake at (614) 355-8080.

A Magnet Three-Peat

Nationwide Children's has achieved Magnet® recognition for the third time from the American Nurses Credentialing Center's (ANCC) Commission on Magnet.

Congratulations to our patient care staff for leading the country in evidence-based practice and research. This achievement is a validation of your commitment to best outcomes and your continuing drive to improve care for our patients and families.

In Recognition

Publications

Anna Haas-Gehres, Sonya Sebastian, Kristen Lamberjack: "Impact of Pharmacist Integration in a Pediatric Primary Care Clinic on Vaccination Errors: A Retrospective Review," *Journal of American Pharmacists Association,* May 2014

Christina Gallagher and Emily McLain: "Pediatric Apheresis Special Considerations for Children <25Kg," *Principles of Apheresis Technology Fifth Edition,* 2014

Margaret Burns: "Creating a Nursing Portfolio," *Ohio Nurses Review,* 2014

Margaret Burns: "Surviving in Your Car, Briefly," *Ohio Nurses Review,* 2014

Nadeem Nimri, Joanne Chisolm, Sharon Cheatham, Ralf Holzer, John Cheatham: "The Melody Valve…Not Just for Conduits: A Single Center Experience," *Catheterization and Cardiovascular Interventions,* 2014

Pamela Horn, Elizabeth Badowski, Kevin Klingele: "Orthopedic Clinical Care Model in a Pediatric Orthopedic Setting Outcomes of a 1:1 Model—Orthopedic Surgeon and Nurse Practitioner," *Orthopaedic Nursing,* May-June 2014

Catie Christensen, Linda Lowes: "Treadmill Training with a Non-Functional Ambulator with Spina Bifida: A Case Report," *Pediatric Physical Therapy,* 2014

Janet Simsic, Sheilah Harrison, Laura Evans, Richard McClead, Douglas Teske: "Quality Initiative to Reduce Inhaled Nitrix Oxide Utilization and Cost While Maintaining Quality Patient Care," *Journal of the American Academy of Pediatrics*, June 2014

Ashley Hodge, Thomas Preston, Jill Fitch, Sheila Harrison, Kathleen Nicol, Patrick McConnell: "Improved Autologous Blood Administration Post Cardiopulmonary Bypass Decreases Allogenic Blood Transfusions in Pediatric Patients," *The Journal of ExtraCorporeal Technology*, March 2014

Presentations

Rosemary Pfeifer: "Employee Safety Initiative: Sharps Safely in the Operating Room" April/May 2014.

Rosemary Pfeifer: "Employee Safety Initiative: Sharps Safely in the Operating Room" May 2014

Christina Gallagher and Emily McLain: "Achieving Best Outcomes: Optimizing Care for Pediatric Apheresis Patients-Pediatric Case Studies," American Society for Apheresis and the World Apheresis Association's joint conference, April 2014

Elizabeth Lucas, Cheryl Baxter, Chandra Singh, Ahmad Mohamed, Birong Li, Jingwen Zhang, Venkata Jayanthi, Stephen Koff, Brian VanderBrink, Sheryl Justice: "Changes in Urinary Microbiological Millieu of Neurogenic Bladder Patients with the Use of a Hydrophillic Catheter as Compared to Conventional PVC Catheter," 2014 Nursing Research Conference, April 2014

N Nimri, Joanne Chisolm, Sharon Cheathem, Ralf Holzer, John Cheatham: "The Melody Valve…Not Just for Conduits: A Single Center Experience," Catheterization and Cardiovascular Interventions, Pediatric Interventional Cardiac Symposium, June 2014

Megan Hall and Tifanie Rose: "It Takes a Village: Integrating Psychosocial Collaboration in Patient Care," Child Life Council's Annual Conference on Professional Issues, May 2014

Melanie Martin, Leah Keller and Terri Long: "Effectiveness of High-Fidelity Patient Simulation on Nurses' Early Identification of Deteriorating Pediatric Patients and on Patient Outcomes," Annual International Nursing Simulation/Learning Resource Centers Conference, June 2014

Helen Carey, Sarah Hendershot, Jessica Brock: "Gross Motor Development and Autism: Linking Research to Practice," American Physical Therapy Association Combined Sections Meeting, February 2014

Lamara Love, Judy Lang, Nancy Ryan-Wenger: "A Nursing Driven Holistic Approach to Improving the Health Outcomes of Children with Cerebral Palsy," American Academy for Cerebral Palsy and Developmental Medicine meeting, September 2014

Corrie Frye and Margaret McGrath: "Oncology Massage," Columbus State Community College Massage Therapy Program, April 2014

Corrie Frye: "Hospital Based Massage Therapy," Miami Jacobs Career College Massage Therapy Program, May 2014

Heather Jolly-Cornette, Lauren Fisher and Jamie Manley: "Patient Centered Rounds: Bridging Gaps in Communication," Ohio Association of Healthcare Quality Conference, May 2014

Sheilah Harrison, Sarah O'Brien, Rick McClead, Bryce Kerlin, Riten Kumar, Terry Davis, Rich Brilli: "Children's Hospitals Solutions for Patient Safety's Venous Thromboembolism Pioneer," Monthly Cohort Meeting, April 2014

Heather Jolly Cornette, Lauren Fisher, Jamie Manley, Sheilah Harrison: "Patient Centered Rounds: Bridging Gaps in Communication," Ohio Association for Healthcare Quality's Annual Conference, May 2014

Roxann Tyner, Janet Simsic, Gina Marcum, Sheryl Keiffer, Sheila Harrison: "Reduction of Adverse Drug Events Causing Patient Harm," Ohio Association for Healthcare Quality's Annual Conference, May 2014

Faye Willen: "Hodgkin Lymphoma-Evolution Through Revolution: Transitioning Toward Targeted Therapy," National Association of Pediatric Hematology Oncology Nurses conference, September 2014

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Nationwide Children's Hospital
700 Children's Drive
Columbus, Ohio 43205-2696

Daisy Award

Jessica Lencke, RN

The seventh Nationwide Children's Hospital Daisy Award was awarded to Jessica Lencke, RN, a nurse on C4B. The Daisy Award is given in appreciation of the important difference our nurses make in the lives of the patients and families at Nationwide Children's. Jessica was nominated by a family who wanted to express gratitude for her patient-centered care. "While in the NICU for a year, this nurse gave extra special care," the parent shared. The parent also appreciated Jessica's questioning attitude. "She openly expressed her opinions to the doctors, giving them insight that truly helped in our baby's treatment. She also learned with us as she was sure to question the doctor if she didn't understand the reason for the treatment that was being suggested. Jessica used her own free time to research and educate herself about the medical issues our baby had."

EVERYTHING MATTERS: IN PATIENT CARE, previously published as *Heartbeat*, is a quarterly publication of the Patient Care Services Division of Nationwide Children's Hospital, Inc., Columbus, OH. Comments regarding the content of this publication are welcomed. References for articles are available by calling (614) 722 -5962. Articles may be reprinted with permission. Send all inquiries and material for publication to EVERYTHING MATTERS: IN PATIENT CARE in care of Rosetta Gordon, Administration, Nationwide Children's Hospital, Inc., or call (614) 722-5962. Nationwide Children's Hospital is an affirmative action, equal opportunity employer.

9929