Two Parts 12

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February 11, 2014

Senator John A. DeFrancisco
Chair, Senate Finance Committee
416 Capitol
Albany, NY 12247

Assemblyman Herman D. Farrell, Jr.
Chair, Assembly Ways and Means Committee
LOB Room 923
Albany, NY 12248

RE: Written Testimony Before the Senate Finance Committee and the Assembly Ways and Means Committee

Dear Senator DeFrancisco and Assemblyman Farrell:

Please accept this letter as written testimony in supplement to my oral testimony at the February 11, 2014 Public Hearing before the Senate Finance Committee and the Assembly Ways and Means Committee. I write specifically to provide a medical opinion and address concerns about policy changes that could potentially result in the removal of some of my patients requiring residential treatment and care from their current placement at the Judge Rotenberg Educational Center, Inc. ("JRC") in Canton, Massachusetts, before it is clinically appropriate to do so. Such removal would place my patients at significant risk of physical harm, and even death.

I have been a consulting physician to JRC for over thirty years. In this capacity, I follow the health and progress of all of JRC's clients, including a number of individuals from New York who are eligible for, or will soon become eligible for, adult services provided by New York's Office for Persons with Developmental Disabilities ("OPWDD"). I visit the JRC facility and examine these clients on a monthly basis. In addition, I speak with the nursing staff at JRC on a daily basis, often having multiple conversations with them daily, to consult on client and medical issues. I also conduct a yearly physical and medical records review for each JRC client.

A brief summary of my credentials is as follows. I graduated from Harvard Medical School in 1973 and completed my residency and fellowship at Children's Hospital Medical Center in Boston, Massachusetts. My fellowship was in Developmental Disabilities. I am a registered Board Certified physician, licensed to practice in Massachusetts since 1976 and in New York since 1994. I am Certified by the American Board of Pediatrics in the area of General Pediatrics and am a Fellow of the American Academy of Pediatrics. Currently, and for

approximately the past seven years, I have served as an Expert Reviewer in Pediatrics for the Office of Professional Medical Conduct in Albany, New York, as appointed by the New York Department of Health. I serve as the Regional Medical Director of Excellus BlueCross BlueShield, Rochester Region, in Rochester, New York, where I am responsible for developing and implementing managed care programs for children throughout all of the Excellus network. Attached at Tab A is my curriculum vita.

Through my education and training and numerous years of experience treating children and adults who suffer from developmental disabilities and severe behavior disorders, it is clear that there exists a small population of individuals who suffer from severe behavior disorders that cause them to attack others and engage in life-threatening self-abuse. These clients have: banged their head to the point of brain damage; bit off their own fingertips; pulled out their teeth; vomited and refused food to the point of starvation; bitten a hole through their cheek; bitten off part of their own tongue; scratched their heel to the point of blood, bone infection and eventual death; broken their own arm; cut off their own earlobe with a scissor; run into moving traffic; punched their eyes causing detached retinas and blindness; pulled out their hair to the point of baldness; swallowed razor blades; and cut their skin with a knife so often that the skin became too tough to be sutured. In addition, many of these clients could not cooperate with necessary medical treatment because their behaviors would prevent medical attention, thereby further threatening their own lives. The individuals with severe behavior disorders who are now at JRC have received the other available forms of treatment, including drug therapies, in many programs and facilities in New York, including psychiatric hospitals, prior to placement at JRC and their life-threatening behaviors could not be effectively treated.

I am familiar with the behavior modification treatment given by JRC to its clients, including the operation and effect of the Graduated Electronic Decelerator ("GED") devices. Since 1990, I have been following the health of hundreds of JRC clients that have received intensive behavioral programming, including, in some cases, treatment with the GED devices at JRC. The addition of the GED as a supplement to an individual's treatment program at JRC must first be consented to by the individual's parent(s) or guardian(s), cleared for use by the individual's physicians, approved by a Human Rights Committee and Peer Review Committee, and finally approved on an individual basis, after a hearing, by a Massachusetts Probate and Family Court. Among other things, one of my duties at JRC is to examine the JRC clients before they receive supplemental aversive treatment with the GED devices and determine whether there are any medical contraindications to using the GED devices with that particular client. I have examined hundreds of clients, dating back some twenty years, some of whom who were receiving applications of the GED devices. These clients suffer from severe behavior disorders that have caused them to inflict severe physical harm on themselves as well as others. While the addition of GED treatment to the treatment programs of JRC clients is not necessary in a vast majority of cases, with some individuals it is extremely effective, where alternative treatments such as psychotropic medications and positive-only behavior therapies are not successful.

JRC has been able to effectively treat these clients' dangerous behaviors with intensive behavioral programming, in some cases including the GED treatment, and, as a result, these

clients are now all in good health and receiving much needed education, vocational training, rehabilitation and other essential services. I am not apprised of all of the residential programs in the State of New York, or their attributes; however, I am aware of the many in-state facilities at which my patients had been placed prior to their referral to JRC. The level of behavior modification treatment and the combination of both the GED treatment and advanced behavior analysis ("ABA") that is available at JRC is not replicated at any of these facilities. They do not have the highly trained and experienced staff, specially equipped facilities, on site medical professionals and 24 hour per day intensive behavioral services that the JRC clients need.

Based on my knowledge of available residential programs in New York, and my review of OPWDD's proposed in-state placements for individuals transitioning from JRC, it is my professional opinion that the removal from JRC and return to New York of many of these individuals would leave this population without any effective treatment options. These clients would suffer severe physical harm, with their most severe behavior returning and putting these clients at risk of injury, including blinding, permanently maiming, or killing themselves. Most, if not all, would require sedation with potent antipsychotic medications, putting them at risk of suffering their dangerous side effects such as major weight gain; severe sedation; acute and chronic extrapyramidal syndromes (e.g. tardive dyskinesia, akathisia, dystonia, parkinsonism); neuroleptic malignant syndrome (a life-threatening neurological disorder typically consisting of muscle rigidity, fever, autonomic instability, and cognitive changes such as delirium); sexual dysfunction; prolactin elevation (which can result in infertility and osteoporosis in women, erectile dysfunction in men, and tumors and visual problems in both men and women); nocturnal enuresis (bedwetting); addiction; increased likelihood of diabetes; life-shortening metabolic changes; and/or sudden cardiac death. The increase in their dangerous behaviors and the sedating side effects of these medications would cause this group of individuals to lose their only opportunity to receive vocational training and other essential services.

By way of example, I would like to provide the Committees with information concerning three New York residents who are JRC clients and patients of mine. These individuals are representative of the larger group of JRC clients who are currently receiving life-saving treatment at JRC, and who would be dangerously and adversely affected by any policy decision requiring their precipitous removal from JRC.

J.C.

J.C. is a 43 year old female with a diagnosis of Autism, Mental Retardation and a severe behavior disorder who was admitted to JRC on September 1, 1981. I have been following the health and treatment progress of J.C. since her admission. Prior to her admission to JRC, J.C. engaged in dangerous behaviors including pulling out clumps of her hair to the point of causing complete baldness; banging her head on hard surfaces, including walls and floors; biting herself to the point of bleeding; slapping herself in the face to the point of redness and bleeding; and picking and pinching her skin causing bleeding. Prior to J.C.'s admission to JRC, she had health issues associated with her engagement in these dangerous behaviors, including infections on her scalp and the back of her neck caused by pulling out her hair and then picking the skin on her scalp and neck to the point of bleeding. J.C. has also had a callus removed from her left thumb that was caused by her constant rubbing. She required finger separators to prevent her from touching her thumb to her other fingers and rubbing this callus, thereby allowing for the injury to

heal and prevent infection. Her parents would take turns sleeping in order to hold her and keep her safe during the night and would keep her in swimming pools as much as possible during the day in an effort to reduce her self-abusive behaviors. Prior to her admission to JRC, J.C. was unsuccessfully treated at programs in New York State for special needs students, including a program connected with the Queens Psychiatric Hospital and the Queens Autistic Program within the Queens Public School System. Additionally, powerful medications, including Mellaril and Ritalin, were prescribed to treat her dangerous behaviors, without success. J.C. suffered adverse side effects from the medication, including significant weight gain and lethargy.

JRC has treated J.C. with an intensive behavioral treatment program catered to her personal needs, including treatment with aversive interventions such as the GED device. Since beginning treatment at JRC, J.C.'s quality of life has dramatically improved. Her treatment at JRC has resulted in suppression of her dangerous behaviors and has kept her from pulling her hair out and banging her head for up to a year at a time. She has been, and continues to be, in excellent health and has suffered no adverse side effects from the treatment. J.C. no longer requires restraints, protective helmets, blankets and long sleeved shirts to use as forms of self-restraint for her hands because her self-injurious behaviors have improved greatly and she no longer goes through periods of severe hair pulling or head banging. In addition, she is cooperative with all medical and dental appointments where prior to her treatment at JRC she would refuse such medical or dental care. For example, in 2010, J.C. received a mammogram as part of routine periodic screening as recommended by the American College of Obstetrics and Gynecology. She would never have been able to cooperate for this test prior to her receiving GED treatment at JRC. In 2009, she had a Dexa scan as part of routine screening. This, too, would never have been accomplished prior to GED treatment. As a result of the findings from the Dexa scan, J.C. was placed on calcium supplements to reduce her risk of bone fractures.

At JRC, J.C. has developed skills and a behavioral repertoire with enough positive/replacement and appropriate behaviors allowing her to integrate with the general community in multiple ways. She takes trips into the community each weekend with her peers where she goes to restaurants, salons, the movies, bowling, mini-golfing and the Special Olympics. J.C. visits with her family regularly as well, both in New York and at JRC. These visits have been successful and her family is very pleased with the progress she has made since her arrival at JRC. J.C. lives in a group residence in a residential neighborhood in Attleboro, Massachusetts where she is able to enjoy some leisure time, though most of her time is structured and she is supervised 24 hours per day. She enjoys walking around outside, talking to staff and using the swimming pool at her residence during the summer months.

In summary, the consistent program of positive interventions and supplemental aversive interventions provided by JRC has removed the need to use psychotropic medications and mechanical restraints, neither of which effectively treated her dangerous behaviors, and allowed J.C. to live in a home in a residential community, receive an education and vocational training, spend time in regular classrooms and enjoy social activities with peers. Her treatment at JRC has enabled her to enjoy the highest level of community integration that has ever been possible for her. Continued treatment at JRC is likely to enable her to make even more progress towards increased community integration in terms of her living arrangements. There is a critical medical need for J.C. to continue receiving intense behavioral treatment and treatment with the GED

device at JRC. Removing J.C. from her successful treatment program at JRC prior to it being clinically appropriate to do so would result in immediate and substantial risk of severe injury to J.C. because all other forms of treatment have failed at suppressing her dangerous behaviors and I do not believe that such treatment would be effective now. Removal of J.C. from her current program at JRC is likely to cause a resumption of her dangerous and self-abusive behaviors, necessitating institutional treatment and significant medication and placing her at risk of further harm from the dangerous side effects of such medication.

B.S.

B.S. is a 37 year old male with a diagnosis of profound mental retardation, Pervasive developmental disorder, NOS, tuberous sclerosis, seizure disorder and a severe behavior disorder who was admitted to JRC on June 2, 1989. I have been following the health and treatment progress of B.S. since his admission to JRC. Prior to his admission to JRC, B.S. engaged in dangerous behaviors including frequent vomiting and ruminating behaviors throughout his childhood. He bit, scratched, pinched, and hit himself at high rates. Restraints were used on his arms/hands to reduce the probability that he would injure himself. He also exhibited other difficult behaviors such as unprovoked aggression, property destruction, and eating inedible objects. Prior to his admission to JRC, B.S. had health issues associated with his engagement in these dangerous behaviors, including lacerations to his mouth, infections, bruising, pick marks and scratches on various body parts, and weight loss. Prior to his admission to JRC, B.S. was unsuccessfully treated in New York State, including a hospitalization at just six months of age at Columbia Presbyterian Medical Center and enrollment at a day program at the Shield Institute. Additionally, powerful medications, including Haldol, were prescribed to treat his dangerous behaviors, without success.

When B.S. was admitted to JRC, he exhibited ruminating and vomiting at such frequencies and suffered such extreme weight loss that his life was in danger. After a two week admission to Boston Children's Hospital, it was determined that there was no medical reason for this and that without intensive behavioral intervention, B.S. would die. He was in a helmet twenty four hours per day, and he was required to wear restraint mitts on his hands to protect his body from constant self-injury. B.S. also inflicted wounds to his skin, exposing him to the risk of infection, especially as he would often pick at wounds, preventing them from healing and causing infection. In addition, B.S. has bitten off portions of his tongue and bitten holes in his cheeks. Other self-injurious behaviors included pressurizing his knuckles or body parts against objects to grind a hole through his skin, at times to the point of exposing bone. Additionally, he slapped and punched himself in the face and pulled the hair out of his own head.

The addition of the GED device to B.S.'s treatment program at JRC resulted in a dramatic suppression of these dangerous and life-threatening behaviors. In particular, his rumination and vomiting has been reduced to levels that have allowed B.S. to maintain a healthy weight and he is no longer inflicting severe injury to his tongue, cheek or skin. Because his self-mutilating and violent behaviors have reduced so dramatically, B.S. is now able to feed and dress himself and communicate with others through prompting. His treatment at JRC has allowed B.S. far greater access to his family and community and have allowed him experience the best

possible quality of life. He is a healthy and happy young man, which is a stark contrast to his affect and quality of life prior to his treatment at JRC.

Removal of B.S. from his treatment program at JRC before it is clinically appropriate to do so would result in immediate and substantial risk of severe injury, if not death for B.S. because all other forms of treatment have failed at suppressing his dangerous behaviors and I do not believe such treatment would be effective now. In the past, when his treatment program has not been available to him for brief periods of time, B.S. has shown immediate regression and the same self-injurious and violent behaviors, as well as rumination and vomiting, have immediately returned. B.S. is one of the most self-injurious individuals I have ever treated. It is imperative that B.S. be able to continue to access his current treatment program. Premature removal of B.S. from JRC would not only significantly reduce his quality of life, but would likely prove fatal.

S.S.

S.S. is a 20 year old woman with Autism, Mental Retardation, Ophthalmologic Problems, and Osteochondromas (benign tumors), who was admitted to JRC on March 7, 2005. I have been following the health and treatment progress of S.S. since her admission to JRC. Prior to her admission to JRC, S.S. exhibited severe self-injurious behaviors including slapping her head, head banging, body slamming against objects and kneeing herself in the chin, ears and eyes. She had health issues associated with her engagement in such dangerous behaviors, including cataracts and bilateral retinal detachments. S.S. hit her head so often that she detached both of her retinas; however; due to her continued engagement in self-injury to her face, surgery could not be performed to reattach her retinas. She was equally non-compliant with other medical procedures, including procedures to fix problems related to the osteogenic cysts on her legs, which if left untreated posed a significant risk of leg fracture. In addition, her skin showed scrapes and bruises secondary to self-injurious behavior. S.S. also exhibited severe aggressive behaviors including hitting, kicking, scratching, biting and pinching others; pulling other's hair; and head butting others.

Prior to her admission to JRC, S.S. was not toilet trained and was required to wear a diaper. She received a wide variety of behavioral services from day and residential programs in New York, including the Developmental Disabilities Institute's Young Autism Program, an AHRC program, and the Anderson School, without success. These programs were forced to use a helmet to protect her head, weighted gloves and a blanket wrap in an attempt to control her behaviors and keep her safe. In addition, she was prescribed numerous medications, including Abilify, Seroquel, Risperdal, Depakote and Prozac, to treat her dangerous self-injury and other behaviors, with no success. She suffered adverse side effects from the medication, including increased agitation, hyperactivity and loss of appetite.

S.S. was admitted to JRC on Risperdal, Depakote and Prozac but was slowly tapered off due to their ineffectiveness in treating her severe behavioral problems. From admission, JRC treated S.S. with an intensive behavioral treatment program catered to her personal needs, including treatment with aversive interventions such as the GED devices. S.S.'s current treatment program at JRC has dramatically improved her quality of life. S.S. no longer engages in the self-injurious behaviors that caused her great physical injury in the past, including

blindness. Based on observation of S.S.'s facial expressions, she is now a calm and happy individual. She has been, and continues to be, in excellent health and has suffered no adverse side effects from the treatment. In addition, S.S. is cooperative with all medical and dental appointments where prior to her treatment at JRC she would refuse such medical or dental care. In 2005, she was able to have the necessary retinal surgeries to restore her vision. S.S. would never have regained her vision without her treatment at JRC, including access to GED treatment. In March 2010, S.S. was doing so well behaviorally that she was able to have bilateral lower leg Osteotomies (surgical operation whereby a bone is cut to shorten, lengthen, or change its alignment) successfully performed at Boston Children's Hospital. She did extremely well operatively and post operatively. S.S. recovered extremely well later at her residence, tolerating a wheelchair, wearing leg braces and participating in physical therapy sessions during the several months following her surgery.

Taken together, S.S.'s treatment while at JRC has completely transformed her life. Her observed mood has improved. Her sleep patterns have improved and she works consistently on her academic tasks. Her verbal communication skills have improved. She is able to attend more frequent field trips, where she is actively engaged in her surroundings, integrate with the community, and goes on home visits, where prior to her admission to JRC her dangerous behaviors impacted her ability to do so. She has become a different person, one who is happy, healthy, and able to learn. She is no longer taking anti-psychotic medications or at risk of suffering the side effects associated with such medications. She no longer requires physical restraint or a medically necessary helmet to keep her safe. Her family is extremely pleased with her progress at JRC. They feel that S.S.'s treatment at JRC has saved—and continues to save—her life, and they support her continued placement at JRC.

If S.S. were to suddenly be removed from her program at JRC, her previous dangerous and self-injurious behavior patterns would almost certainly resume. As a result, various mechanical restraint and emergency restraint procedures would have to be reinstated. However, these procedures were not effective in preventing S.S. from harming herself prior to her admission to JRC. Thus, she would likely blind herself and regress to a point where restraint and protective equipment would be required throughout the day. All of her community integration would likely cease. In addition, the nature of her interactions with her family would change as home visits and other community outings would once again be extremely dangerous for her. There is a critical medical need for S.S. to continue receiving intense behavioral treatment at JRC. Removing S.S. from her treatment program at JRC prior to it being clinically appropriate to do so would result in immediate and substantial risk of severe injury to S.S. because all other forms of treatment have failed at suppressing her dangerous behaviors and I do not believe that such treatment would be effective now.

Attached at Tab B hereto, please find photographs of each of the individuals discussed above. The photos, taken from their records at JRC clearly demonstrate the improved health and quality of life these individuals have achieved through their treatment at JRC. As these representative cases illustrate, based on my medical record reviews and physical examinations of JRC's clients, including a number of individuals from New York who are eligible for, or will soon become eligible for, adult services provided by New York's Office for Persons with Developmental Disabilities, it is my professional opinion that continued treatment at JRC for

certain individuals is necessary in order to avoid immediate and substantial risk of permanent injury or death. Any state action or policy requiring these individuals to be removed from JRC must include sufficient transition planning to avoid, or at least mitigate, severe harm to these individuals based on clinically premature removal from the treatment program. These individuals must have intensive behavioral services or they will be at risk of devastating harm or even death. Because New York State does not have sufficient facilities to provide these intensive services, any alleged cost savings from the Governor's proposed budget will be negated by the extremely high costs of psychiatric hospitalizations for these individuals.

I thank you for your time and consideration. Please do not hesitate to contact me if I can be of further assistance in this matter.

Sincerely,

Edward A. Sassaman, M.D.

Enclosure(s)

CURRICULUM VITAE

Edward A. Sassaman, M.D.
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EDUCATION

Undergraduate:	University of Pennsylvania Biology, BA 1969 – Cum Laude
Medical School:	Harvard Medical School – M.D. 1973

POSTGRADUATE TRAINING

Resident:	Children's Hospital Medical Center, Boston, MA Intern: 1973-1974 Junior Resident: 1974-1975 Senior Resident: 1975-1976
Fellowship:	Children's Hospital Medical Center, Boston, MA Development Evaluation Clinic Fellow in Development Disabilities: 1976-1978

BOARD CERTIFICATION AND PROFESSIONAL LICENSES

Diplomate, America Board of Pediatrics – 1978
Massachusetts – 1976 – Present
Rhode Island – 1978 – 1996
New York – 1994 - Present

PROFESSIONAL EXPERIENCE

2000 – Present	Excellus BlueCross BlueShield, Rochester Region Rochester, NY

(A national indemnity and managed care health insurance company with revenues of over $4 Billion and 2.2 million covered lives.)
Regional Medical Director

Responsibilities: Responsible for developing and implementing managed care programs for children and adults throughout all of Excellus. Consultant for case management, utilization management, and corporate medical policy for all members. Direct responsibility for overseeing all of provider credentialing and re-credentialing throughout all of Excellus and Univera. Reports to the Vice President of Medical Affairs and Chief Medical Officer of Excellus BlueCross BlueShield, Rochester Region.

Accomplishments:

- Implementation of community-wide Pediatric Preventive Health Guidelines
- Creation and implementation of disease state management program for Attention Deficit Disorder
- Common credentialing and re-credentialing policies (with specific guidelines for outliers created for all of Excellus and Univera)
- Established linkage between quality and credentialing (system to identify quality outliers and monitor QIP through credentialing)
- Create community practice guidelines and a disease management program for individuals with Autistic Spectrum Disorder

1994 – 2000

BlueShield

Medical Director, Lifetime Health
Associate Corporate Medical Director, BlueCross

Rochester, NY
(A mixed model HMO with 65,000 members and revenues of
$82 million)

Responsibilities: Direct supervision of entire medical staff, including affiliated health professionals (125 FTEs). Direct responsibility for utilization management, quality management, case management, pharmacy benefit management, disease state management. Reported to the Vice President of Medical Affairs, BCBS Rochester.

Accomplishments:
- Oversaw doubling in size of medical staff
- Created and implemented disease state management programs in diabetes and congestive heart failure
- Created and implemented physician incentive program
- Created and implemented department and individual PCP quality and utilization yearly goals with method to revise goals based on department and individual performance
- Created peer review process to identify medical errors and create quality improvement process to rectify errors

1990 – 1994

Director of Pediatrics, Kaiser Permanente
Springfield, Massachusetts

Responsibilities: Direct supervision of pediatric staff responsible for quality issues. Practicing pediatrician. Reported to the Director of Pediatrics for Kaiser Permanente of Massachusetts.

Accomplishments:
- Oversaw doubling of pediatric department
- Implemented program for evaluation of handicapped children

1984 – 1990

Practicing Pediatrician
Medical West
Springfield, Massachusetts

Responsibilities: Providing primary care to 2,500 children

Accomplishments:
- Creation of consultative service for developmentally disabled children for a group of 12 practicing pediatricians

1978 – 1984

Associate Director, Child Development Center
Providence, Rhode Island
(A Federally and State-funded multi-disciplinary clinic for handicapped children)

Responsibilities: Direct supervision of pediatric staff and fellows as well as pediatric residents and medical students

at Brown University Program in Medicine. Director of Muscular Dystrophy Clinic and Spina Bifida Clinic. Reported to Director, Child Development Center.

Accomplishments:

- Oversaw increase in teaching responsibilities with residents and medical students
- Created outreach program for community-based pediatricians

ACADEMIC/HOSPITAL APPOINTMENTS

1. Clinical Instructor in Pediatrics 1994 - Present
   University of Rochester School of Medicine
   Rochester, NY
   Associate Attending Physician
   Strong Memorial Hospital
   Rochester, NY

2. Attending Physician 1984 - 1994
   Baystate Medical Center
   Springfield, MA

3. Assistant Professor in Pediatrics 1978 – 1984
   Brown University School of Medicine
   Providence, RI
   Associate Physician
   Rhode Island Hospital
   Providence, RI

4. Instructor in Pediatrics 1977 - 1978
   Harvard Medical School
   Boston, MA

STATE OF NEW YORK APPOINTMENTS

Expert Reviewer in Pediatrics
Office of Professional Medical Conduct
New York Department of Health

Albany, NY

MEMBERSHIP IN SOCIETIES

Fellow, American Academy of Pediatrics

RESEARCH INTERESTS

1. Medical Peer Review – categorizing medical errors by physicians and determining antecedent predictive factors.

2. Determining which components of a Diabetes Disease State Management Program correlate best with a positive outcome.

COMMITTEES

1. Lifetime Health Quality Utilization Management Committee – 1994 – 2000
2. Lifetime Health Peer Review Committee – 1995 – 2000
3. Lifetime Health Pharmacy and Therapeutics Committee – 1994- 2000
4. Lifetime Health Medical Management Steering Committee – 1997 – 2000
5. BlueCross BlueShield of Rochester Managed Care Quality Committee – 1995 – present
6. BlueCross BlueShield of Rochester Managed Care Credentialing Committee – 1996 – present
7. Blue Cross/Association for Retarded Citizens/United Cerebral Palsy Task Force to create community based primary care program for developmentally disabled adults – 1998 – present
8. Preferred Care Peer Review Committee – 1998 – present
9. Preferred Care Clinical Quality Team – 1998 – 2000

PUBLICATIONS

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2. Sassaman, E.A., Mulick, J.: Sterilization and the Retarded Female. Pediatrics 66:650, 1980.

3. Sassaman, EA., Zartler, A., and Mulick, J.: Cognitive functioning in children with carbamyl phophate synthetase deficiency. Journal of Pediatric Psychology 6:171-7, 1981.

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5. Sassaman, EA., Zartler, A.,: Mental retardation and head growth abnormalities. Journal of Pediatric Psychology 7:149-156, 1982.

OTHER PUBLICATIONS

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10. Sassaman, E.: Autism in Adolescents and Adults by Eric Scholper and Gary Mesibov; Autistic Children: New Hope for a Cure by Niko and Elisabeth Tinbergen. Book Review. New England Journal of Medicine, 309:675, 1983.

11. Sassaman, E.: No Fault Parenting by Helen Neville and Mona Hulaby. Book Review. New England Journal of Medicine, 317:285, 1985.

12. Sassaman, E.: Sudden Infant Death Syndrome. In: Under Three. O'Shea, J. (Ed.) New York: Von Nostrand, Rhineholt, 1988.

13. Sassaman, W., Sassaman, E.: Twins. In: Under Three. O'Shea, J. (Ed.) New York: Von Nostrand, Rhineholt, 1988.

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J.C. Before Treatment at JRC

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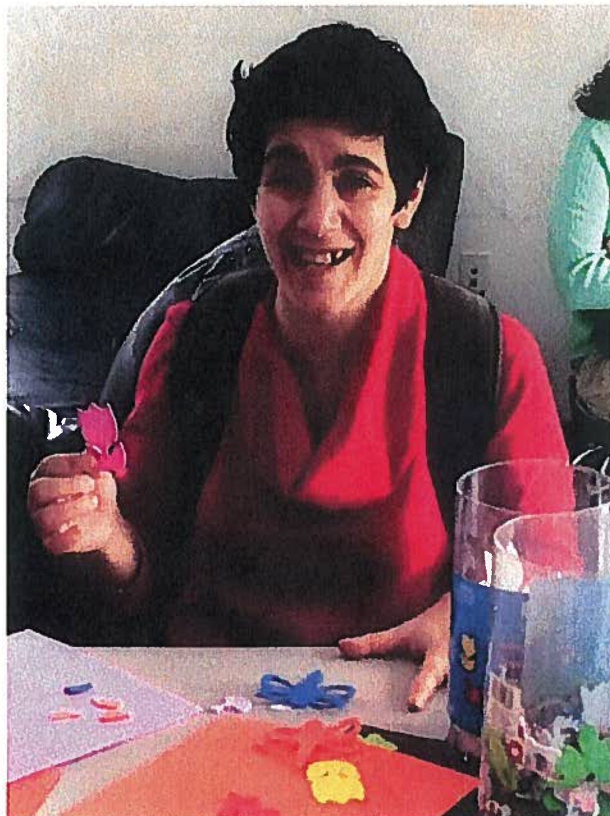
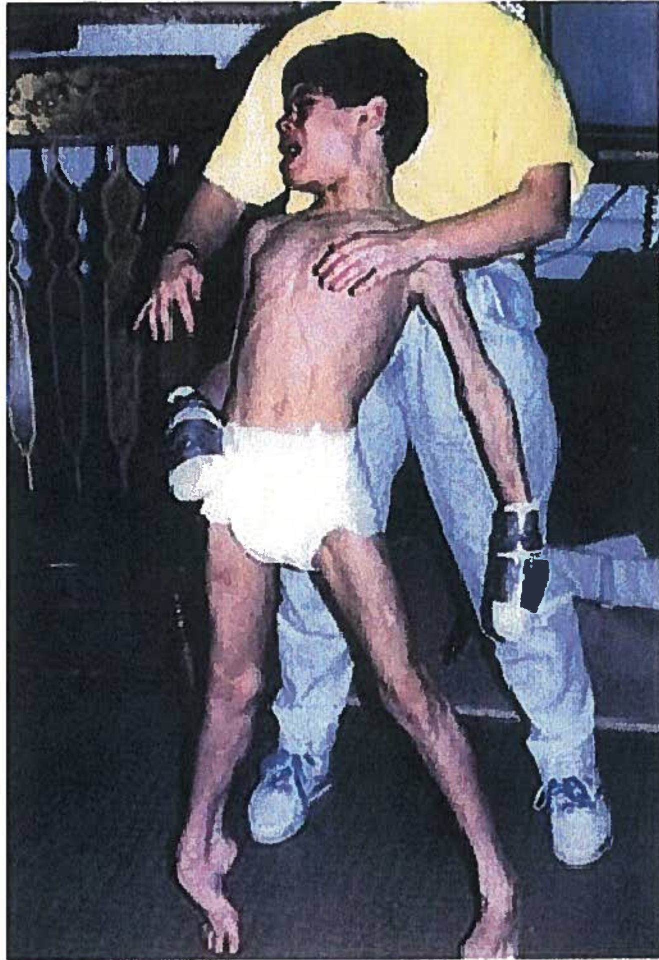
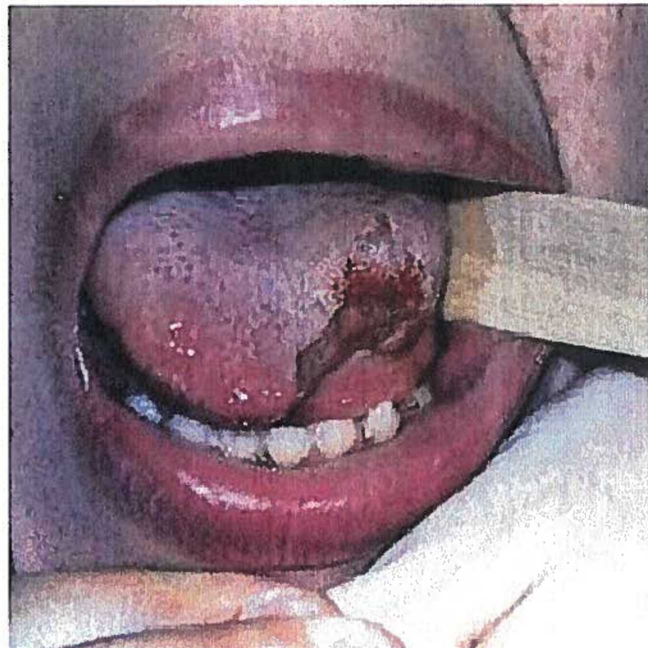


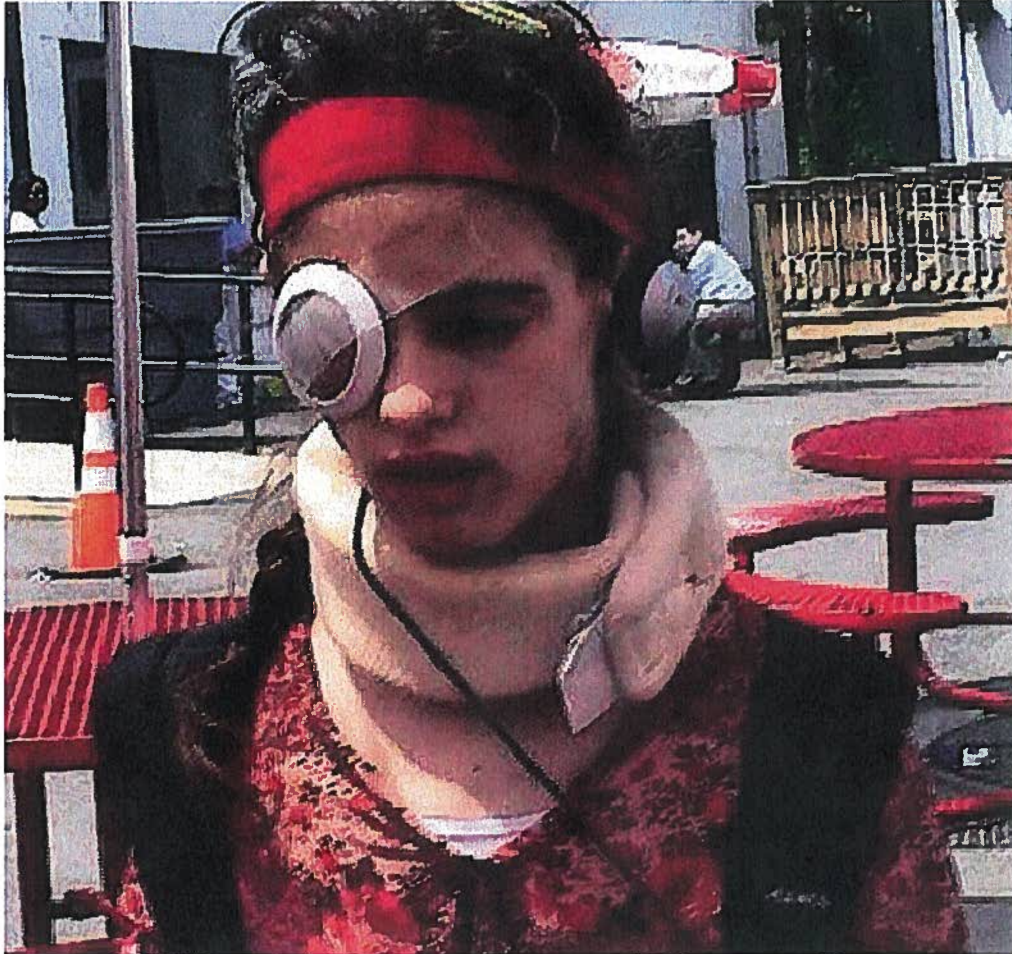
B.S. Before Treatment at JRC





B.S. After Treatment at JRC

S.S. Before Treatment at JRC



S.S. After Treatment at JRC