The Forum
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Massachusetts Chapter
Newsletter of the Massachusetts Chapter of the American Academy of Pediatrics

PRESIDENT'S MESSAGE

Our Voice Needs to Be Heard

"In a nation as rich as ours, it is a shocking fact that tens of millions lack adequate medical care. We need and we must have without further delay a system of prepaid health insurance." — Harry Truman, 1945

Many of us in Massachusetts are scratching our heads, wondering how the prize of universal health care coverage has eluded us for so long and continues to do so. It would be easy to blame the politicians for failure to act or to blame the electorate for failing to hold elected representatives accountable. Upon further reflection, however, I must conclude that we ourselves also bear responsibility.

As pediatricians, we see in our daily lives inefficiencies and inequities in health care delivery. For one child, behavioral/developmental screens are covered by insurance, but the same may not be the case for the next child. Barriers exist to scheduling timely appointments with specialists — or even with ourselves. As insurance costs rise, fewer and fewer of our services are compensated. We hunker down and work harder on behalf of our patients while experiencing increasing amounts of stress and frustration.

This is not our fault. We did not design the "system." Yet could we not be a powerful voice to improve it? Pediatricians are natural advocates for kids. We are respected — often revered — by families and the public. We are passionate about high quality care and the prevention of illness and injury. We are persistent, often caring for kids from birth through college and then caring for their children as well. We communicate well with a

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BOOK CORNER

The Importance of the Spoken Word

In February of 2001, when the American Academy of Pediatrics released their policy statement on children and the media (*Pediatrics* Vol. 107 No. 2 February 2001, p. 423-426) describing the possible negative health effects of television viewing on children and adolescents such as violent or aggressive behavior, substance use, sexual activity, obesity, poor body image, and decreased school performance, many pediatric clinicians were uncomfortable with the force of their final recommendations. Specifically, that clinicians should discourage television viewing for children younger than two years and encourage more interactive activities that will promote proper brain development, such as talking, playing, singing, and reading together. On its base, no one could contest these recommendations, but in reality, many felt uncomfortable advising families not to let their children under age two view *any* television. What often occurred is that many clinicians just didn't bring up the topic until children were over two years when they [the doctors] felt more comfortable with the recommendation — limit children's total media time (with entertainment media) to no more than one to two hours of quality programming per day.

A recent study by Christakis et al. in the article "Audible Television and Decreased Adult Words, Infant Vocalizations, and Conversational Turns," (*Archives of Pediatric and Adolescent Medicine* 163:554-558, June 2009) should give us pause, though, about the importance of "taking on" media anticipatory guidance in the first two years of life. This was an innovative study that followed 329 two- to 48-month-old children. Children wore digital recorders on random days for up to 24 months. A software program incorporating automatic speech identification technology processed the recorded file to analyze the sounds the children were exposed to and made. They used linear regression to analyze the main exposure, audible television, and their outcome measures — adult word counts, child vocalizations, and child conversational turns.

What they found was intriguing. Each hour of audible television was associated with significant reductions in child vocalizations, vocalization duration, and conversational turns. But what was most

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Editor's Note

In this issue of *The Forum*, Dr. Abrams discusses a recent article in *Pediatrics* reviewing the significant number of visits by children to emergency departments (EDs), which likely could be more appropriately and less costly managed in primary care settings. We all know that EDs provide great emergency care but are clearly not the best place for a patient to receive non-emergent care. In keeping with the medical home model, a primary care physician's office is the ideal place for both preventive and acute care unless a condition is truly emergent and requires facilities or expertise beyond the scope of the office.

Keeping patients away from the ED for "unnecessary" visits is something with which we all struggle. In fact, my large multispecialty group is making this one of our highest priorities for the coming year. The million-dollar question, though, is how do we do this? In our group, we are all making a strong effort to educate patients and their families about the availability of our after-hours urgent care. We have the ability to staff an urgent care facility because of our size. However, this is far more challenging to the smaller practices.

Dr. Abrams argues that, despite the more "intensive" work schedules, even a smaller practice can provide weekend and evening hours. While I certainly share Dr. Abrams' belief that this is the ideal way for a practice to run and the model all should strive to achieve, I feel that is less practical now than in years past.

Work-life balance has become an ever-increasing concern for young physicians. Greater than 50 percent of all medical school applicants and far greater than 50 percent of all pediatric residents are female. (I was the sole male resident in the UMass Pediatric Residency Class of 2006; the class below me was 100 percent female.) Many in this group will choose to work part-time. In addition, many of the male pediatricians (myself included) have a spouse who is also a physician. For many young physicians, a position that requires night and weekend hours is not appealing and often not even acceptable.

Some may say that this generation is lazy or does not have the work ethic of previous generations of physicians. Say what you will, but this is the reality we must all live with. I have been involved in recruiting for our medical group recently, and the fact that we have evening and weekend urgent care hours as a required part of our practice has turned away many excellent applicants. We can continue to say, "If they do not want to work that much, they were not right for the job," but eventually, there will be nobody left that is "right" for the job.

The demands on young two-physician or two-professional families are significant. Trying to coordinate childcare and after-school activities and still be part of our own children's lives is difficult. We as pediatricians should and need to be supportive of physician parents and encourage them to provide caring and nurturing environments for their young ones. We better than anyone understand the value of parental involvement in a child's life.

Rather than simply continuing to practice the status quo of our regular daily office hours *and* after-hours care, we need to look for new and innovative ways to provide care to our patients during as many hours as possible. There is no reason that a "regular" work week needs to be 8:00 a.m. to 5:00 p.m. Monday through Friday. Why not have 12:00 to 9:00 p.m. days? What about creating a "work week" that goes from Saturday to Wednesday? Or hiring physicians who only want to work nights and weekends? This schedule may work well for some, and I know there are practices that are already doing this. This will require additional providers for each practice and an increase in the primary care work force. This can only happen through payment reform, and here is where our professional organizations such as the MCAAP and AAP come in.

We also need to recognize that a physician working more than 60 hours per week is likely not part of the future of medicine. As our workforce of part-time and two-professional families grows, we will have to accept changes to the "ideal" work model and be proactive as an organization before other groups decide to regulate our profession for us.

— Lloyd D. Fisher, MD, FAAP

President's Message

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variety of people — parents, grandparents, young children, and even teenagers! Out of necessity, we have good senses of humor and lots of humility. We are patient, and we are good educators. And we have important stories to tell.

Following the election of Scott Brown to the U.S. Senate, the floodgates have opened, and the balance of political power, already precarious and abused by both sides, is likely to shift again. This is an opportunity for us, as advocates for children, to influence change in a positive direction. Politicians on both sides will be much more likely to listen than they have been in the past. The public is confused by all the hype they are hearing and hungry for information that is accurate and makes sense. The media will be receptive to stories that illustrate the challenges people face in their daily lives. We may not have all the solutions, but we certainly can point out bureaucracy and unfairness in health care systems.

Where I work, at Harvard Vanguard Medical Associates, we are very concerned that the current rise in the cost of care is unsustainable. We are focusing our efforts on improving the value of services we provide (value = outcomes/cost). Can we as pediatricians suggest ways to increase value to patients and families? Certainly, the medical home model is one way to do this, and policymakers need to hear about it from us. I'm sure that, every day, each of us sees waste and discrimination occurring in health care. What is more difficult is to point it out, to make it visible. But unless we take the time to do this, it won't improve.

So over the next few months as the election season picks up steam, I encourage each of you to tell your stories — to politicians, to decision-makers, to the media, and to families in your practices. Point out the problems and offer whatever solutions make sense to you. If we all do this, our collective voice will be very powerful, and who knows, perhaps we will be the force that gives our patients a healthy and affordable future.

— Carole Allen, MD, FAAP

Book Corner

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critical was the decreased exposure to discernible human adult speech. In terms of adult word count, they found there were 500 to 1,000 fewer adult words spoken per hour of television watched. Normative data for adult word counts indicates that adults utter approximately 941 words per hour, suggesting that talking is significantly reduced when a television is audible to a child. So much for the theory of TV increasing adult child interaction!

Research has shown that children learn from listening and interacting and that a child's vocabulary is proportional to the amount of words he or she hears in an interactive relationship. Perhaps what we really need to focus on in a media history is not so much *what* children are watching but what they can do *instead* of watching that includes talking, playing, singing, and reading together. One of the greatest strengths of promoting early literacy by giving a book to children and families is that the book *goes home* with the family and acts as a symbol of the clinician and the messages discussed during the visit. Hopefully, it also sits *hiding* the remote control. ***— Marilyn Augustyn, MD, FAAP, Medical Director, Reach Out and Read Massachusetts***

For more information about Reach Out and Read and early literacy, e-mail Gretchen.hunsberger@reachoutandread.org or augustyn@bu.edu or visit Reach Out and Read's national website (www.reachoutandread.org), which has been redesigned and now includes more literacy materials and research data for providers. Check it out!

IN MEMORIAM

Stanley Spevack, MD

Dr. Stanley Spevack, who was chair of pediatrics at Saint Anne's Hospital and cofounder of Highland Pediatrics, recently lost a courageous battle with gastric cancer.

MCAAP Committees and Administrative Appointments

AAP BREASTFEEDING COORDINATOR
Susan Browne

BYLAWS COMMITTEE
Carole Allen

CATCH CO-COORDINATORS
Robert Kossack
Giusy Romano-Clarke

COMMITTEE ON ADOLESCENCE
Rebecca O'Brien

CONTINUING MEDICAL EDUCATION
Mary Beth Miotto

DEVELOPMENTAL DISABILITIES
Beverly Nazarian

EMERGENCY PEDIATRIC SERVICES
Patricia O'Malley

ENVIRONMENTAL HAZARDS
Siobhan McNally
Megan Sandel

FETUS AND NEWBORN
Elizabeth Brown

FINANCE COMMITTEE
Elizabeth Brown

FORUM EDITOR
Lloyd Fisher

FOSTER CARE
Linda Sagor

IMMUNIZATION INITIATIVE
Sean Palfrey
Hadassa Kubat

INFECTIOUS DISEASE
Sean Palfrey

INJURY PREVENTION AND POISON CONTROL
Greg Parkinson

INTERNATIONAL CHILD HEALTH
Jane Cross
David Norton

LEGISLATION
Michael McManus
Karen McAlmon

MASSACHUSETTS HEALTHY FAMILIES
Howard King

MEMBERSHIP
Chelsea Gordner
Walter Rok

MENTAL HEALTH TASK FORCE
Joe Gold
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Carole Allen

NOMINATING COMMITTEE
Open

OBESITY COMMITTEE
Alan Meyers
Elizabeth Goodman

PEDIATRIC COUNCIL
Peter Rappo

PEDIATRIC PRACTICE
Open

PROS NETWORK COORDINATORS
David Norton
Ben Scheindlin

SCHOOL HEALTH
Linda Grant

SUBSTANCE ABUSE
John Knight

SUSPECTED CHILD ABUSE AND NEGLECT
Rebecca Moles

TECHNOLOGY
William Adams

ShotClock

Immunization Legislation

Imagine a world where all recommended vaccines were free for all patients (regardless of insurance status); medical offices received uniform, adequate reimbursements for vaccine administration; and we could find out the vaccine status of all our patients and what they were due for and when, regardless of whether they were vaccinated in our offices or anywhere else in the state.

If we get the immunization bill passed, this dream will be established in legislation in perpetuity.

S859 (and its equivalent H3453) is a bill that the Immunization Initiative of the MCAAP and the Massachusetts Department of Public Health (DPH) developed a year and a half ago after Massachusetts lost its status as a "universal distribution state." It became apparent that we would not be able to obtain state funding for all our vaccination needs each year under the current mechanisms. The Medical Legal Partnership at Boston Medical Center found a group of lawyers at Ropes and Gray who helped us write the bill pro bono. It was sponsored by two senior legislators, Rep. Alice Wolf and Sen. Richard Moore, in their respective chambers and got tremendous support from the DPH and other organizations around the state. The bill has begun working its way through the legislative process (which often takes years).

The first section of the bill allows the state to annually collect an assessment from every health plan in the state sufficient to cover the cost of all nationally recommended vaccines for children in Massachusetts. This money, plus all federal vaccine purchase contributions (Vaccines for Children [VFC], 317 dollars), would go into a state-established Vaccine Purchase Trust Fund through which the DPH could then purchase and distribute all vaccines for every child. Since the vaccines can be purchased at the federal discount rate, this approach will cost the insurance companies 40% less than they would have to pay if the companies bought them on the open market.

The second section of the bill allows the insurance commissioner to set a community standard vaccine administration fee for all practices, health centers, and anyone else allowed to give the vaccines. This would assure that the costs of storage, record-keeping, and administration for every vaccine given would be fairly and equitably covered regardless of the site where the vaccine is given or the child's insurance plan.

The third section of the bill establishes the legal and financial basis for the operation of the Massachusetts Immunization Registry. It would fund the registry out of the Vaccine Purchase Trust Fund. It establishes that information on every child born in the state will be entered into the registry, that all immunizations given everywhere in the state to every child will be entered into the registry, and that unless a child's family opts out, the information about those vaccines may be accessed by the child's doctor and certain public health agencies (i.e., the child's school, WIC office). The registry has been painstakingly built over the course of years and is being piloted this year with federal stimulus funds, but it's full, statewide operation requires permanent funding and the legal elements contained in this bill.

One year ago, as the bill moved slowly through the Massachusetts legislature, the state established in this year's annual budget (FY10) the funding mechanism put forth in section one of the bill. This has allowed the state to receive private, federal, and state funds to buy all recommended vaccines, except for HPV vaccine, which is only funded for VFC-eligible patients. However, the vaccine funding line item must be considered each year and passed as part of the state budget. Also, without the second and third sections of the immunization bill, practices, health centers, and schools that administer vaccines do not get standard administration fees, and the registry is not annually funded.

The medical community and the children of Massachusetts need this bill to be passed into law so that we do not have to fight every year for payments for universal distribution of all vaccines, fair and uniform administration fees, and a fully operational registry. The bill is now in the Senate Ways and Means Committee. The Immunization Initiative of the MCAAP, the Massachusetts DPH, and all our many allies are urging the Senate leadership and this committee to move the bill out of committee so that it can be voted into law this year.

The senators on this committee need to hear from their colleagues in the legislature and their own constituents that this is a critically important bill that needs to take precedence over others and be passed into law by the Senate and the House of Representatives.

If you are in the districts of senators who serve on the Senate Ways and Means Committee, or if you are close to your own senator, we are asking that you speak to him or her to urge the leadership of the committee to move the bill out onto the floor of the Senate for a vote. — ***Sean Palfrey, MD, FAAP***

For additional information about your legislator and this bill, please contact me, Hadassa Kubat, Ed Brennan, or Carole Allen.

Massachusetts Department of Public Health Division of Epidemiology and Immunization

Changes to School Immunization Requirements — Fall 2011

To bring Massachusetts' school immunization requirements up to date with several recent recommendations made by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, the Department of Public Health has made changes to the school immunization requirements. The following changes will be effective in the **fall of 2011** (not the fall of 2010):

Vaccine Requirements

- Two (2) doses measles, mumps, and rubella (MMR) vaccine for entry to kindergarten, seventh grade, for full-time college freshmen, and for health science students (Currently, 2 doses of measles, 1 dose of mumps, and 1 dose of rubella vaccine are required for these groups.)
- Two (2) doses varicella vaccine for entry to kindergarten, seventh grade, for full-time college freshmen, and health science

students (Currently, 1 dose of varicella vaccine is required for entry to kindergarten and seventh grade, and there is no varicella requirement for college.)

- One (1) dose Tdap for entry to seventh grade and for full-time college freshmen and health science students (Currently, 1 dose of Tdap is required for these groups.)

Criteria for Immunity for College Students

The following are the revised criteria for immunity to measles, mumps, rubella, and varicella for college students:

- Students may be considered immune to measles, mumps, and rubella if:
  - The student presents laboratory evidence of immunity
  - Born in the United States before 1957 (with the exception of all full- and part-time students in health science programs who may be in contact with patients)
- Students may be considered immune to varicella if:
  - The student presents laboratory evidence of immunity
  - The student presents a statement signed by a physician, nurse practitioner, physician's assistant, or a designee that the student has a reliable history of chickenpox disease
  - The student has a self-reported history of disease verified by a physician, nurse practitioner, or physician's assistant
  - Born in the United States before 1980 (with the exception of all full- and part-time students in health science programs who may be in contact with patients)

Definitions

- The definition of "certificate of immunization" has been revised to also allow nurse practitioners and physician's assistants, in addition to physicians, to sign and date the form or letter. The definition was also clarified to require the month and year of administration as well as the type/name of the vaccine administered in both electronic and hard copy documentation.

There are **no** changes to the school immunization requirements for the 2010–2011 school year. These changes do **not** go in to effect until the **fall of 2011**. We are providing this information now so that providers can begin to catch up children and adolescents who do not currently have the immunizations that will be required for school entry beginning in September of 2011. Starting catch-up vaccinations now will help to ensure that children have the immunizations they need for school entry in the fall of 2011, as well as help to prevent a large rush to offices for immunizations during the summer of 2011. The current Massachusetts school immunization requirements can be found on our website at www.mass.gov/dph/imm.

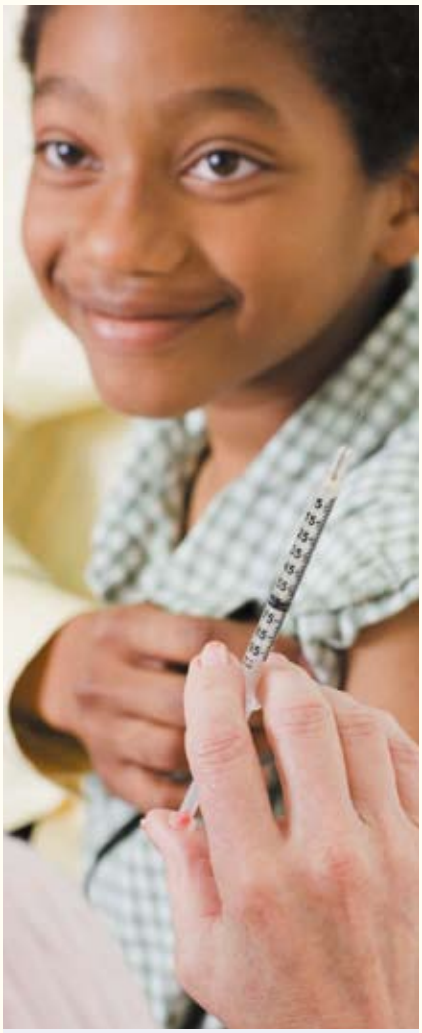
If you have any questions about current or future school immunization requirements, please contact the Division of Epidemiology and Immunization at (617) 983-6800.

New Pneumococcal Conjugate Vaccine, Prevnar13™ (PCV13), Approved by FDA

On February 24, 2010, the United States Food and Drug Administration (FDA) approved the licensure of Prevnar13™ (PCV13), a 13-valent pneumococcal conjugate vaccine. The Advisory Committee on Immunization Practices (ACIP) has recommended its addition to the Vaccines for Children (VFC) Program to replace Prevnar® (PCV7), which has been available to providers since 2000. The final ACIP recommendations for PCV13 can be found at www.cdc.gov/mmwr/preview/mmwrhtml/mm5909a1.htm and were recently published in the Centers for Disease Control and Prevention's Morbidity and Mortality Weekly Report (MMWR). They are available for download at www.cdc.gov/mmwr/PDF/wk/mm5909.pdf.

PCV13 includes the seven serotypes already contained in PCV7 plus an additional six strains (1, 3, 5, 6A, 7F, and 19A). The incidence of disease caused by the seven serotypes that are included in PCV7 is very low now, and serotype19A has now emerged as the primary pathogenic strain. It is projected by Wyeth Labs that, once introduced, PCV13 will provide protection against about 64 percent of remaining pneumococcal disease in children younger than two years and 73 percent in those two to four years.

The Massachusetts Department of Public Health (DPH) is providing additional guidance on PCV13 ordering. For further information on vaccine availability, please contact the DPH Vaccine Management Unit at (617) 983-6828 or visit the DPH Immunization Program's website at www.mass.gov/dph/imm.



REMINDER

State-supplied vaccines are available for catch up of all children through 18 years of age, regardless of insurance status.*

- Tdap vaccine
- MCV4 vaccine
- Varicella vaccine
- Hepatitis A vaccine
- MMR vaccine

Please order and have these vaccines available for your patients.

*These vaccines are also available for adults seen in public sector settings.

Anti-Thimerosal Wording Added to Pandemic and Disaster Preparedness Bill

Last fall, when concern about H1N1 flu was at its height and everyone was scrambling to procure and administer H1N1 vaccine, the Massachusetts legislature was working on a bill entitled H.4272, An Act Relative to Pandemic and Disaster Preparedness and Response. The purpose of this bill was to set in place practices that would enable Massachusetts and its Department of Public Health (DPH) to protect citizens optimally in the case of pandemic or disaster.

Unknown to the public, when the bill was in committee, two senior members of the legislature, who had on several occasions in previous years failed to pass bills banning the use of Thimerosal in any vaccines, added a similar amendment to the pandemic and disaster preparedness bill. This was ironic in the extreme, because if such wording had been in force this winter, it would have prevented many infants from receiving H1N1 vaccine given all the vaccine shortages that were occurring.

Once this amendment was discovered, the MCAAP, in association with the DPH and many other public health organizations, mounted a campaign to have this amendment removed from the important legislation it was appended to. The crux of our arguments was that: 1) There is no evidence that Thimerosal in vaccines is harmful; 2) Far from aiding pandemic preparedness, this amendment could seriously hinder the state's efforts to protect its citizens; and 3) Passing such an amendment would suggest inaccurately that the state had ever considered Thimerosal a dangerous substance.

No action has been taken to date on the amendment or the bill, and we are still trying to get word directly to committee members about the importance of removing this amendment. If you would like to help, please contact Dr. Hadassa Kubat (hkubat@mms.org).
— Sean Palfrey, MD, FAAP

Massachusetts Child Psychiatry Access Project (MCPAP) and Haitian Mental Health Network (HMH) Collaborate to Help the Haitian Community

The Massachusetts Child Psychiatry Access Project (MCPAP) and the Haitian Mental Health Network (HMH) have joined forces to help provide psychological support to the Haitian community here in Massachusetts. MCPAP and HMH are concerned with helping those affected directly and indirectly by the devastating earthquake in Haiti. HMH expects that Massachusetts will absorb some of the Haitian survivors.

HMH will be providing training to providers in psychological first aid and on trauma-informed mental health interventions. The network will also train providers on recognizing signs of mental illness among Haitian children and adolescents and assessing those at risk for emotional difficulties. Also, the HMH is involved in assessing the impact of the disaster, along with gaps in mental health services; offering culturally competent clinical consultation; and developing a "hub" for coordinating mental health services targeting the Massachusetts Haitian community.

The MCPAP provides primary care physicians (PCPs) with timely access to child psychiatry consultation and care coordination. The MCPAP has enrolled 372 pediatric and family practices across the state. The organization's six hubs have strong relationships with PCPs across the state. MCPAP is an ideal partner to help the HMH reach patients showing up in pediatric offices with signs of abnormal reaction to trauma.

Call your MCPAP care coordinator to connect youth/families to HMH culturally competent Haitian mental health providers. MCPAP is also available to provide advice on dealing with acute trauma. See box (right) for the telephone numbers of the regional MCPAP hubs. ***— John H. Straus, MD, FAAP, Vice President, Medical Affairs, Massachusetts Behavioral Health Partnership***

For more information regarding MCPAP, please contact Irene Tanzman at the Massachusetts Behavioral Health Partnership at (617) 350-1990 or irene.tanzman@valueoptions.com.

REGIONAL MCPAP HUBS

Western Massachusetts
Baystate Medical Center
(413) 794-3342

Central Massachusetts
UMass Medical Center
(508) 334-3240

Northeast Region
North Shore Medical Center
(888) 627-2767

Boston/Metro Region I
Mass General Hospital
(617) 724-8282

Boston/Metro Region II
Tufts Medical Center/
Children's Hospital
(617) 636-5723

Southeast Region
McLean-Brockton
(508) 894-8484

Annual Residents' Day at the State House

Young Pediatricians Advocate for Childhood Vaccine Funding

On April 15, 2010, over sixty pediatricians in training will gather at the Massachusetts State House to advocate for children's health care at the fifth annual Pediatric Residents and Fellows Day at the State House (RFDASH). On the top of their agenda: a bill to guarantee funding for all recommended childhood vaccines and to create a vaccine registry to track the vaccine status of all children in the Commonwealth (H3453/S2195).

For a century, the Massachusetts Department of Public Health provided vaccines to health care providers so all children had access to immunizations regardless of health insurance status. However, Massachusetts is no longer a "universal childhood distribution state," so it is no longer able to fully provide such funding. The bill up for debate would create a vaccine purchase trust funded by insurance providers to cover costs not covered by the state. This trust would allow for vaccine purchase through the federal system, which is 40 percent less costly than private purchasing. In addition, Massachusetts is currently one of only two states that does not have a vaccine registry, preventing children's immunization status from being easily tracked. This bill would establish such a registry to improve vaccination rates in the Commonwealth.

"It is impossible not to feel the immense impact vaccines have had on children's health," said Massachusetts General Hospital (MGH) pediatrics resident Jessica Rosenthal. "Our instructors often tell us about the number of seriously ill children with bacterial meningitis that they took care of as residents, describing that many of those children developed devastating neurologic sequelae. I have not seen a single child with bacterial meningitis this year, and Haemophilus influenza b vaccine has clearly had a major role in decreasing the frequency of this largely preventable illness." Kerrin DePeter, a second-year pediatrics resident at MGH, added, "When we have such effective means at our disposal for preventing serious illnesses, it seems irrational and unfair not to do everything possible to facilitate widespread distribution of these resources. We should not be taking steps backwards in 2010 in the initiative to vaccinate children, and this bill would catch Massachusetts up again."

The fifth annual RFDASH at the State House is sponsored by the MCAAP. Pediatricians from all over the state will be in attendance. Featured speakers will be Dr. Greg Hagan, vice president of MCAAP, and Dr. Vivek Murthy, cofounder of Doctors for America.

Other issues at the focus of RFDASH efforts are support for a bill limiting ATV use by children and opposition to a bill that would relax limits on obstetrical care delivered by nonphysician providers. More information can be found at http://mghfcresidents.wordpress.com.

Nonemergent Emergency Department Visits

In the March 2010 issue of *Pediatrics* ("National Profile of Nonemergent Pediatric Emergency Department Visits"[1]), Ben-Isaac et al. describe the inappropriate, increased utilization of emergency departments (EDs) as sources of primary pediatric care.

The authors refer to a study by Billings et al.[2] in which four out of every five patients in ED visits were found to be nonemergent cases, had preventable conditions not requiring a visit to a medical provider, and/or could have received care in a nonemergent setting (or could have been seen more than 12 hours later).

Despite overcrowded EDs and long waiting times, during the period from 1998 to 2006, ED visits increased from 96.5 million to 119.2 million, while the number of EDs in that period decreased by about 10 percent. Contributing to the high use of EDs was the passage of the Emergency Medical Treatment and Labor Act of 1986 in which everyone has the legal right to emergency care, but Congress has yet to provide any funding to pay for the act.[3]

A major factor in spiraling health care costs has been the increased costs of receiving primary care in an ED. This was highlighted by Baker LC and Baker LS[4] in a 1993 article in which the cost of treating a similar condition such as pharyngitis was approximately three times as high in an ED as in a primary care setting. There is no reason to believe this ratio has changed, and it has likely increased since this study was conducted because of the increased utilization and availability of more sophisticated and costly testing such as head CT for head injuries.[5]

For over 40 years, my pediatric group, Holyoke Pediatric Associates, has had night and weekend office hours. The group also continues to treat its patients in hospitals and does not utilize hospitalists. It may have made our working schedules more intensive, but I think it has benefitted our patients and our mission as pediatricians.

To make health care more accessible and affordable for the children of the United States, it would be an important contribution if the American Academy of Pediatrics could facilitate the incorporation of the recommendations at the conclusion of the article by Ben Isaac et al.: "Potential ideas to help resolve these problems may include… collaboration of EDs and local physicians to the joint creation of afterhours clinics."

— Robert Abrams, MD, FAAP

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Swansea, MA 02777
Phone: (508) 379-9605
E-mail: jmonacmd@swanseapediatrics.com

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Contact:
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Pediatric Associates Inc. of Brockton
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Phone: (508) 584-1234
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Shot Clock

For those of you who have been part of the MCAAP for some time, you may remember the Immunization Initiative's *ShotClock* publication that was periodically included with *The Forum*. Starting with this issue of *The Forum*, we are going to bring back *ShotClock* in order to provide more timely and useful information about vaccines. *ShotClock* is a joint project between the Immunization Initiative, the Massachusetts Department of Public Health, and *The Forum*. We hope you all find this helpful to your practice.

SAVE THE DATE

District 1 Connecticut, Massachusetts, and Rhode Island American Academy of Pediatrics' (AAP) Chapters present

Navigating the Mental Health System from the Pediatrician's Office

Friday, May 7, and Saturday, May 8, 2010
Biltmore Hotel
Providence, Rhode Island

(This program was originally scheduled for November.)

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