The Forum

Massachusetts Chapter of the American Academy of Pediatrics Newsletter Summer 2009, Vol. 10, No. 3

PRESIDENT'S MESSAGE

My Vision for the Medical Home

Last month, I wrote requesting your stories about how the economic downturn has impacted your patients and your practices. We have not received many responses, but I am convinced you all have meaningful experiences to share. We hope some stories will come our way in time to print them in the fall edition.

In the meantime, there is a lot of activity regarding health care payment reform at the state and national level. The Payment Reform Commission, established by legislation passed in Massachusetts last year, has held meetings with stakeholders and hearings with the public. At some of these meetings, I've attempted to impress upon those in attendance the importance of the medical home for high quality appropriate and personalized health care delivery.

One important aspect of the medical home in pediatrics is its relationship to family, schools, and community. It appears that someone was listening because Dr. JudyAnn Bigby, Health and Human Services secretary for the Commonwealth, has set a goal "for all primary care practices in Massachusetts to become patient-centered medical homes (PCMHs) by the year 2015." This chapter will be a member of the Initiative Coordinating Council, helping to develop a framework for implementation of a multipayer medical home initiative. So what does this mean for our membership and our patients?

As you no doubt know, the pediatric medical home concept originated from the AAP in 1967. It was originally used to describe the role of the PCP in

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Phase III of the Children's Behavioral Health Initiative:

What Do Primary Care Pediatricians Need to Know?

David Keller, MD, FAAP

As most primary care pediatricians know, Massachusetts' Medicaid program (also known as MassHealth) is in the midst of a massive reform of the systems of care for EPSDT-eligible children and adolescents with "serious emotional disturbance." Last year, we began screening for behavioral health problems in our practices and referring those children to behavioral health providers throughout the Commonwealth for assessment and treatment. For the last eight months, that system has been assessing those children with a single tool (the Child and Adolescent Needs and Strengths instrument or CANS) to establish a common language for a new kind of treatment paradigm called "wraparound" that will be practiced throughout the state. On June 30, the final phase of the Children's Behavioral Health Initiative begins as new forms of mobile emergency mental health services and intensive care coordination are instituted. The new system in complicated; detailed descriptions are available at several state websites. In this article, I will address how this new system will work with you to provide family-centered care for families with children with serious emotional disturbances.

To understand how this new program will work, you need an understanding of the concepts key to the

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Policy Corner

Massachusetts Medical Society's (MMS) Annual Meeting of the House of Delegates (HOD)

Lloyd Fisher, MD, FAAP
MCAAP Delegate to the MMS HOD

As your representative to the MMS HOD, I represent all MCAAP members at the biannual meeting of the policymaking body of the MMS. Delegates representing every district medical society and every specialty come together to discuss and debate numerous resolutions concerning health policy, medical practice, medical education, and public health. Below is a brief summary of just a few of the items of business discussed at this past May's HOD meeting.

Medical Student Debt: The MMS has long been working towards alleviating the issue of increasing levels of medical student debt. In response to a resolution at a previous HOD meeting, the Society formed the Ad Hoc Committee on Medical Student Debt two years ago to investigate ways the MMS can help. Initially, the committee had been moving towards having the MMS establish an endowment fund with contributions from the Society and private companies such as payers, hospitals, and large-group medical practices. While still the ultimate goal, due to the current economic climate, the committee has decided to hold off initiating this project until fiscal year 2011. A report, passed by the HOD at this meeting, approved the funding for a feasibility study for this project.

Health Information Technology: In response to the large amount of

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Editor's Note

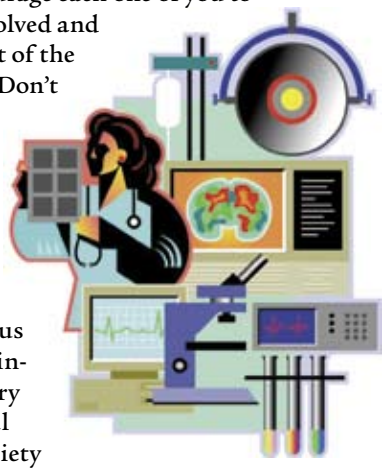
Lloyd Fisher, MD, FAAP

I can say with certainty that health care reform will happen in some form or another and likely very soon. Unlike the numerous times in the past when major reform initiatives have failed, this time all vested parties (government, insurers, organized medicine, and patient advocacy groups) recognize that the status quo cannot continue. The million-dollar question, though, is how the revised system will look, how our profession will be changed, and how our lives as patients will be affected.

There are as many proposals in existence as there are parties with vested interests in the outcome. Every political, special interest, advocacy group, and professional organization has its own idea of what the ideal system should look like. Everything from a 100% government-controlled system to maintaining the private competitive market with employer and individually purchased insurance is on the table.

As physicians, we have a unique role to play. For too long, our profession has allowed others — politicians, insurers, and lawyers — to shape the health care system in ways that are often not beneficial for us or our patients. Regardless of how this current situation is resolved and what our health care system looks like after this year, one thing is clear — it will change, with or without our involvement.

Regardless of your personal interest in health policy or politics in general and irrespective of your specific thoughts on how best to finance and deliver health care, I encourage each one of you to become involved and become part of the discussion. Don't let others dictate to us how we are going to practice medicine.



There are numerous ways to get involved. Every professional medical society is trying to be at the table in this discussion. Even if you do not agree with all of the actions of these organizations, I urge you to join one or several of these associations and let your voice be heard. If you are not a member, you cannot shape their policies, and you cannot have a voice. All of us have limited time (and limited money) to join the numerous medical associations and societies, but at this critical time in our country's history, organized medicine needs a strong voice. Our professional organizations need to speak with a unified message to our elected officials in the federal and state governments.

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MCAAP COMMITTEES & ADMINISTRATIVE APPOINTMENTS

AAP Breastfeeding Coordinators
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 & Newborn
Elizabeth Brown

Finance Committee
Elizabeth Brown

Forum Editor
Lloyd Fisher

Foster Care
Linda Sagor

Immunization Initiative
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Hadassa Kubat

Infectious Disease
Sean Palfrey

Injury Prevention & Poison Control
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International Child Health
Jane Cross
David Norton

Legislation
Michael McManus
Karen McAlmon

Massachusetts Healthy Families
Howard King

Membership
Patricia Moffatt

Mental Health Task Force
Joe Gold
Michael Yogman

MMS Delegate/ House of Delegates
Carole Allen

MMS Interspeciality Committee Representative
Carole Allen

Nominating Committee
Open

Obesity Committee
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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

Submissions for the next issue of The Forum *should be sent to lfisher@mcaap.org by September 4, 2009.*

Phase III

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system. First is "wraparound." To quote Bruce Kamradt of *Wraparound Milwaukee*, "Wraparound is an approach to implementing individualized, comprehensive services within a system of care. Wraparound is not a service or set of services. It is not a type of treatment like multisystem therapy or functional family therapy. It is a unique way of organizing services and supports individualized for youth. It is more of a process that puts the family at the center of care." In a sense, wraparound is remarkable like the system of care pediatricians have proposed under the medical home model. Just look at the essential values of "wraparound" from the Milwaukee model:

- Build on youth and family strengths and not deficits.
- Care should be individualized. One size doesn't fit all.
- Youth are best served in the community.
- Youth/families should have access to the services they need and not just what is available.
- Services should be provided in the context of the family, and families should be fully engaged in the planning and delivery of these services.
- Services and supports need to be culturally competent.
- Care should be unconditional. Plans fail. Not youth!

This sounds an awful lot like the medical home to me. This model of care will not be foreign to pediatricians. So how will this happen in Massachusetts? To understand this, you need to understand two other key concepts in the plan — the CANS and the community service agencies (CSAs). The CANS is a tool that allows behavioral health providers to put a family at the center of the care plan by focusing on their strengths and needs. Pediatricians don't do CANS. It is administered by the behavioral health agency to which you have referred your patient. With the CANS in hand, however, that agency is able to decide whether a child is "seriously emotionally disturbed" and qualifies for full "wraparound services."

If the child does not, he or she may still benefit from either outpatient therapy or in-home therapy without wraparound services. If the child does qualify, however, a care coordinator will work with his or her family to develop an individual care plan that addresses *all* of the family's needs. The care coordinator, working for one of 27 brand new CSAs around the state, will convene a meeting that includes *all* significant forces in the child's life, including mental health workers, school personnel, community workers, DCF, and, quite probably, the primary care pediatrician. The care coordinator's job is to ensure that the family can maximize the effectiveness of these services and to help all involved work together for the benefit of the family. The CSA is the glue that facilitates communication between the various parts of the system, which, as we all know, sometimes do not speak with each other. In the end, this approach has the potential to create powerful synergies for some of our most difficult patients.

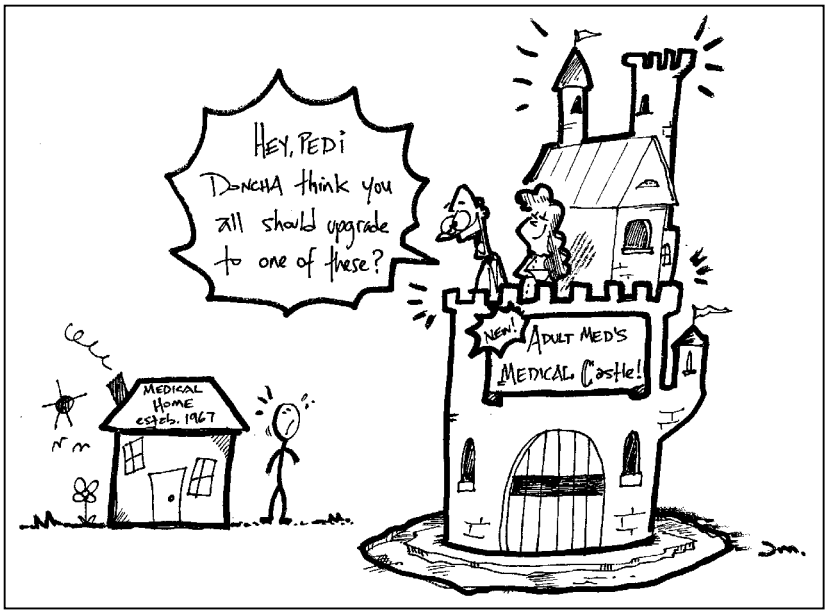
Starting on June 30, we all get to put the pieces of this system together. What can pediatricians do to make sure that it works? Here are a few suggestions:

- Keep screening the children in your practice for behavioral health problems. Our screening efforts are the engine that will make the system work.
- Refer positive screens for evaluation, and learn the language of the CANS. It is the common language for the development of the treatment plans in the new CBHI.
- Comment on the individual care plan that is developed.
- Know your CSA and be part of the team so that you can support families as they work through the new system.

For all of us who have wrestled with behavioral health issues in our practices, the CBHI represents a chance to help. The plan is complicated, though. It has a lot of acronyms, and it risks becoming another impenetrable bureaucracy. If we can keep families at its center, however, it will allow us to offer hope to those families who have had little hope in the past. That, as least, seems worth the risk.

For more information, try these websites:

- Children's Behavioral Health Initiative: **www.mass.gov/masshealth/childbehavioralhealth**
- Rosie D: **http://rosied.org/** (This site focuses on reforming the mental health system in Massachusetts.)
- Mass Behavioral Health Partnership Online: **http://www.masspartnership.com/**
- Rosie D. and Me: **http://olddockeller.blogspot.com/** (A pediatrician reflects on the mental health of children and the systems that are trying to help them.)



PROS Update

David Norton, MD, FAAP, and Ben Scheindlin, MD, FAAP
Chapter Co-Coordinators

Are you interested in participating in collaborative clinical research? PROS (Pediatric Research in Office Settings) is the academy's practice-based research network. PROS is comprised of approximately 1,748 practitioners from 723 practices from every state in the nation, as well as Canada and Puerto Rico. Massachusetts is one of the largest PROS chapters, with 34 practices and nearly 150 practitioners. But there is still room to grow!

Sign up for SSCIB! We need more practitioners!

Is puberty starting earlier for boys than it is for girls? The Secondary Sexual Characteristics in Boys (SSCIB) study has already enrolled over 4,000 boys. Data collection will continue until the end of this year, and to achieve the most representative sample, SSCIB needs practices who serve high numbers of African American and Latino children. Each practitioner enrolls 30 boys, ages 6 to 16, at well-child checks and receives CME credit for completing the study training manual. This is a simple and quick study that will yield important data, particularly good for new PROS practitioners!

PROS studies under way and under development:

- A randomized, controlled trial of an intervention to reduce children's secondhand smoke exposure
- A randomized, controlled trial of moderate and high intensity interventions to reduce BMI in overweight children
- Improving oral health outcomes by training pediatricians to prevent and diagnose early childhood cavities
- Improving mental health outcomes by training pediatricians in "common factors," specific communication skills that are common to effective mental health interventions
- Improving asthma care via a novel, interactive, long-distance learning method

If you would like more information about how to become involved in a PROS study, contact Ben Scheidlin at bscheindlin@yahoo.com or David Norton at nortond@holypeds.com.

President's Message

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managing care for children and youth with special health care needs. More recently, this description has been updated to describe primary care delivery that is family-centered, comprehensive, continuous, community-based, culturally effective, compassionate, and coordinated. Important aspects of the medical home include the patient and/or parent as part of the care team. Payment appropriately recognizes the added value of the medical home to patients and rewards care management and coordination of care. Payment should also support the use of health information technology for quality improvement and enhanced communication, both with other caregivers and with the patients and families themselves.

I envision (and frequently share with others) my construct of a medical home. It is a house. This helps me to remember all the important aspects of care for children. In my picture, the medical home revolves around the *patients* and their caregivers who "live" inside it. The patients range newborns to young adults and come from all backgrounds and diverse cultures in various family configurations and of multiple ethnicities. Some, but not all, of the patients have special health care needs. In this house, the roof

above *protects* the patients, as we routinely do with vaccines, health promotion, advocacy in the community, and partnerships with schools and health departments. The floor *supports* in the same way that pediatricians empower patients and families, provide guidance for child rearing, maintain children's health, treat illnesses, and manage chronic conditions. Part of support is coordination of care.

The roof and the floor of my imagined medical home are connected by two pillars — one being the *relationship* with the patient/family and the second being *quality* of care. The relationship is crucial to establishing trust, which in turn enhances healing and has the potential to promote health. High quality care is predicated upon compassionate and well-trained providers. According to the precepts of the Institute of Medicine, it is safe, effective, efficient, equitable, timely, and patient-centered. A strong medical home is engaged in continuous improvement that results in measurable outcome improvements. We will be advocating for payment methodologies that adequately provide for the development and maintenance of quality measures within practices and that will also permit pediatric providers adequate time and means of communication with patients to contribute to strong relationships.

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Policy Corner
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federal grant money available from the recent federal stimulus bill, the MMS Committee on Information and Technology put forth a resolution asking the Society to establish a nonprofit entity that would be able to apply for these grants. The HOD overwhelmingly supported this very timely proposal.

Retail-Based Clinics (RBCs): As many know, CVS and other companies are quickly coming into Massachusetts and opening RBCs. In some states, insurers have set copayments lower for patients to receive services at an RBC as compared to a primary care office. The HOD presented a resolution asking the MMS to advocate to insurers and state regulatory bodies to disallow this practice. The delegates were highly supportive of this proposal.

AEDs: A resolution asking the MMS to advocate that all high schools and colleges in the state make AEDs available was strongly supported by the delegates.

Junk Food: One resolution, which did not win approval at the meeting, asked the MMS to advocate to the state legislature to implement a sales tax on junk foods and beverages and use the additional tax revenue to promote good health. There was concern that the term "junk food" was too ambiguous for this resolution to have any meaningful positive influence. In addition, testimony was given regarding the lack of evidence that raising taxes on such products would have the benefit of reducing consumption.

In addition to the resolutions summarized above, the MMS discussed many other important issues. I urge anyone interested in seeing the full text of the resolutions and the results of the votes taken on all topics to visit the MMS website at **www.mms.org**. Please feel free to contact me about any of these resolutions or for additional information on the MMS HOD.

President's Message
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The house I envision sits upon a *foundation*. This is the infrastructure of the practice caring for the patient, so it includes the providers and support staff, care coordinators, communication systems and health IT, data collection tools, ancillary services, and supports. We will advocate for investment in strong practice foundations as necessary to the integrity of the medical home.

The door to the house represents *access*. We need the payment system to remove barriers to care so that we can welcome patients and their families through an open door. The garden around the house helps to *sustain* it. Caregivers need to be nurtured through respect, opportunities for learning and sharing best practices, manageable schedules that permit rest and family time, and compensation that does not mandate frenzy in order to survive.

The medical home exists within the context of *community*. In pediatrics in particular, we connect with all aspects of our patients' lives including family, schools, sports, day care, and outside providers. The continuity of care is promoted by good communication.

As we meet with other stakeholders, I and other chapter officers will advocate on behalf of the medical homes that you provide or wish to establish for your patients. We will especially stress the importance of trusting relationships, as well as high quality and strong foundations. And we will make the case that investing in our practices will, in the long run, promote the health of our patients and reduce wasteful and unnecessary costs.

– Carole Allen, MD, FAAP

Letter to the Editor

For those patients who have complex medical problems and need to have their past medical histories easily available to providers to whom they are referred or to emergency room physicians, there is a new memory stick called "traveler-er." One can learn more about this memory stick by going online to www.traveler-er.com. It costs $30, and I think it is an answer to transmitting in a concise manner almost all the important medical data that one would need to expedite the care of a patient. (I have no vested interests in this company.)

Robert Abrams, MD
Holyoke Pediatric Associates
Holyoke, MA

Book Corner

Marilyn Augustyn, MD, FAAP
Medical Director, Reach Out and Read-MA

"Future research should aim to ameliorate literacy-associated child health disparities."

This space is typically devoted to relevant child literacy topics, but in this issue, we depart from our usual focus to discuss a recently published article ("Literacy and Child Health: A Systematic Review," Saunders L.M., Federico S., Klass P., Dreyer B., Arch Ped Adol Med, 163(2):131-140) from which the above quotation came. In this important review, the authors performed a meta-analysis to assess the prevalence of low health literacy among adolescents, young adults, and child caregivers in the United States, as well as the readability of common child health information and the relationship between literacy and child health.

The issue of health literacy is one that impacts all practicing physicians. According to the 2003 National Assessment of Adult Literacy, 78 million U.S. adults are unable to perform basic health tasks such as using an immunization schedule, interpreting a growth chart, or following written instructions to take medication on an empty stomach. Though health literacy specifically focuses on literacy in the health context, there is a strong correlation between health and general literacy skills.

The meta-analysis reviewed a total of 1,267 articles, with 215 meeting inclusion criteria. In summary, they found that 1 in 3 adolescents and young adults have low health literacy. Data on the health literacy of young children is harder to gather, but as early as first grade, about 1 in 3 children are identified by state and national tests as reading below grade level. Also of note, pediatric clinicians have been shown to overestimate the health literacy of the families they serve. Though there was limited evidence, the review also found a consistent, independent relationship between literacy skills and child health outcomes. Adjusting for socioeconomic status, adults with low health literacy are between 1.2 and 4 times more likely to exhibit negative parenting or child preventive care behaviors, including maternal depression, errors in dosing child medication, and decreased use of preventive care services.

Therein lies the link between child and adult literacy — anticipatory guidance about the importance of reading aloud to young children to foster their love of reading into adulthood! The impact we have as child clinicians to help families understand the importance of literacy in their child's lifelong development is critical, perhaps not only for the children we care for today but these children's children, too!

Alert for MCAAP Members

There are new AAP recommendations for the use of Synagis for infants aged 32 to 35 weeks for the 2009–2010 season. For details, go to: **http://aapnews.aappublications.org/cgi/content/full/aapnews.20090604-1v1**.

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Congratulations

MCAAP Member Selected for Highly Sought-After Fellowship

David Keller, MD, clinical associate professor of pediatrics at the University of Massachusetts Medical School and district CATCH facilitator for New England, was selected by the Institute of Medicine to be a Robert Wood Johnson Foundation health policy fellow in Washington, DC, starting in September of 2009. Dr. Keller will spend one year working as part of the congressional staff, helping to develop and implement health policy initiatives at the federal level. He is one of 10 health professionals from across the country chosen for this honor. The fellowship is very competitive, and fellows are selected because of their leadership abilities and demonstrated commitment to health improvement. Many fellows go on to assume important leadership roles in their own organizations or in federal or nongovernmental offices.

The MCAAP is proud of David and congratulate him on this remarkable accomplishment.

MCAAP member recipients of AAP awards:

- **Karen McAlmon, MD**, for her outstanding leadership in collaborating with local health care representatives to create a transparent process for granting waivers to limited service clinics
- **Rebecca O'Brien, MD**, for her outstanding efforts in educating leadership and providing valuable input about a wide variety of adolescent issues
- **Sean Palfrey, MD**, for his outstanding efforts in creating innovative approaches to restoring Massachusetts to a universal immunization state
- **Peter Rappo, MD**, for his outstanding leadership role in effectively restructuring and leading the Massachusetts Pediatric Council
- **Lyle J. Micheli, MD, FAAP**, Thomas E. Shaffer Award, given by the Council on Sports Medicine and Fitness "recognizes lifelong contributions to the field of sports medicine"
- **Vasum Peiris, MD, MPH**, Cardiology Education Travel Grant 2, given by Education Travel Grants, which provides funding for travel expenses to the AAP NCE and are awarded to the top 3 young investigator abstract submissions. Education travel grants are limited to current pediatric cardiology or cardiovascular surgery fellows-in-training.
- **Robert D. Sege, MD, PhD, FAAP**, Fellow Achievement Award, given by the Section on Injury, Violence, and Poison Prevention and "recognizes an AAP fellow who has made an exceptional contribution to the area of injury and poison prevention"
- **Barry Zuckerman, MD, FAAP**, C. Anderson Aldrich Award, given by the Section on Developmental and Behavioral Pediatrics and "recognizes achievement by a physician in the field of child development"

MCAAP international studies recent grants recipients:

- **Venee Tubman** — Liberia
- **Anna Wheeler** — Guatemala
- **Lara Antkowiak** — Bolivia
- **Tarayn Fairlie** — Ecuador
- **Neil Surana** — Uganda

MCAAP members appointed to national committees

- **James Perrin** — AAP Committee on Genetics
- **Rebecca O'Brien** — AAP Committee on Adolescence
- **Vincent Smith** — Committee on Substance Abuse

Important Message Concerning the Recent Influenza Outbreak

Sean Palfrey, MD, FAAP
Immunization Initiative Program Director

We would recommend that all practices schedule a formal review of what went well and what was difficult during the current H1N1 outbreak, decide on individual practice guidelines (for phone triage, rooming of potentially sick children, follow-up), information (sheets for parents, staff), routines such as handwashing and masking, availability of supplies (gowns, glasses, as well as masks and gloves, paper towels), and plan accordingly for ordering and storing. Staffing during times when many are ill and rules for notifying the practice leadership about onset of symptoms is difficult, but essential to plan for.

The Massachusetts DPH will be performing their own extensive reviews and will stay in close contact with all of us.

Inside

The Forum

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Address Service Requested

Looking to Hire or Be Hired?

Job listings are a free service provided by *The Forum* to MCAAP members and residents completing their training. Nonmembers may submit ads for a fee.

Looking to Fill a Position?

MCAAP members: Free

Nonmembers: $250

Please submit the following information:

- Practice name
- Position title and description (25-word limit)
- Availability (e.g., starting July 2008)
- Contact name
- Address, telephone number, e-mail address

Looking for a Job?

MCAAP members and residents: Free

Nonmembers: $50

Please submit the following information:

- Your name
- Contact information
- Residency program
- Availability (e.g., available now)
- Comment (25-word limit)

Please send text information via e-mail to lfisher@mcaap.org. Checks may be mailed to the MCAAP office, c/o Cathleen Haggerty, Executive Director, P.O. Box 9132, Waltham, MA 02454-9132. All submissions are subject to review for appropriateness.

For more information, please contact the editor at lfisher@mcaap.org.

Editor's Note

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Most of you are members of the MCAAP and the AAP. Both of these organizations are actively involved in the political process, specifically working towards improving health care for children. However, I would also encourage you to consider joining your district medical society, the Massachusetts Medical Society (MMS), and the American Medical Association (AMA). Only through a strong unified voice can the physician community effectively advocate for change by speaking for all physicians. For too long, our message has been divided by each specialty advocating for its own individual issues, often pitting one specialty against the other in the political process. There are many issues in medicine that transcend specialties. For these issues, we need the MMS and the AMA. As an active member of the AAP, MMS, and the AMA, I am happy to share my experiences with anyone interested in learning more and becoming involved.