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

Proceed with Caution on Payment Reform

Over the past several months, political pressures to address the cost of health care in the Commonwealth have increased dramatically. The state's Health Care Quality and Cost Council Committee on the Status of Payment Reform Legislation is charged with developing recommendations to inform comprehensive payment reform legislation. While this step is only the first on the road to reform, the first iterations of the proposal are formulated in ways that suggest that policy makers haven't seriously considered the implications of these sweeping changes for children and families.

As the proposal takes shape, I'm concerned that political pressures to get *something* done could result in changes that have unintended consequences for children's services. There is a bias toward replacing the traditional fee-for-service payment model — in a very rapid manner — with a system of global payments to accountable care organizations (ACOs). While concerns about cost are legitimate and compelling, we must caution against precipitous and inadequately planned change of this potential magnitude.

Global payments and ACOs have been discussed tirelessly in policy circles, and pilot models exist nationwide. But precisely how to transform these policy constructs into a model for the daily practice of high-quality pediatric medicine remains unclear. Since Massachusetts is on the cutting edge of reform efforts, we in the pediatric community of the Commonwealth will be at the forefront of the effort to make

continued on page 3

Table of Contents • Winter 2011 • Volume 12 No. 1

Ti Moun Annou Li: One Book per Child in Haiti

Proposal for a Haitian Early Literacy Program with Great Potential Benefits

Perhaps second only to health, education is central to the long-term success of children around the world. The future of all national economies depends on the existence of a healthy, well-educated citizenry.

Haiti has suffered centuries of poverty, the recent devastating earthquake, massive storms, and now a cholera epidemic. Even before these tragedies, Haiti was the poorest country in the Western Hemisphere. There are approximately 3 million children under 15 years of age in the country. Four-hundred thousand (400,000) live in the capital, Port Au Prince, the area hit hardest by recent disasters. The country's adult literacy rate is estimated at between 50 and 55 percent, and the country spends about 1.4 percent of its tiny gross domestic product on education. Few children own books, and many preschool children have never even seen a children's book.

About 20 years ago, the Reach Out and Read (ROR) program was started in the United States, through which pediatricians gave developmentally appropriate children's books to all children at every routine health visit between six months and six years of age. Doctors were trained to teach parents and children key elements of early literacy. Research has shown that the ROR program has significantly improved school readiness and subsequent school success, especially for children living in poor communities across the United States.

This year, pediatricians associated with the AAP, the Haitian Pediatric Society (HPS), and ROR brought donated children's books when they traveled to Haiti to provide medical services to children there. They demonstrated the attractiveness and importance of books and reading to parents in hospitals and clinics where children were being treated. Photographs can be found online at www.flickr.com/photos/palfrey-com/sets/72157625231945065.

The type of book provided — its language, illustrations, and content — all matter in different ways depending

continued on page 5

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EDITOR'S NOTE

My Final Chapter

A little more than five years ago I was about to finish my residency, facing the prospect of having to actually find a real job for the first time in my life. When no positions were immediately obvious to me, I approached one of my most respected mentors from medical school and residency, Dr. Lynda Young, who happened to be president of the MCAAP at the time, and inquired as to whether she might know of any job openings in the area. Unfortunately she did not; however, she did have something to offer me: "Well, Lloyd, I don't know of any jobs that you will get paid for, but I do have a wonderful volunteer position that I think would be perfect for you." Of course she was referring to the editorship of *The Forum* since the previous editor, David Chung, was stepping down. After a little more discussion, Lynda sold me on what a great opportunity this would be and I decided to take on the challenge (soon after I also found a full-time job as a pediatrician).

Today, I can honestly say that being editor of *The Forum* has truly been a wonderful experience. The people I have met, the knowledge I have gained, and the overall pleasure of interacting with so many MCAAP members from around the state has made this "opportunity" (as Dr. Young called it) an enjoyable adventure.

However, I came to the decision a few months ago that I would like to conclude my time as your *Forum* editor after completing five years. With the increasing demands of my practice and the addition of our second daughter to our family, it seemed like the right time to find another capable editor to continue with this publication.

So much has changed over the last five years in both the practice of medicine and the political and economic landscape that affects the care we deliver to our patients. There are many exciting possibilities on the horizon, but many questions and unknowns exist about what the practice of pediatrics — and medicine in general — will look like under these new conditions. I encourage all of you to become involved in shaping our profession and ensuring that we, the physicians, are making the rules. There are many other parties that are doing everything they can to create the policies and regulations under which we will be forced to work.

Over the past few months Cathleen Haggerty, Dr. Greg Hagan, and I searched for a capable pediatrician to become your new editor. We found an exceptional successor in Dr. Anne Light, a hospitalist at Emerson Hospital in Concord, who will be taking over starting with the Spring 2011 issue. You will find her contact information on the bottom of each page so you can send her submissions for the next issue. I am sure she will bring a new creative spark to *The Forum* and I am excited to read future issues under her editorship.

I want to thank all of the executive board members for their support, especially the four MCAAP presidents that I have worked under, for their exceptional stewardship: Drs. Young, Karen McAlmon, Carol Allen, and most recently, Greg Hagan. Our chapter continues to provide an invaluable service to our members and our patients through their leadership. Cathleen has been the "wind beneath my wings" in helping me to put together such a high-quality

continued on page 3

Caroline and Victoria Fisher

Submissions for the next issue of *The Forum* should be sent to alight@mcaap.org by March 7, 2011.

Editor's Note

continued from page 2

publication. Without her assistance with every step in the creation of each issue, I would never have been able to produce *The Forum*. Most importantly, though, it is the members and other contributors that make *The Forum* the publication that it is. I was always amazed at the quality of the articles I received. Please continue to share your experiences and expertise with our readers. I look forward to continuing to work with and for you in other chapter activities.

Have a happy and healthy new year.
— Lloyd Fisher, MD, FAAP

President's Message

continued from page 1

change work in a way that does not penalize children, families, and the robust system of pediatric services that exist here.

In order to guide our efforts, the chapter is bringing together experts on these issues to craft a detailed position vis-à-vis payment reform and ACO formation. Fortunately, in Massachusetts, we are blessed with a number of national leaders with real expertise in these areas who will do everything they can to make their voices heard on Beacon Hill. While there is still much work to be done in formulating comprehensive recommendations for the chapter, we developed an initial set of general principles, which we were asked to submit during testimony last week (see article below).

Moving forward, I would encourage chapter members to weigh in on the issue of global payments and pediatric participation in accountable care organizations. We need your ideas, input, and comments.
— Greg Hagan, MD, FAAP

Editor's Note: Greg Hagan was recently interviewed by Strategies for Children for their Early Education for All Campaign. The interview is posted on their blog, Eye on Early Education, at http://eyeonearlyeducation.org.

Testimony of the MCAAP Relative to Payment Reform

Presented to the Massachusetts Health Care Quality and Cost Council

My name is Gregory Hagan, MD, and I am president of the Massachusetts Chapter, American Academy of Pediatrics (MCAAP), as well as a primary care pediatrician at the Windsor Street Health Center in Cambridge. The MCAAP, representing over 1,600 pediatricians practicing in Massachusetts, is committed to the attainment of optimal physical, mental, and social health for all infants, children, adolescents, and young adults in the Commonwealth.

The MCAAP understands the importance of reform measures that will address the spiraling costs of health care in the Commonwealth. The MCAAP supports the goal of developing a system that delivers the highest quality care at a sustainable cost. In order to achieve this goal, primary care medicine must be central. In particular, in order to achieve long-term, optimal health and to achieve intermediate, long-term savings for the citizens of the Commonwealth, assuring the optimal health of our children must be the first order of business.

Pediatrics comprises a relatively small portion of total health care expenditures. As a result, we must take care that the interests of children and families are not overlooked when fundamental change occurs. It is crucial that we maintain and strengthen the vital and effective systems for *pediatric* care.

Toward this end, the MCAAP urges that payment reform efforts must recognize the following:

- The central role of pediatric primary care within a child- and family-centered medical home: The pediatric medical home is, by necessity, different from an adult-centered medical home in many ways. The care of children and youth with special health care needs resembles, in some respects, the models of care that are envisioned for adult medicine. However, the bulk of pediatric primary care aims to optimize long-term outcomes for *well* children. The real value of these distinct services must be recognized and these services must be appropriately resourced.
- We must also maintain a robust system of pediatric surgical and specialty care that is accessible to all children across the Commonwealth, and provided in community and tertiary hospitals with a demonstrated commitment to children.
- True cost savings in the near and intermediate term requires appropriate resourcing of developmental and behavioral health services within the child- and family-centered medical home. The current system does a poor job of addressing these needs. If we continue to shortchange these areas, we merely displace costs into the arenas of education, adult mental health services, and the criminal justice system.
- Initiation of global payments in an inefficient system characterized by perverse incentives would amplify rather than mitigate problems of quality and cost. We must avoid the very real possibility of further undermining the very primary care providers who are so critical to making these changes work.
- Many pediatrics practices in the Commonwealth are small groups or solo practitioners. From the perspective of practice infrastructure and culture, these smaller, independent practices will be faced with particular challenges that hinder an easy transition to an integrated global payment system. They will be especially vulnerable if change is rapid and forced. As a result, at the current time, there should be no statewide mandate. Pilot programs for global payments should be tried first. Change should be undertaken in a deliberate fashion, informed wherever possible by the evidence and experience developed by specialists in child health. At all stages of the process, there must be substantive, ongoing representation from the pediatric community.
- It will be critical that mechanisms for mid-course corrections are in place for any global payment system that is established in order to respond to the inevitable unintended consequences of payment reform. ***— Gregory Hagan, MD, MCAAP president***

Food Allergy Awareness Act

The Food Allergy Awareness Act was signed into law in January 2009 and applies to all Massachusetts eating establishments. To increase food allergy awareness in restaurants, each establishment will be required to implement a new set of regulations. These new regulations require a statement on menus reminding patrons to alert their servers of any allergies as well as food allergy awareness posters posted in clear view of all staff. By February 1, at least one food protection manager is required to view a food allergy awareness video. By increasing basic awareness and encouraging effective communication, some reactions may be prevented, and eating out will hopefully become less stressful for those with food allergies. Safety is dependent on a partnership between the families of those with food allergies and the eating establishment. Continued effective communication (preferably with a manager), vigilance, and, of course, wise food and restaurant choices will continue to be necessary. For additional information, please visit www.mass.gov/dph/fpp.

— Michael Pistiner, MD, MMSc, clinical instructor, Children's Hospital Boston, Harvard Medical School

BOOK CORNER

More than Just a Message of the Month

When working with pediatric residents many preceptors try to find a theme of the month; a message to drive home as critical to every well-child encounter. For pediatricians working in an urban area, January is the month to focus on getting children signed up for kindergarten. For parents, January is not necessarily the time to be thinking about back to school. Yet that is when the proactive parent must begin thinking about it — isn't that why we call it anticipatory guidance? In Boston, kindergarten sign up begins January 4, 2011, and slots in the most popular schools go very quickly.

A recent article reminds us all that we need to add a 13th month for an additional message. Well before kindergarten, parents are making a choice that significantly impacts their child's later school success: preschool programming. Most pediatric clinicians have always encouraged high-risk families to explore options for Head Start or quality early childcare to enhance their child's development. A recent study shows that message is critical.

In this study, author Daphna Bassok (Child Development November/December 2010, 81(6):1828–1845) studied about 7,400 children who were part of the Early Childhood Longitudinal Study, a nationally representative data set that follows children from birth to kindergarten. She examined the link between preschool programs — including nursery schools, preschool centers, and pre-kindergarten programs — and how children performed on a literacy test when they were four years of age. The literacy assessment included measures of phonological awareness, letter sound knowledge, letter recognition, print conventions, and word recognition.

In 2005, 43 percent of Hispanic children 3 to 5 years of age attended preschool. White and black children participated at far higher rates, 59 and 66 percent respectively. These large differences in participation might partially explain why preschool effects can vary by race. This study set out specifically to examine why preschool effects might vary by race. The model that was used in this study controlled for multiple factors including socioeconomic status, maternal employment and education, family structure, child development knowledge, and frequency of joint book reading in the home.

In this data set, all poor children benefitted substantially from being in a preschool program before they began kindergarten. Among white children, the literacy advantages gained in preschool were largely limited to poor children. Considerable literacy benefits were seen in both poor and non-poor black and Hispanic children with the greatest impact in the latter group in homes where a language other than English was spoken.

Two key lessons can be drawn from this data. One, quality preschool experiences are important for *all* children and particularly for those who may later show poorer achievement in school (i.e., the disparity may start even earlier than we think!). Two, the covariates that were controlled for but not explored (the approach to literacy in the home and frequency of joint book reading) can be very influential.

As pediatric clinicians we may not be able to tackle all the factors that play into disparities in educational achievement for children, even with a "message a month." Ideally we can strive to get all our children enrolled in quality childcare experiences, but in the current economic situation that has become more challenging than before. Nonetheless, we *can* put a book into the hands of every child we see at a well-child visit and we *can* talk about the importance of reading aloud to a child's lifelong literacy. Let's make that our yearlong message for 2011.

— Marilyn Augustyn, MD, FAAP, Medical Director, Reach Out and Read Massachusetts

For more information about Reach Out and Read and early literacy, e-mail the Massachusetts Program Director Alison Corning-Clarke at alison.clarke@reachoutandread.org or Marilyn Augustyn at augustyn@bu.edu.

Ti Moun Annou Li

continued from page 1

upon the age and educational readiness of the child and parental literacy. For example, an infant of 6 to 18 months of age will be most attracted by large, colorful, simple images. At this age, having a loving person reading, showing, or telling them about a book is critically important. The exact words may not matter, but the pictures and personal contact during the reading process do. Between 18 months and 3 years of age, the actual words become much more important, and simple stories become very attractive. Each year from then on the content and complexity of the words and stories gain greater and greater importance.

The goals of the Ti Moun Annou Li ("Children, Let's Read," or TiMALi) program in Haiti go beyond simply giving developmentally appropriate books to every child in the country whenever a health provider sees him or her. At a time when there are so many health and educational needs in the country, the program aims to link medical and educational services together as we have been doing so successfully in the United States for the past 20 years. In this way, we can encourage and empower each parent to prepare their child for school while attending to their other health needs and give each family a book with which to start this critically important process.

The overall plan is to raise and appropriate money to accumulate the most attractive age and linguistically appropriate books possible. These books will give health and education professionals in Haiti the opportunity to establish and implement the Ti Moun Annou Li program. Many volunteers go to Haiti from around the world, bringing a variety of resources (e.g., books, medical supplies, and money) to rebuild the country and support its people. There are several publishers in Haiti and the United States who are printing children's books in Haitian Creole, and through them, this program can give children and families lasting pleasure, improve literacy and school success, and stimulate the Haitian economy.

We're looking for health professionals, educators, book publishers and sellers, and concerned citizens who can donate money, books, time, and energy to this effort. Members of the HPS are eager to work with us, and we're reaching out to international non-governmental organizations like Partners in Health that are active in Haiti. Please join this effort in any way you can.

— Sean Palfrey, MD, FAAP

The chapter established a 501c3 foundation for this effort called the Pediatric Foundation of Massachusetts, Inc. If you are interested in making a tax-free donation to help fund TiMALi, please send your donation to:

The Pediatric Foundation of Massachusetts
c/o MCAAP
860 Winter Street
Waltham, MA 02151

Please make checks out to the Pediatric Foundation of Massachusetts and indicate that your donation is for TiMALi.

For information about how to donate using a credit card via a secured site, please contact Cathleen Haggerty at chaggerty@mcaap.org.

MCAAP Survey on Mental Health and Developmental Services for Children in Massachusetts

Drs. Ellen Perrin and Chris Sheldrick at the Floating Hospital at Tufts Medical Center created a survey to understand pediatricians' experiences in meeting the mental health and developmental needs of children in Massachusetts. The survey was sent by e-mail to pediatricians who practice primary care at least half a day per week. The survey takes only 15 minutes and asks basic questions about how pediatricians access mental health and developmental evaluations and care for their patients.

Thank you to those MCAAP members who have already completed the survey. A reminder will be sent in January. If you haven't already, please take just 15 minutes to respond to the survey. If you have difficulty accessing the survey, please e-mail Ellen Perrin at eperrin@tuftsmedicalcenter.org. The results will be shared with members this spring. Your input will help identify ways in which mental health services for children can be improved.



MCAAP 2010 Legislative Report

Thank you to all of our members who have been legislatively active on behalf of Massachusetts children. Your voices have been heard!

Special thanks to our pediatric residents who actively and effectively advocated for many of the bills (outlined below) at the Annual Residents' Day at the State House.

Following is a summary of final actions taken on bills the chapter followed during the formal legislative session ending July 31, 2010.

Immunization — The Senate Ways and Means Committee did not release S. 2195, the chapter-sponsored Vaccine Trust Fund Bill, but it did address key components of the bill through the budget process. The FY11 budget contains appropriations for the Universal Children's Vaccine Program through an assessment on health insurers, including ERISA self-insurers. The budget also establishes a permanent Immunization Registry in the Department of Public Health (DPH).

The establishment of the Immunization Registry is welcomed, but the Legislature did not fund it. The chapter is working with DPH to achieve that goal.

School Nutrition — After a multiyear effort to move the bill through the Legislature, a school nutrition bill was passed and signed into law. Chapter 197 of the Acts of 2010, "An Act Relative to School Nutrition," promotes healthy school nutrition by limiting the fat and sugar content of foods and beverages served and sold in school systems. The chapter supported the bill.

All-Terrain Vehicles (ATVs) — The Legislature passed the ATV Bill, which is now Chapter 202 of the Acts of 2010, "An Act Regulating the Use of Off-Highway and Recreation Vehicles." The new law regulates the use of off-highway and recreation vehicles by children, requiring riders 18 years of age and under to complete a safety program; prohibiting the use of ATVs by anyone under 14 years of age unless operating in a sanctioned race or event; requiring adult supervision for 14- to 16-year-old riders; and requiring all operators and riders of ATVs to wear helmets. The chapter supported the bill.

Postpartum Depression — The Legislature also passed a stripped-down version of a bill addressing postpartum depression. Chapter 313 of the Acts of 2010, "An Act Relative to Postpartum Depression," requires the DPH to work with an advisory commission to create a "culture of awareness, destigmatization and screening for perinatal depression so that residents of the Commonwealth may be assured effective public health services." The bill calls for the creation of an advisory commission that would help focus attention on postpartum depression and provide guidance and recommendations to the DPH and the Legislature. The Massachusetts Medical Society can nominate four physicians to the advisory commission, one of whom must be a pediatrician. The chapter supported the bill.

Autism Insurance — Through a massive effort of parents and autism advocacy groups, the Legislature passed Chapter 207 of the Acts of 2010, "An Act Relative to Insurance Coverage for Autism." The bill requires insurers to cover the costs for the diagnosis and treatment of autism spectrum disorders. Treatment of autism

spectrum disorders includes "care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or licensed psychologist who determines the care to be medically necessary; habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care." The bill defines habilitative or rehabilitative care as "professional counseling and guidance services and treatment programs, including, but not limited to, applied behavioral analysis supervised by a board certified behavior analyst that are necessary to develop, maintain and restore, to a maximum extent practicable, the functioning of an individual." The law contains a provision that would exempt an insurer from the requirements to provide habilitative or rehabilitative care for three years if an actuary certifies in writing to the commissioner of insurance that the annual cost associated with coverage of habilitative or rehabilitative care required under this act would exceed one percent of the premiums charged over the insurance polices and contracts written by the insurer. The chapter monitored the bill, but did not take a position.

Health Care Cost Containment — The governor signed Chapter 288 of the Acts of 2010, "An Act to Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses." The law requires health insurers to file with the insurance commissioner all premium increases for review. The law encourages insurers to develop selective and/or tiered networks of providers and creates biannual open enrollment periods for health insurance eligibility in order to stop individuals from jumping into and out of small group insurance coverage in order to get a procedure covered. The law also contains a provision that requires the state or its agencies to consider the special needs of children and pediatric patients when developing or utilizing data standards, quality measurement systems, wellness initiatives and making comparisons of costs and prices. This provision also requires that comparative data and reports segregate pediatric patients and providers from adult patients and providers. The chapter monitored the bill, but did not take a position.

The following bills did not make it through the formal legislative session.

Licensure of Midwives (H.R. 4810) — "An Act Relative to Certified Professional Midwives and Enhancing the Practice of Nurse-Midwives." The bill would license lay midwives and allow nurse-midwives to function independently. The bill was reported favorable by the Healthcare Financing Committee to the House, but was not taken up. The chapter opposes the bill.

Mental Health Collateral Services (S. 2156) — "An Act for Coordination of Children's Mental Health Clinicians" received a favorable report from the Mental Health Committee, but was not reported out by the Health Care Financing Committee. The bill would mandate insurance reimbursement for collateral services provided by mental health providers. The chapter supports the bill.

Safer Alternatives to Toxic Chemicals (H.R. 4865) — "An Act Relative to a Competitive Economy through Safer Alternatives to Toxic Chemicals" was reported favorable by the Committee on Environment, Natural Resources, and Agriculture and was referred to the House Committee on Ways and Means, which did not report the bill out. The bill would establish an institute that would develop policies and procedures for recommending safer alternatives to chemicals used in homes and workplaces. The chapter supports the bill.

Religious Exemption (H.R. 1710) — "An Act Relative to Spiritual Treatment through Prayer in lieu of Medical Treatment for Children." The bill would create an affirmative defense for parents who treat their children through prayer rather than medical treatment. The bill was filed on behalf of the Christian Science Church and was referred to the Joint Committee on the Judiciary. The bill was not reported out of committee. The chapter opposes the bill.

Following are other state safety bills that affect children and families that were not officially tracked by the chapter.

Texting/Cell Phone Use — This new law bans texting while driving for all drivers, and cell phone use by junior operators; this legislation bans text messaging for all Massachusetts drivers, prohibits junior operators from using cell phones, and institutes new license renewal procedures for mature drivers.

Under the new law, which took effect in October, any driver caught composing or reading a text message can be fined $100 ($500 for operators of public transportation vehicles). Any driver suspected of texting can be stopped, but the offense will not be considered a moving violation and will not be subject to an insurance surcharge.

Drivers under 18 years of age using any type of cell phone or mobile electronic device with or without a hands-free feature will be subject to a $100 fine and a 60-day driver's license suspension; they will also have to complete a driver attitudinal course.

Concussion Training — Under Chapter 166 of the Acts of 2010, all Massachusetts Interscholastic Athletic Association (MIAA)–member schools will be participating in a mandatory concussion awareness program beginning with the 2010–2011 school year.

The new Massachusetts law provides for the following:

- **A Return-to-Play Provision:** If a student becomes unconscious during a practice or competition, the student shall not return to the practice or competition during which the student became unconscious or participate in any extracurricular athletic activity until the student provides written authorization.

  If a student suffers a concussion as diagnosed by a medical professional or is suspected to have suffered a concussion while participating in an extracurricular athletic activity, the student shall not return to the practice or competition during which the

continued on page 8

Legislative Report

continued from page 7

student suffered, or is suspected to have suffered, a concussion and shall not participate in any extracurricular athletic activity until the student provides written authorization.

- **A Concussion Awareness Course:** The law states, "Participation in the program shall be required annually of coaches, trainers and parent volunteers for any extracurricular athletic activity; physicians and nurses who are employed by a school or school district or who volunteer to assist with an extracurricular athletic activity; school athletic directors; directors responsible for a school marching band; and a parent or legal guardian of a child who participates in an extracurricular athletic activity."

Excellent information is available at the Centers for Disease Control and Prevention website at www.cdc.gov/concussion. The online course can be found at www.nfhslearn.com/electiveDetail.aspx?courseID=15000.

The full text of the concussion law is available at www.mass.gov/legis/laws/seslaw10/sl100166.htm.

Motorcycle Driver Training — Stricter requirements for junior operators of motorcycles include the following:

- Successful completion of an examination and driving test
- Submission of an application, signed by both the applicant and a parent or guardian
- Successful completion of a motorcycle basic rider course

Novelty Lighters — This law bans the sale and use of so-called novelty lighters. The law took effect in November. There is an exemption for collectible lighters made before 1980 and standard disposable lighters with artwork or designs.

— Edward Brennan, Esq., MCAAP legal counsel

If you have questions about any of these bills or you are interested in being part of the chapter's legislative process, please contact Cathleen Haggerty at (781) 895-9852 or chaggerty@mcaap.org.

JOB CORNER

Looking for a Pediatrician in Somerville, Massachusetts

Harvard Vanguard Medical Associates seeks a BC/BE pediatrician to join a well-established practice in Somerville, Massachusetts. This is a great opportunity to build a practice in a collegial and professionally supportive environment combined with supportive staff, an electronic medical record system, and a strong infrastructure. We seek one full-time or two part-time physicians who (1) are looking to join a team of clinicians to contribute to the improvements of the clinical practice, (2) thrive in an academic setting, and (3) seek a diverse patient population. We are located just north of Boston, home to a booming art community, and Tufts University, Somerville, is accessible by the urban subway and public bus systems (the "T"). This practice provides services to a diverse group of patients representing a full spectrum of ages, ethnicities, and socioeconomic backgrounds.

Harvard Vanguard is an affiliate of and the largest medical group in Atrius Health, an alliance of five medical groups. The groups work together to innovate new methods of delivery of care, create efficiencies of scale, and share an electronic medical record. Harvard Vanguard is a physician-led nonprofit multispecialty group serving 480,000 adult and pediatric patients in 20 locations in the greater Boston area. Harvard Vanguard is renowned for its high quality and its service to patients. It incorporates adult and pediatric primary care, specialty care, and ancillary services at each site. Harvard Vanguard is a nationally recognized leader in clinical quality.

We offer a highly competitive salary and benefits. Interested candidates, please forward your CV to:

Kelly Glynn
HVMA Department of
Physician Recruitment
275 Grove Street, Suite 3-300
Newton, MA 02466-2275

Or, fax to (617) 559-8255, e-mail kelly_glynn@vmed.org, or call (800) 222-4606 or (617) 559-8275 within Massachusetts. EOE/AA. Sorry, not a J-1 visa opportunity.

Visit www.harvardvanguard.org for more information.

High-Quality Care for Children with Asthma: The Medical Home Foundation

Do you want to learn more about providing a medical home for children in your practice who have asthma? Look no further! Your AAP chapter is involved in a new program, the Medical Home Chapter Champions Program on Asthma, and now has a member champion who's here to help.

AAP chapter champion programs have been very effective as a conduit for disseminating best policies and practices to pediatric health care providers nationwide through the leadership and volunteer networks of chapters. Champion programs also serve as a mechanism by which pediatricians can advocate for change at the local, state, and national levels.

Background

The AAP developed the medical home model for delivering primary care that's accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to every child and youth.[1] Providers and practices that function as medical homes address preventive, acute, and chronic care from birth through transition to adulthood. A medical home model of care strives to facilitate an integrated health care system with an interdisciplinary team of primary care physicians, specialists, subspecialists, hospitals, health care facilities, public health agencies, and the community, all working closely with patients and families.

In 2007, the AAP partnered with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) to publish the *Joint Principles of the Patient-Centered Medical Home*.[2] This consensus statement describes seven principles of a medical home: personal physicians, the physician-directed medical practice, whole-person orientation, coordinated care, quality and safety, enhanced access, and appropriate payment. Childhood asthma is a serious and chronic condition that affects one in seven U.S. children and their families. Receiving care within the context of a medical home has the

continued on page 13

ShotClock

New Vaccine Administration Codes Go into Effect January 1, 2011

The purpose of the new codes is to better reflect the work involved and costs included in vaccine administration to children, thereby achieving the goal of the AAP statement, "The Business Case for Pricing Vaccine Administration," which can be found at www.aap.org/immunization/pediatricians/pdf/TheBusinessCase.pdf.

Will you be prepared to use the new codes?

The old codes representing vaccine administration and counseling for patients *under 8 years of age* (90465, 90466, 90467, and 90468) will be deleted from the current procedural terminology (CPT) and replaced with new codes. The other vaccine administration codes (90471–90474) won't be deleted or revised in any way.

The new codes are:

- **90460:** Immunization administration *through 18 years of age* via any route of administration, *with counseling* by physician or other qualified health care professional; first vaccine/toxoid component.
- **+90461:** Immunization administration *through 18 years of age* via any route of administration, *with counseling* by physician or other qualified health care professional; each additional vaccine/toxoid component. (List separately in addition to code for primary procedure.)

The "+" sign next to code 90461 indicates that it's an add-on code, just as 90466 was an add-on code to 90465 and 90468 was an add-on code to 90467. An add-on code (e.g., +90461) can only be reported in conjunction with the primary code (e.g., 90460).

A component refers to all antigens in a vaccine that prevent disease caused by one organism. Combination vaccines are those vaccines that contain multiple vaccine components.

Here are some examples:

Vaccine	Number of Vaccine Components	Immunization Administration Code(s) Reported
HPV	1	90460
Influenza	1	90460
Meningococcal	1	90460
Pneumococcal	1	90460
Td	2	90460, 90461
DTaP or Tdap	3	90460, 90461, 90461
MMR	3	90460, 90461, 90461
DTaP-Hib-IPV (Pentacel®)	5	90460, 90461, 90461, 90461, 90461
DTaP-HepB-IPV (Pediarix®)	5	90460, 90461, 90461, 90461, 90461

Here are how the codes differ:

	New Codes	Deleted Codes
	90460 and 90461	90465–90468
Reported "per"	Component	Immunization (single or combination)
Age restriction	18 years and younger	Younger than 8 years
Counseling	Required by physician or other qualified health care professional*	Required by physician
Routes of administration	Use for all routes of administration	Codes differ based on route of administration (e.g., injectable vs. intranasal)

**Note that CPT doesn't define the term "other qualified health care professional." Please refer to your state's scope of practice laws to determine qualification.*

Submissions for the next issue of *The Forum* should be sent to alight@mcaap.org by March 7, 2011.

Depending upon which vaccines are administered on a particular visit you may be using 90460 and 90461 multiple times.

When administering vaccines, what ICD-9-CM codes should be used?
Per ICD-9-CM guidelines, code V20.2 encompasses all age-appropriate vaccines administered during a routine health check to patients through 17 years of age and therefore should be the only diagnosis code reported for any vaccine administered during a routine well-child exam. For patients 18 years of age and older, report V70.0 instead of V20.2.

What about vaccine administration during E/M or vaccine-only visits?
For single component vaccines you should use the appropriate "V" code. For multiple component vaccines you would use V06.8.

What about using units for combination vaccines instead of separate lines for 90461?
Paper claims only allow four procedures per claim page and electronic claims allow eight procedures per page. Using units for 90461 will allow for more efficient coding. It's not clear if all insurance companies will accept a uniform set of coding rules on using units. The AAP currently recommends that you code each vaccine as its own entity. Therefore, you wouldn't "roll-up" the 90460 codes, and the only 90461 codes that you should "roll-up" using units are those that belong to the same vaccine (e.g., Pentacel®).

In addition, be sure to lump all codes related to a single vaccine on one claim form. If you encounter a case where a claim must extend onto a second claim form, it will be important that the vaccine serum code and appropriate immunization administration codes appear on that second claim form together.

Previously, health insurance plans only recognized an initial vaccine administration code (e.g., 90465 or 90471) once. Their claims adjudication systems will have to be updated to prevent inadvertent denials when claims are submitted using multiple instances of 90460.

Will the insurance companies that receive your claims be prepared to process the new codes?
On October 15, 2010, Dr. Marion Burton, president of the AAP, sent a letter to the medical directors at many of the major insurance plans nationwide informing them of the coding changes. While HIPAA regulations require physicians to use the new codes, there is no similar requirement for the health plans to comply in a timely manner. ERISA plans may be exempt from these regulations. Unfortunately, this notice doesn't ensure that health insurance plan compliance in time for the January 1, 2011, rollout.

We anticipate full cooperation from Massachusetts health plans and will inform you when additional information becomes available. ***— Jonathan Caine, MD, FAAP***

Weave a Protective Web around Vulnerable Infants to Prevent Pertussis

Anyone who's ever seen an infant wracked by the paroxysmal cough of pertussis won't forget it (visit, for example, www.youtube.com/watch?v=dZ5jf-5MobE&feature=related). Right now, California is suffering through a pertussis outbreak with over 6,600 cases and 10 deaths to date this year (www.cdph.ca.gov/programs/immunize/Documents/PertussisReport2010-11-09.pdf). Young infants are at the highest risk of serious or fatal outcomes. How can we prevent this awful, tragic thing from happening?

Generally, infants are immunized against pertussis with the DTaP vaccine (part of the combination Pentacel or Pediarix vaccinations provided for all children in Massachusetts). However, maximal immunity isn't reached until the completion of the primary DTaP series at four to five years of age, and immunity wanes by adolescence, leaving teens and adults capable of contracting pertussis and transmitting it to infants.

Most studies to date suggest that infants contract pertussis through contact with parents and adult caregivers (e.g., de Greef et al., Clinical Infectious Diseases 2010; 50(10):1339–1345). The licensure of the adolescent/adult pertussis combination vaccine Tdap (protecting against tetanus, diphtheria, and pertussis) in 2005 opened the door to a new approach to protecting infants: targeting the vector. The strategy involves the surrounding of vulnerable infants with a protective cocoon of immunized adults.

continued on page 12

Preventing Pertussis

continued from page 11

At Harvard Vanguard Medical Associates, we've been evolving our cocooning strategy. When Tdap became available, our first step was immunizing staff. Initially, we targeted clinical staff in our pediatric and obstetrical units. Tdap vaccine is now mandatory for staff with direct patient contact in those specialties. As vaccine became more available, we offered Tdap to clinical staff in all specialties.

Around that time, we also asked our obstetrical and internal medicine clinicians to encourage potential or expectant parents to accept Tdap vaccine. We encouraged our pediatric staff to remind parents of young infants of the importance of immunization to protect their babies. While staff was willing to support this effort, cocooning became yet another task to remember for busy clinicians and adults expecting a baby or dealing with a new infant. We realized after some time that to get our cocooning strategy to protect nearly all babies, we needed to push it up a notch.

We initiated a discussion among the relevant clinical disciplines, which resulted in the current multifaceted strategy.

First, our obstetrical group incorporated a discussion of pertussis protection into their standard prenatal protocols. Because data on Tdap during pregnancy are limited, obstetricians and expectant mothers alike tend to be conservative and most opt not to vaccinate during pregnancy. On the other hand, expectant fathers and partners can be immunized, and our obstetrical staff have extended themselves to offer vaccine to these nonpregnant parents-to-be when they accompany the future moms at prenatal visits. Tdap is being incorporated into standard postpartum hospital care, and is being offered to new moms after delivery, much like the rubella vaccine. It's also been incorporated into standard order sets for routine OB/GYN visits for women of childbearing age.

Second, our internists have been sensitized to the issue and are offering Tdap to any patients with current or near future contact with young infants. This initiative has been bolstered by the recent ACIP recommendation to offer Tdap to adults over 65, allowing doting grandparents to babysit without fear of exposing their babies to whooping cough, and to allow the use of Tdap for those with exposure to infants regardless of the interval since the last Td (www.cdc.gov/vaccines/recs/acip/slides-oct10.htm). Our internists are also trying to use Tdap as widely as possible in place of Td, both for high-risk wounds and for the 10 annual booster doses. We recently assessed our success in this area, and were pleased to find that 90 percent of the tetanus-containing vaccine given to adolescents and adults in our group during 2009 was Tdap (*compared* to 6 percent nationally during 2008, MMWR 10/15/2010, www.cdc.gov/mmwr/preview/mmwrhtml/mm5940a3.htm?s_cid=mm5940a3_w).

Finally, at Harvard Vanguard, our pediatric staff has incorporated routine recommendations of Tdap to new parents during their first and subsequent visits. If there are any barriers for the parents to getting Tdap via their primary care provider, we offer to vaccinate the parents right then and there at the pediatric visit.

Making all of these pieces fit together wasn't entirely straightforward. It's required leadership from our nurses, coordination between different specialties, and a significant effort by our business staff to smooth out the difficulties. Still, the effort is well underway and has been met with immense gratitude from patients.

There are also collateral benefits, since immunizing adults to protect infants provides protection to the adults as well. Pertussis can be dangerous for older children and adults with underlying illnesses, such as immune deficiency and chronic respiratory disease. While pertussis isn't typically dangerous for healthy adults, it's a miserable illness, often termed the "100-day cough." Preventing pertussis among adults reduces morbidity and prevents lost productivity.

There are still barriers to overcome. Sometimes parents request Tdap vaccination for a caregiver who has no health insurance, or the parents themselves have no insurance. Public health clinics may be able fill this gap, and some vaccine manufacturers have patient assistance programs for uninsured low-income patients. Some parents are reluctant to immunize themselves for the same reasons they're reluctant to immunize their babies. As these issues arise, we're working on efficient, practical solutions.

Never hearing the whoop of pertussis again will be all the reward we need. ***— Ben Kruskal, MD, FAAP, director of infection control and travel medicine, Harvard Vanguard Medical Associates***

15th Annual Massachusetts Immunization Action Partnership Pediatric Immunization Skills Building Conference

More than 400 nurses, physicians, and community outreach and public health personnel attended the 15th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference, held on October 7, 2010.

William Atkinson, MD, MPH, medical epidemiologist at the National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, was the guest keynote speaker, and provided attendees with a national immunization update. Local experts also gave plenary talks: Susan Lett, MD, MPH, medical director of the Immunization Program, Massachusetts Department of Public Health, provided a state immunization update; Bill Adams, MD, associate director of pediatrics and director of child health informatics, Boston University School of Medicine/Boston Medical Center, discussed the Massachusetts Immunization Information System; and Bob Morrison, vaccine manager of the Immunization Program, Massachusetts Department of Public Health, provided a VTrckS overview.

The breakout sessions included vaccine preventable disease epidemiology, adolescent immunization, case studies in immunization delivery, VTrckS in depth, and school-based flu clinics. ***— Cynthia R. McReynolds, MBA, immunization initiative administrator***

All presentations, both plenary and breakouts, can be downloaded at www.mcaap.org/whats-new/#MIAP.

William Atkinson, MD, MPH, keynote speaker from the CDC

Children with Asthma

continued from page 9

potential to improve care for children and youth with asthma. The medical home model has demonstrated a positive relationship between the medical home and desired outcomes, including better health status, timeliness of care, family-centeredness, and improved family functioning.[3]

In 2007, the National Asthma Education and Prevention Program (NAEPP), coordinated by the National Heart, Lung, and Blood Institute (NHLBI), released the latest panel report, the *Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma*. These clinical guidelines and recommendations may have the most impact on a child's well-being if they're executed within the patient's medical home.

A Medical Home Framework for Asthma Care

The seven joint principles of the patient-centered medical home provide a framework for implementing these national asthma guidelines:

1. **A personal physician** provides continuity of care in a partnership (e.g., scheduling routine follow-up care and monitoring use of beta2-agonist medications).
2. **A physician-directed medical practice** coordinates family-centered, high-quality, accessible, and affordable services for children with asthma.
3. The practice has a **whole-person orientation** providing comprehensive, compassionate, and culturally effective care in a family-centered partnership. This holistic approach includes control of environmental triggers such as allergens and irritants — especially tobacco smoke — and treats or prevents comorbid conditions that affect asthma. It also promotes physical fitness for children with asthma.
4. **Care is coordinated** and integrated across the community-based system and facilitated by information technology, including asthma registries. Care coordination includes referrals to specialty care (if needed) and eventual transitions to adult care. A medical home with electronic health records improves performance and outcomes measurement and accountability.
5. **Quality and safety** are hallmarks of patient-centered and evidence-based asthma care. The NAEPP provides guidelines on establishing the asthma diagnosis, providing asthma education on patient self-management, prescribing medications — especially inhaled corticosteroids for persistent asthma — using a stepwise treatment approach for patients of different ages, and developing a written asthma management plan to help families.[4] The AAP Chapter Alliance for Quality Improvement and the Medical Home Chapter Champions Program on Asthma offer state and local resources for practices. The AAP Education in Quality Improvement for Pediatric Practice online courses — for both medical home and for asthma — provide continuing medical education credits and maintenance of certification Part 4 support.
6. **Enhanced access** to care includes pediatrician availability to assess, classify, and monitor asthma severity and control. It also reduces disparities in processes and outcomes in asthma care.
7. **Appropriate payment** recognizes the added value provided to asthma patients who receive care in a medical home, as defined above.

Clinical Examples of Asthma Care in a Medical Home

The aforementioned medical home principles can be further illustrated by the following clinical examples of asthma management:

1. **Personal physician:** During urgent care hours, Jackson, seven years of age, comes in to see your on-call partner with a chief complaint of cough. Since he's listed in your registry of children with special health care needs, your scheduling staff and care providers are aware that he's a known asthmatic and had a gastric duplication repaired at birth. Therefore, he needs and is given a longer appointment. He's just spent

continued on page 14

Children with Asthma

continued from page 13

the weekend in his paternal grandmother's home; mom sent his "puffers" but they weren't used during his visit. Your colleague accesses his problem list and current asthma plan from his medical record, stabilizes him, and arranges for him to return to see you the next day for follow-up, sending an e-mail to you and your care coordinator.[5]

2. **Physician-directed medical practice team:** Having recently completed his kindergarten check-up, you know that Jackson's parents aren't together and his dad is only peripherally and episodically involved in his care. His mother, maternal grandmother, and uncle are his usual care providers. You and your care coordinator have worked with a Medicaid case manager to assist in the home by providing education about medicines and compliance.
3. **Whole-person orientation:** Prior to receiving care in your medical home system, Jackson was hospitalized twice for asthma exacerbations, once with a complicating pneumonia. You discovered that he sleeps on the floor on a very old mattress and the family admits that they have lots of cockroaches in the home. You and your care coordinator have arranged for dust-mite covers for his bedding and have contacted his school's social worker to assure his medications are given at school when necessary. You also updated his asthma plan at his recent check-up.
4. **Care is coordinated and integrated:** After Jackson's second hospitalization, he had quantitative IGE allergy testing with you and saw the pulmonologist to consider what role GER might play in his exacerbations. Your review of his pulmonology consult in his medical record confirms your recollection that studies for reflux were negative, but his allergy testing showed marked reactivity to cockroaches and dust mites. You place a reminder on his chart to arrange asthma education for Jackson's father when Jackson is stable; you plan to do spirometry to assess control during that visit.
5. **Quality and safety:** Using NHLBI guidelines, you and your partner move Jackson's medications up to the "yellow zone" in his asthma plan and arrange for him to return for his flu shot and follow-up in two weeks. You remind his uncle of the importance of Jackson using his controller medicines daily. His uncle says Jackson does much better with his nebulizer when he's sick, but they've lost the tubing. You replace his tubing and mask and adapt his asthma plan for nebulizer use until his return visit. An electronic reminder for his flu shot is placed in his chart, along with a reminder that his father needs an asthma education session and an asthma care plan for his home.
6. **Enhanced access:** Jackson arrives with his uncle at 1:00 p.m. on Sunday to be seen during urgent care hours. A consent by proxy is on the chart, which permits his uncle to seek care for him. A same-day appointment is available and scheduled for follow-up by you the next day. An ED visit is unnecessary.
7. **Payment:** Your partner charges an after-hours code (99051) for Sunday care and captures charges for oximetry (94760), nebulization (94640), and nebulizer tubing (A7003). Your visit the following day is moderately complex (99214), sorting out the exacerbation and assuring that Jackson is clinically improved. Your nurse reviews inhaler use with his local family (94664) and makes an appointment in two weeks for spirometry to assess control (94060) and for his father's asthma education visit.

Summary

In 2008, 10.2 million children (or 1 in 7) had lifetime asthma and almost 7 million children (1 in 11) had current asthma. Because asthma is the single most common childhood chronic condition and the second most prevalent childhood condition,[6] the medical home model of care should be the foundation of care for children with asthma. For a child with asthma, care received within the context of medical home that's accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective can be the difference between control and the emergency room.

AAP Medical Home and Asthma Project

In 2009, the AAP established the Medical Home Chapter Champions Program on Asthma with support from the Merck Childhood Asthma Network, Inc. The goals of the two-year program are to:

- Increase access to a medical home for children and youth, especially those with health disparities
- Facilitate pediatric practices' adoption and implementation of NHLBI asthma guidelines within the context of a medical home
- Increase advocacy efforts for implementation of asthma care within medical homes at the chapter/state level(s) — ***Matthew Sadof, MD, FAAP, and the Medical Home Chapter Champion Program on Asthma***

To connect with the Massachusetts Medical Home Chapter Champion Program on Asthma and learn about what is going on in our state, please feel free to contact Matthew Sadof, MD, assistant professor of Pediatrics, Tufts University School of Medicine, Massachusetts Medical Home Chapter Champion on Asthma, Baystate Children's Hospital, High Street Health Center Pediatrics, 140 High Street, Springfield, MA 01199. Fax (413) 794-5995 or e-mail Matthew.Sadof@Baystatehealth.org.

For more information about the Medical Home Chapter Champions Program on Asthma, contact Suzi Montasir, MPH, program manager, American Academy of Pediatrics, at (800) 433-9016, ext. 4311, or smontasir@aap.org.

1. American Academy of Pediatrics; Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home. *Pediatrics*, 2002; 110(1), 184–186.
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3. Homer C., Perrin J., et al. A Review of the evidence for the medical home for children with special health care needs. *Pediatrics*, 2008 (122), 922–937.
4. US DHHS NIH NHLBI NAEPP. Guidelines for the diagnosis and management of asthma, 2007.
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6. Markus A., Lyon M., et al. Changing policy: the elements for improving childhood asthma outcomes, 2010.

SAVE THE DATE

Sixth Annual Residents and Fellows Day at the State House

For the sixth year in a row, pediatric residents throughout Massachusetts will descend upon the State House in Boston to advocate for children. This annual event supported by the MCAAP, known as RFDASH (Residents and Fellows Day at the State House), will occur this June in conjunction with the upcoming legislative cycle. Residents and fellows will attend training sessions on legislation and lobbying and then lobby their legislators regarding bills specific to pediatrics. This event is organized yearly by the Massachusetts General Hospital for Children pediatric residents' advocacy group. For more information, please visit http://mghfcresidents.wordpress.com. We hope to see you there!

ANNOUNCEMENT

2011 MCAAP Call for Nominations

This spring, positions for the MCAAP Executive Committee will become vacant for district representatives in districts 3, 4, 5, 6, 7, 9, and 10.

If you would like more information about the role of the district representative or you want to make a nomination, please contact Cathleen Haggerty via e-mail at chaggerty@mcaap.org, fax to (781) 895-9855, or mail to 860 Winter Street, Waltham, MA 02451. Nominations must be received by February 25, 2011, and electronic ballots will be e-mailed and mailed the first week of March. Individual communities within each district can be found at www.wheredoivotema.com/bal/myelectioninfo.php.

Advertise in *The Forum*

We would like to invite you and your organization to advertise your services in upcoming editions of *The Forum*. *The Forum* is mailed to 1,700 pediatricians and is available online at no charge. If you would like more information about rates and submissions, please contact Cathleen Haggerty at chaggerty@mcaap.org.

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JOB CORNER

Pediatrician Wanted: Massachusetts Hospital School

The Medical Department at the MHS is seeking a FT/PT BC/BE pediatrician interested in caring for children with special health care needs. Excellent benefits package. This position offers excellent call schedules for a physician with a young family. The Massachusetts Hospital School is a unique provider of pediatric inpatient services for children and young adults from ages 6 to 22 with multiple disabilities. The MHS provides a supportive and challenging adaptive learning program that combines the disciplines of medicine, rehabilitation, re-creation, and education. The MHS is a fully Joint Commission-accredited, 120-bed facility. The MHS is an affirmative action/equal opportunity employer.

Submit CV to:
Aruna Sachdev, MD
Medical Director
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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.*

To submit a listing, e-mail alight@mcaap.org. Please include the following information:

- Contact information
- Practice name/residency program
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- Availability (e.g., available now)

**Contact Cathleen Haggerty at chaggerty@mcaap.org for rate and payment information.*

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