Presidents Message

Payment Reform in Massachusetts

Payment reform appears to be rising quickly to the top of the State House agenda once again, now that the Legislature has completed work on several other complex issues and gone into recess.

It’s widely expected that the co-chairs of the Joint Committee on Health Care Finance, Rep. Steven Walsh and Sen. Richard Moore, will each introduce separate bills to compete with the governor’s proposed bill. A final compromise bill will presumably emerge from those three proposals. The Chapter is working to influence these deliberations, and to advance the interests of children, child health, and pediatrics.

At the most recent Chapter board meeting, we discussed a draft of the proposed language we would like to see included in any final payment reform bill and which we will submit to Rep. Walsh, Sen. Moore, and the governor. Given the importance of this process, the board and I want to present this proposed language to chapter membership for review. In crafting this language, we’ve tried to be succinct, stating important general principles and setting key parameters, since language that’s too prescriptive or detailed is unlikely to be considered for inclusion in any bill.

Please review the following proposed language, and make comments, propose changes, or suggest edits by emailing Cathleen Haggerty at chaggerty@mcaap.org.

MCAAP Payment Reform Bill Proposals

The health needs of children are different from the health needs of adults. As a

Table of Contents • Winter 2012 • Volume 13 No. 1

President's Message ................. 1
Physician Participation in Social Media ............. 1
Editor's Note ......................... 2
Letter to the Editor ..................... 6
2011 Summit on Early Childhood a Resounding Success ............. 6

Book Corner ......................... 7
ShotClock .............................. 8
Updates from the Immunization Initiative ............. 8
PROS Update ......................... 10

Physician Participation in Social Media

Over the past few years there has been a dramatic transformation in how people communicate with each other through electronic media. Prior to 2005, electronic communication was primarily via email. Information was gained over the Internet by viewing websites where the users were simply consumers of information and not contributors. All of this has changed dramatically with the continued development of “Web 2.0” technologies. These allow two-way interactions between users and site owners. Every individual has the ability to contribute to the website itself, blurring the line between author, creator, developer, and consumer. Web 2.0 has enabled the development of social media by allowing anybody with Internet access to become a "published author," and of social networking that facilitates making one-to-one and one-to-many connections. Social media consists of blogs where anybody can become an author of any content without any type of review for accuracy, video sharing sites such as YouTube, and social networking sites

continued on page 4
To paraphrase Raymond Whitehead, “Medicine is not a field where sheep may safely graze.” With scientific and medical advances joined by changes in the systems that deliver health care, that statement remains both true and fundamental.

Most MCAAP members have heard about ACOs and payment reform before. To those used to conversing in molecules and anatomy, these new structures and providers may seem nebulous at best. And to be frank, most of them still are. But while our instinct may be to focus on the patient and problem in front of us, changes are inexorably coming closer. Health insurers, drug companies, and politicians are all on the front lines, creating new legislation that will forever change the way we care for our patients. These changes may be better or worse. But one thing is clear; if pediatricians are not at the table when these ideas become law, we’re rolling the dice. And as any Vegas gambler can tell you, odds are that the house will win.

Here in Massachusetts, two important discussions have begun. First, as described in the President’s Letter, state legislatures have begun to seriously draft and revise health care and payment reform legislation. Current discussions will affect more than just our future reimbursement. They’ll have the power to define the roles and responsibilities of ACOs and other major organizations, as well as the roles that we play within these structures.

Equally interesting is a bill before the Massachusetts legislature that would give nurse midwives the ability to perform independent testing, interpretation, evaluation, and provision of patient care. While the use of auxiliary professionals is nothing new, this bill gives more control and power to non-MD practitioners than has ever been proposed previously. At the same time, it would remove practitioner oversight from the Board of Medicine, proposing that nurse midwives be accountable solely to a midwifery organization instead.

Are ACOs and auxiliary providers better for our patients, or worse? Whatever your position, these discussions are crucial. The proposed changes hold promise and pitfalls, and we must be prepared to advocate for our patients concerning the new plans or face the consequences — good or bad.

How can we, as busy — even overwhelmed — physicians, advocate for the future of medicine? The first step is to learn the basics of the debate. If you’re starting from scratch, you can review ACO basics with a brief PowerPoint presentation by Elliot Fisher, a copy of which can be found at https://xteam.brookings.edu/bdacoln/Documents/ACO%20Summit%20Fisher%20final%20(June%207%202010).pdf.
Payment Reform in Massachusetts  
continued from page 1

result, the programs and systems necessary to support optimal child health are often different from those for adults.

In order to adequately address the health needs of children, the MCAAP strongly urges the Health Care Finance Committee to include the following provisions in any payment reform legislation:

• Any system of payment for health services in Massachusetts, including plans based on global payments to provider networks and ACOs, shall recognize the specialized needs of children and families, as well as the specialized programs and services necessary to meet these needs.

• Such networks shall provide coverage which includes, but is not limited to:
  – Sufficient numbers of primary care pediatricians
  – Access, where indicated, to pediatric subspecialists and pediatric surgeons
  – Access to child psychiatrists and other behavioral health providers with demonstrated expertise in the care of children and adolescents
  – Access, where indicated, to pediatric health care facilities necessary to meet the needs of the children covered by the network

• Access to family and child-centered developmental and behavioral health services — critical to child health — must be guaranteed.

• Public health initiatives critical to child health, such as regionalized care of critically ill newborns, pediatric trauma care, and the childhood immunization program shall not be compromised.

• The viability and vitality of pediatric hospital programs and child health research endeavors shall be preserved.

• In recognition of the specialized health needs of children, any advisory body, council, or committee involved in the planning, implementation, and ongoing oversight of health reform shall include a minimum of one pediatrician who is experienced in child health delivery systems and child health services within the Commonwealth.

• Due to the unequal distribution of pediatric subspecialty and surgical services across the Commonwealth, ACOs — or other such plans — shall allow families and pediatric providers to choose appropriate “out-of-plan” subspecialty and surgical care based on medical need.

• Due to the unequal distribution of pediatric hospital and newborn nursery services in community hospitals across the Commonwealth, pediatric providers shall not be restricted to membership in a single ACO, or similar entity.

— Greg Hagan, MD, FAAP

Don’t Stand on the Sidelines  
continued from page 2

Ready for details and some “what will this mean for me” information? Try this excellent Berkeley Law brief: www.law.berkeley.edu/files/chefs/Implementing_ACOs_May_2010.pdf.

In search of even more answers and ideas? Groups, such as the Brookings Institute, have a series of talks and articles on ACOs, health care reform, alternate practitioners, and more available online.

So you know what we’re talking about here: now what? How can you learn more about local developments and when and where you can best make a difference? Luckily, the MCAAP Legislative Committee works hard to educate and advocate for all of us, but they work best when we work with them. Keep your eyes open for legislative updates here in The Forum, and tell us what you agree with and what you want to change. For example, in this issue you can review and comment on a draft proposal that the MCAAP will be submitting to legislators as they discuss statewide health care reform laws. Want to do even more to advocate for the best health care for children? Contact the legislative committee or MCAAP leadership to get involved today.

Yes, it can be hard to find time to look towards the future instead of just staying on top of the present. And the amorphous nature of current discussions on reform doesn’t help. But waiting until these laws are forged to voice our hopes and concerns is be a huge mistake. Arguing about legislation after the fact is simply too late. As the cliché goes, we must strike now, while the iron is hot. Only now can we help create a better health care system, and better health, for the children of tomorrow. — Anne Light, MD, FAAP
such as Facebook, Myspace, and LinkedIn, and Twitter where “regular people” and celebrities alike can “tweet” short updates on their comings and goings to any of their “followers.”

Many professions have embraced social media as a way to better connect with their customers and receive constant information and feedback about what the consumer is interested in and looking for with respect to products and services. Most corporations have their own Facebook page, allowing current and potential customers to communicate with decision-makers at the company. Announcements of new products or services are also easily disseminated in this manner.

The medical community as a whole, and physicians in particular, haven’t been as eager to embrace these new technologies. Many concerns have been raised, including patient confidentiality, liability, and patient/physician boundary issues; these concerns likely contribute to the reluctance of physicians to participate in social media. In addition many physicians feel overwhelmed with their professional lives and see contributing on social media and communicating with patients in this way to be yet another unnecessary demand on their time and something that takes away from their core professional role.

However, even without physician involvement patients have found a use for social media in a variety of ways. Facebook pages devoted to specific medical conditions are prominent (e.g., ADHD, autism, diabetes, asthma), patients blog about their experiences living with a particular chronic illness or going through a surgical procedure, patients rate members of their health care team on doctor rating sites, compare outcomes from procedures, and some non-medical professionals create extensive websites devoted to particular issues (e.g., vaccine safety). A majority of them are not reviewed, regulated, or edited by medical professionals. The public (i.e., our patients) has become heavy consumers of and contributors to social media, even though we’ve historically been largely absent.

Research clearly shows that more and more patients are finding medical information online and are communicating through social media about their conditions and experiences as patients.1 Additionally, despite the overwhelming amount of health-related websites and social media applications, patients still desire the ability to be able to find medical information online from trusted sources, such as their personal physician.

Younger generations of physicians, especially medical students and residents, are regular users of social media in their personal lives and have easily transferred that expertise into their professional lives as well. Unfortunately, there have been numerous reports of medical students or physicians posting inappropriate content online. A recent study found that 60 percent of medical schools in the United States reported incidents of posting unprofessional online content.2

Those who choose to participate in social media need to take certain precautions to reduce their potential risk. There is minimal case law to guide us through this burgeoning medium, so common sense must be used. Creating a definitive separation between your personal and professional online presence is essential. Most social media sites allow you to set privacy settings. Physicians should make sure to set their security at the highest possible setting to prevent uninvited users from viewing personal content. If you make the decision to communicate with patients through social media, the limitation and extent of that online relationship must be explicitly made to the patient.

The same conventions and limitations that exist in non-electronic communication should be followed when setting boundaries for communication in social media. Perhaps most importantly, think...
carefully before posting anything in public forums. Once the send button is pressed the content cannot be erased or taken back; it exists in cyberspace indefinitely. Any statements made online can have a significant effect on how a physician is viewed by their patients and the public at large.

Despite the risks inherent in participation in social media, there are obvious benefits as well. In this era of immediate access to information it’s essential that what patients are accessing is both accurate and timely — a goal that can only be assured through physician involvement. Patients now want to be educated consumers of health care services and to have an understanding of their condition and treatment options. Social networking sites bereft of a physician presence and accurate information could lead to poor choices by our patients.

Both large and small medical practices have found value in marketing their business through social media. When patients are looking for both PCPs and specialists they now turn to online sources. Creating a YouTube video detailing medical interests and expertise can be a tremendous benefit for a physician to reach out to the community and advertise. Physicians who maintain a popular blog that’s linked to a traditional media outlet’s website (i.e., television or newspaper) can become local celebrities and create demand for their services. Nearly all of the large medical organizations have a Facebook fan page to promote new physicians and programs offered. However, even small and solo practices can benefit from developing a presence on this popular social networking site.

Recognizing both the importance and potential hazards of physician participation in social media, professional organizations, hospitals, and medical schools have begun to develop guidelines to direct physicians and medical students towards appropriate and ethical use of these resources. Decisions about how to participate need to be made carefully and deliberately.

At the 2011 annual meeting in June, the MMS became one of the first state medical associations to develop a comprehensive set of guidelines and principles to help physicians in their decisions around social media. The policy was based upon what was adopted by the AMA in November 2010, but gave more specific guidance and practical suggestions about using the most popular sites and services through a “best practices” section.

In summary, the MMS policy states:

- Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must not post identifiable patient information online.
- When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible.
- If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines, just as they would in any other context.
- To maintain appropriate professional boundaries, it is recommended that physicians separate personal and professional content online.
- Physicians’ existing professional responsibility to hold their colleagues to account for maintaining the profession’s code of ethics extends to behavior in online communities.
- Physicians must disclose all financial or other material relationships they have with regard to the maker or provider of products and services they review or discuss in online communities.
- Physicians must recognize that online content can have a significant impact on public trust in the medical profession, both positively and negatively. The content that physicians post online may also influence their reputations among patients and colleagues, and may have consequences for their medical careers, particularly for physicians in training and medical students.

Technology continues to evolve at a rapid pace and it’s impossible to imagine the platforms available next year or even next month. Regardless of the specifics of the electronic medium, it’s clear that social media and networking will continue to transform the way in which our patients receive information and communicate with us and with each other. Patients are now not only looking for information about their medical conditions, but also for information about their physicians and the facilities where they receive their care. As the health care system in the United States undergoes dramatic transformation and moves towards models of care in which patients will have more financial responsibility for their health care expenses, they will be looking for easy access to information about both cost and quality. Wikis, blogs, and social networking sites can provide them with the resources they seek.

It’s likely that our professional organizations will continue to develop and refine policies in order to guide us in our exploration of and contribution to social media. Participation is valuable to our profession, but caution must be taken in order to ensure the highest professional standards are maintained.

— Lloyd Fisher, MD, FAAP, chair, MMS, Committee on Communications, lfisher@massmed.org

The article in the Fall 2011 issue of The Forum is correct in one way, but wrong in many others.

Yes, there should not be a legalization of medical marijuana. That's because medicalization is the back door. The front door should be opened and marijuana should be legalized. Yes, marijuana is dangerous. So are tobacco and alcohol, yet they are legal.

In fact, we tried outlawing alcohol and that was a disaster. With marijuana we are just in another era of Prohibition that is not working. In the meantime, it is corrupting government agencies, destroying neighborhoods, and one-third of Americans have used marijuana. Laws without morals are in vain.

From a political and legal standpoint, the only answer is legalization. Not only that, but there will be better control with legalization.

The Fall 2011 issue of The Forum is correct in one way, but wrong in many others.

Yes, there should not be a legalization of medical marijuana. That's because medicalization is the back door. The front door should be opened and marijuana should be legalized. Yes, marijuana is dangerous. So are tobacco and alcohol, yet they are legal.

In fact, we tried outlawing alcohol and that was a disaster. With marijuana we are just in another era of Prohibition that is not working. In the meantime, it is corrupting government agencies, destroying neighborhoods, and one-third of Americans have used marijuana. Laws without morals are in vain.

From a political and legal standpoint, the only answer is legalization. Not only that, but there will be better control with legalization.

We've managed to reduce tobacco usage dramatically without prohibiting it, but with judicious use of laws. The same could be done with alcohol if we put our minds to it. Respected social thinkers like Thomas Szasz, MD, and Milton Friedman, PhD, are in favor of legalization. So is Lawrence Price, MD, the editor of the Brown Psychopharmacology Report.

As a side benefit, we might reduce the drug phobia that causes parents to refuse psychotropic drugs from children who desperately need them. — Daniel Nussbaum II, MD, FAAP, retired developmental pediatrician, New Bedford, Massachusetts

Have a question or a comment on something in The Forum? Submit your letter to the editor at alight@mcaap.org. Please note that letters are subject to editing for considerations of space and clarity.

— Daniel Nussbaum II, MD, FAAP, retired developmental pediatrician, New Bedford, Massachusetts

Letter to the Editor
In Response to “Medical Marijuana Is Bad for Youth”
As 2011 draws to a close, the pediatric community takes stock on how well it did over the last 12 months. Most of us perform our “self examination” through the “Annual Summary of Vital Statistics,” published every year in Pediatrics. Due to the volume of data to be crunched, the numbers usually lag by a year or two. Nonetheless, the summary is a good indicator of where we need to focus in the coming year and beyond. As clinicians who specifically provide care to children and families, we should go beyond the exam room and start looking at what children are doing after they leave the office. One indicator worth checking out is the U.S. Census, which recently released the analysis of data from 2009. The statistics from the Survey of Income and Program Participation look at how children younger than 18 years of age spend their day. This report card, like those of many of our patients, revealed both strengths and challenges.

Several statistics from this report showed positive growth. The percentage of children who talked or played together with a parent 3 or more times in a typical day increased from 50 percent in 1998 to 57 percent in 2009. The percentage of children who ate dinner with a designated parent 7 times per week on average increased slightly from 69 percent in 1998 to 72 percent in 2009. “Designated” refers to the mother in households where both parents are present, the father if the mother is not, or a guardian if neither parent is in the household. The percentage of children whose parents praised them 3 or more times per day increased from 48 percent in 1998 to 57 percent in 2009. Sadly we’re not close to the 100 percent we wish for all children in our country.

On the “reading aloud” front, we are faring somewhat better in general. Reading interactions are more frequent among families above the poverty line, but even reading interactions among low-income families have increased over the past 10 years. In 1998, only 37 percent of those 1 and 2 years of age below the poverty level were read to 7 or more times per week, compared to 56 percent of children above the poverty level. In 2009, 45 percent of children below the poverty level were read to 7 or more times per week; better, but still not quite half of the children who are most in need. In households above the poverty level, there was no change in reading frequency from 1998 to 2009.

If we were grading on a standard scale, these census numbers might put us slightly above a “C” on all indicators—not the GPA most of us wished for during our premed days. As we ponder what steps to take for change in 2012, perhaps we can strive to change how our country spends time with its children. One concrete intervention is talking about the importance of reading aloud to children every day. A simple sentence from us, perhaps reinforced with giving a book, can go a long way in helping families change their behavior and hopefully push us over the halfway mark for all children in the United States. — Marilyn Augustyn, MD, medical director, Reach Out and Read Massachusetts

For more information about Reach Out and Read and early literacy, email Massachusetts Program Director Alison Corning-Clarke at alison.clarke@reachoutandread.org or Marilyn Augustyn at augustyn@bu.edu.
ACIP Recommends All Males 11–12 Years of Age Get Vaccinated Against HPV

At its October meeting, the Advisory Committee on Immunization Practices (ACIP) voted to recommend routine vaccination of males 11–12 years of age with 3 doses of quadrivalent human papillomavirus (HPV4) vaccine to prevent HPV infection and HPV-related disease. Catch-up vaccination was recommended for males 13–21 years of age. A permissive recommendation was made for males 22–26 years of age. ACIP recommended vaccination with HPV4 through 26 years of age for males having sex with males or immunocompromised males (including HIV-infected), who have not been vaccinated previously or who have not completed the 3-dose series.

At press time the recommendation is still permissive. The recommendation is subject to approval by the CDC. Once approved, it will be published in the *Morbidity and Mortality Weekly Report*.

**Immunization Initiative Survey on Reimbursement of Vaccines Not State-Supplied**

In August 2011, the Massachusetts Department of Public Health (MDPH) announced that due to current federal and state vaccine funding limitations, effective September 1, 2011, the MDPH would no longer supply Hepatitis A, Tdap, and Varicella vaccines for catch-up vaccination of health-insured children. The MDPH also does not supply HPV vaccine or the routine second dose of meningococcal conjugate vaccine (MCV4) for health-insured children.

To meet the needs of children who are not eligible to receive the state-supplied vaccines, providers are required to privately purchase additional doses of these vaccines and bill health plans and insurers for their cost and administration.

A survey of Massachusetts health plans was conducted to determine health plan reimbursement policies for these vaccinations (see table on page 9).

**Immunization Initiative Offers Immunization Updates**

For more than 15 years, the MCAAP Immunization Initiative has worked with pediatric departments to present grand rounds seminars on pediatric immunization. The seminars have been very well received and provided attendees with access to current and practical immunization information.

There have been many recent developments in immunization, including: disease outbreaks (measles, mumps, pertussis), new ACIP recommendations, the introduction of Massachusetts’ immunization registry, the Massachusetts Immunization Information System (MIIS), new guidelines for vaccine management in the office, and increasing parental concern about vaccine safety and the immunization schedule.

Most presentations are an hour long, and our expert faculty addresses current immunization issues and also responds to attendee needs and interests. Each participant receives a packet of handout materials that includes helpful, current information, such as recent guidelines on immunization, summary charts, and guides to the office management of immunization.

We are interested in working with your pediatric department or practice to present an immunization update. If you are interested in scheduling an immunization update or would like more information, please contact Cynthia McReynolds of the Immunization Initiative at cmcreynolds@mms.org or (781) 895-9850.

**Provider Resources for Vaccine Conversations with Parents**

Do more and more parents in your practice have questions about vaccines? Would you like to develop timesaving strategies for communicating effectively with parents about childhood immunizations?

Parents trust you to give them accurate health information for their children. The CDC, the American Academy of Family Physicians, and the AAP have developed *Provider Resources for Vaccine Conversations with Parents*. These free, reproducible resources will help you to stay current on vaccine safety information, strengthen communication and trust between you and parents, and share up-to-date, easy-to-use information about vaccines and vaccine-preventable diseases with parents.

You can download fact sheets, communication tips, waiting room videos, and more at www.cdc.gov/vaccines/conversations. For more information, call 1-800-CDC-INFO (232–4636). — *From the Centers for Disease Control and Prevention (CDC)*

**16th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference**

More than 400 nurses, physicians, community outreach and public health personnel attended the 16th Annual MIAP Pediatric Immunization Skills Building Conference, held on October 13, 2011.

Andrew Kroger, MD, MPH, medical epidemiologist, National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention; and John Snyder, MD, medical director, High Street Health Pediatrics, continuity clinic director, Baystate Children’s Hospital, assistant professor of pediatrics, Tufts University School of Medicine, were the guest keynote speakers for the conference.
Dr. Kroger provided attendees with a national immunization update, while Dr. Snyder discussed vaccine myths. Susan Lett, MD, MPH, medical director, Immunization Program, MDPH, also provided a state immunization update.

The breakout sessions included topics such as: vaccine preventable disease epidemiology, the Massachusetts Immunization Information System (MIIS), vaccine management and site visits, case studies in immunization delivery, generating revenue from school or public health flu clinics, and Ask the Experts: Question and Answer Session with Drs. Kroger and Lett.

MIAAP would like to thank plenary and breakout session speakers Andrew Kroger, MD, MPH; John Snyder, MD; Susan Lett, MD, MPH; Liesl Bradford, MS; Carly Coppola, MPH; Beth English, MPH; Nancy Harrington; Donna Lazorik, RN, MS; Bob Morrison; Holly Oldham, MS; Marija Popstefanija, MPH, MS; Ron Samuels, MD, MPH; Kathleen Shattuck, MPH; and Erin Wnorowski, MPH, for their time and participation.

Plenary and breakout sessions from the conference have been archived and can be downloaded at www.mcaap.org/immunization-cme/#Conferences.

— Cynthia McReynolds

---

### MCAAP IMMUNIZATION INITIATIVE

#### Survey for Reimbursement of Vaccines Not State-Supplied

Updated January 2012

<table>
<thead>
<tr>
<th>COMPANY</th>
<th>HEP A</th>
<th>TDAP</th>
<th>VARICELLA</th>
<th>HPV/GIRLS</th>
<th>HPV/BOYS</th>
<th>MCV4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>Y1</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Comments: <a href="https://www.aetna.com/healthcare-professionals/policies-guidelines/cpb_legal.html">Link</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCBS MA</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Comments: As of October 25, 2011, we will reimburse for the HPV vaccine for males per the recommendation of ACIP.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCBS RI</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Comments: We cover all ACIP recommended vaccines. We also cover HPV for males. When state supply is not available we cover administration and supply. Use modifier 22 on vaccine CPT code if not state supplied. When available, state supply must be used.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMC HealthNet</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Comments: At present, HPV for boys requires prior authorization — this is currently under discussion.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fallon Community Health Plan</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Comments: As of January 2012, Fallon Community Health Plan reimburses for the HPV vaccine for boys.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPHC</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>MassHealth</td>
<td>Y*</td>
<td>Y*</td>
<td>Y*</td>
<td>Y*</td>
<td>Y*</td>
<td>Y*</td>
</tr>
<tr>
<td>Comments: Vaccines for MassHealth and CSMP children are provided by the DPH. MassHealth pays for the administration of the vaccines if they are not billed in conjunction with an office visit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighborhood Health Plan</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Comments: Many of our enrollees are VFC-eligible. We expect that providers will use state-supplied vaccine when available for VFC-eligible children. We reserve the right to perform audit and recovery activities to ensure that VFC-eligible enrollees are receiving state-supplied vaccine rather than privately purchased vaccine.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Health</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Comments: We will cover if the state supply runs out or the state precludes use of their vaccine for medically approved purposes and it is not available at a community clinic. We will not pay for vaccine purchased at a pharmacy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tufts Health Plan</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Comments: Please note that while we have indicated reimbursement for cost in the survey, the reimbursement amount is limited to the amount specified under the terms of the provider’s contract with Tufts Health Plan.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UniCare State Indemnity Plan</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

1. A “Y” response indicates reimbursement of both the vaccine purchase and administration cost, except where indicated by an asterisk (*).
2. An “N” response indicates that providers are not reimbursed for either the vaccine purchase or the administration cost.
Are you concerned about teen smoking? About adolescents’ use of social media? You might be interested in a new Pediatric Research in Office Settings (PROS) study.

Adolescent Health in Pediatric Practice (AHIPP) is a randomized controlled trial of smoking cessation and social media anticipatory guidance for teenagers. We are now recruiting interested practitioners for this study. Practitioners who are new to PROS are welcome to get involved in AHIPP, as are practitioners who are already PROS members.

Practices with a high number of adolescents and higher local smoking rates would be perfect for the study. In Massachusetts, counties with higher adult smoking prevalence are Berkshire, Franklin, Hampden, Worcester, Essex, Suffolk, Bristol, Plymouth, and Nantucket.

PROS is the American Academy of Pediatrics practice-based research network. In the Massachusetts chapter, we have 35 participating practices with approximately 150 practitioners, and there is always room for more! Participating in collaborative clinical research to improve the health of the children we take care of is fun, interesting, and rewarding.

If you would like to learn more or you are interested in participating in the study, please call or email us:

Ben Scheindlin (Burlington Pediatrics): (781) 272-2210, bscheindlin@yahoo.com
David Norton (Holyoke Pediatrics): (413) 536-2393, nortond@holypeds.com

— Ben Scheindlin and David Norton, PROS chapter co-coordinators
MCAAP Committees and Administrative Appointments

AAP BREASTFEEDING COORDINATOR
Susan Browne
sbrowne@mcaap.org

BYLAWS COMMITTEE
Carole Allen
callen@mcaap.org

CATCH CO-COORDINATORS
Robert Kossack
rkossack@mcaap.org
Giusy Romano-Clarke
grclarke@mcaap.org

COMMITTEE ON ADOLESCENCE
Carl Rosenbloom
crosenbloom@mcaap.org

DEVELOPMENTAL DISABILITIES
Laurie Glader
lglader@mcaap.org
Kitty O’Hare
kohare@mcaap.org

EMERGENCY PEDIATRIC SERVICES
Patricia O’Malley
pomalley@mcaap.org

ENVIRONMENTAL HAZARDS
Megan Sandel
msandel@mcaap.org

FETUS AND NEWBORN
Elizabeth Brown
ebrown@mcaap.org

FORUM EDITOR
Anne H. Light
alight@mcaap.org

FOSTER CARE
Linda Sagor
lsagor@mcaap.org

IMMUNIZATION INITIATIVE
Cynthia McReynolds
cmcreynolds@mcaap.org
Sean Palfrey
spalfrey@mcaap.org

INFECTIOUS DISEASE
Sean Palfrey
spalfrey@mcaap.org

INJURY PREVENTION
Greg Parkinson
gparkinson@mcaap.org

INTERNATIONAL CHILD HEALTH
Sheila Morehouse
smorehouse@mcaap.org
David Norton
dnorton@mcaap.org

LEGISLATION
Karen McAlmon
kmcalmon@mcaap.org
Michael McManus
mmcmanus@mcaap.org

MEMBERSHIP
Chelsea Gordon
cgordon@mcaap.org
Walter Rok
wrk@mcaap.org

MENTAL HEALTH TASK FORCE
Joe Gold
jgold@mcaap.org
Michael Yogman
myogman@mcaap.org

MMS DELEGATE/HOUSE OF DELEGATES
Lloyd Fisher
lfisher@mcaap.org

MMS INTERSPECIALTY COMMITTEE REPRESENTATIVE
Greg Hagan
ghagan@mcaap.org

NOMINATING COMMITTEE
Open

OBESITY COMMITTEE
Elizabeth Goodman
egoodman@mcaap.org
Alan Meyers
ameyers@mcaap.org

ORAL HEALTH COMMITTEE
Michelle Dalal
mdalal@mcaap.org

PEDIATRIC COUNCIL
Peter Rapp
prapp@mcaap.org

PEDIATRIC PRACTICE
Open

PROS NETWORK COORDINATORS
David Norton
dnorton@mcaap.org
Ben Scheindlin
bscheindlin@mcaap.org

SCHOOL HEALTH
Linda Grant
lgrant@mcaap.org

SUBSTANCE ABUSE
John Knight
jknight@mcaap.org

SUSPECTED CHILD ABUSE AND NEGLECT
Rebecca Moles
rmoles@mcaap.org

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.

AD SIZE (ALL SIZES ARE BY WIDTH AND HEIGHT)
7” x 9.625” (full page)
7” x 4.75” (1/2 page)
2.125” x 9.625” (1/3 page vertical)
3.125” x 9.625” (1/3 page horizontal)
3.5” x 4.75” (1/4 page horizontal)
3.5” x 3.2” (1/6 page horizontal)

INK
Ads should be submitted as CMYK. As a convenience, we are able to convert your ad into CMYK if necessary.

BORDER
You do not need to include a border with your ad.

REVERSE TYPE
To reduce registration problems, type should be no smaller than 9 point.

SUBMISSION
All ads should be submitted as high resolution PDFs, sent via email to chaggerty@mcaap.org. Please include your name, company, phone, fax, and email address. Remember to label your PDF file with your company name (i.e., CompanyX.pdf). This will assist us in identifying your file.

PDF GUIDELINES
All submissions should be Acrobat PDF files, version 5.0 or higher, and should be sent at the exact size specified herein. Ads not submitted at the proper size will be returned. Native files or other file formats will not be accepted. Fonts must be embedded and TrueType fonts should be avoided.

Please remember to double check that your ad is the correct size and contains the most up-to-date information.

Send your email address to chaggerty@mcaap.org for instant notification of issues important to the MCAAP membership.
Part-Time
Pediatrician Wanted

Pediatric practice in West Cambridge seeks fourth part-time pediatrician to join our group. Ideal start date is summer 2012. Interested applicants should contact Dr. Michael Yogman at (617) 864-7071 or myogman@massmed.org.

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, email alight@mcaap.org. Please include the following information:

• Contact information
• Practice name/residency program
• Position title
• Description (25-word limit)
• Availability (e.g., available now)

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