

The Forum

NEWSLETTER OF THE MASSACHUSETTS CHAPTER AMERICAN ACADEMY OF PEDIATRICS

PRESIDENT'S MESSAGE

Where Have All the Child Psychiatrists Gone?

In case you haven't noticed, it's hard to find a child psychiatrist these days. They are trained in Massachusetts, but go to neighboring states where reimbursement is better, or the new grads "disappear" into the "cash only" economy. Some of the senior psychiatrists give up insurance and charge fee-for-service.

That leaves primary care doctors trying to find psychiatrists for our most vulnerable patients using insurance. One plan listed five child psychiatrists. I called them for one of my patients. No one called back. Faced with a stressed child and a distressed family, I called "customer service" at their plan. They got the child an appointment a week later at a facility an hour from home, further stressing the family.

Health plans are carving out mental health to control costs. The management fee leaves less money for care. The management company limits the doctors they will contract with, further reducing the availability of child psychiatrists. Reimbursement is below market so few sign up. Plans save money if they have no one to deliver care. One training director told me that in last year's graduating class, only one child psychiatrist signed up with any health plan in Massachusetts.

We all want the very best healthcare. We want it accessible when we need it. So much money has been squeezed out of healthcare that we have reduced the very substance of what we need for our health, the caretakers. Are the child psychiatrists heralding things to come throughout healthcare?

— Eugenia Marcus, MD, FAAP
President, Massachusetts Chapter
American Academy of Pediatrics

What Is the MCAAP Doing for You?

David Chung, MD

The MCAAP is focused on advocating for children, but performing effective advocacy is a difficult task

when we are separated from each other by geography and the constant constraint of time. In order to be a potent organization it is imperative that we communicate effectively and have organized goals. Meetings are difficult to coordinate and this logistical nightmare limits participation by members. In short, **we need your e-mail addresses!**

There is a theorem that states that the activity of any community is geometrically related to the number of participants once it has reached critical mass. Communicating via e-mail in conjunction with strong leadership from a small number of individuals will create structure from the chaos of our daily schedules.

Imagine being able to initiate a lobbying effort from your den in fifteen minutes. By building an online community, one could marshal a large number of interested parties in a cost- and time-effective manner.

By establishing an e-mail community, it would be possible to propose a collaborative effort to help alleviate, for example, the mental health crisis in Massachusetts: Every primary care clinician, emergency room physician, and hospitalist is aware of the shortage of acute-care psychiatric beds. Patients languish in medical units for weeks when they really need intensive counsel-

ing and guidance. Unfortunately, this barometer for the shortage of services is so far downstream of the underlying problem that creating more acute-care

beds is like treating bacteremia with Tylenol. Many of these acute situations might have been avoided if there were earlier identification of mental health issues and appropriate early treatment. The number of psychiatrists and psychologists in the Commonwealth is much smaller than in other communities. The most commonly attributed cause for

this condition is the relatively low rate of reimbursement compared to other states in the area. Many counselors in Massachusetts only accept self-pay clients, creating a hierarchical model of care.

Individual payors in the Commonwealth are reluctant to take the first step in raising reimbursement rates due to fears of aggregating an "unattractive" panel of patients. Legislators are becoming increasingly aware of the mental health crisis in the Commonwealth but do not have the clinical expertise to provide the most effective solutions. Primary care clinicians are untrained advocates in mental health issues and are not effectively screening children on a regular basis for mental health disorders because they are afraid to open Pandora's Box. Obviously, the last three observations are gross exaggerations, but there is a kernel of truth to them



Imagine being able to initiate a lobbying effort from your den in fifteen minutes.

continued on page 3

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TO THE EDITOR:

Letters for publication should be less than 300 words, must be signed, and addressed to: Editor, David Chung, Beansprout Networks, 10 Wilson Rd., Cambridge, MA 02138, or by email at david@beansprout.net.

ECONOMICS OF PEDIATRIC PRACTICE

Dear Editor:

President Marcus has invited comment on her column entitled "The Economics of Pediatric Practice: Where Will You Be in Five Years?" (The Forum, Fall 2000). I presume the "You" in the title refers to the community-based general pediatrician. Dr. Marcus has cited several factors which she believes will adversely impact the economic viability of that species; I will add several more.

Increasingly, the general pediatrician is ceding the care of newborns to the neonatologist; the care of the seriously ill child to the hospitalist and emergency room specialist; the evaluation, management and follow-up of what were formerly routine pediatric problems to the subspecialist; after-hours telephone calls to the triage nurse; and well child care and the evaluation of minor illness to the nurse practitioner.

What's left for us? Providing a medical home? Not likely, in view of the above mentioned fragmentation of care. Behavioral counseling, for which we are not well-trained? Psychopharmacology, for which we are even less well-trained? Im-

munizations, which require the expertise of a nurse? School and camp physical exams unlikely to uncover problems not already identified? Paradigm shift number one.

The American Board of Pediatrics has conspired with the American Board of Internal Medicine to offer dual certification in pediatrics and adult medicine (Med/Peds). Since 85 percent of the American healthcare dollar is expended in the adult realm, it is obvious where the economic interest of the dual-certified physician lies. The American Academy of Pediatrics has expanded its interest to young adults, thereby diluting its resources which were formerly expended only on those who by virtue of age did not have the franchise to vote. Once we were just for kids; now we follow the money. Paradigm shift number two.

Dr. Marcus mentioned technological change, which in the past has benefited both the patient and the physician. We may not make any money treating meningitis, but at least we are paid for preventing it. The technological changes on the horizon, however, will strike right at the heart of our profession, with adverse economic consequences for all primary care physicians.

The hallmark of the professional has always been the possession of a specialized fund of knowledge and expertise. The Internet has already guaranteed that the patient will have access to the same information we do at the click of a mouse. The parent who drops a stack of computer

MCAAP COMMITTEES & ADMINISTRATIVE APPOINTMENTS

AAP Breastfeeding Coordinators Susan Browne & Jean Sheeley	Continuing Medical Education Lynda Young	International Child Health Lisa Albers	Nutrition Ronald Kleinman
Accident Prevention & Poison Control Paul Schreiber	Developmental Disabilities Richard Antonelli	Legislative Richard Ringel	Pediatric Council Walter Harrison
Adolescent & Sports Medicine Harris Faigel	Emergency Pediatric Services Pat O'Malley	Massachusetts Healthy Families Howard King	Pediatric Practice Open
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Children's Advocacy Board Barry Zuckerman	FORUM Editor David Chung	MMS Delegate/House of Delegates Carole Allen	Substance Abuse Alan Woolf
	Foster Care Robert Abrams	MMS Interspecialty Committee Reqs Eugenia Marcus & Kevin Petit	Technology Robert Gerstle
	Infectious Disease Sean Palfrey		

printouts on your desk probably knows at least as much about his or her child's disease or the common and uncommon causes of the presenting symptoms as you do. Diagnostic computer programs will improve and become available to the layman as well as to the professional, reducing the need for clinical expertise. Practice parameters developed by professional societies will dictate the mode of treatment; zealous plaintiff attorneys will ensure that they are followed. Although technical expertise will still be required for the evaluation and care of children, it is more likely that these skills will be employed by the surgeon, subspecialist and interventional radiologist than by the community-based general pediatrician. Paradigm shift number three.

It is naive to blame our economic problems on the insurance companies. If we are to survive as an economically viable and socially useful profession, we must critically

examine what we do, how we do it and how we can adapt to the technological changes which lie ahead.

— Philip A. Hourigan Jr., MD
Stoughton, MA

Editor's Reply:

Thank you for your very thoughtful commentary about the transition that is taking place in community-based pediatrics. I agree with you that the healthcare of children is becoming more fragmented, largely due to the explosion of information, diagnostic modalities, and treatment options. Being a generalist is harder than ever. I believe that generalists should become more knowledgeable about common conditions such as asthma, for example.

Technology provides us with the opportunity to provide preventive care in ways that were not possible in the past. We as a

group should advocate for higher rates of reimbursement for preventive services with a portion of reimbursement based on clinical outcomes. In other words, let's use the technology that is available, put our patients first, and get paid for providing excellent service (improving the health of children).

Other thoughts or responses from our readership may be directed to me at david@beansprout.net for publication in the next issue of the Forum. Submissions are due by March 15, 2001.

— David Chung, MD

Submissions for the next issue of The Forum should be sent to david@beansprout.net by March 15, 2001.

What Is MCAAP Doing for You?

continued from page 1

all. There are groups who are discussing the issue, but no group is large enough to effect change, each group is too big to have effective core leadership, and no one feels capable of taking the first step.

An e-mail community could provide a forum to propose initiating a three-month evaluation of other states in New England to find out how many counselor FTEs there are per child from 0-18 and what the average reimbursement rate is. The insurers could collaboratively attempt to achieve parity in the region by increasing reimbursement by 10 to 15 percent over two years, with the benchmark goals of increasing the number of counselor FTEs in the Commonwealth by 50 in year one and 75 in year two. Creative solutions could be applied to increase counselor participation by using one-time funds

available to the Commonwealth as a "signing bonus" for current providers and to attract providers from other states (funds like this exist — they are tied to the tobacco settlement and will go unspent unless we come up with a good way to spend them).

Other outcome measures could include the participation rate of counselors in a panel of insurers (including MassHealth), any change in the number of ER visits for psychiatric issues, the average length of stay for patients with psychiatric problems on medical floors, and the number of referrals for psychiatric care from primary care offices. Discussion could take place asynchronously to sharpen this proposal, and then it could be sent as a package to the payors and legislators for further discussion. In fact, legislators, hospital administrators, and payors should participate in the proposal

planning to expedite the effort.

The discerning reader may observe that this column isn't really about what the MCAAP is doing for physicians, but rather about what physicians can do for the children in the Commonwealth. Although this is true, creating a coordinated e-mail community that can speak with one voice will allow pediatricians to fulfill one of our core needs — advocacy for children — in a time-efficient and powerful manner. Send an e-mail to Bonney Erskine, berskine@mms.org, to be included in the MCAAP e-mail list. As the Technology Committee helps implement an electronic infrastructure, it will be possible to move forward with these types of advocacy efforts. Feel free to fax your e-mail address if this is more convenient, (781) 893-2105, attn: Bonney Erskine.

Get on the List

Send an e-mail to berskine@mms.org

or

Fax your e-mail address to (781) 893-2105, attn: Bonney Erskine

My e-mail address:

Early Intervention Programs: A Parent's Experience

By Stacey Ellender

I was late in understanding the benefits that early intervention programs can provide for our children. My oldest daughter, AnFei, arrived from China at 11 months old in July of 1995, yet it was not until February of 1997 that I began to use early intervention services.

THE FIRST SIGNS

Although AnFei did not walk until she was 18 months old, I did not seek an assessment until she was two-and-a-half, and only then because friends convinced me that I should look further into why she was barely speaking. Two hearing tests had returned normal results, so we presumed she would speak whenever she was ready. In the meantime, we simply adored her, noting her every step, becoming increasingly convinced of her innate intelligence and great potential. We attributed the slowness of her speech development to a slew of factors: transition issues, trauma, separation from Chinese-speaking caregivers, early malnutrition and general poor health.

We were uncomfortable if it was hinted that her development was “delayed,” or that she required special services in order to catch up with her peer group. We wondered, in fact, who was in her peer group. Was it wise to compare her to other children her age when her start in life had been so different, and so difficult? After all, her strides in those first 18 months with us had been enormous, even if they weren't in areas evident to outsiders. She had overcome her fear of hunger, for example, and finally, at just over two years old, stopped stashing food in funny little alcoves in the house. She came to trust that she would always be fed. I no longer had to slip packets of saltines into the pockets of her jacket, and when she let me know that she no longer needed them, a great understanding passed between us.

I knew she was growing, changing, challenging herself, taking risks, even if others thought she needed help to move

forward. But it was the limited nature of her communication with adults and playmates that forced me to reconsider. We thought she would enjoy preschool, but to thrive there, she needed to be able to express herself adequately.

A RELUCTANT CALL FOR HELP

I decided to explore what early intervention had to offer. With a heavy heart, I went into the initial assessment meeting. I didn't want AnFei to be pushed or prodded to achieve performance “norms” or devel-



It was a collaborative effort; not just a testing and subsequent evaluation, but an open meeting to set mutual, clearly understood goals.

opmental targets. I feared being told that there were other age-appropriate skills that were late in making an appearance. I thought AnFei was resilient, brave, and wonderful, and I hoped they would see that, too. To my great relief they did. And what followed was extraordinarily helpful for AnFei and for her father and me.

The initial meeting was with an early intervention agency team: a speech therapist, a physical therapist, and a developmental specialist. AnFei and I were together throughout the whole interview and assessment process, playing games together and completing simple tasks. It was

an easy, interesting 90 minutes. The team placed as much emphasis on what AnFei liked and did well as what she found frustrating. I was able to ask questions and raise concerns. It was a collaborative effort; not just a testing and subsequent evaluation, but an open meeting to set mutual, clearly understood goals.

The assessment ended by affirming AnFei's particular strengths, as well as my ongoing efforts to foster her development. We left feeling supported and eager to start our service plan: AnFei was to receive the anticipated speech therapy once

a week, and would join a bi-weekly playgroup to enhance her emotional and social development.

POSITIVE CHANGES

The subsequent six months, until AnFei turned three and aged out of the program, went by quickly. At first I noticed only that she loved her speech work, which largely involved playing games that she had to participate in verbally. Her therapist was engaging, patient and competent, working with me to develop daily techniques that could continue AnFei's skill development. In a short time, her speech did come, and she was greatly pleased with herself and the results brought by using words. Would she have spoken at the same time without intervention? I don't know. But I do know that the last lap toward speech was much less stressful than it might otherwise have been. In fact, it could not have been more positive.

I believe that AnFei felt that we were all rooting for her, her private pep team. She was not pressured, but encouraged, and her playgroup was like a rehearsal for preschool. For the first time, she met

continued on page 5

Early Intervention Programs

continued from page 4

many other children in a structured setting, and she began to see herself as part of a group put together to play and have fun. I believe that all of this made her later entry into preschool go much more smoothly.

EARLY INTERVENTION, PART TWO

Because of this positive experience, I wasted no time in getting a referral to the same early intervention program for my younger daughter, MeiRose, who arrived from China a year ago at the age of 19 months. Mei's needs were very different from AnFei's. She had been in the orphanage longer, but was in better health. Like many Chinese adoptees, her speech was slow in coming, but she also seemed unable in any way to communicate what she needed. She was clearly not used to interaction, and was an extraordinarily quiet and compliant child.

Mei was terrified of bright lights, loud noises, and sunshine. If, while I was driving, the sun shone into the car and across her car-seat, she would scream in horror and throw her hands across her face. We surmised that she had had little sensory stimulation. Additionally, she could not suck nor control her tongue adequately to eat solid foods. She could chew her food into bite-size morsels, but they would pop out of her mouth before she could swallow them. I was concerned about her receiving sufficient nutrition. Finally, she had an unusually wide gait and seemed to favor one foot, turning it in slightly as she walked. She fell down a lot as a result. I believed that her gross motor skills and muscle development warranted review.

This time, I obtained my referral to Riverside Early Intervention Program in Needham, one week after my return from China. I knew we had issues, and I knew they could help us. The format for Mei's assessment was similar to AnFei's, although it seemed longer and more comprehensive. The collaborative nature of the goal-setting was similar, although this time we were to receive services that were entirely new to me.

Mei's service plan involved a physical

therapist to work on gross motor issues, specifically with her legs and feet; a speech therapist to foster language development; a general developmental specialist who would coordinate her service plan, provide direct services, and oversee her progress; and an occupational therapist who would work on eating and sensory stimulation issues. Meetings were to be at our home once, sometimes twice per week. Additionally, I was invited to join an adoptive par-

For the first weeks that Mei received services, she interacted with her various service providers while keeping a hand on my knee. Then she sat with them on the floor as I sat nearby. Eventually, I was able to move across the room to a chair.

ents' support group, to meet and exchange information with other families in similar situations.

MORE SUCCESS

We are now 11 months into our service plan and MeiRose is blooming. At 30 months, she is talking and communicating well. Her self-care skills, such as brushing her teeth and feeding herself, are very good, and we are pleased with her progress in gross motor skills. She walks, runs, and climbs the backyard play set like all the other neighborhood kids. MeiRose is a happy, loving, sweet child, quiet in temperament and blessed with a good sense of humor. Recently, she has surprised us by showing an extraordinarily strong will and determination. This summer she discovered the beach, and as I walked with her along the water she smiled in the sun and easily explored her world with a newfound curiosity. We are thrilled with her growth and how readily she now seems to be moving forward.

Perhaps what I like best about the early intervention experience is how much I learned about my children. I watched them build a relationship of trust with other adults, and I observed as they struggled with the frustration of developmental issues, only to see the stress diffuse through play. They unfolded before me, building on the strength of the relationships in our

family, using that security to stretch, to bring others into their world, and to grow.

For the first weeks that Mei received services, she interacted with her various service providers while keeping a hand on my knee. Then she sat with them on the floor as I sat nearby. Eventually, I was able to move across the room to a chair. She came to love her time with them because she sensed her own growth. She began to "get" their games, and her time doing puzzles became shorter and shorter. She would sit there on the floor, beaming up at me, joyful at her successes.

I believe that the early intervention people provided my daughters with their first experiences of real world accomplishment. It was different than the love and encouragement I gave them; different because it came from outside the family, and it was skills-based. It was tangible. It led to the internal statement: "I can do that!" Early intervention provided an arena where small steps were heralded, every effort was recognized, and there was rejoicing when a milestone was reached. What a gift it has been for all of us.

Interested in early intervention? Check out the website zerotothree.org for additional information including mission statements, terminology, and how to find a program near you.

The author can be reached at ellenderst@aol.com.

AD RATES FOR THE FORUM

Sponsorship of newsletter.....	\$2000
Full inside page.....	\$800
Half-page.....	\$400
Quarter-page.....	\$200

Rates are subject to change. Please contact berskine@mms.org for details.

Medical Students and the MCAAP

*Are you missing the opportunity to teach in your community-based practice?
Would you like assistance with a research project you have been itching to
get off the ground?*

Patricia Moffatt, MD, is helping to coordinate a group of medical students around the state who have an interest in pediatrics. There are many opportunities for interaction including having medical students shadow clinicians in the office and speaking opportunities for pediatricians to discuss life in pediatric practice.

Please contact Dr. Moffatt at dmoffatt@hbs.edu if you would like to volunteer your services to foster physicians in training.

FORUM JOB LISTINGS

LOOKING TO BE HIRED

Name: CHRISTINE FREEMER, M.D.
(617) 323-0494; ChristineFreemer@cs.com
Residency Program: Children's Hospital, Boston 1993-1996
Fellowship in pulmonary medicine: Children's Hospital, Boston
1996-present. *Pediatric Board Certification:* 1998
Availability: Immediate

Name: RUCHI GUPTA, M.D.
528 3rd Ave. West Apt. 301; Seattle, WA 98119
(206) 352-6595; (206) 978-0373 (pager);
ruchi@residentweb.com
Residency Program: University of Washington
Graduation Date: ... June 30, 2001
Availability: July 2001
Comment: *I'm interested in a job in the Boston area, either private practice or academic, starting in the summer of 2001.*

Name: THERESA L. SHANAHAN, M.D.
18 Lakewood Road; Natick, MA 01760-2615
(508) 653-1441 (home); (617) 604-5317 (beeper)
tshanahan@usa.net
Residency Program: Floating Hospital for Children, New England Medical Center
Availability: June 2001

Name: KAREN E. WANG, M.D.
105 Beech Street #1; Belmont, MA 02478
(617) 484-3102; (617) 604-6180; karenewang@massmed.org
Residency Program: Tufts Floating Hospital
Graduation Date: ... June 2001
Availability: July 2001

Looking to Hire or Be Hired?

Job listings are a free service provided by the Forum to MCAAP members and residents completing their training. Non-members may submit ads for a fee.

If you are looking to fill a position

MCAAP members: Free.

Non-members: \$250

Please submit the following information:

- Practice Name
- Position Title and Description (25-word limit)
- Availability (e.g., starting June 2001)
- Contact Name
- Address
- Telephone Number
- E-mail address

If you are looking for a job

MCAAP members and residents: Free

Non-members: \$50

Please submit the following information:

- Your Name
- Contact Information
- Residency Program
- Availability (e.g., available now)
- Comment (25-word limit)

Please send text information via e-mail to david@beansprout.net. Checks may be mailed to the MCAAP office c/o Bonney Erskine, Executive Director, P.O. Box 549132, Waltham, MA 02454-9132. All submissions must be received by March 15, 2001 to be included in the next issue of the Forum. All submissions are subject to review for appropriateness. For further information, please contact the editor at david@beansprout.net.

TEPR 2001

YOUR CONNECTION TO ELECTRONIC HEALTHCARE

Documenting the Pediatric Outpatient Visit

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A New Approach to Parental Smoking Cessation

Jonathan Winickoff, MD

WHAT IS STOP?

The Stop Tobacco Outreach Program is a new initiative to help smoking parents who have a child with a respiratory illness stop smoking. It is being offered at Boston Children's Hospital for eventual dissemination to other hospitals and health centers in Massachusetts and around the country. STOP makes use of the unique teachable moment when a smoking parent has a child hospitalized. This moment creates an opportunity for a successful intervention even when other programs and efforts have failed.

WHAT DOES STOP OFFER?

STOP offers a menu of options to provide participants with the tools they need to stop smoking. Additionally, for those who are not ready to give up smoking entirely, STOP helps to educate parents about how to reduce the harmful effects of environmental tobacco smoke (ETS) on their children. STOP participants can receive:

- ★ Three free sessions with a smoking cessation counselor held either in person or over the phone for parental convenience
- ★ Free nicotine replacement therapy
- ★ Notification to the primary doctor or nurse for each participant about his/her involvement in the program
- ★ Notification to the child's pediatrician about the parent's participation in the program
- ★ Referral to the Massachusetts Smoker's Quitline for information and additional free telephone counseling sessions
- ★ Materials and worksheets especially designed for parental smokers

WHO IS BEHIND STOP?

STOP was developed by leaders in tobacco control and pediatrics at Harvard Medical School to address the problem of parental smoking. Participating institutions include Children's Hospital, Massachusetts General Hospital, Institute for Health Care Improvement, Dana-Farber Cancer Institute, Boston University, and the Massachusetts Smoker's Quitline.

A PROGRAM THAT WORKS.

As opposed to many population-based interventions that generally receive less than 2 percent enrollment, STOP has enrolled 53 per-

cent of the parents who have been offered the program. Eighty percent of parents have completed the program, 62 percent made at least one quit attempt (at least 24 hours of continuous abstinence from smoking), and 25 percent were no longer smoking at the time of their two-month follow-up (7 days or more of continuous abstinence). Additionally, 56 percent of our participants now have rules prohibiting smoking in their homes, an increase of 100 percent.



THE STOP CONSULT SERVICE IS COST-EFFECTIVE FOR HMOs.

A young smoking mother with a child who has asthma is an important person to focus on from a financial standpoint. Smoking parents cost HMOs real money. In pediatrics, smoking is the leading preventable cause of low birth weight and premature births, is responsible for 1.8 million excess asthma visits, millions of excess respiratory illnesses of both parents and children, 10,000 house fires with horrible burn morbidity, 2,000 cases of SIDS, and 3.4 million excess cases of otitis media, some of which end up needing costly ORL referral and surgical intervention. In Massachusetts, the direct medical costs of smoking are estimated at \$4 billion and the costs of environmental tobacco smoke are estimated at \$400 million. Each HMO parent who quits smoking

saves money for their own health utilization and that of all the children and unborn children in that family.

The STOP Program is already available; it just needs to be supported by payers.

HMOs that reimburse the STOP program as an in-hospital consult service will get the full STOP program for their patients and families. Unfortunately, STOP costs money to deliver, so if the HMO cannot reimburse the program, the members cannot get this service. We would like to brainstorm with Massachusetts payers to find out the best way to code these consults in order to insure prompt reimbursement for an important service.

How to contact STOP:

VALERIE HILLIS,
Program Coordinator
JONATHAN WINICKOFF, MD,
Project Director
300 Longwood Avenue
Boston, MA 02115

(617) 355-5374

hillis@a1.tch.harvard.edu

What Should the Academy Do to Advocate for Pediatricians?

Editor's Note: The title question was posed to the two candidates for Vice President of the American Academy of Pediatrics. The following are the candidates' responses:

E. STEPHEN EDWARDS, MD, FAAP
RALEIGH, NC

My conversations with fellow pediatricians indicate that our single biggest concern is loss of control in the current medical environment. Though my perspective arises from private practice, this is true regardless of the practice situation, and whether primary care, specialist, or subspecialist. What can the Academy do to help us?

Address Compensation Issues. Because the best way to help children is to assure pediatrician care, the Academy must continue our efforts to support fair compensation. The Task Force on Reimbursement calls for a pediatrician at AAP headquarters to spearhead ongoing AAP efforts related to compensation issues: to coordinate reimbursement efforts, to fix the public and private payment systems, to promote the value of the pediatrician to purchasers and payors, and to empower pediatricians in our delivery of quality healthcare. We must pursue each of these objectives vigorously.

Prepare for Quality Evaluation. In the near future pediatricians will have to prove that we are providing quality healthcare. We must provide our members with the tools to give evidence of quality and value in our services. The AAP can do this better than anyone else.

Encourage Education. Pediatricians depend on the AAP for quality educational programs. These programs should become more accessible, user-friendly, and less expensive. Additionally, we must teach more members to use our practice management resources.

Other Important Issues:

- ★ Attain universal health insurance for children
- ★ Develop pediatric scientists by removing financial barriers to subspecialty training
- ★ Obtain adequate funding for academic programs
- ★ Assure access to subspecialty services
- ★ Improve coordination among Chapters, Committees, and Sections
- ★ Increase immunization availability
- ★ Boost member awareness of AAP services
- ★ Enhance communication of major AAP initiatives with members
- ★ Expand member Web services and access to AAP materials
- ★ Ensure diversity in our decision makers

Prepare for the Future. Because change is inevitable, AAP leadership must fulfill today's agenda even as we prepare our profession to meet new challenges. I believe that I have the experience, dedication, energy, and consensus-building skills to lead the Academy into that future.

GEORGES PETER, MD, FAAP
PROVIDENCE, RI

Until the importance of quality child healthcare is recognized, our nation will not allot the necessary resources to guarantee access to essential health services for every child, especially in today's political climate. By articulating and demonstrating the value of quality and comprehensive child healthcare, we enhance the recognition by society of the value of those best prepared to care for children, specifically pediatricians. Nothing advocates more powerfully for pediatricians than advocating for children.

To achieve our goals for children, we need to educate the public, health insurance purchasers and our political leaders about not only the importance of quality care provided in the medical home but also of specific child health issues, including immunizations, developmental and behavioral problems, children with special needs, child abuse, nutrition and exercise. The Academy's public education efforts should be both national and local, and provide chapters opportunities to address specific problems in their communities, such as violence and child abuse. The message also must stress that pediatric specialists and subspecialists are the best trained, most skilled and cost-effective healthcare professionals for children.

The Academy currently has a number of initiatives that advocate for pediatricians, including universal child health insurance with appropriate reimbursements and community programs for enhancing child healthcare. The Academy's recent legal action against HCFA exemplifies its commitment to addressing the inequities in reimbursement for child healthcare. Reimbursement by managed care contracts and other insurance plans should reflect the importance of time in counseling parents and adolescents about preventive healthcare, such as the benefits and safety of immunizations, child development, injury prevention, and the dangers of smoking and substance abuse.

The Academy's ultimate success in achieving our goal of universal health insurance without means testing is a critical element in advocating for pediatricians. The proposal includes comprehensive age-based benefits and simple administrative procedures, and emphasizes quality of care. Removal of the financial barrier will enhance access to healthcare for all children. Pediatricians also would no longer need to subsidize the care of the currently uninsured and underinsured children.

CALL FOR NOMINATIONS

This Spring, positions for the MCAAP Executive Committee will become vacant for Districts 3, 5, 7, and 9. Please send nominations to Bonney Erskine via e-mail at berskine@mms.org, fax at (781) 893-2105, or mail to: PO Box 549132, Waltham, MA 02454-9132. Nominations must be received by February 28, 2001, and ballots will be mailed the first week of March. Communities in each district are listed below.

DISTRICT 3

ATTLEBORO	FALL RIVER (Ward 6 - P'cts A, B)	MANSFIELD (P'cts 1, 2, 3, 4)	SHREWSBURY
AUBURN (P'cts 1, 3, 4)	FOXBOROUGH (P'cts 1, 3, 4, 5)	MEDWAY	SOMERSET
BERLIN	FRANKLIN	NORTH ATTLEBORO	STERLING
BOYLSTON	GRAFTON	NORTHBORO	SWANSEA
CLINTON	HOLDEN	NORTHBRIDGE	UPTON
DARTMOUTH	HOLLISTON	PAXTON	WESTBOROUGH
FALL RIVER (Wards 1, 2, 3)	HOPKINTON	PLAINVILLE	WEST BOYLSTON
FALL RIVER (Ward 4 - P'cts A, B, C)	LANCASTER (P'cts 1, 2)	PRINCETON	WESTPORT
		RUTLAND	WORCESTER
		SEEKONK	WRENTHAM

DISTRICT 5

ACTON	CONCORD	LINCOLN*	SHIRLEY
ANDOVER	DRACUT	LITTLETON	STOW
ASHLAND	DUNSTABLE	LOWELL	SOUTHBOROUGH
AYER	GROTON	LUNENBERG (P'ct 1)	SUDBURY
BILLERICA	HARVARD	MARLBOROUGH	TEWKSBURY
BOLTON	HUDSON	MAYNARD	TYNGSBOROUGH
BOXBOROUGH	LANCASTER (P'cts 1, 2)	METHUEN	WAYLAND
CARLISLE	LAWRENCE	PEPPERELL	WESTFORD
CHELMSFORD			

**part of a district*

DISTRICT 7

ARLINGTON	MALDEN	READING (P'cts 2, 7, 8)	WALTHAM
EVERETT	MEDFORD	REVERE	WESTON
FRAMINGHAM	MELROSE	STONEHAM	WINCHESTER
LEXINGTON	NATICK	WAKEFIELD	WINTHROP
LINCOLN*			WOBURN

**part of a district*

DISTRICT 9

BOSTON (Wards 3, 6, 7, 8, 13, 16, 19, 20)	BOSTON (Ward 17 - P'cts 4, 12, 13, 14)	BROCKTON (Ward 2 - P'cts B, C, D)	MILTON
BOSTON (Ward 5 - P'ct 5)	BOSTON (Ward 18 - P'cts 7-14, 16-20, 22, 23)	BROCKTON (Ward 5 - P'cts A, C)	NEEDHAM
BOSTON (Ward 11 - P'cts 6, 7, 8, 9, 10)	BRAINTREE	CANTON	NORWOOD
BOSTON (Ward 15 - P'ct 6)	BROCKTON (Wards 1, 3, 4)	DEDHAM	RANDOLPH
		EASTON (P'cts 1-5)	STOUGHTON
		MEDFIELD	TAUNTON
			WALPOLE
			WESTWOOD

Every Child Deserves a Medical Home – Boston

Richard Antonelli, MD

In the summer of 2001, our Chapter will be the host of the Every Child Deserves a Medical Home Training Program. This is a full-day educational experience, which brings together families, providers (pediatric and family medicine MDs, RNs, NPs, and allied health personnel), Title V staff, third-party payers, and regulatory personnel.

The purpose of the program is to raise awareness of the essential elements of a medical home (care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent), to create linkages for developing a statewide network of medical homes, and to reinforce our commitment to family-centered care principles. Specifically, the program focuses on how to provide a medical home in managed care arrangements. The training materials include guidelines for working with families, collaborating with all service providers and agencies, and coordinating with community-based resources.

The training program is a collaborative initiative of, and has been endorsed by, the American Academy of Pediatrics, Family Voices, the federal Bureau of Maternal and Child Health, the National Association of Children's Hospitals and Related Institutions, and Shriners Hospitals for Children. Additional information about the trainings is posted on the AAP website, www.aap.org (Keyword Search: "AAP Medical Home Training Main").

The planning committee for the Boston event has begun its work. We need more MCAAP members to make this a successful program. In fact, attendance at this training will likely be a critical component of practice models' eligibility in the Massachusetts Medical Home Project.

If you would like to participate in the program, contact

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MCAAP Committee on Disabilities
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Fax: (978) 422-7561

News From the MCAAP Committee on Disabilities

Richard Antonelli, MD

The MCAAP Committee on Disabilities (COD) is gearing up for an exciting and busy year. The good news is that federal health policy for the next decade, as outlined in Healthy People 2010 (www.health.gov/healthypeople/), has an explicit goal that all children with special healthcare needs (CSHCN) will have access to care that is accessible, comprehensive, coordinated, continuous, compassionate and culturally competent: namely, a medical home.

CREATING A STATEWIDE NETWORK OF COORDINATED HEALTHCARE DELIVERY: THE MASSACHUSETTS MEDICAL HOME ENHANCEMENT PROJECT

To respond to the growing need for all children to have access to a medical home, the Massachusetts Medical Home Enhancement Project will be implemented over the next three years. The goals of this project will be to add substantive support, guidance, and leadership to programs designed to provide medical homes. Activities will include collaborative initiatives between the MCAAP and other stakeholders in caring for CSHCN; presentations in varied settings including grand rounds, family-sponsored events, and allied health professional meetings; and topic-specific training opportunities targeted at our entire MCAAP membership as well as our family practice colleagues and physicians in training.

Our state's leadership role in creating medical homes has recently been recognized by the federal Bureau of Maternal and Child Health. We were among only 12 states selected to participate in a National Medical Home Conference. This will give us the opportunity to discuss our medical home initiatives with our colleagues from around the U.S. and learn from them as we move our programs into the implementation phase. Our state team includes representation from the MCAAP COD, our state Title V program (Department of Public Health), Family TIES and Family Voices, our state AAP CATCH leadership, and the Massachusetts Consortium for CSHCN.

THE MASSACHUSETTS CONSORTIUM FOR CSHCN

The Massachusetts Consortium for CSHCN is a broadly representative group of primary and tertiary care providers, third-party payers, Title V/DPH, families and advocates, as well as the MCAAP. The Consortium meets every six weeks and to date has accomplished both a comparison of methodologies for identification of



CSHCN and an assessment of case management programs across all state agencies in Massachusetts. We continue to work on issues relative to developing medical homes and incorporating care coordination activities into practices. A recent pediatric grand rounds at the UMass Medical School included a presentation by the Director of SERVE, representing the Consortium.

The Consortium and the MCAAP welcome involvement of other members of our chapter. For information about the Consortium, its activities and meeting schedule, please contact Susan Epstein, MSW, executive director of New England SERVE, at (617) 574-9493.

THE MASSACHUSETTS MEDICAL HOME PROJECT

The Massachusetts Title V Children with Special Health Care Needs program, part of the state Department of Public Health, has announced an important initiative aimed at promoting and supporting the national AAP Medical Home Initiative. This winter, DPH will be issuing a Request for Responses (RFR) to identify pediatric practices that are interested in serving as medical homes for children

with special needs. Practices will be asked to demonstrate interest in and commitment to care of children with special needs and to affirm willingness to work collaboratively with DPH to provide comprehensive care to the population. Practices that respond successfully will be eligible to serve as sites for outstationing of DPH care coordinators. At present, DPH case managers work out of DPH regional offices with a relatively small group of medically involved children and their families. Deborah Allen, ScD, director of the department's Division for Special Health Needs, explains that the shift in the locus of this service is intended to broaden and enlarge its caseload and increase providers' capacity to implement the AAP medical home model.

DPH plans to work closely with an advisory committee of parents, MCAAP representatives, state agency staff, and other stakeholders to design and oversee this initiative. Input from the group will help determine criteria for placement of care coordinators, guidelines for comprehensive care of children with special healthcare needs, the nature and extent of training required to ensure effective collaboration within medical home practices, and the optimal approach to evaluation of the project.

A CALL FOR MEMBERS

Please e-mail me as soon as possible with your interest in joining (or re-joining) the Committee on Disabilities. I would like to make a special appeal for inclusion of medical students, interns, residents, and fellows! Please spread the word.

FOR MORE INFORMATION

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Massachusetts Consortium for CSHCN
SUSAN EPSTEIN, MSW
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Healthy People 2010 website:
www.health.gov/healthypeople

SAVE THE DATE

The Sixth Annual Skills Building Conference Massachusetts Immunization Action Partnership

MAY 17, 2000
8:30 AM – 4:30 PM

HOLIDAY INN, WORCESTER

*Registration forms will be mailed out
in late March.*

For more information about the program and
continuing education, or to be added to the
MIAP mailing list, Contact MIAP:

*Tel: (617) 451-0049 ext. 806
Email: miapma@hotmail.com*

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individuals will create structure from the chaos of
our daily schedules.

*Send your e-mail address to berskine@mms.org
or*

*Fax your e-mail address to (781) 893-2105,
attn: Bonney Erskine*

My e-mail address:

Save the Date

MCAAP ANNUAL MEETING

May 23, 2001

Massachusetts Medical Society
at Waltham Woods

INSIDE

What Is the MCAAP Doing for You?	1
President's Message	1
Letter to the Editor	2
Early Intervention Programs: A Parent's Experience	4
Forum Job Listings	6
A New Approach to Parental Smoking Cessation	8
AAP Advocacy for Pediatricians	9
Call for Nominations	10
Every Child Deserves a Medical Home . .	10
Committee on Disabilities News	11

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