



The Forum

NEWSLETTER OF THE MASSACHUSETTS CHAPTER AMERICAN ACADEMY OF PEDIATRICS

PRESIDENT'S MESSAGE

The Medical Home

Just what is this medical home? Do you provide one for your patients?

The MCAAP Board is grappling with this definition. We think all pediatricians provide a medical home: This is where our patients get comprehensive primary care. This is the place where the doctor knows your name. This is the place where the siblings get care too. Checkups, immunizations, and assessment of growth and development, nutrition, educational progress, and psychosocial development all happen here. If the patient has special needs, these are addressed here, too. In addition, the office coordinates all special care, like specialists' appointments, special gear and supplies, special education needs, and helps at home to support the family.

The Department of Public Health is entering into a pilot program which would place case managers in some practices (12 in the pilot) to support special needs children. While supporting the concept of helping practices care for special needs children, the MCAAP Board is concerned that the practices chosen for the pilot will carry a special designation of "Medical Home" and become preferred destinations for special needs children. This designation will give these practices an undue competitive advantage.

We propose a solution to place the case managers in a neutral location where they can be accessed by several practices. This becomes a win/win situation for the children, who will get the extra support they need from ALL doctors who need help in providing that support.

– Eugenia Marcus, MD

FIRSTLink:

Connecting Families and Their Newborns to Health Care and Community Services

The FIRSTLink program, sponsored by the Massachusetts Department of Public Health, is looking to incorporate pediatric involvement in its mission to provide ALL Massachusetts families of newborns, within six weeks of birth, with the opportunity for a free, one-time, home-based needs assessment; health education and support; and referrals to services within their community.

HOW FIRSTLINK WORKS:

FIRSTLink uses the Electronic Birth Certificate to identify newborns and mothers with certain clinical and nonclinical high-risk conditions. Families become involved with the program when the mother signs a consent form at the hospital following the birth or calls an 800 number to request a home visit.

FIRSTLink provides a home visit automatically to at-risk families and other families upon request.

The home visit is conducted by a registered nurse, licensed social worker, child development specialist, or community home visitor four to six weeks after the birth of the baby. Early Intervention home visitors provide the FIRSTLink home visit to families meeting infant risk conditions; Healthy Families provides the home visit to families with first-time mothers under 21; and a network of 75 community agencies provides home visits to families meeting maternal risk criteria or with no specific risk.

The visit provides health education to the family on topics such as smoking cessation, breastfeeding support, nutrition, postpartum depression, and drug

and alcohol treatment. The home visitor also encourages well visits to the pediatrician and OB/GYN and provides a connection to a medical home for all family members.

Some of our most common service referrals include Early Intervention, Healthy Families, WIC, child care, food/nutrition, housing/shelter, and parent education/support.

FIRSTLink currently operates in 15 birthing hospitals, representing approximately 50 percent of Massachusetts births: Beth Israel Deaconess Medical Center, Boston Medical Center, Brigham & Women's Hospital, Mass. General Hospital, New England Medical Center, St. Elizabeth's Hospital, Brockton Hospital, Caritas Good Samaritan Hospital, Cambridge Hospital, Hale Hospital, Health Alliance Leominster Hospital, Baystate Hospital, Mercy Hospital, UMass Memorial Hospital, and St. Vincent's Hospital.

THE HOME VISIT:

The FIRSTLink home visit comes at a crucial time for families. About four weeks after the birth of the baby, parents often find that many of the support systems that were present initially, such as family, friends, and hospital visiting staff, have left. As the family members work at establishing a routine within their home, they frequently realize that they have

continued on page 3

"Family support programs play an important and, in some instances, essential role in promoting the positive functioning of families and ensuring the well-being of children."

– American Academy of Pediatrics¹

¹ American Academy of Pediatrics. *The Pediatrician's Role in Family Support Programs*. Pediatrics. 2001;107(1):195-197.

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TO THE EDITOR:

FUNDAMENTAL PRINCIPLES

To the Editor:

The predicament pediatric generalists face is in large measure of our own making. Insurance companies took over the financing of health care, then its practice. When reimbursement dropped, physicians stood silent. Instead of organizing and advocating for patients, physicians responded by lining up to contract with health maintenance organizations. Before long, out of financial necessity (or physician depression), pediatricians stopped seeing their own newborns, taking care of their patients in the hospital, even answering phone calls from parents at night! It is no wonder pediatricians feel undervalued.

Yet our patients and their families still need a physician who will care for them. Parents need someone who will come to the hospital to see their newborn infant, and visit when their child is in the intensive care unit or having an appendectomy. More than ever, parents need a physician who will sit and listen to their concerns and help them navigate the maze of specialists in a complex medical world. No one is better qualified to do this than a primary care physician who is well trained and committed to the well-being of children.

This commitment means returning to the fundamental principles of good pediatric medicine, including comprehensiveness, continuity of care, and a broad understanding of the bio-psycho-social model of disease. Such a commitment also requires appropriate compensation.

— Jonathan A. Benjamin, MD, Newton Centre

MEDS/PEDS SPECIALTY ISSUES

Dear Editor,

I feel compelled to express my distaste after reading the letter "Economics of Pediatric Practice" by Dr. Philip Hourigan, Jr. (*The Forum*, Winter 2001). I was sure I had misinterpreted Dr. Hourigan's words, but after reviewing the letter, his language and tone were quite clear. He asserts the emergence of combined medicine/pediatric training is one of three "paradigm shifts" that will "adversely impact the economic viability" of the community pediatrician.

By using terms like "conspired" and "economic interest of the dual-certified physician," it is obvious just how Dr. Hourigan views med/peds. As a second year med/peds resident in Springfield, MA, I am happy to say this is the first time I have encountered such blatant disrespect for med/peds as a specialty. However, that does not make it tolerable.

A recent report in the *ACP/ASIM Observer* (February 2001) exposes the first flaw in Dr. Hourigan's logic, showing that average pay for pediatricians rose 10.79 percent between 1995 and 1999 to an average of \$143,011. In that time, the average for internists rose 4.36 percent to \$145,397. Both fields face similar pressures of poor reimbursement, increasing demands from patients and insurers, and a shift toward productivity incentives to determine compensation. As physicians struggle to find their economic foothold in a changing market, pediatricians are doing well to regain the reimbursement they deserve.

The residents and faculty in our med/peds program deliberately chose to

continued on page 3

MCAAP COMMITTEES & ADMINISTRATIVE APPOINTMENTS

AAP Breastfeeding Coordinators Susan Browne Jean Sheeley	Continuing Medical Education Lynda Young	International Child Health Lisa Albers	MMS Interspecialty Committee Rep. Eugenia Marcus Kevin Petit
Accident Prevention & Poison Control Paul Schreiber	Developmental Disabilities Richard Antonelli	Legislative Richard Ringel	Nutrition Ronald Kleinman
Bylaws Committee Carole Allen	Emergency Pediatric Services Pat O'Malley	Massachusetts Healthy Families Howard King	Pediatric Council Walter Harrison
Catch Co-Coordinators David Keller Emily Roth	Environmental Hazards Jordan Leff	Membership Ernest Wu	Pediatric Practice Open
Child Abuse Robert Nelken	Fetus and Newborn Elizabeth Brown	Mental Health Howard King	PROS Network Coordinator Henry Bernstein
Children's Advocacy Board Barry Zuckerman	Finance Carole Allen	Mental Health Task Force Walter Harrison Eugenia Marcus	Public Relations Michael Rich
Committee on Adolescence Harris Faigel	Forum Editor David Chung	MMS Delegate/ House of Delegates Carole Allen	School Health Linda Grant
	Foster Care Robert Abrams		Substance Abuse Alan Woolf
	Infectious Disease Sean Palfrey		Technology Robert Gerstle

Help Prevent Poisonings in Your Patients

Last year, the Regional Poison Center received approximately 5500 calls from physicians in Massachusetts requesting consultation on the diagnosis and treatment of someone who had been poisoned. Callers requested advice on to how to treat a person with an adverse reaction to an herbal remedy of unknown origin or a person who arrived in the emergency room with life-threatening symptoms from an overdose of an unknown substance. The Regional Poison Center

LETTERS

continued from page 2

care for both children and adults, consolidating family-oriented health care. Dual certification takes nothing from our dedication to the health and development of children in our practices and communities. Success in that endeavor requires collaboration, not derision, between pediatricians and med/peds. Thankfully, collaboration has been the norm in my brief career. The AAP must resolutely foster that collegiality, and avoid publishing such divisive commentary in the future.

— *Chris Jalbert, MD*
Second Year Resident, Med/Peds Residency Program, Baystate Medical Center

Editor's Reply:

Thank you for your response to Dr. Hourigan's letter in the previous issue of *The Forum*. I think that you make some valid points on the improvement in reimbursement in pediatrics. In my personal experience, I valued the opinions and perspectives of those in med/peds residency training.

It is my editorial policy to voice the opinion of our membership and print representative samples of letters with as little editing as possible. I reserve the right to edit responses for length and content. The viewpoints are solely those of the respondents and not myself or the MCAAP. 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 June 15, 2001.

— *David Chung, MD*

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 e-mail: david@beansprout.net.

provides emergency telephone consultation to health care professionals and consumers in Massachusetts and Rhode Island 24 hours a day.

The American Association of Poison Control Centers estimates over 2 million poisonings are reported each year and nearly 900,000 people visit emergency rooms as a result of a poisoning. Locally, the Regional Poison Center received 35,000 calls last year from people in Massachusetts, with approximately 50 percent of these calls involving children under five. Many of these poisonings are accidents and can be prevented through education about home safety and "poison-proofing" the home. In the rush of everyday life, adults forget that the plants, personal care products, and household products found in many homes can be poisonous and should be kept in locked cabinets or out of reach of children. Parents also need to be reminded that "children act fast, and so do poisons."

The Regional Poison Center is asking physicians, particularly pediatric care providers, to assist us in preventing poisonings and educating families about how to poison-proof their homes. Pediatricians and nurses serve as key sources of information for families with young children. Your visits with parents, particularly at the nine-month visit, provide a unique opportunity to spread the word about poison prevention and safety in the home.

FIRSTLINK

continued from page 1

many questions. The FIRSTLink home visitor, at this point, is able to assess the family's needs and provide support.

HOW PEDIATRICIANS CAN BECOME INVOLVED WITH FIRSTLINK:

FIRSTLink hopes that a relationship with pediatricians will enhance the well-being of patients and families. FIRSTLink can be a partner in pediatricians' pursuit to identify problems, and addresses and supports parental concerns by acting as an added resource to which pediatricians can refer a family. Incorporating FIRSTLink into the existing network of care will complement the services provided by pediatricians and support a continuum of care.

Pediatricians can contact FIRSTLink to do the following:

We are asking you to help promote the concept of "poison safe" homes by teaching families the "4 Rs of Poison Prevention":

- ★ **Recognition** – Recognize what is hazardous in your environment.
- ★ **Removal** – Remove poisons from your home and safely store household cleaners, personal products, and medications in locked cabinets and out of reach of children.
- ★ **Readiness** – Be ready in case of an emergency. Keep ipecac in your home. Only use ipecac if instructed to do so by a physician or the Regional Poison Center.
- ★ **Response** – Respond to a poisoning emergency by calling the Regional Poison Center at (800) 682-9211. Know how to provide first aid for poisonings.

Throughout the year, you can help promote the "4Rs of Poison Prevention" by providing educational materials and poison center telephone stickers to all families when they check in for their visit. You can also display poison prevention materials in your exam rooms and waiting rooms. If you are interested in making an extra effort to promote poison prevention, we suggest the following activities:

- ★ Write letters to the editor in your local paper promoting poison prevention efforts in the home.

continued on page 7

- ★ Request a FIRSTLink pediatrician packet
- ★ Request FIRSTLink pamphlets to refer families with newborns up to six weeks of age.
- ★ The 800 number within the pamphlet will connect the families to the program, where they can ask for a FIRSTLink home visit or obtain information and service referrals over the phone.

Pediatricians may also refer families directly to the following phone number:

- ★ 1-800-531-BABY(2229)

— *Jodi Anthony, (617) 624-6017*
jodi.anthony@state.ma.us

— *Erin Boles, (617) 624-6025*
erin.boles@state.ma.us

FIRSTLink, Department of Public Health
250 Washington Street, 5th Floor
Boston, MA 02135

FORUM JOB LISTINGS

Looking to Hire or Be Hired?

LOOKING TO HIRE:

Framingham Pediatrics is seeking a part-time pediatrician to work approximately three or four sessions per week. Modern, well-managed office. Strong relationship with MetroWest Medical Center and Children's Hospital. Position available July 2001 or sooner.

Contact: Richard Garber, MD
Framingham Pediatrics, PC
161 Worcester Road
Framingham, MA 01701
www.framinghampediatrics.com
(508) 820-1105
rgarber@mediaone.net

LOOKING TO HIRE:

Pediatric Associates of Brockton is seeking a full-time pediatrician to work four full days a week and share night and weekend call with eight pediatricians. Well-run office with good compensation. Position available July 2001.

Contact: Peter Rappo, MD
Pediatric Associates, Inc. of Brockton
370 Oak Street, Suite A
Brockton, MA 02301
go to: www.beansprout.net
enter our telephone number
(508) 584-1234
prappo@beansprout.net

LOOKING TO BE HIRED:

Debaroti "Debbie" Addy, MD
7477 Cambridge #82
Houston, TX 77054
(713) 797-1828
(832) 824-2099 (pager)

Residency Prog.: Baylor College of Medicine

Graduation Date: June 30, 2001

Availability: July/August 2001

Comment: I have a special interest in advocacy and adolescent medicine and am looking to join a group practice in a medium- to large-sized community.

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 9132, Waltham, MA 02454-9132. All submissions must be received by June 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.



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TEPR 2001

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Documenting the Pediatric Outpatient Visit

Wednesday, May 9, 2001
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Tune In, Turn On, Stop Out

Jim Hammel, MA, HMS II/III

Editor's Note: This is the first in a series of articles authored by medical students and residents with a clinical interest in pediatrics. The purpose of the series is to keep the general pediatric community in touch with the experiences of our colleagues in training. – DC

On a typical day, I leave home by 8:30 am, and don't return until 11:00 pm. Lunch and dinner are usually eaten while simultaneously checking e-mail and getting business done on the phone. I'm becoming far too skilled in multitasking and learning on the fly. Waking hours are filled with reviewing medical records, interviewing parents, organizing patient consults, and communicating with numerous doctors, nurses, and care providers — all while learning how to navigate the medical environment of two of the world's top medical institutions.

Only a handful of my colleagues know that I am a medical student, though.

Having finished my first two preclinical years and passing Step I of the USMLE, I have taken time off to pursue two of my passions: pediatric oncology and palliative care. I have been drawn to these areas since high school, when I lost a close friend and classmate to cancer. Although I have been involved in pediatric oncology and palliative care for a decade, including work in molecular biology, clinical psychology, chaplaincy, and ped-onc summer

camp, I have only recently begun to explore these areas as a medical student.

Since the Spring of 1999, I have had the privilege of working with Dr. Joanne Wolfe of the Dana-Farber Cancer Institute and Children's Hospital, Boston. I am currently coordinator of the Pediatric Advanced Care Team (PACT), a multidisciplinary team formed by Dr. Wolfe in 1997 to improve pediatric end-of-life care for children and their families.

PACT provides counseling, education, and professional consultations at Dana-Farber and Children's Hospital. As one of the country's only hospital-based pediatric palliative care services, we have made it our goal to facilitate and improve early recognition of palliative care issues by caregivers. Areas that we often address include pain and symptom management, communication between families and primary care teams, quality of life (with an emphasis on meaningfulness), and coordination between inpatient, outpatient, and home settings. Our core PACT team includes Medical Director Dr. Wolfe, a senior oncologist, psychologist, inpatient nurse specialist, clinical nurse specialist, chaplain, and child-life specialist. We also have a number of consultants, including a pain treatment consultant, radiation oncologist, patient care coordinator, and pulmonologist/ethicist.

As PACT coordinator, I am responsible for coordinating the day-to-day activities of the service as well as meetings and

research activities, including outcome studies on PACT's efficacy. In essence, I am continuously juggling clinical, administrative, and research hats. The position has also given me a chance to work with PACT members and several others in the Boston Pediatric Palliative Care Consortium in drafting a Pediatric Palliative Care legislative bill for the Massachusetts State Legislature. Finally, since this time off allows me to get to know numerous pediatricians on a more personal level, I have been lucky to work with other medical students in forming the Harvard Pediatric Mentorship Program.

Although "stopping out" or taking time off may seem like a detour during medical school, more and more medical students are following this less traditional path. Only 55.9 percent of last year's graduating class at Harvard Medical School completed their degree in four years. Adding a year between preclinical and clinical or before residency applications for research, nontraditional clinical experiences, travel, or other advanced degrees is hardly uncommon today; in fact, 29.2 percent of our last class graduated in five years. Some 11.2 percent, including PhD and MPH recipients, graduated after six years or more at Harvard Med. The remaining 3.7 percent entered with advanced standing.

Ultimately, this "time off" provides me a unique opportunity to fully explore two areas that I love without the professional pressure of being evaluated for a grade. Each day I find myself reaching back to my former lives as a desktop publisher, administrative assistant, and psychologist to fill the demands of the position. These opportunities simply won't be present on the wards. My work with PACT is constantly changing, always challenging, innately rewarding, often exhausting — and I wouldn't want it any other way.

Jim Hammel, MA, HMS II/III, is originally from Sacramento, California, and is one of the AAMC's five Herbert Nickens Scholars.

Technology Corner

CALL FOR WEBMASTER

David Chung, MD

The MCAAP website has moved! Visitors will notice few changes, except that the website will now be kept up-to-date more regularly. The MCAAP Executive Committee voted unanimously to move the site from its previous home at the Massachusetts Medical Society (MMS) to servers provided by Beansprout Networks (www.beansprout.net). The MCAAP has ownership of the domain www.mcaap.org, and the server space is provided by Beansprout Networks at no charge to the Chapter. The Chapter would like to thank the MMS for its previous contribution to the website and its continuing support in the publication of this newsletter.

Since the MCAAP will be responsible for keeping the site current, we are looking for a volunteer to become webmaster. The responsibilities of the webmaster would be to make periodic updates to the content of the site using a browser-based editing program. It is anticipated that this responsibility will take fewer than two hours per month, and no experience in website design or HTML is required. Making changes to the site is as simple as logging on to the Internet and using a word processor.

Please contact me by e-mail at david@beansprout.net or Bonney Erskine at berskine@mms.org or (781) 434-7314 if you are interested or have questions about the position.

Save the Date

MCAAP ANNUAL MEETING

May 23, 2001

Massachusetts Medical Society
at Waltham Woods

What Is the MCAAP Doing for You?

David Chung, MD

Members of the Executive Committee of the Massachusetts Chapter would like to inform you that the American Board of Pediatrics (ABP) has decided to move to a test center-based recertification process beginning in 2003. The rationale behind this decision is to increase public confidence in the recertification process through proctored exams, and to provide a system for verifying physician identities, which can't be done via the current computer home-based exams. Other specialties are also administering proctored exams.

The most commonly stated objections to this change are as follows:

- 1) Proctored exams are more expensive, particularly the initial setup cost.
- 2) Travelling to test centers is onerous for those physicians who will need to drive a considerable distance or even find flights and accommodations.
- 3) Technology has already been developed to provide unique and strong identification, such as thumbprint technology on laptops. By 2003 or soon thereafter, this technology should be widely available.

- 4) The current procedure of proctored exams for initial board certification does not provide strong identity verification, since it only requires a driver's license. A proctored exam for recertification, therefore, should not realistically increase public confidence, as fake driver's licenses can be purchased for \$20.
- 5) Since proctored exams provide no method of immediate or even delayed feedback on individual questions, the learning experience is diminished compared to home-based, open-book exams.

It is notable that the ABP consulted the national AAP leadership, who opposed the change without success.

The Massachusetts Chapter would like to survey the opinion of its members and draft a response to the ABP reflecting the views of both sides with appropriate percentages of respondents. It should be clear to readers that I disagree with the policy change, but I promise to reflect the sentiment of our membership fairly in the response to the ABP. Please send your comments to me via e-mail: david@beansprout.net.

PREVENT POISONING

continued from page 3

- ★ Display Poison Prevention Week posters and educational materials in your office throughout the year.
- ★ Set up a "look-alike" display in your waiting room to demonstrate how some hazardous products and nonhazardous products are packaged similarly.

While Poison Prevention Week (March 18-24) may have passed, you can still obtain educational materials and posters to raise awareness by contacting the Consumer Products Safety Commission at (800) 638-2772 or via the Internet at http://www.cpsc.gov/cpscpub/pubs/pois_prv.html. The Regional Poison Center can also provide you with poison center stickers and general information. If you are interested in more educational information about the Regional Poison Center, please contact us at (617) 355-6609.

Please copy and distribute these basic reminders to families to prevent poisonings among your patients:

- ★ All medications should be kept in child-proof containers. Store medications in

their original containers and in cabinets that are out of reach of children.

- ★ Personal care products (e.g., diaper creams, cosmetics) and household cleaners (e.g., bleach, ammonia) should be stored in cabinets with childproof locks or in cabinets that are out of reach of children.
- ★ Read the labels of medications carefully to make sure you are taking or giving the correct medication.
- ★ Look for the expiration date on your medications and flush old medications down the toilet.
- ★ Know the names of plants in your home and keep poisonous plants out of reach of children.
- ★ Keep ipecac syrup in your home. Only use it if instructed to do so by your physician or the Regional Poison Center.
- ★ Keep the Regional Poison Center phone number, (800) 682-9211, on your telephone.

— Stephanie Lentz, Educator
Regional Poison Center
(401) 222-5954 or (617) 355-2227

Documenting the Outpatient Visit

WEDNESDAY, MAY 9, 2001

8:30 AM – 3:00 PM

HYNES AUDITORIUM

In keeping with the strategic plan of the MCAAP to move forward with technology, the chapter is using existing tools and developing new ones to improve communication and increase productivity within budget. Looking beyond the chapter itself, implementing the strategic plan includes providing opportunities to educate members about technology and how it can be used in practice.

In partnership with the Medical Records Institute, we are sponsoring a day-long meeting on electronic documentation in the office. Eleven vendors are participating; eight will present back-to-back demonstrations of their software using the same scenario of a standardized well child visit and a sick visit. These scenarios will include all the elements needed for full evaluation of the pediatric patient. Vendors will show how their software tracks growth and development, immunizations, diagnoses, medications, and allergies; how it generates school and camp forms; how it writes prescriptions; and so on. Another set of vendors will demonstrate web applications of interest to pediatric practices. This is a unique opportunity to learn why you need this technology to practice in the new millennium and what you need to do to migrate your practice toward embracing it.

Thanks to the sponsorship of the vendors, this portion of the meeting is FREE to physicians and their office managers. The day-long event will also include an exhibit hall pass for the TEPR (Towards Electronic Patient Record) meeting, which is being held at the same location. For those physicians interested in attending the TEPR meeting, a special registration is being offered by the Medical Records Institute for the entire TEPR meeting at a rate of \$295 — which is 70% off the regular fee. To register for the outpatient documentation event or the entire conference, go to www.tepr.com/physician. For more information about TEPR go to www.tepr.com or call the Medical Records Institute, who is handling registration, at (617) 964-3923.

SAVE THE DATE

“ADHD and Beyond: An Update on Childhood Mental Health Issues”

Wednesday, May 23, 2001, 9:00 AM – 3:30 PM

Massachusetts Medical Society, Waltham Woods, Waltham, MA

SPEAKERS AND TOPICS:

BRUCE BLACK, MD, COMPREHENSIVE PSYCHIATRIC ASSOCIATES, WELLESLEY, MA
ANXIETY DISORDERS

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INSIDE

Letters to the Editor	2
Help Prevent Poisonings in Your Patients	3
Forum Job Listings	4
Tune In, Turn On, Stop Out	6
Technology Corner	6
What Is the MCAAP Doing for You?	7
Documenting the Outpatient Visit	7

The Forum

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