

The Forum

NEWSLETTER OF THE MASSACHUSETTS CHAPTER AMERICAN ACADEMY OF PEDIATRICS

PRESIDENT'S MESSAGE

MANAGING FEAR

The specter of "killer flu," cancer, or mental illness can be a debilitating illness in itself. Managing fear is not something we are taught well, and we are certainly not well reimbursed for doing it. This winter, we may all have to address our patients' fears of flu, or possibly SARS, and forms of terrorism in the examination room and at the community level.

The MCAAP has attempted over the past 10 years to establish itself as a respected spokesperson for information, education, and advocacy. Now the media and legislators frequently turn to us, as they have recently about MassHealth, mental health, obesity, immunization, and infectious disease issues. We have many contacts who can provide us with definitive and balanced information quickly, that, in turn, we disseminate as simply and accurately as possible to you, to the press, to the administrators of state agencies, and to state legislators.

As you did with the issues relating to the shortage of flu vaccine, we rely on you to tell us what you need, and we rely on you to give sensible, reliable information to all your patients, health departments, and communities. Much of the fear about this flu was fanned by the press, and the MCAAP spent a great deal of time and energy feeding the media what we thought was balanced and accurate data and opinions. But each of us has also had to expend significant effort communicating reassuring sound bites to our patients and their parents in language they can understand.

Please let us know how we can get information and advice to you

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A New Program for Children Requiring Long-Term Care

Julie Meyers, M.D.
Pediatric Consultant, Community Case Management

In August, MassHealth launched a new program to help families who care for children with complex medical needs at home. The Community Case Management (CCM) program will help families to work collaboratively with medical service providers to develop a comprehensive service plan for their children.

This pilot program targets the 480 most medically complex children in the state. These are children who require home nursing care and often have medical equipment. When a child with long-term health care needs is sent home from the hospital (e.g., a premature infant from the NICU with a tracheostomy and a gastrostomy), a pediatric nurse case manager from CCM



will go to the family's home and spend several hours discussing the child's needs with the family. She then completes a detailed Comprehensive Assessment. If there are other services needed by the family, the case manager can contact any one of a number of CCM

consultants — physical and respiratory therapists, a social worker, or a pediatrician. She can also streamline the prior authorization process to reduce headaches and paperwork for families, durable medical equipment suppliers, and MassHealth.

At times, the case manager may need to speak with the child's primary care provider or subspecialists to gather more information. If the case manager does call, please remember that she is trying to help your patient's family take care of their child at home.

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What Is the MCAAP Doing for You?

David Chung, M.D.

A revised version of the MCAAP formulary guide is available in this issue. Substantial changes include the addition of information from Tufts Health Plan. Small changes have been made to the BCBS and Network Health formularies. There were no updates provided by HPHC, GIC, and Neighborhood Health Plan. Although MassHealth is not specifically included in this list, Network Health is one of the four MassHealth HMO administrators and is a reasonable proxy for MassHealth drugs. Information on

the coverage of anti-flu drugs has been included where available.

The MCAAP Formulary Guide is currently archived among the past issues of *The Forum* on the MCAAP website at www.mcaap.org. In the near future, updates of this guide will be made available in the "downloads" section of the website and will no longer be provided in hard copy.

Great care has been taken to provide the most accurate information, but if you identify any errors, please do not hesitate to contact me at dchung@mcaap.org.

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FORUM JOB LISTINGS

LOOKING FOR POSITION:

Name: Donna Kerr, M.D.

Contact: 617-429-0960

dkerr@tufts-nemc.org

Residency: Floating Children's Hospital – New England Medical Center

July 2001 to June 2004

Availability: July 2004

Comment: I am originally from Boston. I went to the University of Rochester School of Medicine and returned home for residency. I have my immediate and extended family in Massachusetts and would like to stay to practice.

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.

If you are looking to fill a position

MCAAP members: Free

Nonmembers: \$250

Please submit the following information:

- Practice Name
- Position Title and Description (25-word limit)
- Availability (e.g., starting July 2003)
- Contact Name
- Address, Telephone Number, E-mail Address

If you are looking for a job

MCAAP members and residents: Free

Nonmembers: \$50

Please submit the following information:

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

Please send text information via e-mail to dchung@mcaap.org. Checks may be mailed to the MCAAP office, c/o Cathleen Haggerty, Executive Director, P.O. Box 9132, Waltham, MA 02454-9132. All submissions must be received by March 15, 2004, to be included in the next issue of *The Forum*. All submissions are subject to review for appropriateness. For information, please contact the editor at dchung@mcaap.org

MCAAP COMMITTEES & ADMINISTRATIVE APPOINTMENTS

AAP Breastfeeding Coordinators Susan Browne Jean Sheeley	Emergency Pediatric Services Patricia O'Malley	International Child Health Open	Nominating Committee Eugenia Marcus
Bylaws Committee Carole Allen	Environmental Hazards Open	Legislation Alan Meyers	Nutrition Open
CATCH Co-Coordinator Robert Kossack Emily Roth	Fetus & Newborn Elizabeth Brown	Massachusetts Healthy Families Susan O'Brien Howard King	Pediatric Council Walter Harrison
Child Abuse & Family Violence Robert Nelken	Finance Committee Paul Schreiber	Membership Patricia Moffatt	Pediatric Practice Open
Committee on Adolescence Harris Faigel	Forum Editor David Chung	Mental Health Task Force Walter Harrison Eugenia Marcus	PROS Network Coordinators Hank Bernstein Ben Scheindlin
Continuing Medical Education Lynda Young	Foster Care Linda Sagor	MMS Delegate/ House of Delegates Carole Allen	School Health Linda Grant
Developmental Disabilities Richard Antonelli	Immunization Initiative Sean Palfrey Hadassa Kubat	MMS Interspecialty Committee Representatives Carole Allen Sean Palfrey	Substance Abuse Open
	Infectious Disease Sean Palfrey		Technology David Norton William Adams
	Injury Prevention & Poison Control Paul Schreiber		

Obesity: What's a Pediatrician to Do?

Laura Bayon, M.D., PGY-1 at UMass Memorial Health Care

Julie Meyers, M.D., District 3 Representative, MCAAP

Several members of the Massachusetts Chapter of the AAP, along with nutritionists and lobbyists, met recently to discuss childhood obesity and the role of pediatricians in this growing problem. The MCAAP Obesity Initiative Committee meeting focused largely on new state legislation to promote healthy choices and lifestyles for children.

At present, there are two bills being put forth. One is House Bill 3519: An Act to Promote Child Health, submitted by Rep. Peter Koutoujian (D-Waltham). This bill aims to promote healthy food and beverage choices in public schools by ensuring the foods and beverages available during school hours meet specific nutritional guidelines.

The guidelines for beverages include promoting water, milk or nondairy substi-

tutes (such as soy milk), and fruit juices containing limited amounts of added sweetener; limiting the serving size of juice containers to 12 ounces; and making soft drinks unavailable during school hours. The guidelines for food include restricting the amount of fat, saturated fat, sugar, and portion sizes. In addition, fruit and non-fried vegetables will be offered where any food is sold.

This bill was discussed at the Obesity Initiative meeting. We discussed the difficulty of instituting these changes given the financial benefits the schools receive from contracts with corporations and sales of food and beverages. We were also concerned that the bill might appear to promote fruit juice as a healthy drink. Perhaps prices could be set to encourage healthy choices. For instance, water could be the least expensive option.

The second bill, Senate Bill 303: An Act Promoting Healthy Food Alternatives

in Public School Food Programs was filed by Sen. Richard Moore (D-Milford). This bill aims to establish a five-year school nutrition demonstration project that would implement guidelines similar to the House Bill at a select number of schools. Data would be gathered to see if the project is economically feasible and if it has an impact on childhood obesity.

Please monitor the progress of these bills (www.mphaweb.org/legisalerts2.html) so that when the time is right, you can contact your local legislators. The Obesity Initiative Committee meets periodically at the Massachusetts Medical Society in Waltham. All are welcome. Please contact Cathleen Haggerty at chaggerty@mcaap.org or (781) 895-9852 if you would like to attend. For any questions about the Obesity Initiative Committee, please contact Julie Meyers, M.D., by e-mail at jmeyers@mcaap.org.

Membership Committee Updates

Patricia Moffatt, M.D.
District I Representative to the
Committee on Membership

MEDICAL STUDENTS

The AAP has agreed to accept the Committee on Membership's recommendation to decrease the medical student membership dues from \$30 to \$15 per year, and medical students will have access to *Pediatric Grand Rounds* online in addition to the former benefits they enjoyed. Locally, meetings with the medical students at Boston University School of Medicine have been going well. The students are asking good questions and are eager to get involved in some clinical work. Many are interested in shadowing a pediatrician to see exactly how the hours of book work result in helping patients. Students who are interested in this kind of mentorship should send their name and contact information to pmoffatt@mcaap.org.

RESIDENTS

Through constant conversation and evangelistic promotion, I am proud to inform you that every pediatric resident in an approved training program in the state of Massachusetts now has the \$50 AAP dues paid for by their training programs. The

residents are grateful and are using the benefits of AAP membership to improve their own knowledge and patient care skills.

The residents are grateful to be able to participate in the MCAAP, which has only been possible with your support throughout the years. Recently, the Executive Committee of the MCAAP voted to provide a \$3,000 scholarship to help cover travel and housing costs for pediatric residents

Remember, the louder the lion roars, the greater the chance the jungle will hear.

and students pursuing a pediatric clinical/research activity in a developing nation. It was felt that this was a concrete method to support these amazing young folks in their attempt to learn and help others. Thanks to all our members that allowed this type of program to develop. A report on individual experiences will be published in an upcoming issue of *The Forum*.

CHAPTER DUES

At a recent meeting of the Committee on Membership in Chicago, all of the district representatives urged the AAP to

continue having a reminder check box for Chapter dues on both the AAP bills members receive and on the online billing form on the Members-Only Channel. This will be discussed with the AAP Board. If you haven't paid your dues, please do so now so we can continue to support the needs of children.

DEMOGRAPHICS

A recent study of pediatric practitioners reveals that young members make up 40% of the total AAP membership. Sixty-five percent of residents leaving training are female, 33% are minority, and 58% will be looking for part-time employment — food for thought for those looking to recruit to your practices.

FINAL CALL

I would ask all of you to urge your colleagues who are not members of the MCAAP to become a member. If they have questions, they should contact Cathleen Haggerty at chaggerty@mcaap.org, or myself at pmoffatt@mcaap.org. I feel that we need as many voices for children's issues in this state as we can muster. Remember, the louder the lion roars, the greater the chance the jungle will hear.

Pediatricians: Advocates for Education, In and Beyond the Exam Room

Amy Kershaw,
Early Education for All
Sean Palfrey, M.D.

Pediatricians are highly trained and sensitive observers of a child's social, emotional, and cognitive development. They are also often a family's primary source of information about the child's developmental progress and needs.

For decades, we have urged parents and educators to provide a rich diversity of activities to infants and preschoolers as key elements in optimal development. In the 1970s, Robert Haggerty, M.D., defined behavioral, developmental, and psychosocial problems as the "new morbidity" facing children. Medical and educational research has repeatedly demonstrated the important and lasting benefits of high-quality early childhood education on a child's social, emotional, and cognitive readiness for school. Children, particularly those from high-risk environments, who are enrolled in quality early education programs fare significantly better in

school and have improved long-term outcomes. Children who begin school lagging behind their peers often never catch up, and the success or failure of certain adolescents in school has been correlated with their degree of "readiness" at the time of entry into elementary school.

The Early Education for All Campaign, a bold new statewide initiative, was

*high-quality early childhood
education has long-term
benefits on a child's
school readiness*

recently launched in Massachusetts. Its goal is to make high-quality early childhood education and full-day kindergarten universally available to every Massachusetts 3-, 4- and 5-year-old. To achieve this goal, the Campaign filed legislation at the State House in December 2002 entitled

"An Act Establishing Early Education for All" (H.1838/S.239). This bill has been endorsed by many professional groups and legislators, including the Executive Committee of the Massachusetts Chapter of the American Academy of Pediatrics. MCAAP President Sean Palfrey, M.D., is an active member of the Campaign's Advisory Committee.

The Advisory Committee — which is made up of state leaders in education, business, health care, and child advocacy — hopes to engage pediatricians as advocates in support of the goals of the Campaign. Over the next year, Early Education for All will be developing resource materials for pediatricians to discuss the components and importance of high-quality early childhood education. To learn more, contact Sean at spalfrey@mcaap.org or Cathleen at chaggerty@mcaap.org. Detailed information may also be found at the Early Education for All website: www.earlyeducationforall.org.

My "Critical Incident" as a Third-Year Medical Student

Dear Dr. _____,

I would like to share with you my ideas regarding concerns that I have about orientation for the clerkship years. Nothing we did during orientation prepared me for what I've seen this past week during my surgery rotation. Please do not read this as a complaint, for I am having probably the most maturing, life-forming week of my life. It's just very heavy, and I feel that emotional preparations would serve future medical students well.

This week, I've been on call twice in the ER trauma room. I saw an adolescent who was thrown down the stairs by his uncle and beaten in the head by a baseball bat or some other blunt instrument. I think he's a vegetable. A young man was shot in his leg, the bullet just missing a major artery. He had previously been stabbed in the back. A younger man was shot in the neck, and the bullet exited his cheek. He already had a bullet lodged near his spine from a previous shooting. I saw a toddler girl whose spine was severed by a

bullet. I saw a 15-year-old child who was shot in the abdomen and during the surgery in which I scrubbed and participated in, it was discovered that his aorta and vena cava were bleeding profusely. After several heroic hours of surgery consisting of open heart massages and countless transfusions, he died in the OR. I heard that his family was informed of his death in an elevator. I saw a young man stabbed in the neck, and when we tried to perform an X-ray or any other form of treatment, he fought back against us as if we were the enemy. I saw a young man who was in a motorcycle accident, and his arm and entire shoulder were amputated. His mother looked devastated. This is just an example of what I've seen in less than a full week on the job.

Dr. _____, I'm 31, I grew up in _____, I read the newspaper every day, I'm political, and I've witnessed my share of heart-break and wonder in my life. This past week, however, has hit me from left field. I feel as if I've been dropped in the middle

of a ferocious battle that no one even knows is occurring. I'm strong and can hack this, but I'm worried about future students, particularly younger ones from more privileged, sheltered backgrounds. How would they respond to witnessing and partaking in such events? I just don't want to see a bunch of scarred, disillusioned med students if, and when, I teach one day.

Briefly, something needs to be implemented in orientation to prepare us for this. I feel that this is as important, if not more important, than anything else we learn in orientation.

Once again, please do not see this letter as a complaint, I have loved this week. I just want to ensure that all future med students are adequately prepared for what they are about to see. It really can be brutal, as I'm sure you well know.

This letter was submitted by a medical student at Boston University School of Medicine, Class of 2005.

MCAAP Formulary Guide: Tiers

BCBS	HPHC	GIC	Neighborhood HP	Network Health	Tufts	additional notes
Acne, topical						
benzoyl peroxide (1)	benzoyl peroxide (1)	benzoyl peroxide (3)	benzoyl peroxide (1)	benzoyl peroxide (\$)		
Cleocin-T (1)	Cleocin-T (1)	Cleocin-T (1)	Cleocin-T (1)	Cleocin-T (\$\$)		
Benzaclin (3)	Benzaclin (2)	Benzaclin (2)	Benzaclin (3)	Benzaclin (\$\$\$)		
Duac (3)	Duac (1)	tretinoin (1)	tretinoin (2)	Retin A (\$\$\$)		
tretinoin (1)				Tazorac (\$\$\$)		
				Differin (\$\$\$)		
Acne, oral						
doxycycline (1)	doxycycline (1)	doxycycline (1)	doxycycline (1)	doxycycline (\$)	doxycycline (\$)	
minocycline (1)	minocycline (1)	minocycline (1)	minocycline (1)	minocycline (\$\$\$)	minocycline (\$\$)	
tetracycline (1)	tetracycline (1)	tetracycline (1)	tetracycline (1)	tetracycline (\$)		
ADHD						
methylphenidate (1)	methylphenidate (1)	methylphenidate (1)	methylphenidate (1)	methylphenidate (\$)		
Ritalin SR (3)	Ritalin SR (1)	Ritalin SR (3)	Ritalin SR (2)	Ritalin SR (\$)		
Adderall (3)	Adderall (1 or 2)	Adderall (1)*	Adderall (1)	Adderall (\$\$)**		*PA/**PA if > 17 years
Strattera (NF)*	Strattera (3)	Strattera (2)	Strattera (NF)**	Strattera (3)**		*under review/ **PA
Adderall XR (3)	Adderall XR (2)	Adderall XR (2)*	Adderall XR (2)	Adderall XR (\$\$)**		*PA/**PA if > 17 years
Concerta (2)	Concerta (3)	Concerta (2)	Concerta (3)*	Concerta (\$\$)		*PA
Metadate CD (2)	Metadate CD (2)	Metadate CD (2)	Metadate CD (2)	Metadate CD (\$\$)		
Ritalin LA (NF)*	Ritalin LA (NF)*	Ritalin LA (3)	Ritalin LA (2)	Ritalin LA (\$\$)		*under review
Allergy, eye (consider OTC Naphcon A, Opticon A, Visine A)						
cromolyn (1)	cromolyn (1)	cromolyn (1)	cromolyn (1)	cromolyn (\$\$)		
Patanol (2)	Patanol (2)	Patanol (2)	Patanol (2)	Patanol (\$\$\$\$)		
Allergy, nasal (consider OTC cromolyn [Nasal crom] and nasal saline washes [e.g., Neti pots])						
Astelin (2)	Astelin (2)	Astelin (2)	Astelin (2)	Astelin (\$\$\$)	Astelin (\$x8)	
flunisolone (1)		Flonase (2)*	Flonase (2)*	beclomethasone/	Nasacort (\$x7)	*preferred agent
Flonase (2)		Nasonex (2)	Nasonex (2)*	Flonase/Nasarel	Nasonex (\$x7)	*preferred agent
Nasonex (2)			Beconase (2)	Nasonex/Nasacort	Rhinocort (\$x7)	
Rhinocort (2)			Rhinocort (2)	AQ/Rhinocort/	Flonase (\$x8)	
Vancenase AQ (2)				Rhinocort AQ/	Nasacort AQ (\$x8)	
				Tri-Nasal (\$\$)	Rhinocort AQ (\$x8)	
Antibacterial, oral (cephalosporins 1st generation)						
cephalexin (1)	cephalexin (1)	cephalexin (1)	cephalexin (1)	cephalexin (\$)	cephalexin (\$\$)	
cephadrine (1)	Duricef (3)	Duricef (1)	Duricef (2)	Duricef (\$\$\$)		
cefadroxil (1)						
Duricef (3)						

MCAAP Formulary Guide: Tiers

additional notes

Tufts

Network Health

Neighborhood HP

GIC

HPHC

BCBS

Antibacterial, oral (cephalosporins 2nd generation)

cefaclor (1)	cefaclor (2)	cefaclor (1)	cefaclor (\$\$)	cefaclor (\$\$)
cefuroxime (1)	cefuroxime (2)	cefuroxime (2)	Cefzil (\$\$\$)	Omnicef (\$x5)
Cefzil (2)	Cefzil (2)		cefuroxime (\$\$\$\$)	
Lorabid (NF)	Lorabid (3)		Lorabid (\$\$\$\$)	
	Vantin (3)			

Antibacterial, oral (cephalosporins 3rd generation)

Suprax (2)	Suprax (3)	Suprax (2)	Suprax (\$\$\$)	
	Cedax (3)	Cedax (3)	Cedax (\$\$\$)	

Antibacterial, oral (macrolides)

Zithromax (2)	Zithromax (2)	Zithromax (2)	Zithromax (\$\$\$)	Zithromax (\$\$5)
Biaxin (2)	Biaxin (3)	Biaxin (2)	Biaxin (\$\$\$)	Biaxin (\$\$\$)
erythromycin (1)	erythromycin (1)	erythromycin (1)	erythromycin (\$)	erythromycin (\$)

Antibacterial, oral (penicillins)

amoxicillin (1)	amoxicillin (1)	amoxicillin (1)	amoxicillin (\$)	amoxicillin (\$)
amox/clav (1)	Augmentin (2)	Augmentin (2)	Augmentin (\$\$)	Augmentin (\$x5)
Augmentin (3)	Augmentin ES (2)	Augmentin ES (2)	Augmentin ES (\$\$)	
Augmentin ES (3)	Pen Vee K tabs (1)	Pen Vee K tabs (1)	Augmentin XR (\$\$\$)	
Pen Vee K tabs (1)			Pen Vee K tabs (\$)	

Antibacterial, eye

Ilotycin (1)	Ilotycin (1)	Ilotycin (1)	Ilotycin (\$)	tobramycin (\$)
Polytrim gtts (3)	Polytrim gtts (3)	Polytrim gtts (3)	Polytrim gtts (\$\$)	Polytrim gtts (\$\$5)
Sulamyd gtts (1)	Sulamyd gtts (1)	Sulamyd gtts (3)	Sulamyd gtts (\$)	Ocuflox (\$x5)
Ciloxan (2)	Ciloxan (2)	Ocuflox (2)	Ocuflox (\$\$\$\$)	
		Ocuflox (2)		

Antibacterial, otic (consider rubbing alcohol/vinegar for mild cases)

Cortisporin (3)	Cortisporin (1)	Cortisporin (1)	Cortisporin (\$\$)	
gentamicin (1)	gentamicin (1)	gentamicin (1)	gentamicin (\$)	
Cipro HC (2)	Cipro HC (2)	Floxin (2)	Floxin (\$\$\$\$)	

MCAAP Formulary Guide: Tiers

BCBS	HPHC	GIC	Neighborhood HP	Network Health	Tufts	additional notes
Antidepressants						
bupropion (1)	bupropion (1)	Prozac (1)*	bupropion (2)	bupropion (\$\$)	bupropion (\$x7)	*preferred agent
fluoxetine (1)		Luvox (1)	Prozac (1)	Prozac (\$)*	Wellbutrin SR (\$x8)	*See dosing notes
paroxetine (1)		Celexa (2)	Celexa (2)*	Paxil (\$\$)**	Prozac (\$)	*PA/**See dosing notes
fluvoxamine (1)		Lexapro (2)	Lexapro (2)*	Celexa (\$\$\$)**	Celexa (\$x6)	*PA/**See dosing notes
Celexa (2)		Paxil (2)	Paxil (2)*	Lexapro (\$\$\$\$)**	Paxil/Paxil CR (\$x7)	*PA/**See dosing notes
Lexapro (2)		Zoloft (2)	Zoloft (2)*	Paxil/Paxil CR (\$\$\$\$)		*PA
Paxil (2)				Prozac Weekly (\$\$\$\$)		
Zoloft (2)				Zoloft (\$\$\$)*		*See dosing notes
Prozac (3)				Luvox (\$\$\$\$)		
Antifungal, oral						
Diflucan (2)	Diflucan (2)	Diflucan (2)	Diflucan (2)*	Diflucan (\$\$\$\$)	Lamisil (\$x7)*	*PA
Lamisil (2)	Sporanox (3)*	Sporanox (2)*	Sporanox (3)*	Sporanox (\$\$\$\$)		*PA
	Lamisil (2)*	Lamisil (2)*	Lamisil (2)*	Lamisil (\$\$\$\$)		*PA
Antifungal, topical (consider OTC fungostatic clotrimazole [Lotrimin] or fungocidal terbinafine [Lamisil])						
clotrimazole (1)						
ketoconazole (1)						
Antihistamine (non/low sedating)						
Allegra (3)	Zyrtec (2)	Zyrtec (3)	Zyrtec (3)*	Zyrtec (\$\$\$\$)*	Allegra (\$x7)	*PA
	Allegra (2)	Allegra (2)	Allegra (3)*	Allegra (\$\$\$\$)*	Claritin (\$x8)	*PA
			Claritin (3)*	Claritin (\$)		*PA
Antihistamine (sedating — consider OTC diphenhydramine [Benadryl])						
Periactin (1)	Periactin (1)	Periactin (1)	Periactin (1)	Periactin (\$\$)		
Atarax (1)	Atarax (1)	Atarax (1)	Atarax (1)	Atarax (\$)		
Antiviral (herpes treatment/prophylaxis for adults)						
acyclovir (1)	acyclovir (1)	acyclovir (1)	acyclovir (1)	acyclovir (\$\$)	acyclovir (\$)	
Famvir (2)	Famvir (3)	Famvir (3)	Famvir (3)	Famvir (\$\$\$\$)	Valtrex (\$\$\$)	
Valtrex (2)	Valtrex (2)	Valtrex (2)	Valtrex (2)	Valtrex (\$\$\$\$)	Tamiflu (NF)	
Tamiflu (3)	Tamiflu (3)				Relenza (NF)	
Relenza (3)	Relenza (3)					
Asthma therapy (bronchodilators, immediate relief)						
albuterol (1)	albuterol (1)	albuterol (1)	albuterol (1)	albuterol (\$\$\$)	albuterol \$\$	
Xopenex (2)	Xopenex (3)	Xopenex (2)	Xopenex (3)	Xopenex (\$\$\$\$)		

MCAAP Formulary Guide: Tiers

BCBS	HPHC	GJC	Neighborhood HP	Network Health	Tufts	additional notes
Asthma therapy (controller medications)						
Serevent (2)	Serevent (2)	Serevent (2)	Serevent (2)	Serevent (\$\$\$\$)	Pulmicort Turb (\$x5)	
Singulair (2)*	Singulair (2)	Singulair (2)	Singulair (2)	Singulair (\$\$\$\$)*	Flovent (\$x7)	*Step therapy edits apply
Accolate (2)*	Accolate (3)	Accolate (2)	Accolate (3)	Accolate (\$\$\$\$)	Flovent Rotadisk (\$x7)	*Step therapy edits apply
Advair (3)	Advair (2)	Advair (2)	Advair (2)	Advair (\$\$\$\$\$)	Advair (\$x10)	
Flovent (2)	Flovent (2)	Flovent (2)	Flovent (2)	Flovent (\$\$)		
Aerobid (2)		Foradil (2)				
Pulmicort (2)		QVAR (2)				
Gastrointestinal (consider OTC cimetidine, famotidine, ranitidine [Tagamet, Pepcid, Zantac])						
omeprazole (1)		cimetidine (1)	ranitidine (1)	cimetidine (\$)	ranitidine (\$\$)	
Prilosec (2)		ranitidine (2)	Aciphex (1)	ranitidine (\$)	Aciphex (\$x5)	
Protonix (2)		Prilosec (2)		famotidine (\$)	Nexium (\$x5)	
		Nexium (2)		Prilosec OTC (\$\$)	Protonix (\$x5)	
		Prevacid (2)				
		Aciphex (3)				
		Protonix (3)				
OCPS						
Monophasic (may not be a complete list)						
Necon 1/35, 1/50 (1)*		Apri (1)	Loestrin (2)*	The following are (\$):	Loestrin Fe (\$\$\$\$)	*preferred agent
Zovia (1)*		Necon 1/35, 1/50 (2)	Nelova (2)	Brevicon/Desogen/	Loestrin (\$x6)	*preferred agent
Mononessa (1)*		Ortho Novum 1/35 (2)		June/Levite/Levora/		*preferred agent
Sprintec (1)*		Ortho Novum 1/50 (2)		Loestrin/Modicon/		*preferred agent
Yasmin (1)		Yasmin (2)		Norinyl 1/35, 1/50/		
Cryselle (1)*				Ortho-Cept/		*preferred agent
Microgestin (1)*				Ortho-Novum 1/35, 1/50		*preferred agent
Triphasic (may not be a complete list)						
Trivora (1)*		Trivora (1)	Tri-Levlen (2)*	Cyclessa (\$)	Estrostep Fe (\$\$\$)	*preferred agent
Enpresse (1)		Tri-Levlen (2)	Tri-Norinyl (2)	Trivora (\$)	Tri-Norinyl (\$\$\$\$)	
		OrthoNovum 7/7/7 (2)		OrthoNovum 7/7/7 (\$)		
				Tri-Norinyl (\$)		
				Necon (\$)		
				Nortrel (\$)		
Progestin only						
Camila (1)*		Camila (1)	Nor-QD (2)	Norethindrone (\$\$)	Nor-QD (\$x6)	*preferred agent
Errin (1)*		Errin (1)				*preferred agent
		Micronor (2)				

MCAAP Formulary Guide: Tiers

BCBS	HPHC	GIC	Neighborhood HP	Network Health	Tufts	additional notes
OCPs (continued)						
Other						
Ortho Evra patch (2)	Ortho Evra patch (3)	Ortho Evra patch (2)	Ortho Evra patch (3)	Ortho Evra patch (\$\$)		
NuvaRing (3)	NuvaRing (3)	NuvaRing (2)	NuvaRing (NF)*	NuvaRing (\$\$\$)		*PA
Steroids, oral						
prednisolone (1)	prednisolone (1)	prednisolone (2)	prednisolone (1)	prednisolone (\$\$)		
Orapred (3)	Orapred (1)	Orapred (2)	Orapred (2)	Orapred (\$\$)		
Pediapred (3)	Pediapred (1)	Pediapred (2)	Pediapred (2)	Pediapred (\$\$)		
Steroids, topical (always consider using generics rather than branded steroids)						
Medium potency						
betameth val (1)		hydrocort val (1)*	fluocinolone (1)*	betameth val (\$)		*preferred agent
fluocinolone (1)		triamcinolone (1)	betameth dipro (1)	triamcinolone (\$)		
High potency						
desoxymeta (1)		betameth dipro (1)	fluocinolone (1)	fluocinolone (\$)		*preferred agent
fluocinolone (1)			betameth val (1)	betameth dipro (\$\$)		

MCAAP Formulary Guide:: Drug Formulations and Dosing

<i>Note: Please consult your own dosing reference and consider drug interactions and contraindications. Doses by weight may not indicate maximum dose.</i>	
Acne, topical	
benzoyl peroxide 5/10% cream, gel, or lotion	Apply qday-bid
clindamycin (Cleocin-T) gel, lotion, or solution	Apply qday-bid
benzoyl peroxide 5%/clinda (Benzacilin or Duac) gel	Apply qday-bid
tretinoin (Retin-A) 0.025/0.05/0.1% cream or 0.025/0.1% gel	Apply qhs
Acne, oral	
doxycycline 50/100 mg caps or 100 mg tabs	100 mg po bid
minocycline (Minocin) 50/100 mg caps and tabs	50-100 mg po bid — less affected by dairy
tetracycline 250/500 mg caps and tabs	500 mg po bid-tid
ADHD	
methylphenidate (Ritalin) 5/10/20 mg tabs	Titrate to effect
methylphenidate (Ritalin SR) 20 mg tabs	Titrate to effect
mixed amphetamine salts (Adderall) 5/10/20/30 mg tabs	Titrate to effect
atomoxetine (Strattera) 10/18/25/40/60 mg capsules	0.5 mg/kg qday for 4 doses then 1.2 mg/kg qday

Adderall XR 5/10/15/20/25/30 mg capsules	Titrate to effect
Concerta 18/27/36/54 mg capsules	Titrate to effect
Metadate CD 20 mg capsules	Titrate to effect
Ritalin LA 20/30/40 mg capsules	Titrate to effect
Allergy, eye	
cromolyn 4% solution	1-2 gtts qid
olopatadine 0.1% solution (Patanol)	1-2 gtts bid
Allergy, nasal	
azelastine (Astellin)	2 sprays per nostril bid
Most nasal steroid sprays	1 spray per nostril qam
Antibacterial, oral (cephalosporins 1st generation)	
cefadroxil (Duricef) 125/250/500 per 5 susp or 500 mg caps or 1 g tabs	15 mg/kg/dose bid
cephalexin (Keflex) 125/250 per 5 susp or 250/500 mg caps	10-12 mg/kg/dose tid-qid
cephradine (Velosef) 250/500 mg tabs	250-500 mg q6 hours (adult dosing only)

Antibacterial, oral (cephalosporins 2nd generation)

cefactor (Ceclor) 125/187/250/375/500 per 5 susp or 250/500 mg caps	13 mg/kg/dose tid — has unique serum sickness reaction
cefdinir (Omnicef) 125 per 5 susp or 300 mg caps	7 mg/kg/dose bid, max dose 300mg bid
cefepoxime (Vantin) 50/100 per 5 susp or 100/200 mg tabs	5 mg/kg/dose bid
cefprozil (Cefzil) 125/250 per 5 susp or 250/500 mg tabs	15 mg/kg/dose bid
cefuroxime (Ceftin) 125/250 per 5 susp or 125/250/500 tabs	15 mg/kg/dose bid
loracarbef (Lorabid) 100/200 per 5 susp or 200/400 mg caps	15 mg/kg/dose bid

Antibacterial, oral (cephalosporins 3rd generation)

cefixime (Suprax) 100 per 5 susp or 200/400 mg tabs	8 mg/kg/dose qd — consider alternative given inavailability
ceftibuten (Cedax) 90 mg per 5 susp or 400 mg tabs	9 mg/kg/dose qd

Antibacterial, oral (macrolides)

azithromycin (Zithromax) 100/200 per 5 susp or 250 mg caps	10 mg/kg on day 1, 5 mg/kg days 2–5 for OM, 12 mg/kg/day x 5 days for strep pharyngitis
clarithromycin (Biaxin) 125/250 per 5 susp or 250/500 mg tabs	7.5 mg/kg/dose bid x 7 days — consider alternative to suspension due to poor flavor
erythromycin 200/400 per 5 susp (EES) or 250/333/500 mg tabs (base)	10–15 mg/kg/dose tid — higher rate of GI upset

Antibacterial, oral (penicillins)

amoxicillin 250/500 per 5 susp or 250/500 mg caps	15–30 mg/kg/dose tid (max dose 4 g per day)
amoxicillin/clavulanate (Augmentin) 200/400 per 5 susp or 250/500 mg tabs	20 mg/kg/dose bid (not recommended for otitis)
amoxicillin/clavulanate (Augmentin ES) 600 per 5 susp	45 mg/kg/dose bid
Pen Vee K tablets 250/500 mg tabs	250 mg tid or 500 mg bid x 10 days for strep pharyngitis

Antibacterial, eye

erythromycin ointment	Apply to affected eye tid–qid x 5 days
Polytrim drops	1 gtt q4 hours x 7–10 days
Sulfacetamide (Sulamyd) drops 10/15/30 % solution	1–2 gtt q4 hours x 7–10 days
ciprofloxacin (Ciloxan) 0.3% solution	1–2 gtt q2 hours while awake x 2 days then 1–2 gtt q4 hours while awake x 5 days
ofloxacin (Ocuflox) 0.3% solution	Dosing same as Ciloxan

Antibacterial, otic

Cortisporin otic suspension	3–5 gtt in ear tid
gentamicin ophthalmic or otic drops	3–5 gtt in ear tid
Most fluoroquinolone drops	3–5 gtt in ear bid

Antidepressants (dosing for adult patients)

fluoxetine (Prozac) 20 per 5 solution or 10/20 mg caps	Start 20 mg qday, max dose 40 mg qday (Network Health: Use 20 mg tabs instead of 40 mg)
citalopram (Celexa) 20/40 mg tabs	Start 20 mg qday, max dose 40 mg qday (Network Health: Use 1/2 20 mg tabs instead of 10 mg and 1/2 40 mg tabs instead of 20 mg)
fluvoxamine (Luvox) 25/50/100 mg tabs	Start 25 mg qhs, increase by 25 mg in bid dosing to max of 200 mg per day
escitalopram (Lexapro) 10/20 mg tabs	10 mg qday (Network Health: Use 1/2 20 mg tab instead of 10 mg)
paroxetine (Paxil) 10/20/30/40 mg tabs	20 mg qam, max dose 50 mg qday (Network Health: Use 1/2 20 mg tab instead of 10 mg)
sertraline (Zoloft) 25/50/100 mg tabs	Start 50 mg qday, max dose 200 mg qday (Network Health: Use 1/2 50 mg tab instead of 25 and 1/2 100 mg tab instead of 50 mg)
bupropion (Wellbutrin) 100/150 mg sustained release tabs	Start 150 mg qam, after one week, increase to 150 mg bid — rate of seizures 0.4%

Antifungal, oral

fluconazole (Diflucan) 10/40 per 5 susp or 50/100/150/200 mg tabs	10 mg/kg on day 1, then 5 mg/kg per day for oral/esophageal candidiasis /150 mg po x1 for vaginal candidiasis
itraconazole (Sporanox) 10 per 5 liquid or 100 mg caps	200 mg bid x 1 week, repeat qmonth (2 months for finger-nails, 3–4 months for toenails)
terbinafine (Lamisil) 250 mg tabs	500 mg qday x 1 week, repeat qmonth (2 months for finger-nails, 4 months for toenails)
Antifungal, topical	
ciclopirox (Loprox) 1% cream (fungicidal)	Apply bid x 7–14 days
clotrimazole (Lotrimin) 1% cream (fungostatic)	Apply bid x 3–4 weeks
ketoconazole (Nizoral) 2% cream (fungostatic)	Apply qday x 3–4 weeks

Antihistamine (non/low sedating)

cetirizine (Zyrtec) 5 per 5 syrup or 5/10 mg tabs	2.5 mg age 2-5, 5-10 mg age 6 and over
fexofenadine (Allegra) 30/60/180 mg tabs	30 mg bid for age 6-12, 60 mg bid or 180 mg qday for adults
loratadine (Claritin) 5 per 5 syrup or 10 mg tabs	5 mg age 2-5, 10 mg age 6 and over

Antihistamine

cyproheptadine (Periactin) 2 per 5 syrup or 4 mg tabs	4 mg tid, max 32 mg per day (adult dosing)
hydroxyzine (Atarax) 10 per 5 syrup, 25 per 5 susp, or 10/25/50/100 mg tabs	0.5-1 mg/kg/dose up to 100 mg per day divided qday-qid

Antiviral (herpes treatment/prophylaxis for adults)

acyclovir 200 per 5 susp, 200 mg caps, 400/800 mg tabs	400 mg tid x 7-10 days for 1st genital herpes, x 5 days for recurrent/400 bid for suppression
famciclovir (Famvir) 125/250/500 mg tabs	250 mg tid x 7-10 days for 1st genital herpes, 125 bid x 5 days for recurrent/250 bid for suppression
valacyclovir (Valtrex) 500/1000 mg tabs	1000 mg po bid x 10 days for 1st genital herpes, 500 bid x 5 days for recurrent/500-1000 qd for suppression
oseltamivir (Tamiflu) 60 per 5 or 75 mg caps	2 mg/kg bid x 5 days for treatment, max 75 mg bid or 75 mg po qday x7 days for prophylaxis
zanamivir (Relenza)	2 inhalations bid x 5 days

Asthma therapy (bronchodilators, immediate relief)

albuterol MDI or 0.5% conc soln or 0.083% premixed soln	2 puffs or 1.25-2.5 mg nebulized q4 hours prn
levalbuterol (Xopenex) 0.31/0.63/1.25 mg unit doses	0.31-1.25 mg nebulized q4 hours prn

Asthma therapy (controller medications)

fluticasone (Flovent) 44/110/220 mcg inhalers	2 puffs bid
montelukast (Singulair) 4/5 mg chewable or 10 mg tab	1 tab po qhs
salmeterol (Serevent)	2 puffs bid
zafirlukast (Accolate) 20 mg tab	20 mg po bid
fluticasone/salmeterol (Advair) 100/250/500 mcg discus	1 inhalation bid

flutisolide (AeroBid)	2-4 puffs bid
formoterol (Foradil)	1 inhalation bid
beclomethasone HFA (QVAR) 40/80 mcg inhalers	1-2 puffs bid
budesonide (Pulmicort turbuhaler) 200 mcg/inhalation	1-2 inhalations qday-bid

Gastrointestinal

cimetidine (Tagamet) 300 per 5 syrup or 100/200/300/400/800 mg tabs	10 mg/kg/dose q6 hours — Adults: 800 mg per day divided qday-bid
famotidine (Pepcid) 40 per 5 syrup or 10/20/40 mg tabs	0.4 mg/kg/dose q8 — Adults: 40 mg per day divided qday-bid
ranitidine (Zantac) 75 per 5 syrup or 75/150/300 mg tabs	1.5 mg/kg/dose q8 — Adults: 300 mg/day divided qday-bid
esomeprazole (Nexium) 20/40 mg caps	1 po qday
lansoprazole (Prevacid) 15/30 mg caps	1 po qday
omeprazole (Prilosec) 10/20/40 mg caps	1 po qday
pantoprazole (Protonix) 20/40 mg tabs	40 mg bid
rabeprazole (Aciphex) 20 mg tabs	1 po qday

OCPs

Most oral contraceptives	1 tab qday
Ortho Evra patch	Change patch weekly
NuvaRing	Insert ring vaginally qmonth, remove after 21 days

Steroids, oral

prednisolone (15mg/5ml)	2 mg/kg x1, then 1 mg/kg/dose q12
Orapred prednisolone (15mg/5ml)	2 mg/kg x1, then 1 mg/kg/dose q12
Pediapred prednisolone (5mg/5ml)	2 mg/kg x1, then 1 mg/kg/dose q12

Steroids, topical (c = cream, l = lotion, o = ointment)

Medium-potency formulations	
betamethasone dipropionate (Diprosone) 0.05% (l)	Apply sparingly qday-bid
betamethasone valerate 0.1% (c)	Apply sparingly qday-bid
fluocinolone (Synalar) 0.025% (c, o)	Apply sparingly bid-qid
hydrocortasone valerate (Westcort) 0.2% (c, o)	Apply sparingly bid-tid
triamcinolone (Aristocort/Kenalog) 0.025/0.1/0.5% (c, o)	Apply sparingly tid-qid
High-potency formulations	
betamethasone dipropionate (Diprosone) 0.05% (c, o)	Apply sparingly qday-bid
betamethasone valerate 0.1% (o)	Apply sparingly qday-bid
desoxymetasone (Topicort) 0.25% (c, o)	Apply sparingly bid
fluocinolone (Synalar) 0.2% (c)	Apply sparingly bid-qid
fluocinonide (Lidex) 0.05% (c, o)	Apply sparingly bid-tid

President's Message

Continued from cover

most effectively. Please share with us any meaningful approaches you have found effective. Finally, please reach out to your local radio stations, newspapers, parent groups, and school groups to provide them with good information. Our office has handouts and examples of articles and Op-Ed pieces for you to use. Your work with your local communities will pay great dividends in terms of the time you have to spend educating and reassuring your patients in your office. We are here to help.

– John G. (Sean) Palfrey, M.D., FAAP

New Program for Children

Continued from cover

These children are obviously complex, and you often know them the best. As the pediatric consultant to CCM, I will try to field questions whenever possible. On occasion, I may be the one calling you for more information.

What does the family get from this process? A comprehensive needs assessment is completed in their home by a trained pediatric nurse who will become the family's single point person to access home-nursing services and medical equipment needs. This same nurse can help

the family each time services need to be re-authorized.

How does MassHealth benefit? The nurse is able to provide an impartial initial assessment of the family's needs. She also has access to an array of consultants to help determine the family's need for services. As part of the process, the nurse will help identify third-party payers who can share some of the cost of these services, potentially saving MassHealth (and the taxpayers) some money.

In the end, we're all working together for these kids and their families. If we can make their lives less complicated, this pilot program will be a success.

Call for Nominations

This spring, positions for the MCAAP Executive Committee will become vacant for President-Elect/Vice-President, Secretary, Treasurer, District 1 Representative, District 2 Representative, and District 8 Representative. Please send nominations to Cathleen Haggerty via e-mail at chaggerty@mcaap.org, fax at (781) 895-9855, or mail to P.O. Box 9132, Waltham, MA 02454-9132. Nominations must be received by February 27, 2004, and ballots will be mailed the first week of March. Communities in each district are listed below.

DISTRICT NO. 1

BERKSHIRE COUNTY

Adams
Alford
Becket
Cheshire
Clarksburg
Dalton
Egremont
Florida
Great Barrington
Hancock
Hinsdale
Lanesborough
Lee
Lenox
Monterey
Mount Washington
New Ashford
New Marlborough
North Adams
Otis
Peru
Pittsfield
Richmond
Sandisfield
Savoy
Sheffield
Stockbridge
Tyringham
Washington
West Stockbridge

Williamstown

Windsor

FRANKLIN COUNTY

Ashfield
Bernardston
Buckland
Charlemont
Colrain
Conway
Deerfield
Erving
Gill
Greenfield
Hawley
Heath
Leverett
Leyden
Monroe
Montague
New Salem
Northfield
Orange
Rowe
Shelburne
Shutesbury
Sunderland
Warwick
Wendell
Whately

HAMPDEN COUNTY

Blandford
Chester
Granville
Holyoke
Montgomery
Russell
Southwick
Tolland
Westfield
West Springfield
HAMPSHIRE COUNTY
Amherst
Belchertown
Chesterfield
Cummington
Easthampton
Goshen
Granby
Hatfield
Huntington
Middlefield
Pelham
Plainfield
Southampton
Ware
Westhampton
Williamsburg
Worthington

MIDDLESEX COUNTY

Ashby
Pepperell
Townsend
WORCESTER COUNTY
Ashburnham
Athol
Barre
Fitchburg
Gardner
Hardwick
Hubbardston
Leominster
Lunenburg
New Braintree
Oakham
Petersham
Phillipston
Royalston
Sterling
Templeton
West Brookfield
Westminster
Winchendon

DISTRICT NO. 2

HAMPDEN COUNTY
Agawam
Brimfield
Chicopee
East Longmeadow
Hampden

Holland
Longmeadow
Ludlow
Monson
Palmer
Springfield
Wales
Wilbraham

HAMPSHIRE COUNTY

Hadley
Northampton
South Hadley

NORFOLK COUNTY

Bellingham

WORCESTER COUNTY

Blackstone
Brookfield
Charlton
Douglas
Dudley
East Brookfield
Grafton
Hopedale
Leicester
Mendon
Milford
Millbury
Millville
North Brookfield
Northbridge
Oxford

Southbridge

Spencer
Sturbridge
Sutton
Upton
Uxbridge
Warren
Webster

DISTRICT NO. 8

MIDDLESEX COUNTY

Cambridge
Somerville

SUFFOLK COUNTY

Boston
(Wards 1, 2; Ward 3,
Pcts. 1-4, 7, 8;
Ward 4; Ward 5, Pcts.
1, 2, 6-10; Ward 7,
Pct. 10; Wards 8-12;
Ward 13, Pcts. 1, 2, 4,
5, 6; Ward 14; Ward
15, Pcts. 1-5, 7, 8, 9;
Ward 16, Pcts. 1, 3;
Ward 17, Pcts. 1, 2, 3,
5-12; Ward 18, Pcts
1-8, 13-15, 21; Ward
19, Pcts. 1, 3-6, 8, 9;
Wards 21, 22)

Chelsea

CATCH Grants Available — Don't Miss This Opportunity

Robert Kossack, M.D.

CATCH grant applications submitted by Massachusetts pediatricians are of exceptionally high quality, but the number of applications is distressingly small. Most pediatricians have a hard time finding the time to complete a grant application on a deadline when other pressing issues are occupying their time

Each year, there are a number of opportunities for practicing pediatricians to apply for grants for program development and implementation. These grants represent an opportunity for pediatricians to put their ideas about collaborative efforts for delivering quality care to children into practice. The CATCH program can give the practitioner valuable experience in grant writing that can then be used in pursuing subsequent, more ambitious grants. Busy practitioners often feel that they do not have the time to get the materials together to submit a proposal by the deadline. Colleagues in academic practice always have a grant application or two in the works, so when announcements come out, they just have to polish them up and send them in. By knowing the general timing for applications, one can have most of the work done before the announcement comes out, leaving only details and paper work for the month between the application announcement and deadline. Each year, pediatricians have several predictable opportunities to apply for funds, especially in delivery of services to underserved populations:

CATCH Planning Grants are grants of up to \$10,000 for six months to support the development of new programs to serve the health needs of underserved children. These should be partnerships with other community agencies that either increase children's access to medical homes or increase access to specific health services not otherwise easily available, such as dental or mental health services. The funds cannot be used to support an existing program and cannot be used for capital purchases or operational expenses. They can provide money to explore a cooperative effort to identify and pursue ultimate sources of funding. Recent applications have addressed programs for obesity prevention and the expansion of mental health services. These grant announcements generally come out in May or June with an application deadline sometime in July.

CATCH Implementation Grants are six month grants of up to \$10,000 to support the initial implementation or the piloting of a new or expanded program that addresses the local needs of children in the community. These programs are not necessarily prior recipients of CATCH Planning Grants. Announcements went out in early November, and applications are due January 31, 2004.

Healthy Tomorrows Grants are substantial awards of up to \$50,000 per year for five years, sponsored by a collaborative arrangement between the Maternal Child Health Bureau of the Health Resources and Services Administration and the AAP.

The goal of these grants is to encourage community-based solutions to problems of access to care, including the provision of primary care services for uninsured children, care coordination services for children with special health care needs, and health promotion activities for adolescents and vulnerable families. The program has funded 97 projects to date. Announcements generally go out in September with application deadlines in late October.

The AAP and the Massachusetts Chapter are committed to supporting area pediatricians in applying for these grants. There are several useful resources on the AAP website, including *A Pediatrician's Guide to Proposal Writing*, which is an excellent starting point for anyone thinking of submitting a grant application. In addition, chapter officers and the chapter's CATCH facilitators are available to offer technical assistance with proposals or to help review a project.

It is never too early to start thinking about a project. Assessing community needs, collecting demographic information, and making initial contacts with community partners are all things that can be done before grant announcements come out. Begin to sketch out narrative material, including a description of your practice, the need to be met, and the proposal. If you need any assistance, you can contact your CATCH co-facilitators Emily Roth, M.D., at eroth@mcaap.org, or Robert Kossack, M.D., at rkossack@mcaap.org.

Massachusetts Medical Society House of Delegates Adopts Medical Home Model

Richard Antonelli, M.D.
Chair, MCAAP Committee on Disabilities

At the most recent meeting of the Massachusetts Medical Society House of Delegates, the HOD unanimously adopted the following resolutions:

RESOLVED, That the Massachusetts Medical Society (MMS) agrees with the definition of a medical home as care that is accessible, comprehensive, continuous, coordinated, family-centered, compassion-

ate, culturally competent, and in which the primary care physician shares responsibility; and, be it further

RESOLVED, That the MMS support the concept that children with special health care needs (CSHCN) should receive care within a medical home; and, be it further

RESOLVED, That the MMS encourage both primary and specialty care physicians involved in caring for children with special

health care needs to become familiar with the medical-home concept and to work within their practices and their specialty societies to incorporate this concept.

The medical home is now POLICY of the Massachusetts Medical Society!

We have lots more to do to achieve the Healthy People 2010 outcome goal that all CSHCN will have access to a medical home by the end of the decade. Stay tuned, and thanks for all your support.

President-Elect Candidates 2004

EILEEN M. OUELLETTE, M.D., J.D., F.A.A.P.
NEWTON CENTER, MASS.

Dr. Eileen Ouellette is District I Chair and is in her sixth year on the Board of Directors of the AAP. She has served on every Advisory Committee to the Board and currently chairs the committee on Education, having previously chaired the committees on Federal Affairs, Membership, and Information Technology. She was vice-president and president of the Massachusetts Chapter, Chapter Forum Committee representative, and Alternate District Chair (ADC).

Active in the Section on Neurology, she is a member of the Senior and International Child Health Sections, has served on Committees on Women in Pediatrics and Career Opportunities, the Council on Government Affairs, Council on Sections and Sections Management. In addition to her AAP activities, she has held leadership positions in the Child Neurology Society where she currently is on its Legislative Committee.

After graduating from Smith College and Harvard Medical School, she completed residencies in pediatrics and child neurology at Massachusetts General Hospital. She is a practicing pediatric neurologist at North Shore Children's Hospital in Salem, Mass. She has a law degree from Suffolk University Law School, Boston, and is a member of the Massachusetts Bar and the American Bar Association. She has extensive experience advocating for children's health issues at the state and federal level.

Dr. Ouellette has a long-term commitment to the care of developmentally disabled children. She served on the Executive Committee of the Massachusetts Developmental Disabilities Council and chaired its Human Studies Committee.

In addition to her professional activities, she is an opera buff and weaves Nantucket lightship baskets for relaxation.

ROBERT P. SCHWARTZ, M.D., F.A.A.P.
WINSTON-SALEM, N.C.

Dr. Robert Schwartz's career has combined general pediatrics and pediatric endocrinology, clinical practice and teaching, advocacy, and clinical research. His pediatric residency was at Carolinas Medical Center in Charlotte, N.C., followed by a Fellowship in Pediatric Endocrinology at Duke University Medical Center. He returned to Carolinas Medical Center and served for 18 years as assistant chair and director of a general pediatric residency program. In 1992, he moved to Wake Forest University School of Medicine, where he is currently a professor of pediatrics and chief of the Section of Pediatric Endocrinology. Dr. Schwartz was a member and vice-chair of the Pediatric Residency Review Committee. He is a primary investigator for a national office-based obesity prevention study in young children and a medical advisor for the North Carolina Task Force for Healthy Weight in Children and Youth.

Dr. Schwartz came up through the grassroots of the AAP gaining leadership experience as North Carolina chapter president (receiving the AAP Large Chapter Award during his term), member and chair of the Chapter Forum Committee, member of the Committee on Development, member and chair of the Executive Committee of the Section on Endocrinology, and a member of the Council on Sections and the National Conference and Exhibition Planning Group.

Bob has been married to Rebecca Chambers Schwartz for 38 years; they have two children, Mike and Sharon Lee, and two granddaughters, Isabella and Sophia.

Medical Home Training Program in Western Massachusetts a Success

Matthew Sadof, M.D.

On Saturday, November 8, an Every Child Deserves a Medical Home training program was hosted at the Shriner's Hospital in Springfield, Mass. This event — co-hosted by Baystate Medical Center Children's Hospital, the American Academy of Pediatrics, and Shriner's Hospital — provided a forum where the community of providers and families in Western Mass. collaborated in the spirit of improving care for children with special health care needs (CSHCN). This was the first program nationally to ever reach its target audience number of 125, with on-site registration final numbers reaching approximately 142 people, half of whom were physicians, one-third allied health professionals, and one-sixth families. Physician participation was the highest in the program's history.

Health New England and Boston Medical Center's HealthNet managed care organiza-

tions offered registration subsidies to physicians attending the program who brought a parent from his or her practice. This model proved to be an effective way to foster additional parent-physician collaboration.

Presentations were given on defining the medical-home concept, practical ways to institute the medical home for CSHCN, and regional concerns regarding the care of these children. A comprehensive resource guide for CSHCN in the western part of Massachusetts was developed and distributed in hard copy and CD-ROM format. Copies will continue to be distributed by Massachusetts Family Voices and the Mass. Dept. of Public Health. This information is posted on the Every Child Deserves a Medical Home training website and the Health New England and HealthNet provider websites.

Lead by Baystate Medical Center Children's Hospital, the planning committee has

formed the Western Massachusetts Consortium for CSHCN to continue medical-home efforts. Their first meeting was held on Dec. 11 in Holyoke, Mass. This group will work collaboratively with the Massachusetts Consortium for CSHCN, formed after the Boston 2001 training program. The goal of this group is to foster further models of medical home partnerships and enhance care delivery for CSHCN in a peer-to-peer environment. To join our initiative in Western Massachusetts, or to be added to the mailing list, please contact Gloria.Connelly@state.ma.us

For further information on medical home activities in Western Massachusetts, please contact Matthew Sadof, M.D., F.A.A.P., Department of Pediatrics, Baystate Medical Center Children's Hospital, Tufts University School of Medicine, in Springfield, Mass., at (413) 794-5083 or matthew.sadof@bhs.org.

What Do You View as the Key to Energizing and Involving the Grassroots Membership?

EILEEN M. OUELLETTE, M.D., J.D., F.A.A.P.
NEWTON CENTER, MASS.

We must address the issues of concern to pediatricians and children and convince our members that their becoming involved will make a difference. We must actively reach out to pediatricians at all stages of their professional and personal lives. Each group has different interests and needs.

Residents: In collaboration with training programs, we must enroll residents into the AAP. Chapter leaders can provide residents with child advocacy education. They can invite and support residents' attendance at chapter meetings; describe chapter initiatives; section membership opportunities in the surgical, medical subspecialty, and special interest groups at grand rounds; and assist residents to apply for CATCH grants. We can provide bulletin boards for medical students and residents to network and exchange information.

Young Physicians: We can provide new members with written information that explains the mission of the AAP and describes its committees, sections, chapters, and programs. Leaders should contact members to match their interests and expertise with local and national opportunities. We must provide leadership training to these pediatricians and make childcare available at meetings. AAP websites can provide special sections devoted to the interests and needs of young physicians.

Midcareer Physicians: Pediatricians in their middle years are struggling with all the issues affecting medicine today: access, quality, reimbursement, medical liability, medication pre-approval, and other regulations. We must continue to inform them regularly of AAP efforts on their behalf at the national, state, and community level and convince them that their participation is vital to achieve our goals. We can teach them to contact and effectively influence their elected officials.

Seasoned Physicians: These pediatricians have the experience and wisdom so vital to impart to our medical students, residents, and young physicians. We can collaborate with pediatric training programs to develop pediatric preceptorship and mentoring programs. Senior pediatricians command respect from legislators and make excellent advocates.

Finally, we must collaborate with minority medical associations to identify pediatricians of diverse backgrounds and assist chapters and sections in mentoring them into leadership positions. Involving all our membership will make our Academy stronger and more effective in advocating for children and pediatricians.

ROBERT P. SCHWARTZ, M.D., F.A.A.P.
WINSTON SALEM, N.C.

The first step in energizing the grassroots is to find out the concerns of our members.

HOW DO WE FIND OUT THE CONCERNS OF OUR MEMBERS?

★ Provide AAP support for chapters to develop a member survey to aid in the identification and prioritization of issues. This would help chapters in formulating resolutions for the Annual Chapter Forum. The survey could also include a list of committees available for members to join.

★ Encourage chapter officers to hold "town meetings" in various regions of their state to get feedback on issues from members.

★ Schedule a time at the National Conference and Exhibition for members to ask questions and voice concerns to the Board of Directors.

★ Create a place on the AAP members-only website to ask questions, with a mechanism for delivering a response in a timely manner.

HOW DO WE GET MEMBERS INVOLVED IN THE ACADEMY?

★ Focus on issues of importance to the membership, such as fair reimbursement for physician services, contracting with managed care, malpractice, etc.

★ Provide AAP support to chapters to enhance their newsletters and websites.

★ Reduce chapter dues/meeting registration fee for members in their first years of practice.

★ Reconfigure chapter committee activities, so the members can participate more easily by listserv rather than travel to meetings.

★ Provide perks to established members for bringing new members to meetings.

★ Involve residents in the AAP at an early stage of their career through the advocacy curriculum now required by the Residency Review Committee.

The key issue is the perception of the value of AAP membership. We should make it easier for young pediatricians, who increasingly are women, to have meaningful participation in the AAP. We must help them understand that we need their input, and even a limited amount of time can make a significant contribution. Personal contact from members in leadership positions will further stimulate efforts to increase grassroots involvement in the Academy.

Ballots will be sent by mail, and you may also receive instructions on how to vote online. If you happen to cast both an electronic and a paper ballot, only the electronic ballot will be considered.

Save the Date

Western Massachusetts Medical Home Three-Part Discussion Series

Thursdays, March 4, April 1, and May 6, 2004

9:00 – 11:00 a.m.

at the Baystate Medical Center Children's Hospital in Springfield

Facilitated by Matthew Sadof, M.D., Baystate Medical Center Children's Hospital,
and Lisa Jeronimo, parent of a child with special needs.

Sponsored by
University of Massachusetts Medical School Office of Continuing Education
New England SERVE
Massachusetts Department of Public Health

To register or request additional information, please contact Alexa Halberg at
(617) 574-9493 or e-mail: ahalberg@neserve.org.

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