FALL 2000

NEWSLETTER OF THE MASSACHUSETTS CHAPTER AMERICAN ACADEMY OF PEDIATRICS

PRESIDENT'S MESSAGE

The Economics of Pediatric Practice: Where Will You Be in Five Years?

What a dumb question! "Of course," you say. "I'll be practicing pediatrics." Well maybe, or maybe not. "2000 Doctors Leave Medicine" announces a headline from California, a trend-setting state. "The Doctor Is Out" graces the front page of a recent *Boston Sunday Globe*, atop an article detailing the non-medical career choices that people trained as physicians are taking. Could that be you?

There are signs that this might be closer than you think. Harvard Vanguard fired a number of pediatricians this year. Senior pediatricians are retiring and not being replaced in their groups. Some people are running their practices on their home equity line. This is just lunch table talk, but *The American Medical News* (the AMA weekly newspaper) said 27 percent of doctors borrowed money last year to stay afloat. Lahey jettisoned several of their pediatric practices purchased five years ago since they were losing money for Lahey.

Here in Massachusetts most of the reimbursement formulas have been fixed (or should I say stuck) for years. Medicaid's fees haven't gone up in ten years. Has your overhead stayed constant for ten years? Become more efficient! Cut your costs! Squeeze the "fat" out. Barney Frank once said at a local meeting that you can only cut so much fat. The rest is marbled in the meat. Cut more fat, and you cut quality and access and finally you cut the doctors, the heart and soul of medical care.

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Pneumococcal Conjugate Vaccine Now Available

Vaccine Availability Updates
Massachusetts Department of Public Health
Massachusetts Immunization Program

On February 17, 2000, the FDA approved Wyeth Lederle's pneumococcal conjugate 7-valent vaccine (PCV7) Prevnar™ to prevent invasive pneumococcal disease in infants and young children. The Massachusetts Immunization Program (MIP) is now providing this vaccine to all pediatric providers.

PCV7 Vaccine Recommendations

PCV7 is recommended for the routine immunization of all children <24 months of age at 2, 4, 6, and 12–15 months of age. Children starting the series at <6 months of age will need 4 doses. Children starting at 7–23 months of age should be "caught up," but will need fewer doses. This vaccine is also recommended for some children 24–59 months of age who are at high risk for invasive disease. For information about the schedule and other guidance about the use of PCV7, please consult the package insert. Additional information about this vaccine can also be found on the following websites: 1 **www.aap.org** (American Academy of Pediatrics); and 2 **www.pneumo.com** (Wyeth Lederle, edited by Jerome Klein, M.D.). When recommendations concerning PCV7 are available from the Advisory Committee on Immunization Practices (ACIP), the MIP will issue a more definitive advisory.

Patient Education

The Vaccine Information Statement (VIS) for the pneumococcal conjugate vaccine was recently published. You can view and print copies from the Centers for Disease Control and Prevention (CDC) website, **http://www.cdc.gov/nip/publications/VIS/default.htm.**

Packaging and Storage

Each package of Prevnar™ contains five single-dose vials of vaccine. The vaccine must be stored in a refrigerator at a temperature range of 35° F to 46° F (2° C to 8° C).

Two New Abbreviations for Pneumococcal Vaccines

In order to avoid confusion between the two pneumococcal vaccines available through the MIP, and in accordance with the specifications of the ACIP, we will be using the following abbreviations:

PCV7: pneumococcal conjugate vaccine 7-valent vaccine, for use in infants and children six weeks through 59 months of age

PPV23: pneumococcal polysaccharide vaccine 23-valent vaccine, for use in individuals >2 years of age

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Thimerosal-Free HibTiter® Vaccine Now Available

The MIP is pleased to announce the availability of thimerosal-free HibTiter® vaccine. The new formulation is supplied in a package of four single-dose vials. This formulation will replace the current 10-dose vial of HibTiter®, which does contain thimerosal. Please continue to use the 10-dose vials until your inventory of this product is depleted.

Report Invasive Pneumococcal Disease

The MIP is conducting enhanced surveillance of invasive pneumococcal disease in children <5 years of age. We urge you to report all cases in this age group to your local board of health and the MIP at (617) 983-6800.

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Technology Corner

TOYSMART BOWS TO PUBLIC PRESSURE AND A COOL MARKET

David Chung, MD

You may have heard a lot about **Toysmart.com**, a defunct Internet toy-seller here in Massachusetts. Since filing for bankruptcy, Toysmart.com attempted to sell off its assets, including personal information about their users, despite a privacy policy to the contrary. The attempted sale of the user list created a storm of controversy around the privacy rights of individuals on the Internet. Attorneys General from 39 states, including Massachusetts, filed an objection to the sale of the customer list. Additional concerns arose regarding the collection of information on children without parental permission, outlawed by the Children's Online Privacy Act of 1998.

The Federal Trade Commission (FTC) approved the sale of the material so long as the purchasing company was in a family-oriented business and agreed to keep the data private in a similar fashion to Toysmart.com's original privacy policy. Toysmart.com voluntarily removed the information collected on children from the auction items. A federal judge who heard the objections of the 39 state Attorneys General refused to overturn the FTC decision.

Fortunately for privacy advocates, Toysmart.com has most recently chosen to remove the entire customer list from the auctioning block at the time of this writing (August 1). Because of the controversy, there were no significant offers for the information. The good news is that free speech and appropriate legal actions prevented the dissemination of private information after the bankruptcy of a company based on market forces alone. The bad news is that there is nothing in the courts or regulatory agencies prohibiting similar sales in the future. As advocates for children, it is imperative that pediatricians stay tuned in to these issues surrounding children and apply appropriate pressure when necessary. Please take the time to thank our Attorney General, Tom Reilly, and Assistant Attorney General, Pamela Kogut, for their efforts: Office of the Attorney General, One Ashburton Place, Boston, MA 02108-1698, (617) 727-2200 or at **webmaster@ago.state.ma.us**. Please feel free to share your opinions with the Massachusetts pediatrics community by sending a letter to the Editor of the MCAAP Forum: David Chung, MD, Ten Wilson Road, 3rd Floor; Cambridge, MA 02138 or to **david@beansprout.net**.

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Jean Sheeley, MD

Accident Prevention & Poison Control
Paul Schreiber, MD

Adolescent & Sports Medicine
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Bylaws Committee
Carole Allen, MD

Catch Coordinator(s)
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Emily Roth, MD

Child Abuse
Robert Nelken, MD

Continuing Medical Education
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Developmental Disabilities
Richard Antonelli, MD

Emergency Pediatric Services
Pat O'Malley, MD

Environmental Hazards
Jordan Leff, MD

Fetus and Newborn
Elizabeth Brown, MD

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David Chung, MD

Foster Care
Robert Abrams, MD

Infectious Disease
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International Child Health
Lisa Albers, MD

Legislative
Richard Ringel, MD

Massachusetts Healthy Families
Howard King, MD

Membership
Ernest Wu, MD

Mental Health
Howard King, MD

MMS Delegate/ House of Representatives
Carole Allen, MD

MMS Interspecialty Committee Rep.
Eugenia Marcus, MD,
Kevin Petit, MD

Nutrition
Ronald Kleinman, MD

Pediatric Council
Walter Harrison, MD

Pediatric Practice
Open

PROS Network Coordinator
Henry Bernstein, DO

Public Relations
Michael Rich, MD

School Health
Open

Substance Abuse
Alan Woolf, MD

What is the MCAAP Doing for You?

David Chung, MD

The Massachusetts Chapter is utilizing technology to benefit its members and in its advocacy for children. For this edition of my column, I would like to describe the applications of technology currently used by the MCAAP, some challenges the Chapter has faced in that effort, and steps to be taken toward better use of technology.

Belonging to a forward-thinking organization with respect to technology has many advantages. From my personal perspective, using asynchronous communication effectively to perform chapter business has made my participation possible and active. Participation in our committees or events has never been easier, and getting involved in child-advocacy efforts, such as how to utilize the tobacco settlement fund to decrease teen smoking and pay for unplanned advances such as the pneumococcal vaccine, is just a mouse-click away.

The MCAAP currently has three active listservs for chapter business of the Executive Committee, the Finance Committee, and the Mental Health Task Force. For those of you unfamiliar with the term listserv, it refers to a single e-mail address which allows you to correspond with all of the members on the list. It is an easy way to obtain the input of various committee members without calling a formal meeting. The groundwork for issues can be discussed via e-mail, saving valuable time in face-to-face meetings.

The MCAAP has also begun utilizing an outbound e-mail service to its members to keep physicians up-to-date on issues such as pneumococcal vaccine dosing guidelines. We currently have e-mail addresses for the majority of our members, but we would like to provide this timely information to everyone. If you would like to receive these notices, please provide your e-mail address to Bonney Erskine, via e-mail at **berskine@mms.org**, or fill out the box to the right and fax this page.

Because of the ongoing collaborative relationship between MCAAP and the Massachusetts Medical Society (MMS), the MMS obtained a domain name for MCAAP several years ago and developed a website for the organization. Over time, however, the technology needs of the MCAAP became so involved that the MMS could no longer provide staff to adequately maintain the site. Thus, while the Chapter has a presence on the Web, more enhancements are needed to make the site useful and valuable for members. Given these circumstances, the Executive Committee agreed that the best course of action would be to relocate the website to another server and to use the opportunity to upgrade many of its features and interactivity. A committee on technology has been formed, chaired by Dr. Robert Gerstle, former editor of the Forum. Other committee members include Dr. Bruce Korf, Dr. Eugenia Marcus, Dr. Karen McAlmon, Dr. David Norton, Executive Director Bonney Erskine and myself.* The purpose of this committee is to evaluate technologies that might be of use to our membership. Our plan is to make the mcaap.org site a place not only to disseminate the Forum, but also a resource for Massachusetts pediatricians, for discussion, continuing medical education, and professional development. Please bear with us as we develop these new tools, but keep checking back.

** As a matter of full disclosure, I am a non-voting member of the Technology Committee and am available for consultation and analysis. I am an equity-holder in the privately held company Beansprout Networks. I would encourage anyone to send comments to the Editor,* **david@beansprout.net** *or David Chung, MD; Ten Wilson Road, 3rd Floor; Cambridge, MA 02138.*

ADD MY E-MAIL TO THE LIST

Name: ____________________

E-mail: ____________________

Fax to Bonney Erskine at (781) 893-2105

A Pediatric/Musical Evening

Bonney Erskine, CAE

On the evening of May 12, over 100 pediatricians gathered at the Sheraton Hotel in Boston to attend a special lecture and presentation by Dr. Eli Newberger, a chapter member and nationally acclaimed expert on family life and parent-child relationships. Highlighting his research for his recently published book, *The Men They Will Become*, Dr. Newberger spoke about character development in boys and men. He described the developmental processes associated with boyhood, punctuating his remarks with poignant stories about adolescence, including his own.

A truly unique aspect of Dr. Newberger's presentation was that he not only informed the group about the developmental differences between boys and girls, he also entertained them. An accomplished and noted tuba player, Dr. Newberger celebrated the differences between boys and girls by playing selected songs from his new CD, *The Men They Will Become – Jazz Takes on Male Character*. To assist him, he brought along Jimmy Mazzy, a vocalist and renowned banjo player. Within this context, their renditions of favorites like "It's a Sin to Tell a Lie," "There'll Be Some Changes Made," and "Ain't Misbehavin'" took on interesting new dimensions. The encore requested by the audience, "When the Saints Go Marching In," had everyone on their feet and clapping to the contagious rhythm.

The occasion for the program was the MCAAP's Annual Meeting 2000. The evening began with a reception, followed by dinner, and Dr. Newberger's presentation. The program coincided with the American Academy of Pediatrics' and the Pediatric Academic Society's spring program in Boston.

Massachusetts Behavioral Health Partnership (MBHP)

CHILD AND ADOLESCENT SERVICES

The Massachusetts Behavioral Health Partnership (known as "MBHP" or "the Partnership") is a managed behavioral health organization under contract with the Division of Medical Assistance. The Partnership manages mental health and substance abuse services for MassHealth members who are enrolled in the Primary Care Clinician (PCC) plan of the Division of Medical Assistance. Our goal is to ensure that anyone who qualifies gets the mental health and substance abuse services they need from the network of behavioral health providers we manage.

If you need help in making a referral to one of the Partnership's behavioral health programs for an eligible child or adolescent who is in need of mental health and/or substance abuse services, you may call the Partnership's Access Line at 1-800-495-0086. The Access Line is staffed by trained clinicians 24 hours a day, 7 days a week. You may also call the Partnership during regular office hours for information about eligibility, benefits, and claims.

A Partnership priority is to continue to improve care coordination between primary care clinicians and behavioral health providers by strengthening the linkages for referral and consultation between these systems of care. In the fall of 2000, the Partnership plans to begin an assessment of the linkages and referral patterns between these systems of care, with a focus on pediatricians and behavioral health providers. Based on the results of this assessment, we hope to develop strategies to facilitate and strengthen these linkages and referral patterns.

The Partnership's network of behavioral health programs for children and adolescents has undergone many changes during the last twelve months. What follows is an overview of some of the Partnership's recent initiatives:

TREATMENT IMPROVEMENT SERIES

Series #1: Clinical Diagnostic Assessments for Children/Adolescents in Acute Settings

- Phase 1: Clinical Diagnostic Assessment Process
- Phase 2: Stabilization, active short-term treatment
- Phase 3: Discharge and aftercare planning, transition transition-focused treatment

Series #2: Well Child Care Protocol

- Protocols established for behavioral health providers to routinely ask parents/guardians when child had last Well Child Care Visit
- If last visit not within EPSDT Medical Protocol and Periodicity schedule, provider assists family to schedule and keep an appointment
- Well Child Care Materials Order form – available through MBHP to access a training guide to Well-Child Services specific for Mental Health and Substance Abuse treatment personnel

IMPROVED TREATMENT LINKAGES

Routine Chart Reviews are conducted to measure provider performance related to linkage, and treatment and discharge planning. Recent results indicated that providers have significantly improved in these areas. More specifically:

- Aftercare Planning Completion
  7/99–12/99: 95% (Inpatient providers)
  7/99–12/99: 92.66% (Acute Residential Treatment Programs (ART))
- PCC Linkage and Outreach Completion
  7/99–12/99: 80.69% (Inpatient providers)
  7/99–12/99: 86% (ART)

ACCESS TO CARE

Access to Acute Care is measured in a variety of ways. One indicator is the amount of acute inpatient psychiatric capacity within our provider network. Many have experienced difficulty in accessing such services over the past year. Another indicator of access is within our community outpatient setting. The Partnership has been working to improve access to an array of service types within communities. The following activity is a sample of what has occurred over the past twelve months:

Acute Inpatient/Diversionary Bed Development

Date	April 1999	July 2000	Sept. 2000
Beds Available	352	533	552

Most recent new programs (examples)

Program	Beds
Vinfen Crisis Stabilization:	12 beds
Carney Hospital:	14 beds
NEMC:	12 beds
Hunt Hospital:	20 beds
Providence Hospital:	12 beds
New Bedford ART (Acute Residential Treatment):	9 beds

ACCESS TO OUTPATIENT CARE *Outpatient Initiatives (examples)*

- Child/Adolescent Capacity Analysis completed to identify areas where increased outpatient therapy services are needed
- Development of on-site psychiatry at Dept. of Youth Services (DYS) facilities
- Integration of therapy services at DYS Day Reporting Centers
- Proposed FY 2001 Initiative to improve linkages between PCCs and behavioral health care providers

For additional information regarding any of the above initiatives, or other projects currently underway, please contact Lori Button, Director of Child and Adolescent Services, at (508) 890-6400.

President's Message
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Many practices are barely keeping their heads above water. The projected trend in Massachusetts for the next ten years is that newborn numbers are going down and there will be a bulge in adolescents as all those babies born in the 1980s mature. Are you ready?

As we are busily and happily vaccinating kids against pneumococcus and influenza, has anyone thought about the impact of the patient volume next winter and the impact on the financial health of the practice? I'm glad to have the tools to keep kids healthier, but I raise the question of how are we going to keep our practices healthy.

The MCAAP is addressing these issues with advocacy. The Pediatric Council meets every other month with insurers to discuss practice issues that cut across all companies. The goal is to create uniformity of policy and administrative functions in the best interests of children and the medical offices that provide their care. With our lobbyist, Ed Brennan, the Legislative Committee monitors the legislative docket for children's issues and issues that affect practice environment. We support or oppose legislation in accordance with our policy and work with the legislators in developing new legislation. The Mental Health Taskforce has articulated the difficulties of caring for children with behavioral issues and has been advocating for improved services and adequate funding for those services. We testified on your behalf at the hearings about increasing Medicaid fees. We represented you at administrative meetings with the regulatory agencies. I would like to engage you in conversation about the economics of pediatric practice, so please give us your thoughts by sending a letter to the Editor of the Forum: David Chung, MD, Ten Wilson Road, 3rd Floor, Cambridge, MA 02138, or e-mail to **david@beansprout.net**.

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

Pneumococcal Vaccine
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This is how these vaccines will now appear on the: 1) new blue Vaccine Order Form; 2) new blue Vaccine Usage Report; 3) Certificate of Immunization; 4) Vaccine Administration Record; and 5) Lifetime Health and Vaccination Record (Blue Book).

Ordering and Accountability

PCV7 can be ordered from your vaccine distributor by completing a blue Vaccine Order Form. Please order an initial two-month supply of this vaccine, and reorder when you have a one-month supply left on hand. Since PCV7 has the same dosing schedule as Hib vaccine, you can use this as a guide to estimate your first order of pneumococcal conjugate vaccine. (If you typically order 40 doses of Hib vaccine each month, your initial two-month order of pneumococcal conjugate vaccine should be approximately 80 doses. When your inventory reaches 40 doses, you should reorder 40 doses.) Since the vaccine is distributed as single-dose vials in a 5-pack, be sure to order in 5-dose increments.

As with all other vaccines (except varicella vaccine), please document administering pneumococcal conjugate vaccine (PCV7) on the new blue Vaccine Usage Report. It is located between Hib and MMR on this report. It is imperative that we account for all vaccines in order to continue receiving the federal and state funds necessary for the universal distribution of vaccines.

The MIP is pleased to make this important childhood vaccine available to you. If you have questions, please contact your regional immunization office or the Immunization Program at (617) 983-6800 or (888) 658-2850.

WIC Program Announces New Bloodwork Schedule

The Massachusetts WIC Program is happy to announce its new, long-awaited bloodwork schedule. This new schedule takes effect June 1, 2000. One of the primary purposes of the WIC Program is to help alleviate iron-deficiency anemia. A screening test for iron levels is therefore still required for most applicants, at the times of highest risk for iron-deficiency anemia.

WIC, the Massachusetts Nutrition Program for Women, Infants, and Children, provides nutrition services to low- and moderate-income pregnant and postpartum women, infants and children under 5 years of age.

The new bloodwork schedule is a major departure from the previous federal requirements. It follows the CDC's recommended bloodwork schedule for high-risk populations, and supercedes the requirement for bloodwork within 90 days of WIC certification. The new requirements for each category are to the right:

Please note that the WIC Program may defer the receipt of the above blood test results for up to 90 days after the date of WIC certification, but ONLY for patients who present at least one nutrition risk factor at the appointment. If no nutrition risk factor can be determined, a blood test must be performed on-site by WIC, or be obtained from a clinician, before the person can be certified for WIC services. To avoid the risk of needing duplicate bloodwork, WIC strongly encourages pediatricians to provide bloodwork according to the new schedule.

Revised WIC Medical Referral Forms are now available from your local WIC Program, or from the state WIC Office at (800) 942-1007. (You may use old forms to document bloodwork values if needed.) WIC fliers with information for patients are also available in 14 languages.

WIC staff would be pleased to answer any questions about the new policy or other WIC issues. Please feel free to call your local WIC Program or state nutrition staff at (800) 942-1007.

The WIC Program appreciates your support and hopes that this new policy will simplify and strengthen collaboration between pediatricians and WIC.

WIC'S BLOODWORK SCHEDULE

- ★ **Pregnant women:** At the earliest opportunity during their current pregnancy.
- ★ **Postpartum women:** Once within the postpartum period, ideally within 6 weeks after delivery.
- ★ **Infants:** Between 9 months and 13 months.
- ★ **Children:** Between 15 and 18 months of age and thereafter every 12 months if blood values are normal and every 6 months if blood values are low.

Legislative Report

Edward Brennan, Jr., Esq.

The Massachusetts Legislature concluded its formal session for the year at midnight, July 31, 2000. A number of important issues affecting children and pediatricians were acted upon during the session.

Child Fatality Review Teams

Legislation establishing child fatality review teams in the Commonwealth passed in the closing hours of the Legislature. The Chapter has long supported this initiative, which requires that the deaths of all children under the age of 18 be reviewed by child fatality review teams. Valuable public health and safety information can be discerned from such reviews and would help the Commonwealth develop policies to decrease the incidents of preventable deaths and injuries. A pediatrician with experience in diagnosing or treating child abuse and neglect, who is appointed by the MCAAP, will be a member of the statewide review team. The bill is currently before the Governor, and is expected to be signed into law.

Pneumococcal Vaccine

The Chapter, working with other advocates, secured funding in the state budget for pneumococcal vaccine. To our dismay, the Governor vetoed half the amount of the appropriation. The Governor's action creates a distinct possibility that a shortage of vaccine may occur later in the year. The Chapter will closely monitor the amount of vaccine available and will seek a supplemental appropriation if a shortage develops.

Mental Health Parity

After years of effort, the Legislature passed a mental health parity law, which will take effect January 1, 2001. The law requires that certain biologically-based mental disorders be covered by insurance to the same extent as physical conditions. Those conditions would include schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive disorder, panic disorder, delirium and dementia, affective disorders, and any biologically-based mental disorders that are scientifically recognized and approved by the Commissioner of the Department of Mental Health.

In addition, for children under the age of 19, the law requires coverage for diagnosis and treatment of nonbiologically-based mental, behavioral or emotional disorders which substantially interfere with or limit the functioning and social interactions of a child or adolescent, provided that the diagnosis and treatment is made by the primary care physician, primary pediatrician or a licensed health professional, or is evidenced by conduct related to (1) an inability to attend school as a result of such disorder, (2) the need to hospitalize the child or adolescent as a result of such a disorder, or (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

For all other mental disorders not described in the above two paragraphs, health insurance policies must cover the diagnosis and treatment of such disorders as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association during each 12-month period for a minimum of 60 days of inpatient treatment and for a minimum of 24 outpatient visits.

Tobacco Control

Tobacco control was a priority of the Chapter during this session. The Chapter has worked with other anti-tobacco advocates to hold the Legislature to its commitment to use the state's share of the tobacco settlement – negotiated by the Attorneys General of 46 states with the tobacco industry – for smoking cessation programs and expansion of public health programs.

One of this year's disappointments was the Governor's decision to slash by veto $10 million in the state budget for the tobacco control program run by the Department of Public Health. The tobacco control program, responsible for the anti-smoking ads in the media, is viewed by anti-tobacco advocates as an effective anti-smoking tool which is largely responsible for a reduction in smoking by young people in the Commonwealth.

As part of the 1999 state budget, an advisory committee was created with a mandate to advise the Legislature as to how the monies from the tobacco settlement should be spent each year. Through its own efforts, the Massachusetts Chapter, American Academy of Pediatrics was awarded a seat on the advisory committee by the Legislature. Dr. Carole Allen was nominated by the Chapter's Executive Committee as the Chapter's representative to the committee, and she was recently appointed to the committee by Attorney General Tom Reilly, who along with the Governor has appointment authority.

Special Education Reform

The issue of special education reform was taken up as part of this year's budget debate. The Legislature changed the standard for eligibility and benefits for special education from the unique Massachusetts "maximum feasible benefit" to the federal "free and appropriate public education" standard, which is in use in the 49 other states. The Legislature increased state funding for special education and included a provision requiring that the cost of independent evaluations be shared between parents and the school. For those families with income under 400% of the poverty level, the schools will pay for the independent evaluation. The change in special education laws will go into effect in a year and will be closely monitored.

Seat Belts

Despite strong efforts by the Chapter and other advocates, efforts to pass legislation to enable police officers to stop and ticket drivers who are not wearing seat belts passed the Senate but failed to pass the House. Currently, failure to wear a seat belt is a so-called secondary offense and police can only ticket a driver for a seat belt violation if the driver is stopped for another moving violation. The only exception is if a child under 12 is not wearing a seat belt, which is a primary offense. The bill was set aside in the closing hours of the session after some opponents in the Legislature threatened to filibuster the bill. Some legislators were concerned that the primary enforcement law would place too much power in the hands of police who may selectively enforce the law.

Patient Bill of Rights

The Governor signed into law managed care reform on July 21, 2000. The law, Chapter 141 of the Acts of 2000, would provide:

★ a grievance and appeals process for certain adverse decisions of health insurers with a right of appeal to an external authority

★ all insurers must cover emergency care, whether by a network or out-of-network physician or provider, in cases which a prudent layperson would consider medical emergencies

★ children in managed care networks will have access to pediatric specialists

★ managed care organizations will be subject to greater regulatory control and the state will develop "report cards" enabling consumers to evaluate and compare health care plans

★ reasonable standards for provider compensation mechanisms are set in place to

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Legislative Report
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ensure that medically necessary care is not denied

★ health insurers would be required to pay interest on payments due to physicians within 45 days of receiving a completed claim form

★ provisions are included to ensure physicians ability to advocate on behalf of their patients for health care services and to communicate with such patients as to the way physicians are paid by the plan

★ plans would be prohibited from including in their provider contracts provisions requiring a provider to indemnify the plan for costs related to claims brought against a plan based on the plan's actions

★ plans would be prohibited from including termination without cause clauses within their contracts with providers; in addition, providers being denied participating provider status by a plan would be entitled to written explanation of such denial

★ safeguards are put in place giving the Attorney General authority to review for-profit conversions of nonprofit acute care hospitals and health maintenance organizations in order to protect charitable assets and community benefits

SAVE THE DATE • SAVE THE DATE • SAVE THE DATE • SAVE THE DATE • SAVE THE DATE • SAVE THE DATE

BICYCLE SAFETY 2000
More than Just a Helmet

Wednesday, September 27, 2000
Holiday Inn, Worcester

Sessions on education, enforcement, the economic, community and health benefits of bicycling, advocacy for bicyclists, and traffic and urban design. Case studies from across Massachusetts.

$25 registration fee includes continental breakfast, lunch, and materials.
For registration information, contact: BayState Roads Program
tel: (413) 545-3149; fax: (413) 545-9569; e-mail: spalluzz@ecs.umass.edu

Intended audience: public works officials, traffic engineers, planners, EMS and law enforcement personnel, educators, school and emergency department nurses, public health and highway safety advocates, and elected officials.

Conference funded by the Executive Office of Transportation and Construction, Massachusetts Highway Department and Governor's Highway Safety Bureau

Argeo Paul Cellucci, Governor • Jane Swift, Lieutenant Governor • Kevin J. Sullivan, Secretary, Executive Office of Transportation & Construction • Matthew J. Amorello, Commissioner, Massachusetts Highway Department • Howard K. Koh, MD, MPH, Commissioner, Public Health • Nancy J. Luther, Executive Director, Governor's Highway Safety Bureau

Early Vision Screening for Massachusetts Preschoolers

Jean E. Ramsey, MD

Vision problems are common in preschool children, with an estimated prevalence of 5% to 10%. If not detected and treated early, when there is still plasticity in the visual system, some of these problems will lead to permanent visual deficits, including blindness.

One common reason for vision problems to develop is misalignment of the eyes, i.e., strabismus. Even an imperceptible eye turn can lead to dense visual loss. If there is high refractive error, whether it is farsightedness, nearsightedness or astigmatism, the brain will not receive a clear visual image and will fail to develop fine visual acuity. If there is an asymmetry in the refractive status of the two eyes (i.e., one eye is much more farsighted than the other, or one eye is farsighted and one is nearsighted) again the brain may suppress an eye, with the development of amblyopia. Thus, amblyopia is not just an eye problem, but a brain problem. The estimated prevalence of amblyopia is 2% to 2.5% (ranging from 1% to 5%) of the general population.

The good news is that amblyopia is, in most cases, treatable if detected early. The bad news is that 80% of preschool children are not being screened for these treatable vision problems. We continue to see eight- and nine-year-olds in our offices who have dense visual loss from unrecognized amblyopia. Unfortunately, children in this age group typically respond poorly to amblyopia treatment.

A child who has risk factors known to be associated with strabismus and amblyopia should be referred for a comprehensive eye examination, which includes dilation and cycloplegic refraction. (Note: This should be done regardless of the results of a screening examination.) These risk factors include a history of prematurity, neurologic disease, family history of strabismus, amblyopia or "lazy eye." Certainly if any eye turn, squinting, or anomalous head position is being observed by the parents or primary care provider, that child should also be referred for examination.

Over the past two years a group of professionals, including pediatric ophthalmologists, optometrists, school nurses, preschool teachers, day care providers, and representatives from the Department of Public Health, has been working to develop a strategy whereby all preschool children in the Commonwealth of Massachusetts would be screened for vision problems. This is not an easy task, as preschoolers are not a centralized group. As the plan takes shape, it is clear that all of us involved in the care of our young children will need to play an active role in this project for it to be successful. We want to include your ideas in the evolution of this program and welcome your participation. Feel free to contact me: Jean E. Ramsey, MD, pediatric ophthalmologist at the Massachusetts Eye and Ear Infirmary; executive board member of the Massachusetts Society of Eye Physicians and Surgeons; Pager: (617) 523-3844 #3048; Work: (617) 573-3048; E-mail: **jeanramsey@mediaone.net**.

Upcoming Educational Events

Clinical Pearls from the Chiefs

Date: Wednesday, November 15

Location: Massachusetts Medical Society

Co-sponsor: New England Pediatric Society

Time: 10:00am to 5:30pm

Description:
Chiefs of Pediatrics from area academic institutions will speak about clinical pearls in pediatric practice. More details to follow.

Continuing Medical Education Credits: 6.5 hours

Cost: $75

Registration Information:
Contact Bonney Erskine at berskine@mms.org.

Reach Out and Read

Description:
This session will teach you how to apply for grants to provide books to children during well-child visits. Pointers will be given on how to start a successful Reach Out and Read program in your office. The session will be held on October 19 at MMS headquarters in Waltham. Keep an eye out for more information.

Too Young for ADHD?

Date: Thursday, November 16

Location: Children's Museum, Boston

Co-sponsor: WellChild Foundation

Time: 8:00am to 4:00pm

Description:
Each year WellChild brings together policy makers, parents, early childhood educators and clinicians to discuss, debate and document an issue that is critical to early childhood emotional health and development. WellChild supports parents and families, educates pediatric health care professionals and raises awareness among those who are in a position to influence the lives of children. BlueCross BlueShield of Massachusetts, the state's largest health insurer, is WellChild's underwriting sponsor.

Continuing Medical Education Credits: Educational credit availability and amount pending.

Cost: Free to attend. CME, if available, will be at a rate to be determined.

Registration Information: Call 617-83-CHILD for more information.

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The Forum

– Volume 1 No. 3 –

Published by the Massachusetts Chapter of the American Academy of Pediatrics, designed and printed by the Massachusetts Medical Society.

Editor: David Chung, MD

Designer: Lisa Salvo

Copy Editor: Jennifer Gonzalez

Massachusetts Chapter American
Academy of Pediatrics
P.O. Box 549132
Waltham, MA 02454-9132

First Class
U.S. Postage
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Boston, MA
Permit #59673