

ADVISER'S VIEWPOINT

Reach Out and Read: Best Rx for School Readiness

America's public education system is in crisis. Despite investing hundreds of billions of dollars each year in our schools, third grade reading scores and high school dropout rates have not improved.

A growing group of pediatricians believe they may have the answer – and it all begins at the 6-month well-child visit.

They are the front lines of Reach Out and Read, a national organization that prepares America's youngest children to succeed in school by partnering with doctors to prescribe books and encourage families to read together.

Children in the Reach Out and Read program receive a brand-new, age-appropriate book at every regular check-up from 6 months old until they're ready to enter kindergarten. Pediatricians also speak with parents at every visit about the importance of reading aloud and give them developmental guidance and tips for how to incorporate reading into their daily routine.

Reach Out and Read works. Fourteen peer-reviewed, published studies demonstrate the efficacy of the program. Parents served by Reach Out and Read are four

times more likely to read to their young children (Am. J. Dis. Child. 1991;145:881-4), and their children enter kindergarten with larger vocabularies, stronger language skills, and a 6-month developmental edge (Pediatrics 2001;107:130-4).

Both the American Academy of Pediatrics (AAP) and the National Association of Pediatric Nurse Practitioners (NAPNAP) have officially endorsed the Reach Out and Read model of early literacy promotion, which is included in the official Bright Futures guidelines.

Today, 27,000 pediatricians, family physicians, and nurse practitioners are participating in Reach Out and Read. If our

ultimate goal is to ensure that all children are prepared to achieve their enormous potential, then Reach Out and Read must become the standard of care for every pediatric provider nationwide. That's because pediatricians have unrivaled access to children aged 5 years and under (96% of children in this age group see their doctor at least once annually).

The lack of exposure to books and reading has created a widespread school readiness gap. More than one-third (or 34%) of American children enter kinder-

garten without the basic language skills they will need to learn to read (Carnegie Foundation for the Advancement of Teaching, 1991).

Millions of those children will never catch up. In fact, 88% of first graders who are below grade level in reading will continue to read below grade level in fourth grade. (J. Educ. Psychol. 1988;80:437-47). And, according to the national 2010 Annie E. Casey KIDS COUNT Report and the National Assessment of Educational Progress (NAEP), 68% of American fourth graders, including a majority from every state, cannot read proficiently.

As the years go on, children with reading difficulties are at a higher risk for school failure, dropping out, juvenile delinquency, substance abuse, and teenage pregnancy.

Since its founding at Boston City Hospital (now Boston Medical Center) in 1989, Reach Out and Read has expanded to more than 4,600 hospitals, health centers, and clinics nationwide. Together, those programs serve 3.9 million children, including 33% of American children growing up in poverty.

I became a Reach Out and Read provider in 1998 and have since seen firsthand the joy that books bring to children. With Reach Out and Read, the book becomes an integral part of the

developmental assessment at every well-child visit from 6 months to 5 years of age. Our residents also have embraced the concept of using a book both to assess development and to promote literacy to the families they serve.

At our clinical site in New Hampshire, we serve a large refugee population. I can remember one little boy from an African country who was reduced to tears when he inadvertently lost his book on his way to get an x-ray, and the smile on his face when we happily replaced the book for him.

As a result of the books, children learn to love school – and learning. They become lifelong readers. They're better prepared to achieve their potential.

And it all starts with the turn of a page.

Medical providers interested in participating in Reach Out and Read can visit www.reachoutandread.org/providers. Active Reach Out and Read providers also are eligible to participate in the program's new Quality Improvement Project, which has been approved by the American Board of Pediatrics for 25 Category IV Maintenance of Certification points. ■

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LETTERS

More About HPV Counseling

I appreciated the article "How to Meet the HPV Counseling and Vaccination Challenge" (January 2011, p.1). The article should have discussed moral implications of sexual activity in more depth, as well as challenges to vaccinating male patients.

The majority of my HPV vaccine refusals are related to parents' naiveté, which is similar to what was stated in the article: "Both parents and pediatricians underestimate the likelihood that their child or patient is sexually active or about to become sexually active." Most of my refusals come on the heels of a statement similar to: "My daughter/son won't need it," or "She won't have sex before she's married because we'll teach her to abstain," or "My daughter's a 'good' girl." We also should be careful with our male patients to not encourage a "boys will be boys" mentality. No double standards here, thank you.

In many of my discussions with parents, I listen and reaffirm them, then take the discussion further. I mention to the parents that yes, indeed, they are right to advise their daughters/sons to abstain from sex for as long as possible, whatever their justification. I tell them about how we know that young women who initiate sexual activity at later ages have lower rates of HPV. I then remind them that many people contract HPV at their first sexual contact, that there may not necessarily be any outward signs of infection, and that even if their daughter is a "good girl" and decides

to abstain until marriage, her future partner may have made a different choice.

I often remind parents that adolescents – at least in my practice and training experience – are not always honest about their sexual histories. I never imply that their daughter/son may be dishonest. One issue that I feel I am obligated to mention to parents – and I try to discuss it without the child/adolescent in the room – is that many young women are not able to decide on their own when and where they become sexually active. I know young men are sexually abused and assaulted as well. Right or wrong, it is important to remind parents that they can protect their children for only a limited period of time.

But I also feel that we must be continually aware of the risks that our young people experience, voluntarily or not, once they step outside the "bubble."

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Worried About Iron Supplementation

Thank you for the article about Dr. Richard Schanler's challenge to the iron supplementation guideline promoted by the American Academy of Pediatrics' Committee on Nutrition ("Experts Challenge AAP Iron Supplement Policy," December 2010, p.1). Although many studies have shown that iron deficiency is detrimental to the health of infants and children, how best to prevent the deleterious effects of iron deficiency is not as well established.

Is the problem best prevented by iron-containing drops, infant formula (supplemented with 12 mg/L ferrous sulfate in the United States), iron-rich foods at the appropriate time, or some other strategy? What is the optimal time to introduce these strategies? How much is best, and is too much bad? These questions have not been well answered.

At the Pediatric Academic Societies meeting in 2008, Dr. Betsy Lozoff and her colleagues presented data that should make us consider the AAP committee recommendation with caution. Her group studied 494 well-nourished Chilean infants, and gave half of them regular iron formula (12 mg/L ferrous sulfate) and the other half low-iron formula (2.3 mg/L ferrous sulfate). The children had hemoglobin studies done on every visit until they were 10 years of age. Neurodevelopmental studies were done at that time.

The results were surprising. Those infants who had the highest hemoglobin levels at 6 months of age and were fed the higher-iron formula had the worst neurodevelopmental scores at 10 years, whereas those with the lowest hemoglobin levels at 6 months of age greatly benefited from the higher-iron formula supplementation. Those with higher initial hemoglobin levels who received the higher-iron formula had IQ scores that were 11 points less than those of the other groups, and they did statistically worse or trended strongly in that direction in every development area tested.

The lesson is, if we begin supplementing all breastfed infants with 1 mg/kg

iron starting at 4 months of age, are we harming some while helping others? Are there enough long-term neurodevelopmental data (not iron studies) that show this is the best way to help our children? Even more disconcerting is the AAP policy on publishing guidelines and policy statements. Although these are vetted by associated sections, there is no assurance that concerns and disagreements from these sections change the official publication. The result is that the pediatric public is frequently short-changed, and not getting the full story on these important issues. Publishing responses in another edition of Pediatrics gives less credibility and far less legal power to disagreements and is not fair. The Committee on Nutrition report on iron supplementation is a perfect example. If the Section on Breastfeeding were to have had the opportunity to publish its challenge simultaneously, the pediatric public would read both sides of the story and be much better informed and educated. These guidelines and technical reports should be about education!

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Correction

In the article entitled "Antibiotics for Acute Otitis Media Get a Boost" (December 2010, p. 10), Dr. Alejandro Hoberman's affiliation should have read chief of pediatrics at Children's Hospital of Pittsburgh.