



**PRESIDENT'S MESSAGE**

## Working for Our Children

The MCAAP Committee on Legislation (capably led by Karen McAlmon and Brenda Anders Pring, and expertly supported by legal counsel, Ed Brennan) tracks legislation relevant to children's health care, provides testimony on bills, and updates the Executive Board on the state budget process and the specific ways it may impact children's health. The committee works in collaboration with AAP committees and other organizations invested in the well-being of children.

The goals of the committee are to consider relevant issues affected by local, state, and national legislative action; to research and discuss such issues as they are brought to the attention of the Committee by its members, Chapter members, and others; and to recommend appropriate actions to the Executive Committee after study and discussion. Ed plays an enormous role, assisting the Chapter as it navigates the legislative process and tracks legislation that affects children and families. To access the 2016 MCAAP Legislative report, please visit this site: <http://mcaap.org/wp2013/wp-content/uploads/2016/06/MCAAP-Report-of-Counsel-2016-Annual-Meeting.pdf>

Recently, the MCAAP has played a major role in the national legislative arena. Last fall, led by the Campaign for Tobacco-Free Kids legal staff, the Chapter and three of its members — Ted Kremer, Jon Winikoff, and Lynda Young — joined the AAP and six other medical and public health groups in a federal lawsuit against the Food and Drug Administration to force officials to follow through on a

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## Update on Newborn Hearing Screening and Follow-Up Recommendations from the Early Hearing Detection and Intervention (EHDI) Program



For the past 20 years, Massachusetts has helped lead the way in newborn hearing screening. In 2014, 99.5% of the 72,479 infants born were screened. Of the 1,313 infants who did not pass the newborn screen, 177 (13.5%) were identified to have hearing loss with a hearing loss rate of 2.46/1000 infants screened. When we look at the next critical next step after diagnosis — referral to early intervention, or EI (allowing infants and families to benefit

from services that will optimally develop their communication development), we still have some work to do. Eighty-four percent of the infants diagnosed with hearing loss were enrolled in early intervention programs eventually but only 60% were enrolled by the age of 6 months. This is better than the national rates of 65% overall enrollment and only 44%

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## EDITOR'S NOTE

## Food, Glorious Food!

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Photo by Lisa Dobberteen

I've been thinking a lot about food lately, not just in terms of what I'm cooking and eating myself (and I love to cook), but about how many of my families face food insecurity on a daily basis. I've also been thinking about how much talking about food I do during well-child visits. I talk to families about vegetables and fruit, and how much, if any, of these they eat every day. The good news is that children are eating more fresh fruit and vegetables, and drinking less juice ([www.pbhfoundation.org](http://www.pbhfoundation.org)), but we still have a long way to go to meet the goal of *five a day*, five servings of fruit and vegetables daily.

Over the years, I continue to learn lots of families just don't cook. Maybe a grandma from the home country cooks a wonderful big pot of something culturally appropriate, often packed with nutrition, but the kids won't eat it. Busy parents short on time, ideas, and basic cooking skills end up driving through fast-food windows or relying on microwavable snacks to please everyone.

A valued colleague, Dr. Amy Smith, is spending her tenure as a Kraft Fellow ([www.kraftcommunityhealth.org](http://www.kraftcommunityhealth.org)) thinking about food insecurity, surveying families and linking those in need of food support to Project Bread. She is using a two-question screen that is highly validated: [www.pediatrics.org/cgi/content/full/126/1/e26](http://www.pediatrics.org/cgi/content/full/126/1/e26). It's a wonderfully simple intervention that can change the food landscape for families. As with most things, once we ask, we open the door to families in need that we might not have realized need help. Approximately 20% or more of families seen in pediatric outpatient settings at the Cambridge Health Alliance admit to food insecurity issues.

I recently had the opportunity to attend a wonderful conference that provided lots more food for thought — literally. *Healthy Kitchens, Healthy Lives* ([www.healthykitchen.org](http://www.healthykitchen.org)) brings together health care providers, chefs, and people from the food industry to consider all factors involved in healthy eating and

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## Working for Our Children

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requirement to incorporate graphic warnings on cigarette packs. In the United States, cigarette packs have had text warnings since the 1960s but because they have not been updated for 30 years, they often go unnoticed. Graphic warnings are required in more than 90 countries, and have been shown to prevent people from starting to smoke and encourage others to quit.

The 2009 Family Smoking Prevention and Tobacco Control Act included a provision that required graphic warnings on the front and back of cigarette packs and 20 percent of cigarette advertising. Three years later, after the FDA had released proposed images, in response to a tobacco company challenge, the U.S.

Court of Appeals struck down those specific images; however, it left intact the FDA's legal obligation to implement some type of graphic warnings. Our legal action was undertaken when it did not appear that the FDA intended to follow through with implementation.

The court filing resulted in a series of meetings, and after several months of negotiation, the government agreed to legally bind itself to a proposal by 2019 and a final rule by January 2021. Although the plaintiffs insisted that this time period was longer than necessary, a settlement was felt to be reasonable, given the prospect of ongoing litigation that might push implementation back even further. Unfortunately, at the eleventh hour, despite the recommendations of the Department of Justice and the Food and

Drug Administration representatives, high-level officials failed to sign off on the agreement. We'll keep you updated as the case continues to unfold.

We encourage members to weigh in on legislative issues of importance that affect children and families. Recent MCAAP Legislative Committee agenda items included recreational marijuana regulations, ACA repeal, Reach Out and Read funding, epinephrine auto-injector regulations in schools, and acceptable lead levels in children.

If you are interested in joining the MCAAP Legislative Committee, please contact Cathleen Haggerty at [chaggerty@mcaap.org](mailto:chaggerty@mcaap.org).

— *DeWayne Pursley, MD, MPH, FAAP*

## Food, Glorious Food!

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food security. We should all be thinking of ways to get our patients and their families into teaching kitchens for some hands-on cooking and eating activities. During the conference we heard about strategies to partner with local farmers, faith-based organizations, hospital and other commercial cafeterias, cooking schools, and more to translate these ideas into action.

With the recent changes in Washington, some of the very programs our families rely on such as WIC, SNAP, and NSLP may be in jeopardy. We need to continue to advocate for protection for these programs as well as support local organizations such as Project Bread, the Greater Boston Food Bank, and the Food Bank of Western Massachusetts. In 2016, hunger for children and adults is sadly still a public health issue.

I will write more on all these issues as we move ahead. For now, get ready to plant your garden and think about dinner. As my father always said, "You'll never go broke, eating at home!"

— *Lisa Dobbertein, MD, FAAP*

## Social Emotional Learning: What It Is and How to Foster Parents' Understanding of Its Importance

The importance of social and emotional issues in children's development is well known to pediatricians, who already address social and emotional learning (SEL)\* issues with parents. What I hope to provide here is a perspective on how difficult these issues may be for parents and how you can help parents address them.

Pediatrics focuses on the health of the whole child, and pediatricians focus on both emotional and physical well-being during well-child visits. It can be a challenge in the midst of a busy office to figure out the subtext of hidden concerns. Yet in my experience as a parent with three sons, and now in my volunteer work as a parenting educator, I have seen that emotional well-being is key. Both eliciting and addressing these hidden concerns of families is critical.

In "Partnering with Parents," Michael Yogman and Andrew Garner emphasize that pediatricians are best suited to support parents in promoting their child's emerging social, emotional, and language skills, all of which contribute to the foundation of resilience. Peer support and professionally led parenting programs can

complement your guidance, as can professional counseling if needed. But parents can be difficult customers, resistant to well-intentioned advice even while desperately needing it! Two internal barriers stand in the way of our accessing parenting support.

The first is our natural — but in this realm regrettable — competitiveness. We want our children to do well in school and in life, for their own sakes, of course, but also for our sake, so we can tell other people about all the wonderful things our kids are doing. When there are problems, parents may confide only in their closest friends or just post anonymous queries online. One hopes with a trusting and supportive relationship with their pediatrician, they will share their worries about their children's struggles and issues.

The second is the association of parenting programs with child abuse prevention. In some cases, this has created a stigma that discourages participation in programs by those who may benefit from them the most.

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## Update on Newborn Hearing Screening and Follow-Up Recommendations from the Early Hearing Detection and Intervention (EHDI) Program

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enrollment by 6 months but still clearly an area that needs to be improved.

### Frequently Asked Questions Regarding Early Intervention Referrals

#### **Who refers infants diagnosed with hearing loss to EI?**

The audiologist is usually the one who refers infants to their local early intervention program, but referrals can come from parents, pediatricians, nurses, or other care providers.

#### **How severe does the hearing loss need to be for an infant to be eligible for EI?**

Infants who have been diagnosed with a permanent hearing loss of any degree (that includes mild and unilateral or bilateral) are eligible for early intervention services in Massachusetts at no cost to the family.

#### **Do all EI programs provide the needed services for a child who has been diagnosed with hearing loss?**

Individual programs may not have providers who are specially trained in this field. It is important to know that services are available from Specialty Service Providers who have special skills and knowledge around hearing loss and are trained to work with families of children with hearing loss. Families exploring communication options can request services from more than one Specialty Service Provider ([www.mass.gov/eohhs/docs/dph/com-health/prego-newborn/hear-screen-specialty-services.pdf](http://www.mass.gov/eohhs/docs/dph/com-health/prego-newborn/hear-screen-specialty-services.pdf)). There are 9–10 specialty centers in Massachusetts.

#### **Are there any free resources for learning sign language?**

Yes!

1. In Massachusetts, the Family Sign Language Program provides free in-person sign language instruction for the family. Their website is <http://bit.ly/2mFwvoa>.
2. There is also a collaborative new project with the National Center for Hearing

Assessment and Management (NCHAM) ([www.facebook.com/NCHAM.USU](http://www.facebook.com/NCHAM.USU)) and Signingtime online. Sign It! is an online curriculum for learning American Sign Language free to families of children ages birth to 36 months (<https://infanthearing.org/signit>).

The initiation of language stimulation right away is very important in the long-term development of language and communication. For eligible infants, this means fitting hearing aids promptly. Likewise, visual communication via sign language can provide a rich mode of communication for infants during their early months of life and during a period of time for children with profound deafness when they cannot receive auditory input even with assistive technology.

#### **What family resources are available for my patient? There are excellent resources for your patient's parents and other care providers.**

When a baby is identified to have a diagnosis of deafness or hearing loss of any degree they will receive a call from a parent outreach specialist at the Massachusetts Department of Public Health,



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**Update on Newborn Hearing Screening and Follow-Up Recommendations from the Early Hearing Detection and Intervention (EHDI) Program**

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Universal Newborn Hearing Screening Program, to discuss the diagnosis and the intervention services that should be initiated. The outreach specialist helps identify and organize the important next steps. Parents consistently report that talking with another parent of a child with hearing loss helps tremendously in those first weeks after diagnosis.

Contacts and resources in Massachusetts include:

Massachusetts Universal Newborn Hearing Screening Program  
(800) 882-1435  
Family Outreach Specialist —  
Richard Wentworth

Mass Commission for the Deaf and Hard of Hearing  
www.mass.gov/eohhs/gov/departments/mcdhh

Family Ties  
www.massfamilyties.org  
Hand and Voices  
www.handsandvoices.org  
The Decibels Foundation  
www.decibelsfoundation.org  
Phone (978) 637-2622  
Contact b.dressel@decibelsfoundation.org

**Late Onset Hearing Loss**

Did you know that approximately 2–3 per 1,000 children who pass their newborn hearing screening will develop late onset hearing loss? This number is equal to the amount of children identified with hearing loss through the Universal Newborn Hearing Screening process. To help ensure children at higher risk for developing late onset hearing loss are identified and followed properly, the Massachusetts Universal Newborn Hearing Screening program revised their risk factor follow-up protocols for birth hospitals several years ago.

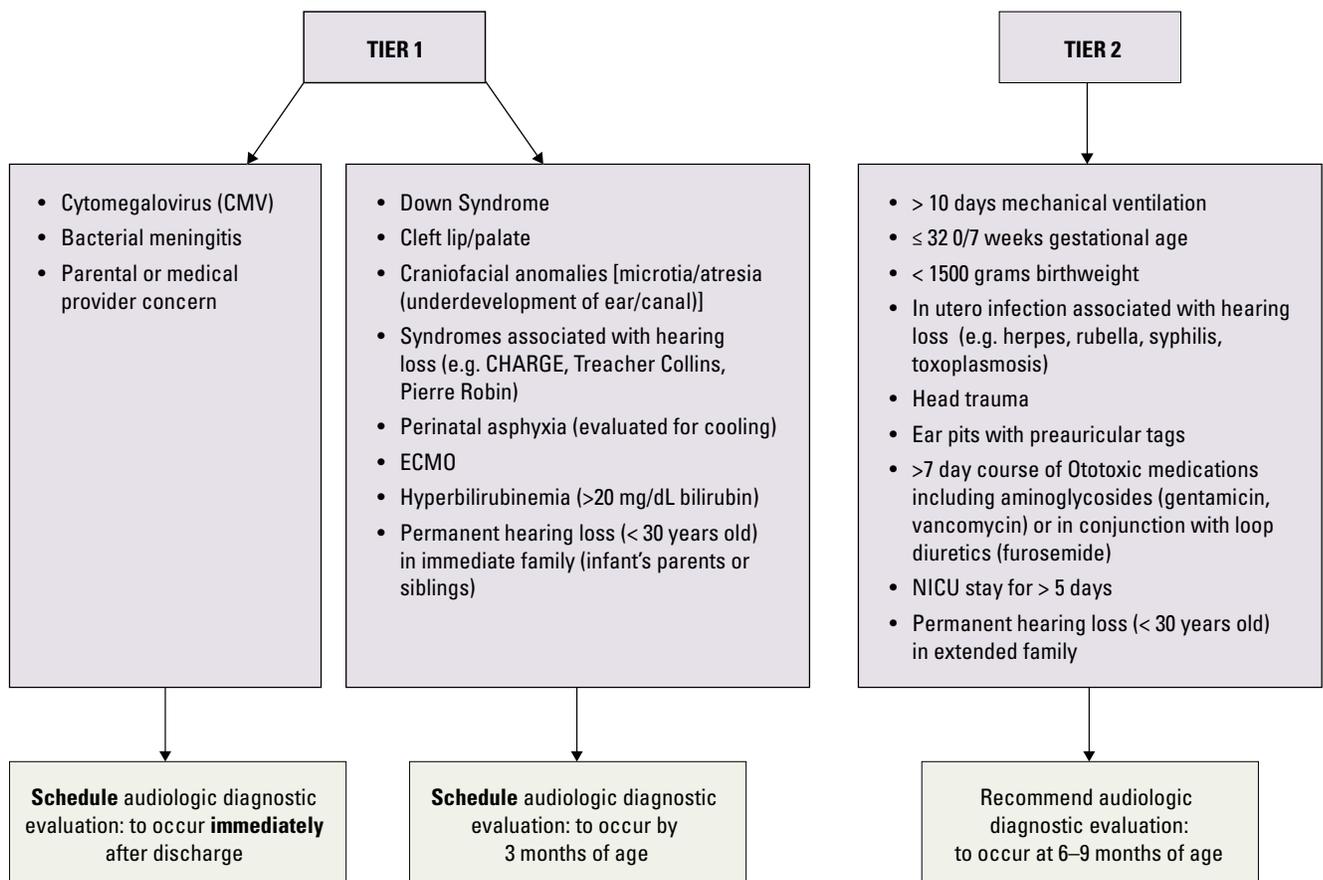
The revised risk factor algorithm (seen below) allows the birth hospital to initiate the follow-up process. The risk factors are divided into two tiers, with each tier defining the action and time frame for

testing. Infants identified with a Tier 1 risk factor (e.g., Trisomy 21, Hyperbilirubinemia) are required to have an audiologic diagnostic appointment *scheduled* prior to discharge from hospital to home. Infants identified with a Tier 2 risk factor are discharged with the recommendation for a diagnostic appointment to be scheduled by the family or pediatrician in 6–9 months (for preterm infant this should be at 6–9 months corrected age).

If you have any questions about your patients with newly diagnosed hearing loss, please feel free to contact either of the following:

1. The Massachusetts Universal Newborn Hearing Screening Program at [www.facebook.com/MassNewbornHearingScreening](http://www.facebook.com/MassNewbornHearingScreening) or (800) 882-1435
2. Jane Stewart, MD, Massachusetts Chapter representative for the AAP Early Hearing Detection and Intervention (EHDI) Program at (617) 667-3277

— *Jane Stewart, MD,*  
[jstewart@bidmc.harvard.edu](mailto:jstewart@bidmc.harvard.edu)



# ShotClock

## Call to Action: Reporting Data to the Massachusetts Immunization Information System

### We Fought For It; We Got It; Let's Use It!

The Massachusetts Immunization Information System (MIIS) is an essential component for ensuring optimal health of Massachusetts' children. Pediatricians and the MCAAP advocated for a statewide registry for over two decades. We are fortunate now to have one of the best registries in the United States! The MIIS is one of the most powerful ways for all of us to insure that our pediatric patients are up-to-date on their vaccines.

The MIIS now houses almost 6 million patient records and over 40 million vaccine records, due to reporting by over 2000 provider sites. However, of the 2000 sites that are reporting, only about 500 are Vaccines for Children program sites. It's great news that nearly half of all pediatrics practices in the Commonwealth are sending patient-level immunization data to the MIIS; however, a nearly equal number still need to get connected! Submitting data on administered immunizations is required by state law (more information below) and more importantly, complete immunization histories in the registry will ensure that clinicians, schools, and the Massachusetts Department of Public Health (MDPH) have the data they need to protect the patients they serve. Your participation in the MIIS is critical for its success!

In June 2010, legislation (<https://malegislature.gov/laws/generallaws/parti/titlxvi/chapter111/section24m>) was passed charging the MDPH to establish a statewide lifespan immunization registry and outlined requirements for reporting. One year later, in February 2011, the MDPH launched the MIIS. Then regulations governing the MIIS, 105 CMR 222.000, were promulgated by the Massachusetts Public Health Council and were effective as of January 2, 2015. The complete regulatory language can be found at [www.mass.gov/courts/docs/lawlib/104-105cmr/105cmr222.pdf](http://www.mass.gov/courts/docs/lawlib/104-105cmr/105cmr222.pdf). These regulations also included a timeline for compliance, which may be accessed at [www.mass.gov/eohhs/docs/dph/](http://www.mass.gov/eohhs/docs/dph/)

[cdc/advisories/miis-compliance-schedule.pdf](http://cdc/advisories/miis-compliance-schedule.pdf). According to the Compliance Schedule, all Massachusetts' immunizing providers were to report data by June 1, 2016.

**The primary benefits of the MIIS are the following:**

- **Shared immunization records.** Records are available across multiple sites and locations to help identify under-immunized children and pockets of unmet need.
- **Better decision making.** Practices, schools, and electronic health record (EHR) systems are able to increase on-time delivery and reduce inappropriate immunization using advanced immunization forecasting decision support. As of January 2017, the MIIS is also able to share immunization histories and forecast recommendations with EHRs via bidirectional data exchange.
- **Reduced waste and increased efficiency.** Vaccine administration is monitored and assessed on an ongoing basis to optimize distribution and use.
- **Improved disaster preparedness** by providing an essential infrastructure for responding to natural disasters, bioterrorism events, influenza pandemics and other emergencies.
- **Decreased paperwork** for practices by making immunization records available on line to school nurses.

Full participation by pediatric practices statewide is critical to the success of the MIIS! If your practice is not yet reporting data, the following are ways you can assist with a smooth roll-out in your practice:

- Ensure your staff is working closely and in sync with your EHR vendor staff during the entire MIIS onboarding process. Both the clinical and IT side must be responsive to ensure a smooth and efficient process.
- Establish a clinical champion at your practice who is willing and able to champion the project throughout the entire onboarding process. The clinical champion is often the sole correspondent between the MIIS team and the rest of the clinical staff at the practice. It is essential that the clinical champion effectively communicates all the practice's legal responsibilities to inform its patients regarding the MIIS.

- During the onboarding process you will need to register your practice, develop workflows, and complete staff trainings. The final step is the data quality review (looking up and confirming accuracy of 10 patient records). It is important to complete this data quality review in a timely manner to ensure the practice can complete the MIIS onboarding process in accordance with state law and free up MIIS resources to onboard more practices.

We need all pediatric and family medicine practices in Massachusetts to establish their connections to the MIIS! It will simplify your vaccine ordering, your practice record-keeping, and your access to information on children transferring in and out of your practice. MIIS staff members are on hand to answer any questions that you have about onboarding to the MIIS. They can be reached at [MIIShelpdesk@state.ma.us](mailto:MIIShelpdesk@state.ma.us) or (617) 983-4335.

Please contact Cynthia McReynolds at [cmcreynolds@mms.org](mailto:cmcreynolds@mms.org) or (781) 895-9850 if you have any questions or suggestions for how the MCAAP can assist you.

Thank you for your efforts in ensuring the health of Massachusetts' children!  
— **MCAAP Immunization Program**



## National Infant Immunization Week is April 22–29, 2017



National Infant Immunization Week (NIIW) is an annual observance to highlight the importance of protecting infants from vaccine-preventable diseases and to celebrate the achievements of immunization programs and their partners in promoting healthy communities.

When the NIIW observance was established in 1994, immunization programs were facing significant challenges. The nation was in the midst of a serious measles outbreak and communities across the United States were seeing decreasing immunization rates among children. NIIW provided an opportunity to draw attention to these issues and to focus on solutions. Communities have continued to use the week each year to raise awareness about the importance of ensuring all children are fully protected from vaccine preventable diseases through immunization. Today, many immunization programs, partners, and communities can celebrate high infant immunization rates.

During NIIW, communities across the 50 U.S. states, 8 U.S. territories, and the District of Columbia celebrate the CDC Childhood Immunization Champions. The CDC Childhood Immunization Champion Award is an annual award given jointly by the CDC Foundation and CDC to recognize individuals who make a significant contribution toward improving public health through their work in childhood immunization. Young children rely on the champions in their lives to keep them safe and healthy. Be on the lookout for an announcement about this year's Massachusetts CDC Childhood Immunization Champion Awardee!

The CDC has a number of resources that you can use during NIIW to promote vaccination in your practice. Among these resources are print ads and posters, web banners and buttons, public service announcements that you can post on your website, articles for your newsletter, and even coloring sheets that you can print for your patients. To access these materials, visit [www.cdc.gov/vaccines/events/niiw/promotional.html](http://www.cdc.gov/vaccines/events/niiw/promotional.html).

Health care professionals remain parents' most trusted source of information about vaccines for their children by playing a critical role in supporting parents in understanding and choosing vaccinations. Thanks for all that you do to keep Massachusetts' children healthy! — *MCAAP Immunization Program*

## MDPH Announces 2017 Immunization Updates

Each spring, the Massachusetts Department of Public Health Immunization Program hosts regional immunization updates as well as webinars for health care professionals to receive updated information on immunization-related topics. The program includes updates to the childhood and adult immunization schedules, current trends in the epidemiology of vaccine preventable diseases in Massachusetts and recommendations for control, resources for addressing vaccine confidence, guidance in the proper storage and handling of vaccines, and an overview of the key functionality and legal responsibilities for reporting immunizations to the MIIS. For more information and where to register, please visit the MDPH Immunization Program Website at [www.mass.gov/dph/imm](http://www.mass.gov/dph/imm) and click Events. See schedule below.

Several Immunization Update webinars also are planned. For more information and how to register, please visit the MDPH Immunization Program Website at [www.mass.gov/dph/imm](http://www.mass.gov/dph/imm) and click Events.

Please contact Rebecca Vanucci, Immunization Outreach Coordinator, MDPH Immunization Program, at [Rebecca.vanucci@state.ma.us](mailto:Rebecca.vanucci@state.ma.us); (617) 983-6534 if you have any questions or need additional information.

— *MCAAP Immunization Program*

### Immunization Updates In-Person Meeting Schedule

Date	Location	Room
Monday, May 8	UMASS Medical School Worcester, MA	Albert Sherman Center; ASC Auditorium
Friday, May 12	The Conference Center at Massasoit Brockton, MA	Conference rooms
Tuesday, May 16	MDPH Hinton State Laboratory Institute Jamaica Plain, MA	Auditorium
Thursday, May 18	Cape Cod Community College Hyannis, MA	Science Building, Lecture Hall
Wednesday, May 24	Holyoke Community College Holyoke, MA	Kittredge Center, People Bank Conference room
Tuesday, May 30	Northern Essex Community College Haverhill, MA	Building TC Technology Center 103 AB
Friday, June 2	BMC Hillcrest Hospital Pittsfield, MA	Conference room

# From the MDPH Immunization Program

## Bidirectional Data Exchange Now Available for the MIIS

On January 23, 2017, a new version of the Massachusetts Immunization Information System was released. The major functionality associated with this release includes an inventory deduction tool, data quality dashboard, and HL7 query and response (otherwise known as bidirectional data exchange). Bidirectional data exchange enables providers that use electronic health records not only to submit data from their EHR to the MIIS, but also to query the database and receive a response. EHR systems may receive an evaluated immunization history with a forecast or just an immunization history for a patient, depending on the system's capability. These messages are sent through the standard HL7 messaging format and interface connection.

Provider sites that are interested in bidirectional data exchange with the MIIS, and are currently sending immunization

administration data by HL7 should check with their EHR vendor to see if their system has the capability to also query and display messages from the MIIS. If your EHR is capable, please contact the MIIS Helpdesk to get started.

For a more comprehensive description of the recent changes to the MIIS, please visit the ContactMIIS Resource Center at [www.contactmiis.info](http://www.contactmiis.info). Select the Training tab, go to Guides and Resources, and click on the "view" link next to MIIS Release Notes v4.5. To contact the MIIS Team, call (617) 983-4335 or email us at [miishelpdesk@state.ma.us](mailto:miishelpdesk@state.ma.us) with any questions.

## AFIX HPV Grant

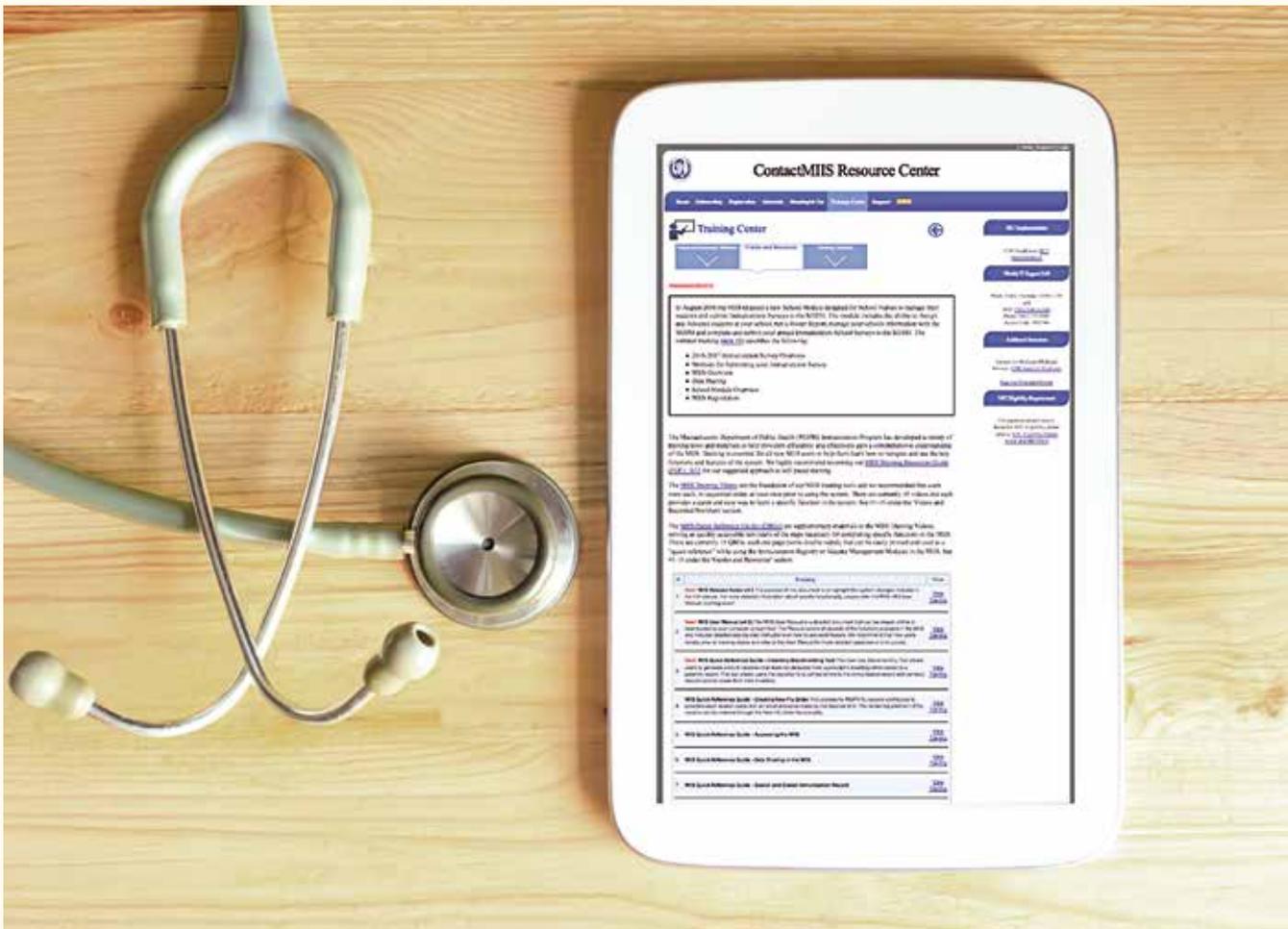
The MDPH Immunization Program received a two-year CDC grant to work on a project entitled "Increasing HPV Vaccine Coverage by Strengthening Adolescent AFIX Activities." AFIX (or Assessment, Feedback, Incentives and eXchange) is a continuous quality improvement process focused on implementing practices to increase immunization

coverage levels and decreased missed vaccination opportunities at the provider level.

Since 1993, the MDPH has been conducting AFIX-quality reviews. The MDPH has been using the MIIS since 2014 to provide immunization coverage rates to individual practices for their 2-year-old and 13-18-year-old patients. During an AFIX Quality Review, staff members from the MDPH work with each practice to formulate a quality improvement plan to increase coverage levels at their site by improving immunization practices and services. The new grant will enhance AFIX activities in several ways, such as using local physician experts to provide physician-to-physician education to increase provider-level participation and impact from AFIX.

The MDPH encourages providers to participate in AFIX and learn valuable ways to increase their HPV vaccination rates. For more information on AFIX, please contact the MDPH Assessment Unit at [immassessmentunit@state.ma.us](mailto:immassessmentunit@state.ma.us) or at (617) 983-4330.

— MDPH Immunization Program



## Pharmaceutical Grade Refrigerator Secondary Unit Requirement 2018

### New for 2018!

The Massachusetts Department of Public Health will require the use of pharmaceutical-grade refrigerators for all refrigerator storage units (primary and secondary). A secondary storage unit is defined as storing smaller amounts of vaccine than your primary storage unit, usually located in exam rooms or departments throughout the facility. Typically, pharmaceutical-grade refrigerators have a narrow operating range (less than 2 °C or 3 °F).

— *MDPH Immunization Program*

### Characteristics of Pharmaceutical Grade Refrigerators

- Internal overhead fans to disperse cold air throughout the unit, eliminating cold pockets of air
- Adjustable wire shelves to allow better air flow
- No storage bins, or shelves on door
- Micro Processor Temperature Controller



## Mumps Outbreak 2016

An outbreak of mumps occurred during 2016 in Massachusetts, primarily among vaccinated college students. This was the largest mumps outbreak in over 30 years in Massachusetts. The outbreak coincided with a large national outbreak of mumps, in which 46 states reported more than 5,000 cases (CDC data are preliminary and subject to change). Eight states, including Massachusetts, reported more than 100 cases.

The MDPH and local health partners, particularly Cambridge Public Health Department and the Boston Public Health Commission, investigated almost 800 suspect cases from January to December 2016. Of the approximately 250 confirmed and probable cases of mumps, approximately 85% were linked to college and universities in the Boston area. The majority of cases had documentation of two doses of MMR vaccine.

Mumps outbreaks tend to happen when people have repeated, prolonged close contacts, such as in dormitories and at parties. Boston-area colleges and universities responded to this outbreak using creative means and resources for isolating suspected cases of mumps, and discouraging saliva-sharing activities which can spread mumps.

Here are some important things to remember:

- Two doses of MMR are 88% effective (at best) in preventing mumps.
- Early recognition of suspect cases, prompt testing, and isolation of ill patients for five days after onset of parotitis is key to stopping it from spreading.
- Call the MDPH at (617) 983-6800 if you have questions or concerns about mumps, or to report a suspected case.
- Vaccinated health care providers can develop mumps following an exposure. Using standard infection control measures when seeing patients reduces risk.
- Vaccinated people appear to have less severe illness than unvaccinated people.

— *MDPH Immunization Program*

## Upcoming Conferences and Meetings

### 22nd Annual Massachusetts Adult Immunization Conference

Tuesday, April 25, 2017  
Best Western Royal Plaza Hotel,  
Marlborough

For more information and to register, visit <http://maic.jsi.com/2017-massachusetts-adult-immunization-conference>.

### MCAAP Immunization Initiative Advisory Committee Meeting

Wednesday, September 13, 2017,  
6:30 p.m.  
Massachusetts Medical Society,  
Waltham

For more information, contact Cynthia McReynolds at [cmcreynolds@mms.org](mailto:cmcreynolds@mms.org).

### 22nd Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference

Thursday, October 12, 2017  
Best Western Royal Plaza Hotel,  
Marlborough

Updated information will be posted as it becomes available at [www.mcaap.org/immunization-cme](http://www.mcaap.org/immunization-cme).

### MCAAP Immunization Initiative Advisory Committee Meeting

Tuesday, December 5, 2017, 6:30 p.m.  
Massachusetts Medical Society,  
Waltham

For more information, contact Cynthia McReynolds at [cmcreynolds@mms.org](mailto:cmcreynolds@mms.org).

## Mindfulness to Improve Children's Well-Being

As many children face demanding schedules with increased academic work loads and an abundance of extracurricular activities, some react by showing signs of increased stress and anxiety.<sup>1</sup> Our academic system has accelerated so children are now expected to complete school work previously given to children in higher grade levels. Early education is less play-focused and children receive a more academically rigorous curriculum.

This change is evident by the amount of time children spend preparing for third-grade exams that measure performance in math and reading as well as the increase in time spent on academic pursuits at earlier and earlier ages. In 1998, only 32% of kindergarten students received daily reading instruction. In contrast, 77% of kindergarteners received 90 minutes of daily reading



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### Social Emotional Learning: What It Is and How to Foster Parents' Understanding of Its Importance

*continued from page 3*

A few words from you can go a long way toward helping parents see these two barriers and set them aside. I urge you to take a minute or two, during children's regular and urgent care visits, to ask parents about their child's social emotional development and further, to ask parents what support they have or may need with parenting.

Both peer-led and professionally led programs teach parents about developmental stages and age-appropriate expectations for their children's behavior. While nothing takes the place of in-person support, online resources can be a useful starting point.

SEL4MA.org, the home for the Social Emotional Learning Alliance for Massachusetts ([www.sel4ma.org/sel-for-parents](http://www.sel4ma.org/sel-for-parents)), an all-volunteer group of over 1,000 individuals and providers, suggests 10 ways parents can foster their children's social emotional learning. The Adverse Childhood Experiences Study (ACES), which may be familiar to some of you, may not be known to parents. Parents of your youngest patients might benefit from checking the ACES Too High site and

particularly this February 14, 2017 blog post titled "Be worried about boys, especially baby boys" (<http://bit.ly/2lDmYR5>).

Many other disciplines are now recognizing the importance of social emotional learning. In many school districts, SEL is now included in the curriculum. Since January 2015, SEL proficiency has been mandatory for new teachers in Massachusetts. Last fall, the Boston Public Schools hired an assistant superintendent to head the Office of Social Emotional Learning and Wellness, with responsibilities also for athletic programs. In the announcement of Dr. Amalio Nieves' arrival, it was noted that the newly created position is believed to be the first such cabinet-level post in a public school district in the nation. Interviewed for this article, Dr. Nieves said, "Both educators and medical care providers can better support young people and their parents, as well as each other, by increasing our attention to social emotional learning."

According to Mitch Lyons, president of the Social Emotional Learning Alliance for Massachusetts, "SEL in schools must be part of our long-term education plan, not only to improve young peoples' academic achievement, but to reduce violence and addictions in our communities."

"Parents," Lyons asserts, "are even more important than schools in influencing their children's emotional growth and academic performance."

Many parents, despite a firm intention to avoid the mistakes their own parents made, risk perpetuating those same mistakes, or just make different ones, as I am afraid I did. Parenting education is still in its early stages, and the National Parenting Education Network provides an overview of the field at <http://npen.org/about-npen/history-of-npen>.

The MCAAP Children's Mental Health Task Force (<http://mcaap.org/mental-health>), led by Dr. Michael Yogman, conducts a wide range of advocacy and professional activities focused on improving children's behavioral health and increasing access to behavioral health care. These important initiatives can have even greater benefit when they are supported by each of you in your individual interactions with parents.

— *Eve Sullivan, Founder, Parents Forum, Cambridge, Massachusetts*

#### Reference

\*According to [www.casel.org](http://www.casel.org), "Social and emotional learning is the process through which children and adults acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions."

## Mindfulness to Improve Children's Well-Being

*continued from page 10*

instruction in 2010. The practice of mindfulness is quickly gaining recognition as an effective tool to help children manage feelings of stress and anxiety resulting from the many pressures they are subject to.

Mindfulness can be practiced during breaks at school, between homework assignments, before bedtime, and when children may be experiencing heightened feelings of stress or anxiety. Families can initiate a mindfulness session by sitting in a relaxing environment and concentrating on their sensory perceptions such as how they feel when taking deep breaths.<sup>3</sup> This simple form of meditation allows children to temporarily let go of distractions in their lives and focus only on a sensation of their choosing without overreacting or feeling overwhelmed. With practice, children can benefit from mindfulness both behaviorally and developmentally by learning how to process and understand their thoughts, emotions, and surrounding environment. The activity is a form of reflection, which can improve their well-being.<sup>4,5</sup>

Since mindfulness is an emerging topic, much of the research published evaluates adult populations. However, studies on children have revealed similar results that connect the practice of mindfulness to positive states of mind. Teaching children to be mindful can improve all of the following:

- Ability to manage anxiety<sup>6</sup>
- Executive function skills<sup>4</sup>
- Attention capabilities<sup>7</sup>

One of the important executive functions children build through mindfulness is emotional control. Mindful children are more equipped to process their feelings instead of resorting to a habit or impulse response.<sup>4</sup> A 2014 study conducted in Richmond, California, observed the implementation of the Mindful Schools program where teachers worked with children to practice mindfulness over the course of seven weeks. Students in 17 different classrooms participated in 15-minute mindfulness sessions, and teachers used a rubric to report their behavior. Results indicated that practicing

mindfulness improved students' ability to pay attention in class, maintain self-control, respect others, and participate in classroom activities.<sup>7</sup>

The benefits of children practicing mindfulness can also be observed in very young children, possibly as young as preschool age. Data from a 2015 study measuring preschoolers' inhibition responses revealed that mindful yoga improved their ability to manage impulses. The study used a series of assessments including asking the children to not watch while an adult wrapped a gift, asking children to not touch the present after it was wrapped, and asking children to play "Head, Shoulders, Knees, and Toes" by performing the opposite motion as the interviewer. The children who studied mindful yoga performed better on the assessments by showing a greater ability to delay gratification and control both behavior impulses and attentional impulsivity.<sup>8</sup>

Ultimately, the goal of introducing children to mindfulness is to improve their self-reflection outside of designated times when they're focused on breathing — to gain a greater awareness about their experiences, thoughts, and feelings. Caregivers who are interested in helping their children practice mindfulness at home can follow these three tips:

- 1. Use mindfulness to focus on different types of sensations:** Although basic mindfulness helps children concentrate on their breathing, they can also focus on how their legs or arms feel or on scents such as the smell of an orange peel. Focusing on sounds is another good mindfulness exercise. Children can concentrate on the sound of a fan rotating, birds chirping outside, or another sound that is part of the environment where they are practicing.<sup>3,9</sup>
- 2. Practice mindfulness during activities that require movement:** This helps children incorporate mindfulness into everyday activities. Walking can be a good way to start because children focus on the physical sensation of how their legs or feet feel while moving.<sup>10, 11</sup>
- 3. Make time for mindfulness as a family:** Families can dedicate an area of the house to practice mindfulness together and they can also set aside a

time of day such as before bedtime. Both caregivers and children should talk about how they felt throughout the day or what they focused on to help become more mindful.

### About Pathways.org

Pathways.org is a national not-for-profit dedicated to maximizing children's development by providing free tools and resources for medical professionals and families. Medical professionals can contact Pathways.org to receive free supplemental materials to give away at well child visits and parent classes. Our free brochures can be viewed at Pathways.org. For a free package of brochure to give away to families, please email friends@pathways.org.

### References

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### IN MEMORIAM

## John E. Manning MD

Dr. John E. Manning of Falmouth, MA, January 27, 1921–February 8, 2017. Predeceased in 2001 by his wife Lily, he is remembered lovingly by his two sons, Mike and Jack, eight grandchildren, and two great-grandchildren, as well as the many children and families whose lives he touched. For the full text of his obituary, please go to [www.legacy.com/obituaries/bostonglobe/obituary.aspx?pid=184099199](http://www.legacy.com/obituaries/bostonglobe/obituary.aspx?pid=184099199).

Editor's note: The *Forum* has reconsidered the need to recognize its deceased members. If current members would like to recognize a cherished colleague, please submit an obituary to [ldobberteen@mcaap.org](mailto:ldobberteen@mcaap.org). We will publish brief "In Memoriam" notices in each edition, with the full text of obituaries available online.

## BOOK CORNER

## Speak to Me



**Talking.** This seems such a basic component of our human existence; yet in the era of ever-present screens, how often do we genuinely engage in it? What gets in the way of talking to each other and the children we encounter? That decision, to talk or not, may literally rest in our hands. We are reminded of the conclusions from a 2014 study by Radesky and colleagues (Radesky JS et al, “Patterns of Mobile Device Use by Caregivers and Children During Meals in Fast Food Restaurants,” *Pediatrics* 2014) which examined 55 caregivers eating with one or more young children in fast-food restaurants in a single metropolitan area. Using nonparticipant observational methods (i.e., watching only but not connecting or consenting), observers wrote detailed field notes, continuously describing all aspects of mobile device use and child and caregiver behavior during the meal. Field notes were then

analyzed using grounded theory methods to identify common themes of device use.

The themes they explored were notable. They found 40 of the 55 caregivers used devices during their meal. The major theme regarding mobile device use and caregiver-child interaction was the *degree of absorption* in devices caregivers exhibited. *Absorption* was defined as the extent to which primary engagement was with the device, rather than the child, and was determined by frequency, duration, and modality of device use. Likewise, they coded the child’s response to caregiver use, which ranged from entertaining themselves to escalating bids for attention. In addition, they noted how caregivers managed the child’s behavior as well as separate versus shared use of devices. They found that highly absorbed caregivers often responded harshly to child

misbehavior, essentially choosing texting rather than talking to the child.

In considering any positive applications of digital devices, two recent initiatives show the possibility of mobile devices actually encouraging parent-child interaction. Boston Basics (<http://boston.thebasics.org/en/the-basics>) is an initiative with public private partnership promoting five evidence-based parenting and caregiving principles that encompass much of what experts find is important for children from birth to age three. Every child from every background can benefit from routinely experiencing Boston Basics and the organization has produced free booklets and videos to promote them. The five principles are as follows:

1. Maximize love, manage stress
2. Talk, sing, and point

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## Speak to Me

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3. Count, group, and compare
4. Explore through movement and play
5. Read and discuss stories

These are not complicated, yet they are all very powerful in the life of a young child.

In the spirit of “if you can’t beat them, join them,” Health Resources and Services Administration (HRSA) recently sponsored a challenge to address the word gap. The *word gap* is the well recognized difference between the number of words children from low-income families are exposed to as compared to those from high-income families. By age three, children from low-income families are hearing an estimated 30 million fewer words than those from higher-income families. The Bridging the Word Gap Challenge ([www.wordgapchallenge.hrsa.gov](http://www.wordgapchallenge.hrsa.gov)) will award \$300,000 in prizes to support innovative solutions that can help promote early-language development among children from low-income families in the United States and is currently in phase three.

**One phase two winner is the Word Gap App from Aimee’s Babies** (<http://thewordgapapp.com>). This free app provides valuable resources to help parents bridge the word gap and interact with their babies in some new ways using videos of parents in everyday interactions.

**Talking.** It really does matter. As pediatric clinicians, we need to consider what gets in the way of talking among children and their caregivers. More importantly, we need to offer parents and caregivers tools to help talking flourish. This time, talking without doing will not work.

— **Marilyn Augustyn, MD, FAAP**

For more information about Reach Out and Read and early literacy, email Massachusetts Program Director Alison Corning-Clarke at [alison.clarke@reachoutandread.org](mailto:alison.clarke@reachoutandread.org) or Massachusetts Coalition Medical Director Marilyn Augustyn at [Marilyn.augustyn@bmc.org](mailto:Marilyn.augustyn@bmc.org).

## What Pediatricians Should Know about Bone Marrow Failure Syndromes



Pediatricians face a difficult task determining when to refer a child for a suspected bone marrow failure syndrome ([www.danafarberbostonchildrens.org/centers-and-programs/blood-disorders-center/programs/bone-marrow-failure-program.aspx](http://www.danafarberbostonchildrens.org/centers-and-programs/blood-disorders-center/programs/bone-marrow-failure-program.aspx)). We now realize that only a subset of children with bone marrow failure syndromes present with findings described in textbooks. These children often appear well and lack classical physical signs. By the time they look sick, their marrow’s ability to produce blood cells can be so weakened that it could be too late, or at least much more difficult, to treat them successfully.

These rare disorders can range from life-threatening conditions requiring a hematopoietic stem cell transplant ([www.danafarberbostonchildrens.org/centers-and-programs/stem-cell-transplant-center/what-is-a-stem-cell-transplant.aspx](http://www.danafarberbostonchildrens.org/centers-and-programs/stem-cell-transplant-center/what-is-a-stem-cell-transplant.aspx)) to mild cases treated with medication and/or watchful monitoring. Left untreated, a number of bone marrow failure syndromes can lead to cancers, particularly acute myeloid leukemia (AML) ([www.danafarberbostonchildrens.org/conditions/leukemia-and-lymphoma/acute-myelogenous-leukemia.aspx](http://www.danafarberbostonchildrens.org/conditions/leukemia-and-lymphoma/acute-myelogenous-leukemia.aspx)). Once

AML develops in patients with bone marrow failure syndromes, outcomes are generally poor, so current strategies focus on early diagnosis and surveillance to initiate transplant prior to the development of AML.

Fortunately, there are several indications that should lead a primary care physician to refer a patient for evaluation. Children with anemia and low red blood cell counts can present with fatigue and an inability to pursue their normal activities. A baby might not have the energy to feed. Children with low white blood cell counts might present with infections, ranging from mouth sores or skin infections to serious potentially life-threatening infections. Children with low platelet counts might bruise easily and have nosebleeds.

What about the patient without symptoms? Here the clues may come from complete blood counts ordered for an unrelated reason, such as preparation for surgery or as part of a well-child visit. Likewise, other combinations of symptoms and characteristics might warrant ordering a complete blood count to see if bone marrow failure might be at work.

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## What Pediatricians Should Know about Bone Marrow Failure Syndromes

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- Children with a viral infection often have low blood cell counts. These patients should be monitored to make sure the count returns to normal within a few weeks after the child recovers.
- Often children with bone marrow failure present with short stature without a clear reason for it. Being short, of course, is very common, but if a child has short stature and abnormal blood counts, that raises the degree of suspicion.
- A child with low counts in more than one type of blood cell line should be referred for evaluation.
- Mild anemia is not an automatic signal for referral, but if the child has anemia with large red cells without an apparent cause, then the child should be evaluated because enlarged red blood cells can be a sign of marrow stress. They are often an early indication of a bone marrow failure disorder or a malignant or premalignant condition.
- If a patient reports a family history of cancer — particularly leukemia or solid tumors — at a young age, obtaining a complete blood count is in order. Leukemias, such as acute myeloid leukemia, are most common in people older than 60. If a patient's father had leukemia at 30 or a cousin/sibling had leukemia at 7, that's a red flag.
- Neutropenia, or low white cell count, is common and not, in and of itself, a reason for referral. But if a patient has neutropenia together with short stature or poor growth or severe diarrhea or physical anomalies, then the child should be evaluated.
- Unexplained, persistently low platelets can be a presenting sign of bone marrow failure. The most common reason for low platelets in childhood is immune thrombocytopenia, which typically resolves over 3–6 months. If it doesn't, then the child should be evaluated.
- Patients with physical anomalies together with blood counts that are low and without an apparent cause may have a bone marrow failure disorder.



If you suspect a child might have a bone marrow failure syndrome, then it's important to refer the patient to a multidisciplinary program with the expertise to evaluate and treat problems in the wide range of organs — including the gastrointestinal system, lungs, heart, and kidneys — that might be affected by marrow failure syndromes. Cutting-edge genomic testing now allows individualized tailored therapies and surveillance strategies. Such patients benefit from referral to a center with expertise in evaluating and treating these complex disorders. The Dana-Farber/Boston Children's Cancer and Blood Disorders Center, for instance, is leading several diagnostic studies and clinical trials with the goal of improving outcomes for these patients.

Working together, the primary care pediatrician and specialty clinic can ensure that children with bone marrow failure are caught early enough to enjoy the maximum likelihood of successful treatment.  
— *Akiko Shimamura, MD, PhD*

Akiko Shimamura, MD, PhD, directs the Bone Marrow Failure and MDS Program at Dana-Farber/Boston Children's Cancer and Blood Disorders Center ([www.danafarberbostonchildrens.org/centers-and-programs/blood-disorders-center/programs/bone-marrow-failure-program.aspx](http://www.danafarberbostonchildrens.org/centers-and-programs/blood-disorders-center/programs/bone-marrow-failure-program.aspx)). For more information call (844) 222-9991 or email [bmf\\_pedi@dfci.harvard.edu](mailto:bmf_pedi@dfci.harvard.edu).

### SAVE THE DATE The 2017 MCAAP Annual Meeting Pediatrics and Injury Prevention

The Annual MCAAP Edward Penn Memorial CME Lecture and Business Meeting will take place on May 11 at the Massachusetts Medical Society from 9:30 a.m. until 4 p.m. The program will focus entirely on child maltreatment and will offer CME credits and an MOC module for parts 2 and 4, which contain information on how to conduct parent injury prevention surveys in practice. The program cost is \$80 for members and is free for medical students and residents.

For more information or to preregister, please contact Cathleen Haggerty at [chaggerty@mcaap.org](mailto:chaggerty@mcaap.org).

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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.\*

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\*Contact Cathleen Haggerty at [chaggerty@mcaap.org](mailto:chaggerty@mcaap.org) for rate and payment information.



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