The Forum
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Massachusetts Chapter
Newsletter of the Massachusetts Chapter of the American Academy of Pediatrics

PRESIDENT'S MESSAGE

Building the Future

I am excited and humbled to be chosen to serve as your MCAAP president for the coming term. Certainly, we have a lot to be proud of here in Massachusetts: a strengthening economy, universal health insurance, open-minded legislators, and a seemingly endless supply of good people eager to improve the lives of children. No wonder the Anne E. Casey Foundation places Massachusetts first in its 2014 rankings of child well-being.

Our chapter also has a lot to be proud of: superb leadership, exemplary committees, recent legislative victories, and a growing membership. Among our leaders we have past president John O'Reilly, current AAP President Jim Perrin, and District I Chair Carole Allen (who also serves as the only physician member of the Massachusetts Health Policy Commission). Our Immunization Initiative, Mental Health Task Force, Legislative Committee, and Pediatric Council are models of effectiveness. After years of hard work led by Sean Palfrey, legislation establishing universal immunization and a statewide registry has finally passed. Meanwhile, our membership now exceeds 1,800, includes a wide range of pediatric specialists, and enjoys renewed popularity among residents and medical students.

Yet however well positioned our chapter may be, we face challenges that will soon test both our commitments and our resourcefulness. As the drumbeat quickens for health care reform, we are called to speak up for children and advance our models of care. As economic pressures threaten to narrow networks and diminish access to pediatric services, we must document this narrowing and advise our policymakers accordingly. As our

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The Toll of the Ebola Outbreak in West Africa

Much has been written about the Ebola outbreak in West Africa. By the time this article is published, much is likely to have changed. I have had the privilege to work on several occasions in Liberia, currently the country hardest hit by the Ebola outbreak. Beyond the numbers, it's hard to convey the human toll of this outbreak and the devastation that's been wrought to Liberia's already fragile health care system.

History has not been kind to Liberia. The nation has only recently started to recover from 14 years of brutal civil unrest and begun the process of rebuilding its health care infrastructure. A year ago, Liberia restarted its graduate medical

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EDITOR'S NOTE

Enterovirus D68 and Respiratory Compromise

Recently, the CDC's *Morbidity and Mortality Weekly Report* (*MMWR*) described a new strain of enterovirus, EV-D68, that has been causing severe respiratory illness in children in Missouri and Illinois.[1] EV-D68 was first identified in California in 1962 in four children with bronchiolitis and pneumonia. Since then, it has been reported in occasional small clusters averaging about 20 cases per year. [2, 3]

In mid-August, Children's Mercy Hospital in Kansas City, Missouri, and Comer Children's Hospital in Chicago, Illinois, both reported larger than usual numbers of patients with severe respiratory illness. In both cities, the majority of ill children tested positive for enterovirus. Furthermore, 29 of the 35 ICU cases admitted as of September 8 were positive for EV-D68.

Although the demographics varied slightly by location, EV-D68 patients admitted to an ICU had similar characteristics. Age was not a distinguishing feature: cases ranged from 6 weeks to 16 years of age, with a median age of 4 years of age. However, 70 percent of the children had a history of wheezing or asthma. Most presented with shortness of breath and hypoxemia, with an additional 20 percent presenting with wheezing. Less than a quarter of patients were febrile.

Of the children admitted to the ICU, approximately 25 percent required BiPAP or traditional mechanical ventilation, and one required ECMO. The rest did well with supportive care including IV fluids and oxygen.

With news coverage of this virus growing, families are likely to be anxious about the outbreak. Prepare them to expect excellent clinical care rather than a firm diagnosis: only a few locations in the United States are equipped to test for EV-D68, and the CDC urges all providers to contact their national Picornavirus Laboratory[4] prior to obtaining samples for testing. As I write this article, testing is reserved for health department–directed research and the EV-D68 strain is not reportable to state or federal labs. However, pediatricians are encouraged to report all unusual clusters of clinically severe respiratory infection to their local health department, regardless of etiology.

Relatively little specific information is available regarding EV-D68. It is thought to function like most other enteroviruses, with respiratory and possibly fecal oral transmission and an incubation period of

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Building the Future

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economy recovers, we need to restore past investments in children (see http://children.massbudget.org) and inform new investment by communicating our knowledge of early childhood, toxic stress, and epigenetics. As the Commonwealth enjoys renewed prosperity, we need to make sure that this prosperity extends to all children.

We know that change is coming, which will undoubtedly bring uncertainty and fear. But we are fortunate as a chapter to be in a position to navigate across the changing landscape together. We are also fortunate that ours is the most open and welcoming organization imaginable — whether you are new to the chapter or have been a member for decades. I invite you to join in and help shape the future pediatrics and health care by getting involved in any way you like. Offer your expertise, join a committee, write an article, build a web page, help evaluate legislation, or simply come and use the chapter to connect with like-minded people and advance your own ideas. Over the years, the MCAAP has been my antidote to apathy. Let it be yours, too.

— Michael McManus, MD, MPH, FAAP

State of the State: A Recent MCAAP Survey of Massachusetts Pediatric Practices

Recently the MCAAP sent a survey to its members to explore the State of the State regarding pediatric practices and their ability to provide adequate services to the children of the Commonwealth. Barriers were explored in terms of pediatric practices and ACO participation; adequacy of subspecialist and especially mental health providers; and the existence of narrow and very narrow networks as well as restrictive access due to tiering policies, excessive copays, and high deductibles.

More than 50 percent of the respondents represented groups and 10 percent represented solo and small practices. The issues surveyed were pertinent to all: about 50 percent of providers were not in an ACO, and 70 percent of those providers felt that limited access was a problem for their pediatric patients. Similarly, of the 40 percent of providers in an ACO, only 50 percent indicated they had enough access to providers, subspecialists, and surgeons. Even among those respondents, just 20 percent reported adequate access to mental health providers.

Of the 25 percent of physicians who worked with self-insured groups or plans, more than 40 percent noted limited access to providers, and almost two-thirds noted limited access due to tiering and excessive copays or high deductibles.

Almost a quarter of respondents were willing to share their experiences and 20 percent wanted to talk with our chapter in an effort to remediate these problems. Finally, a third of all respondents wanted help in navigating new insurance networks.

Clearly, our chapter needs to explore these issues further. Adequate access to care, the negative effects of large deductibles, excessive copays and restrictive tiering, and very narrow networks and self-insured networks/plans may have detrimental effects on the children of the Commonwealth. Hopefully the Pediatric council, Legislative committee, and the Health Care Policy Commission can work together to raise public awareness and address these issues soon.

— Walter J. Rok, MD, FAAP

BOOK CORNER

Essential ABE

In 1989, the idea of Reach Out and Read was born in a resident's continuity clinic. Reach Out and Read is an evidence-based nonprofit organization of medical clinicians who promote early literacy and school readiness in pediatric exam rooms nationwide by giving new books to children and advice to parents about the importance of reading aloud. Twenty-five (25) years and millions of books later, the American Academy of Pediatrics Council on Early Childhood officially deems literacy promotion "essential" in the "Policy Statement: Literacy Promotion, An Essential Component of Primary Care Pediatric Practice" (*Pediatrics* 134 (2), 2014; doi: 10.1542/peds.2014–1384).

Think about that: *essential*. Merriam-Webster's dictionary defines essential as two very different adjectives. The first we more commonly think of being "absolutely necessary; extremely important."

Promoting children's ability to read is absolutely necessary. Ample research demonstrates that reading aloud to young children promotes the development of language and other emergent literacy skills, which in turn help children prepare for school. We have had the evidence for years: in 2002, Monique Senechal, PhD, followed a cohort of 168 children for five years describing the role of parental involvement in the development of reading skills (*Child Dev* 2002;73:445–60). She found that children's exposure to books was related to the development of vocabulary and listening comprehension skills, and that these language skills were directly related to children's reading in third grade. Similarly, the parent's role in teaching children about reading and writing words was related to the development of early literacy skills. Various pathways that lead to fluent reading have their roots in different aspects of children's early experiences with their parents.

The second, "medical" definition of *essential* is equally thought-provoking: "(of a disease) with no known external stimulus or cause; idiopathic." This may be where the use of the term essential in the policy statement takes a twist. We clearly know the consequences of a lack of early parent–child reading. The 2011–2012 *National Survey of Child Health* found that 60 percent of American children from birth to 5 years of age from families whose incomes were 400 percent of the federal poverty threshold or greater were read to daily, and only 34 percent of children from families whose incomes were below 100 percent of the poverty threshold received the same (http://childhealthdata.org). Each year, approximately two-thirds of children in

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Massachusetts Mandate for Delayed School Start Times

A recent AAP policy statement recommended that schools delay start times so that school children, especially adolescents, receive the required amount of sleep time. Dr. Judith Owens, the lead author of the September 2014 policy statement, wrote a clear, irrefutable, and detailed argument for delaying school start time. This statement has made national headlines and been the subject of many positive editorials.*

In the western part of Massachusetts, namely in Amherst, Northampton, and South Hadley, school advocates have introduced motions to start schools at a later time, but have been rebuffed over the last three years.

The three main reasons for failure of school committees to implement a change were the inconvenience of parents having to change their schedules, the need to alter starting times of sporting events, and an increase in school bussing expenses.

The Department of Education (DOE) should mandate a common start time for all schools in Massachusetts because it seems impossible for all of the school districts to agree on a later start time. The DOE already mandates certain local school requirements (e.g., public schools need to be in session for 180 days), so mandating a common later start is a legitimate function of their authority.

— Robert Abrams, MD, FAAP

Reference

*Adolescent Sleep Working Group, Committee on Adolescence, and Council on School Health. *School Start Times for Adolescents. Pediatrics* (online). Aug 25th, 2014. http://pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-1697.

ShotClock

From the MDPH Immunization Program: Recommendations for Administering Influenza Vaccine during the 2014–15 Influenza Season

Seasonal flu vaccine is recommended for everyone 6 months of age and older. Influenza vaccine should be administered as soon as the vaccine is available. Vaccination should not be delayed to procure a specific vaccine formulation.

State-supplied flu vaccine should be *prioritized* for children 6 months–18 years of age. State-supplied vaccine can also be used for *uninsured* adults who are seen at public sites, such as community health centers, or for all adults regardless of insurance status if seen at local health department-sponsored clinics.

When immediately available, the Advisory Committee on Immunization Practices (ACIP) recommends live attenuated influenza vaccine (LAIV) for use in healthy children 2–8 years of age without contraindications and precautions. If LAIV is not immediately available, inactivated influenza vaccine (IIV) should be administered; however, *vaccination should not be delayed for a specific vaccine preparation.*

Vaccine dosing recommendations for children *8 years of age and younger* are that children 8 months–8 years of age need only one dose of vaccine in 2014–15 if they have received any of the following:

- At least one dose of 2013–14 seasonal influenza vaccine
- Two or more doses of seasonal influenza vaccine *since* July 1, 2010
- Two or more doses of seasonal influenza vaccine *before* July 1, 2010, and one or more doses of monovalent 2009 (H1N1) vaccine
- One or more doses of seasonal influenza vaccine *before* July 1, 2010, and one or more doses of seasonal influenza vaccine since July 1, 2010

All other children 6 months–8 years of age who do not meet at least one of the aforementioned conditions *require two doses* in 2014–15.

Management of Those with Egg Allergy

There are minor revisions for management of those with egg allergy. Persons who have had reactions to egg involving such symptoms as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who required epinephrine or another emergency medical intervention may receive recombinant hemagglutinin influenza vaccine trivalent formulation (RIV3), if they are aged 18–49 years and there are no other contraindications. If RIV3 is not available or the recipient is not within the indicated age range, IIV should be administered by a physician with experience in the recognition and management of severe allergic conditions.

Contraindications and Precautions for LAIV

Contraindications: Severe allergic reaction to any component of the vaccine, including egg protein, or after previous dose of any influenza vaccine; concomitant use of aspirin or aspirin-containing medications in children and adolescents.

In addition, ACIP recommends LAIV4 not be used for pregnant women, immunosuppressed persons, persons with

egg allergy, and children aged 2–4 years who have asthma or who have had a wheezing episode noted in their medical record within the past 12 months, or for whom parents report that a health care provider stated that they had wheezing or asthma within the last 12 months. LAIV should not be administered to persons who have taken influenza antiviral medications within the previous 48 hours. Persons who care for severely immunosuppressed persons who require a protective environment should not receive LAIV, or should avoid contact with such persons for seven days after receipt. Also, persons younger than 2 years or older than 49 years should not receive LAIV.

Precautions: Moderate to severe illness with or without fever; history of Guillain-Barré syndrome within 6 weeks of receipt of influenza vaccine; asthma in persons aged 5 years and older; or medical conditions which might predispose to higher risk for complications attributable to influenza (e.g., chronic pulmonary disease; cardiovascular disease [except isolated hypertension]; renal, hepatic, neurologic, hematologic, or metabolic disorders [including diabetes]).

Influenza Vaccine Information Statements (VIS)

The two VISs (IIV and LAIV) for the 2014–15 influenza season can be found at cdc.gov/vaccines/hcp/vis/current-vis.html. Providers should use these VISs.

Additional Information

For more detailed guidance about these new flu recommendations, see Summary Recommendations: Prevention and Control of Influenza with Vaccines: Recommendations of the ACIP — United States, 2014–15 (*MMWR* 2014;63:691–697), at cdc.gov/mmwr/preview/mmwrhtml/mm6332a3.htm?s_cid=mm6332a3_e.

Visit cdc.gov/flu or mass.gov/dph/flu for general information on influenza guidelines and resources.

Questions

For questions about *flu vaccine availability and ordering*, please contact the MDPH Vaccine Management Unit at (617) 983-6828. For questions about *flu vaccine recommendations*, please call the MDPH Immunization Program at (617) 983-6800 and ask to speak to an immunization epidemiologist or immunization nurse.

— MDPH Immunization Program

Immunization Initiative Advisory Committee

The Advisory Committee meets quarterly at the MMS headquarters in Waltham. The Committee discusses current state and national immunization topics, including how it can support immunization initiatives from the Massachusetts Department of Public Health. The Committee also provides guidance to the Immunization Initiative program. Committee membership includes physicians and nurses, DPH Immunization Program officials, and representatives from organizations interested in improving immunization practices and immunization rates in communities across Massachusetts.

The next Committee meeting is scheduled to be held at 6:30 p.m., Monday, December 8.

Your participation is welcome! For more information about participating in the Immunization Initiative Advisory Committee, please contact Cynthia McReynolds at cmcreynolds@mcaap.org, or by telephone at (781) 895-9850.

Immunization Initiative Grand Rounds Seminars

For almost 20 years, the MCAAP Immunization Initiative has worked with pediatric departments to present Grand Rounds seminars on pediatric immunization. Expert faculty address current immunization issues and respond to attendees' needs and interests. Most of the presentations will be an hour long and each participant will receive a packet of materials that includes helpful current information, such as recent guidelines on immunization, summary charts, study results, and guides to the office management of immunization.

There have been many recent developments in immunization, including disease outbreaks (e.g, measles, mumps, pertussis), new ACIP recommendations, introduction of the Massachusetts Immunization Information System (MIIS), new guidelines for vaccine management in the office, and increasing parental concern about vaccine safety and the immunization schedule.

The seminars have been very well received and provided attendees with access to current, practical immunization information. Seminar presentations are posted on the MCAAP Immunization Initiative website (mcaap.org/immunization-cme) to download as a convenient resource.

We welcome the opportunity to work with your pediatric department or practice to present an immunization update. If you are interested in scheduling an immunization update or would like more information, please contact Cynthia McReynolds of the Immunization Initiative at cmcreynolds@mms.org or (781) 895-9850.

2nd Annual HPV/Cervical Cancer Summit

Moving Forward Together: Responding to the President's Report

The 2nd Annual HPV/Cervical Cancer Summit will be held on Friday, November 7, 2014, from 8:00 a.m. to 2:00 p.m., at the Dana Farber Cancer Institute, Boston, MA.

The 2nd Annual HPV/Cervical Cancer Summit is a collaboration between Dana Farber, the MCAAP, and the MDPH, and one of the larger educational activities offered as part of the MA HPV Vaccination Initiative. Although the focus will be on increasing HPV vaccination and reducing HPV-related cervical cancer, there will be content related to reducing other HPV-related cancers.

For more information and to register, visit dana-farber.org/Adult-Care/Treatment-and-Support/Treatment-Centers-and-Clinical-Services/Susan-F--Smith-Center-for-Women-s-Cancers/HPV-Cervical-Cancer-Summit.aspx.

If you have further questions about the summit, please contact Eileen Duffey-Lind at Dana Farber (eileen_duffey-lind@dfci.harvard.edu).

Immunization Initiative Webinar Series — November 13, 2014

The next webinar in the series, "Vaccine Storage and Handling and Vaccines for Children (VFC) Compliance Training," will be held on Thursday, November 13, from noon to 1:00 p.m. Robert Morrison, vaccine manager, MDPH Immunization Program, will present.

By participating in this CME program, attendees should be able to:

1. Identify the new guidelines and requirements for the federal VFC Program.
2. Explain the new recommendations regarding vaccine storage units and temperature monitoring devices.
3. Describe the latest MDPH information about vaccine supply and availability, as well as programmatic updates.

For more information and to register, visit mcaap.org/immunization-cme/#webinar.

To access previous webinars, visit mcaap.org/immunization-cme/#webinar.

Essential ABE

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the United States and 80 percent of those living below the poverty line fail to develop reading proficiency by the end of third grade — a point where proficiency strongly predicts high school graduation and career success. So this *essential* activity — promoting literacy — has a known benefit and a clear advocacy measure that lies with us to champion!

The policy statement above has straightforward recommendations that fit the Reach Out and Read mantra, also know as **TELL ABE**: **Advice:** Tell all parents about how reading aloud can enrich their parent-child interactions and counsel parents about developmentally appropriate reading activities. **Book:** Provide developmentally, linguistically, and culturally appropriate books at health supervision visits for all high risk, low-income children. **Environment:** Change your practice environment to promote literacy through a robust spectrum of options including posters and parent information materials.

The policy recommendations are officially here. The baton has been passed to us. Will we take it? For more information about Reach Out and Read and early literacy, email the Massachusetts Program Director Alison Corning-Clarke at alison.clarke@reachoutandread.org or the MA Coalition Medical Director Marilyn Augustyn at augustyn@bu.edu.
— Marilyn Augustyn, MD, FAAP

The Toll of the Ebola Outbreak in West Africa

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education programs and launched residency training in pediatrics, surgery, OB/GYN, and internal medicine. The Ebola outbreak has put all of these programs on hold and in jeopardy of a relapse into disarray. The World Health Organization (WHO) estimates that there are only about 250 physicians in Liberia, serving a population of over 4 million people. Less then 10 of those physicians are certified pediatricians and Liberia has less than 1 doctor per 100,000 people — Massachusetts has 474 doctors per 100,000 people, in comparison. Amidst the Ebola outbreak, Liberia has lost some of its best doctors, educators, and medical leaders to the virus. These individuals worked in incredibly difficult situations, and are true heroes of our profession. The long-term damage to Liberia's struggling health care system is likely to be felt for years to come.

In addition to Ebola's direct impact on Liberia's nascent health care system, the virus has also resulted in the countless deaths of adults and young children — many, many, more than the WHO estimates are able to convey. Due to the outbreak, nearly every hospital in Monrovia, Liberia's capitol, has been closed for over a month now. Facilities need decontamination after Ebola patients are identified, but lack protective equipment to keep health care workers safe. Many doctors and nurses refuse to come to work, and who can blame them? Who among us would work with Ebola patients without access to basic supplies like gloves or hand sanitizer? As a result, most of Monrovia's hospitals are empty shells devoid of patients and staff. At Redemption Hospital, where I volunteer, we typically saw 20–30 critically ill children a day who suffered from malaria, pneumonia, and/or severe malnutrition. Even though mortality was very high in our hospital, we saved many children. They have nowhere to go now, and are almost certainly dying at home. Ebola has taken many lives, but the indirect toll on young, vulnerable, and sick children is even more worrisome. It will be hard to quantify the impact, but after the outbreak ends, hopefully sooner rather then later, thousands of children will die throughout Liberia and West Africa because of the devastating effects Ebola has had on their fragile health care system.

These problems can seem overwhelming, especially when there are so many other crises brewing throughout the world today. But this epidemic has the potential to affect and reach all of us. It's not a war between two nations, but a virus that we as a unified medical community must respond and devote resources to combating. Our fellow co-workers and human beings in West Africa are in desperate need help. It's time for the world community to stand up and reach out to help meet that need.
— Jackson Williams, MD, FAAP

Primary foreign aid group currently working in West Africa is Doctors without Borders (MSF) (doctorswithoutborders.org).

Baystate Medical Center in Springfield will be hosting a New England Regional Global Health conference on March 14, 2015.

Resources:

AAP Section on International Child Health
aap.org/sections/ich

World Health Organization
who.int/csr/disease/ebola/en

Promoting Safer Sleep

While the incidence of Sudden Infant Death Syndrome (SIDS) has largely decreased since the launch of the Back to Sleep campaign in 1992, the number of infant deaths resulting from accidental suffocation, asphyxia, and entrapment has increased in recent years.[*] In 2011, the AAP expanded its recommendations to promote a safer sleep environment for infants.

A recent study presented at the Pediatric Academic Societies annual meeting in Vancouver, British Columbia, indicated that a significant number of parents continue to engage in high-risk sleeping behaviors.[†] Of the 1,030 mothers surveyed, almost 20 percent reported sharing a bed with their infant and 10 percent reported routinely putting their infant to sleep on their stomach.

Physicians and hospital staff should set a clear example of safe sleep practices in the inpatient setting. Parents and caregivers are more likely to model the actions demonstrated by their health care providers than follow their verbal instructions. Encourage caregivers to follow the ABC's of safe sleep: Alone, Back, Crib.

- Sleep in the same room (i.e., safest place) as their infant, but not in the same bed.
- Place infants on their backs to sleep and their tummies to play.
- Use a crib or bassinet that meets current safety standards.
- Provide a firm sleep surface.
- Keep loose bedding, bumpers, and toys out of the crib.
- Do not let an infant overheat.

In addition to promoting safe sleeping environments, health care providers should convey to parents the importance of practicing Tummy Time[**] while their infant is awake to support motor development[‡] and prevent positional plagiocephaly and torticollis.

— Virginia Li, Pathways.org

Founded in 1985, Pathways.org empowers parents and health professionals with free educational resources on the benefit of early detection and early intervention for children's motor, sensory, and communication development. For more information, visit Pathways.org or email friends@pathways.org. Pathways.org is a 501(c)(3) not-for-profit organization.

References

[*]Task Force on Sudden Infant Death Syndrome. "SIDS and other sleep-related infant deaths: expansion of recommendations for a safe infant sleeping environment." 2011;128(5):1030–39.

[†]Colson E, et al. Reports of infant sleep behaviors from a national sample of mothers: the study of attitudes and factors affecting infant care (SAFE). Platform session presented at: Pediatric Academic Societies Annual Meeting; 2014 May 3–6; Vancouver, British Columbia.

[‡]Pin T, Eldridge B, and Galea MP. "A review of the effects of sleep position, play position and equipment use on motor development of infants." *Development Medicine and Child Neurology.* 2007;49:858–67.

[**]www.youtube.com/watch?v=M3rCtW9DMD4

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Enterovirus D68 and Respiratory Compromise

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3–10 days. Most children show symptoms for 7–14 days. We do not know what percentage of children with this virus will fall ill. Since there is no widespread testing, the community burden of disease and percentage of infected patients who will present as severely ill is unknown. However, it may be worth reminding anxious parents that most viral illnesses, including enterovirus, influenza, and other respiratory illnesses, lead to far more mildly ill cases than severely ill ones.

Since there are no virus-specific treatments available, all care is supportive in nature. For parents eager to have more information, the CDC has a reassuring webpage with basic virus facts and answers to some common questions.[4] In the same location, providers can access updates regarding virus testing and current and past *MMWR*s, which track severe illnesses throughout the United States and provide key clinical and public health data.

As the fall progresses, experts predict increased geographic spread with a peak incidence in late September mirroring the classic spread of enteroviral infections. If EV-D68 follows the same seasonal trends, we will likely see cases trailing off towards the end of October. In the meantime, keep your eyes and ears peeled for updates from the CDC. Signing up for the *MMWR* is a great way to get timely information delivered straight to your inbox and stay abreast of recent developments.

— Anne Light, MD, FAAP

References

[1]www.cdc.gov/mmwr/preview/mmwrhtml/mm63e0908a1.htm; referenced throughout this article

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