



PRESIDENT'S MESSAGE

Special Models of Care

Since 1998, the federal Maternal Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) has defined Children with Special Health Care Needs (CSHCN) as those who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required for children generally. Children are considered to have a special health care need if, in addition to a chronic medical, behavioral, or developmental condition that has lasted or is expected to last 12 months or longer, they experience either service-related or functional consequences, including the need for prescription medications and/or specialized therapies.

In its National Surveys of Child Health, the MCHB attempts to “take the pulse” of American child health and includes a five-question screening tool to identify CSHCN. Many other areas are also surveyed, including family interactions, parental health, insurance status, neighborhood safety, and the quality of each child’s medical home. In its 2010 survey, 15.1% of children under 18 years of age were identified as having special health care needs. Here in Massachusetts, that number was even higher (18.3%) and included nearly a quarter (23.3%) of all children 12–17 years of age.

The definition of CSHCN encompasses a broad range of physical and mental conditions that bring many management challenges and often require complex care coordination. Children with special health care needs are most likely to benefit from care in a patient/family-centered medical home, yet the MCHB survey suggests that fewer than half (47.1% in

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New Chapter Committee for Immigrant Health

The MCAAP Immigrant Health Committee convened its founding meeting on December 1, 2014. We are excited to have the opportunity to focus on this underserved community and hope to develop a wide and active membership. Why have an Immigrant Health Committee?

- Immigrants are 14.4% of the Massachusetts population, but among children, the percentage is far higher. Twenty-seven percent (27%) of all children in Massachusetts, and 30% of all children under 6 years of age, have a foreign-born parent and most of these children are U.S. citizens.¹

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State Senator Sonia Chang-Diaz speaks at a rally at the State House on August 7th 2014. The rally was held in support of the unaccompanied children coming from Central America. Holding the megaphone is Massachusetts Immigrant and Refugee Coalition Director of Organizing Cristina Aguilera. Photo by Julia Koehler, 2014

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EDITOR'S NOTE

Fostering Collaboration

In every issue of MCAAP's *The Forum*, you will find articles that highlight the collaboration of our members. From the quarterly ShotClock, which supports pediatricians in vaccination administration, to new committees and expert articles, our goal is to connect our members to more effectively care for the children of Massachusetts.

In this issue, you will hear from a variety of MCAAP members teaming up to improve health outcomes for children across the Commonwealth. On page 1, Dr. Michael McManus describes the recent HRSA push to integrate care for children with special health care needs (CSHCN). Nearly one-quarter of Massachusetts children fit this definition and would benefit from a medical home, yet less than half of them receive it, likely because creating such a home can be confusing or difficult for providers. Thankfully, this year's annual meeting will not only describe possible models of care, but also provide workshops and Q&A sessions for members to explore implementing these models in their own practice.

Also on page 1, Dr. Julia Koehler introduces us to a new Chapter Committee on Immigrant Health to support the pediatricians who care for immigrant families across the state. Especially useful to practitioners is Dr. Sheila Cleary's EMR-compatible template for addressing the health needs of children recently arrived from Central America.

On page 4, Drs. Lisa Diller and Peter Manley discuss ways in which pediatricians and oncologists can work together to care for children who have had cancer, and on page 7 the Massachusetts Immunization Action Partnership (MIAP) announces its 20th Annual Skills Building Conference.

Clearly, our chapter is lucky to have a wealth of hard-working team players to guide the rest of us through the challenges of patient care. Yet as important as collaboration is, it can be hard to initiate. All of us are pressed for time and energy, and new projects can be a gamble. They have the potential to re-energize us for another year, or sap what little time and energy we have left.

How do we collectively choose which initiatives to get behind, what causes to support, and where to share our strength? And how can we at the MCAAP work to reduce barriers to collaboration and physician engagement?

In this issue, I ask for your thoughts and comments. What projects have you participated in, and what drew you to them? Which types of collaborations are easiest to join, and which require more time and commitment? Are there particular issues that you feel we should be addressing? Email me at alight@mcaap.org. I would love to know what you need most, and how the MCAAP can help provide it.

— *Anne H. Light, MD, FAAP*

SAVE THE DATE

The Annual Edward Penn Memorial Lecture and CME Program

**Caring for Children and Youth with Special Health Care Needs:
How to Make It Work in the World of Health Care Reform**

May 14, 2015 — 10 a.m. to 4 p.m.

**Massachusetts Medical Society
Waltham, Massachusetts**

For more information, contact Cathleen Haggerty at chaggerty@mcaap.org.
To view the entire program and/or register, visit www.mcaap.org/cme.

Getting Intensive, Early Treatment for Patients with Autism

April is National Autism Awareness Month. The American Academy of Pediatrics recommends that all children receive autism-specific screening at 18 and 24 months of age by their primary care pediatrician, in addition to age-appropriate developmental screening. This screening is essential because the earlier a child is diagnosed with Autism Spectrum Disorder (ASD) and the sooner intensive treatment for ASD begins, the better the outcome for the child.

To identify children at risk for autism, pediatricians can use free assessments such as the Modified Checklist for Autism in Toddlers (M-CHAT) at www.m-chat.org or the Survey of Wellbeing of Young Children (SWYC) at www.theswyc.org. When the results of these assessments are concerning, pediatricians should then conduct a simple follow-up interview with the parent to clarify answers, available for free at www.mchatscreen.com. If these findings indicate a high likelihood of ASD, the pediatrician should write a letter to Early Intervention (EI) with the diagnosis, requesting intensive services for a child with ASD. If the child is over 3 years of age, the pediatrician can write a letter to the local school district making the request.

At the same time the letter to EI or the school system is written, the pediatrician should make a referral for a comprehensive evaluation with a specialist (www.maactearly.org/diagnostic-services-in-massachusetts.html) who will conduct a full assessment and make recommendations for ongoing treatment and advocacy for the child. Please note: Because there can be a lengthy wait for an evaluation, it is *very helpful* for you to give the diagnosis of ASD to the child at the time you write a letter to EI or the school so that the child can receive services as soon as possible.

— **Ellen Perrin, MD, FAAP**

For additional information about autism, visit the CDC's Act Early website at www.cdc.gov/ncbddd/actearly/hcp/index.html.

Immigrant Health

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- Immigrant children (defined in demographics as children with at least one foreign-born parent) face unique challenges, including language barriers, poverty, and discrimination. However the most deleterious challenge is the fear of family breakup — which is something all families with an undocumented family member currently live under.²
- Immigrant children bring many strengths to our communities. Multiple studies show better physical and emotional health outcomes among immigrant youth and adults compared to their native-born socioeconomic peers, including lower rates of violent crime and of low birth weight.^{3,4}

The goals of the Immigrant Health Committee are to provide support to pediatricians caring for immigrant children, to inform and educate on the unique challenges immigrant families face, and to advocate for measures that can improve the health and well-being of immigrant children.

Our work so far includes:

- Creating an EMR-compatible template for primary care pediatricians seeing recently arrived children from Central America. This template is authored by Dr. Sheila Cleary of Springfield.
- Advocating for support of the Safe Driving Bill and the Trust Act by the Chapter in the legislative session that began in January (more on this in upcoming issues).
- Beginning a partnership with the Department of Public Health on diagnosing Chagas disease.

We welcome new members, including students and residents! We also welcome input on issues that Chapter members would like us to work on.

Please see our website at <http://mcaap.org/immigrant-health> for more information or to join us. — **Julia Koehler, MD**

References

¹ www.migrationpolicy.org/data/state-profiles/state-demographics/MA

² www.nytimes.com/2012/04/21/opinion/deporting-parents-ruins-kids.html

³ www.nytimes.com/2012/04/21/opinion/deporting-parents-ruins-kids.html

⁴ www.ncbi.nlm.nih.gov/pmc/articles/PMC1449156



Immigration and Human Rights lawyer Julio Henriquez and his son Marcelo Antonio attended the rally at the State House on August 7, 2014. The rally was held in support of the unaccompanied children coming from Central America.

Photo by Julia Koehler, 2014

Five Things Pediatricians Should Know about Treating Children Who Have Had Cancer

As survival rates for pediatric cancer continue to improve, more and more pediatric practices include children who have been treated for cancer. Many patients are making the transition back to primary care after finishing their cancer treatment and some who are in post-treatment are still being closely monitored for recurrence. Others have survived five years or more and are considered cured. Whatever their circumstances, these patients can present challenges for primary care providers that range from early and late effects of treatment to emotional needs. We would like to share our recommendations for pediatricians caring for children and adolescents who have been treated for cancer.

1. Make sure you have a treatment summary and survivorship care plan from the patient's oncologist. It is standard practice when a child transitions off active treatment for the oncology team to generate a summary for the patient and the primary care provider that includes an overview of the patient's diagnosis and treatment, as well as information about what to expect in terms of disease surveillance in the immediate off-therapy period.

As the pediatrician, you should expect to receive recommendations for ongoing routine care such as a re-immunization

schedule or recommendations for management of fevers. This communication can help clarify the pediatrician's and the oncologist's respective roles in the child's ongoing routine care. These roles can differ from patient to patient based on the treatments they have undergone. A child who received hematopoietic stem cell transplants or is otherwise immunosuppressed, for instance, may need to see his or her oncologist for routine symptoms longer than a patient who received less intensive therapy.

Between three and five years after the completion of therapy, survivors often have a follow-up visit with their oncologist that focuses less on disease recurrence and more on organ toxicity from treatment, assessment of growth and development in the face of prior therapy, and treatment-related risks that should be evaluated. At that visit, a new survivorship care plan can be created to lay out which survivorship screenings should be conducted and when, and which subspecialists should be included in the child's care going forward.

2. Understand that transition is a time of anxiety for children and families.

When a child finishes cancer therapy, it is often cause for both celebration and anxiety for the family. Parents may be

particularly anxious about the end of therapy, the fact that their child will not be seen as frequently in the oncology setting, and the risk of cancer recurrence. If you have concerns about an increase in anxiety around this time, the oncology psychosocial provider at your patient's cancer center can work with you to arrange for your patient and her family to be seen by a community provider.

In addition, families may express concerns about the risk of cancer in their other children. For example, if a child's leukemia first manifested with a high fever, it is logical that the family would be anxious if her brother also developed a high fever. However, with the exception of families with a strong history of cancer, most pediatric cancers do not run in families, and a sibling's risk of cancer is not significantly higher than normal.

3. Watch for signs of early and late treatment effects, and be aware of screening recommendations. Issues around treatment-related toxicities can emerge both during treatment and shortly after transition. For instance, patients who received platinum-containing drugs might experience hearing loss. Effects of treatment that can develop after completion of therapy include:

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DEVELOPMENTAL CORNER

Children's Executive Function Skills

Executive function is a mental process that allows us to understand our past experiences with present action. The brain uses this skill to guide behavior toward accomplishing a goal, prioritizing tasks, controlling impulses and focusing our attention. Doctors can explain to parents that children are born with the potential to gain these abilities through their experiences with caregivers, family members, teachers and other influential persons impacting their development.¹ Executive functions are evaluated in children based on their behavior in non-routine situations that require them to use their own degree of judgment.² Children may show differences in working memory, emotional control, and the ability to think flexibly and engage in self-monitoring.³ If a child has difficulty with executive functions she might:

- Be disorganized (e.g., forget to hand in school assignments or prioritize tasks with calendars)
- Struggle with time management (e.g., have difficulty with open-ended tasks, assignments with little direction, or moving from the planning phase of a project to its implementation)
- Struggle with task initiation (e.g., will not know the length of an appropriate break before beginning homework after school)
- Be unable to complete tasks efficiently (e.g., have trouble staying on task without direction or guidance⁴)
- Be easily frustrated or intolerant of criticism (e.g., have rigid routines and dislike change)
- Display memory difficulties (e.g., forget rules easily and struggle to retrieve items from memory³)
- Appear impulsive (e.g., have uncontrolled impulses¹ or an inability to manage emotions⁴)

When children do not demonstrate appropriate executive function skills, they may show signs of learning differences that require further evaluation. These differences do not necessarily suggest that a child has ADHD, as there are many other reasons children may display discrepancies in executive function abilities. Difficulty



with executive functions could be a sign of Autism, OCD, or traumatic brain injury — to name only a few possibilities. Doctors can evaluate children and discuss strategies with parents to help their children with executive function difficulties. Some common strategies include:

- Engaging in activities that strengthen executive function skills
 - Regular practice can help children develop executive function skills. Parents can increase the complexity of these activities over time.⁵
- Making checklists
 - Checklists provide kids with manageable steps to complete tasks. Parents can create a list of things that must be completed before the child leaves the house in the morning or a list of steps that are related to completing an assignment in school. Checklists can gradually guide children to independence.
- Setting time limits
 - It may be helpful to assign certain tasks time limits to help children understand how long each task should take.
- Explaining the importance of a new process or technique
 - Children should understand why checklists and guidelines are important and related to their successful changes in behavior. They will feel more committed to meeting expectations.
- Sticking to Routines
 - A child should know what is expected of them when they return home from

school, such as an appropriate break time before beginning homework and eating dinner.⁶

- Helping children build social connections with adults
 - Children need a reliable presence that they can trust. Healthy relationships with adults will keep children engaged in creative play and guide them toward gaining better executive function skills.⁵

Doctors can inquire about children's executive function abilities during their yearly check-up. Because a child's difficulty with executive functions may be an indication of other learning differences, it is important for doctors to refer the child for an evaluation as soon as possible.

— *By Bobbie Vergo, OTD, OTR/L and Emmy Lustig, BA, Pathways.org*

For more information about issues related to childhood development, please visit www.pathways.org or email friends@pathways.org. Pathways.org empowers parents and health professionals with FREE tools and resources to maximize a child's motor, sensory, and communication development.

References

- ¹ Key Concepts: Executive Function. Center on the Developing Child Harvard University. www.developingchild.harvard.edu. Accessed 19 Nov 2014.
- ² Banich M. Executive Function: The Search for an Integrated Account. *Current Directions in Psychological Science*. 2009; 18(89); 89-94.
- ³ Morin A. 9 Terms to Know If Your Child struggles With Executive Functioning Issues. *National Center for Learning Disabilities*. www.ncl.org. Accessed 6 Nov 2014.
- ⁴ The Executive Function and School Performance: A 21st Century Challenge. *National Center for Learning Disabilities*. 2010. www.ncl.org. Accessed 6 Nov 2014.
- ⁵ In Brief: Executive Function Skills for Life and Learning. Center on the Developing Child Harvard University. www.developingchild.harvard.edu. Accessed 19 Nov 2014.
- ⁶ Ehmke R. Helping Kids Who Struggle with Executive Functions. *Child Mind Institute*. 2012. www.childmind.org. Accessed 6 Nov 2014.

ShotClock

From the Massachusetts Department of Public Health (MDPH)

The Changing Face of AFIX

You may have experienced an AFIX visit from the Massachusetts Department of Public Health (MDPH) Immunization Program. AFIX, which stands for Assessment, Feedback, Incentive, and eXchange, is a continuous quality improvement process that uses coverage rate data to identify ways to maximize immunization systems and practices at provider offices. The AFIX process is informed by research and we've recently changed the format of these visits.

Instead of reviewing a random sample of immunization records for 19–35-month-olds to determine if your coverage rate meets a pre-determined threshold, as we have in the past, the new AFIX process uses reports built into the Massachusetts Immunization Information System (MIIS). These reports can provide objective data to analyze and improve processes. Under the new AFIX process, we are first targeting providers sharing their information with the MIIS to receive visits. MDPH staff will connect via webinar with provider staff who are responsible for immunizations and immunization policy. Together, we'll review coverage rate reports from the MIIS for children (2-year-olds) and adolescents (13–19-year-olds). Providers will learn how to run standard childhood and adolescent coverage reports, as well as custom coverage reports, through the MIIS. Following a continuous quality improvement process, providers will then choose areas where they would like to focus to improve systems and immunization services. If your practice currently shares information with the MIIS and you're interested in AFIX, or would like to learn more, please contact the Assessment Unit at (617) 983-4330.

Immunization Rates by School Now Online

Detailed immunization coverage and exemption rates for public and private kindergartens from the 2013–14 statewide school immunization survey are now available on the MDPH Immunization Program website, www.mass.gov/eohhs/docs/dph/cdc/immunization/school/kinder-rates-by-school.pdf. Data are

not available for schools reporting fewer than 30 kindergarteners or for schools that did not return the school immunization survey. Sharing these data is important for public health prevention efforts, given rising exemption rates and cases of vaccine preventable diseases both nationwide and in Massachusetts.

Publicly Available, School-Specific Kindergarten Immunization and Immunization Exemption Rates

In January 2015, the Massachusetts Department of Public Health (MDPH) joined a growing number of states by making school-specific immunization and immunization exemption rates available to the public.

Detailed immunization coverage and exemption rates for public and private kindergartens from the 2013–14 statewide school immunization survey are now available on the MDPH Immunization Program website, www.mass.gov/eohhs/docs/dph/cdc/immunization/school/kinder-rates-by-school.pdf.

As I wrote in previous issues of *The Forum*, the public availability of this information is crucial to our efforts to push back against the dangers of vaccine refusal. Unfortunately, the Massachusetts data are missing key elements critical to this effort. While I applaud the MDPH for its work on this important project, they have been constrained by their own internal data release policy prohibiting the release of data for schools with fewer than 30 reported kindergarten students. This includes the smaller, private schools that are often the choice of the more affluent, educated, and self-informed parents most likely to hold anti-vaccine beliefs and to request vaccine exemptions for their children.

The rationale for this policy is that the smaller the class size, the more difficult it becomes to protect the identities of children who may be vaccine-exempt. In other words, in a class of only five children it may be possible to figure out which children are exempt. I find this argument questionable and beside the point. Individuals are not identified by the data, and it is unlikely their identities

would be compromised even at class sizes considerably smaller than the 30-child threshold set by the MDPH. What this policy does do is deprive parents of important information about the safety of their child's environment.

Full transparency would allow discussions to take place based on school-specific risk, and pressure could be placed on those parents who attempt to hide their children in the herd. But releasing data on *all* schools is not sufficient. What we really need to protect our community from vaccine preventable disease outbreaks is a reassessment of our priorities. It is time to eliminate all non-medical vaccine exemptions and stop pretending that the dangerous practice of not immunizing one's child is a choice worthy of respect and protection.

Several states are making it a bit more difficult for parents to exempt their children. In California, where the exemption rate has doubled since 2007, parents must meet with a provider to discuss the risks of their decision, and provide proof of that encounter and a written statement from them. In Michigan, exempting parents must meet with a local health care worker to hear about the risks of under-immunization and sign a state form taking responsibility for these risks. A similar law has been enacted in Oregon.

As the data now stand, most Massachusetts parents have the information they need to determine if their child's school is more or less likely to be the epicenter of a vaccine-preventable disease outbreak. But parents who send their children to the smaller private schools most likely to harbor unvaccinated children are still in the dark.

The MDPH should revise their internal data release policy to allow inclusion of smaller schools. In California, data are released for schools with kindergartens larger than 10 students in size. In Vermont, data are released for schools with more than 6 students. In Illinois there is no data release threshold. If Massachusetts joins these states with more sensible data release policies, we may soon have a true map of our state's potential hot-zones of under-immunization, and parents can begin to have the conversations — and arguments — that we need to have.

— *John Snyder, MD, FAAP*

Massachusetts HPV Vaccination Report (January 2015)

The Centers for Disease Control and Prevention (CDC) has released the second quarterly Massachusetts HPV Vaccination Report. The report contains key data specific to Massachusetts and relevant strategies related to HPV vaccination. Last quarter's report focused on reducing missed opportunities. This report focuses on **the importance of a strong provider recommendation**. Visit http://mcaap.org/wp2013/wp-content/uploads/MassachusettsHPVReport_Jan2015.pdf to access the complete report.

Report highlights include:

- ≥ 1 dose HPV vaccine coverage was higher among girls who received a recommendation versus those who did not (63.8% versus 57.7%).
- A higher proportion of girls received a recommendation for HPV vaccine than boys (70.3% versus 59.1%).

The report also includes 2014 public sector vaccine distribution in Massachusetts compared with earlier years, and estimates of teen vaccination coverage in the United States (NIS-Teen 2013). HPV vaccination coverage at the national level and in most states has been increasing at a very slow pace and remains far below Healthy People 2020 targets of 80% coverage by 2020.

Clinicians can utilize the following methods to help deliver a strong, concise and clear HPV vaccination recommendation:

- Recommend the HPV vaccine in the same way and during the same visit as the other adolescent vaccines. Some evidence suggests that the best recommendation for HPV vaccination includes all indicated adolescent vaccinations.
- Use the "HPV vaccine is cancer prevention" message, because parents identify cancer prevention as important in their decision to vaccinate their children.
- Emphasize your personal belief in the importance of the HPV vaccine.
- Remind parents that the HPV vaccine is safe and effective. If parents have questions, address questions directly and confidently.

Additional clinician resources:

- A new CME Medscape activity is available that discusses communication strategies. "Communicating Safety and Efficacy of HPV Vaccine to Parents and Pre-adolescents" can be found at www.medscape.org/viewarticle/834038.
- Additional Medscape materials addressing the clinician recommendation for HPV vaccine can be found at the CDC HPV portal for clinicians, under the tab "Tools for Your Practice" at www.cdc.gov/vaccines/YouAreTheKey.
- The CDC's "Tips and Timesavers for Talking with Parents about HPV Vaccine" at www.cdc.gov/vaccines/who/teens/for-hcp-tipsheet-hpv.pdf.
- The clinician-specific CDC web portal, which has more resources and materials, at www.cdc.gov/vaccines/YouAreTheKey.

- The CDC's HPV Portal, www.cdc.gov/hpv, which has HPV-related resources that can be shared with clinicians, parents, and patients.

We urge you to identify who may not yet have this information — both within your organization and beyond — so that collectively we can reach everyone in the state involved with vaccinating our adolescents!

If you have any questions, please contact Susan Lett at (617) 983-6823 or susan.lett@state.ma.us, or Rebecca Vanucci at (617) 983-6534 or rebecca.vanucci@state.ma.us.

Thank you for your current efforts.
— *Susan M. Lett, MD, MPH*

The 20th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference

Mark your calendar! The 20th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference will be held on Thursday, October 15, 2015, at the Best Western Royal Plaza Hotel in Marlborough, MA. Updated information will be posted as it becomes available on the MCAAP website at <http://mcaap.org/immunization-cme>.



POVERTY AND PEDIATRICS

Clearing a Path

The young mother was back in the office with her 18-month-old son. "He's still not sleeping at night. He wakes up every two hours all night long and cries if he's not with me." She looked tired. Her thriving and energetic 18-month-old looked anything but tired. The mother and I had been down this road before. I had done my best to problem solve with her, asking detailed questions about who is in the home, who her supports are and reviewing tried and true strategies for sleep. I asked yet another question, "What is the hardest thing for you about letting your son cry?" The mom replied, "I'm afraid the neighbors are going to call DCF."

Providing anticipatory guidance comprises much of the essence of our work as pediatricians. But through the years I have learned that this advice often hinges on resources, and supports a worldview that is not entirely shared by families in poor communities. Institutions that we rely upon for our well-being are not necessarily trusted community partners. In many of our families' eyes, schools focus more on punishing than educating their children; police actions appear aggressive beyond what the circumstances warrant; the Department of Children and Families (DCF) seems to exist to take families apart, not to keep them together, and even the pediatricians dispense truisms that ring false.

When I began my career as an internal medicine/pediatric primary care physician at Baystate Brightwood Health Center in the north end of Springfield in July of 1993, I felt somewhat prepared for what my families would be doing without. The 01107 neighborhood, where the health center was located, encompassed the poorest census tract in the state. I had completed my residency in Springfield and was aware of the poorly performing schools, significant under-employment, food scarcity, and overall poorer health of the city's children, almost 50 percent of whom lived with poverty.

What I was not prepared for was what appeared as a whirlwind overnight. The late 1980s and 1990s brought the HIV epidemic home to the neighborhood served by the health center. Coupled with mass incarceration, where 10 percent of the adult population was passing through the correctional services in any given year, the impact on the neighborhood was simply staggering. Entering primary care in the early 1990s in the north end of Springfield meant being part of a community being emptied by HIV and swallowed by incarceration. Children were dying from AIDS, or found themselves as primary caretakers for parents and family members who had fallen ill. In addition, children were further traumatized by witnessing relatives being hauled off in handcuffs.

I am ambivalent about sharing these stories, even as I write these words. Feeding into stereotypes of poverty and poor urban chaos is not who we want to be as advocates for children, and responding to these stereotypes is not the source of the energy that sustains us. Being witness to the inordinate adversity of circumstances has driven me to look for points of connection with my patients and to listen intently to the understory. *How has poverty impacted my work?* It has compelled me to practice as if the health center was built without walls. Forces of change and inspiration for creativity must grow out of the experiences of our patients and the communities where they live. I strive to take what I have learned from hearing so many voices. That is where the work begins.

How do we support change? Resources do exist in many forms. Grants are helpful as a starting point, but sustainability is key. In 2000 I applied for and received a Child Health Incubator Research Project (CHIRP) grant focused on "Helping children with incarcerated parents." The health center already had a presence in the local correctional facility, providing health care to community members who were incarcerated. However, the impact of parental incarceration on their children, and the family members left caring for them, was not being addressed. Around the table sat representatives from the

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Clearing a Path

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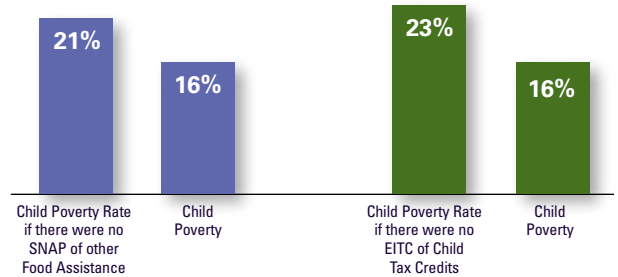
schools, the Department of Children and Family Services, law enforcement and parents. I was haunted by one parent’s challenge early on in the conversation, “Why should I get my hopes up that something will change... what will be left when the grant/group goes away?” I still hear her voice whenever I sit at a table where a new project or initiative is being discussed.

Recognizing the disconnect that our families have with institutions, Brightwood Health Center’s outreach has focused on aligning health needs with community based organizations. The “walking school bus” began in the north end of Springfield a number of years ago as part of a concerted effort to create safe passageways to school, increase school attendance, and support opportunities for exercise. Most children lived within walking distance to the four neighborhood schools, but very few children were walking due to well-grounded fears about the safety of the streets. The “walking school bus” is a collaboration that includes one of our local elementary schools, parent volunteers, local and state police departments, and the health center. Children are “picked up” by the walking team of teachers and parent volunteers at designated

stops by their homes and a mini-parade ensues as the routes converge upon the school. Police officers are visible in a positive and even nurturing role as they banter with the children and parents along the way.

I was asked to write this piece to share why I have chosen to work with children who live in poverty. Well, the work is hard and often heartbreaking as we witness the poverty that surrounds peoples’ lives. But we work inch by inch and row by row together. One of the health center’s most recent projects was creating a community school garden and outdoor learning space. At least six community partners joined in this endeavor. The local elementary school now utilizes a “garden curriculum” and the students spend time regularly tending the raised beds. We were harvesting potatoes, which look impressive from the amount of greenery above ground, but the clump of dirt that appeared was deceptively unimpressive. A child pulled the potato plant up to a chorus of disappointed “awes”. However, after shaking off the dirt, an impressive cluster of potatoes appeared and

Public Benefits and the Safety Net Keep Children Out of Poverty



the chorus changed to “wow” as the child declared, “a potato is born.”

So what comes after being born for the children living in an impoverished neighborhood? Nicholas Kristof and Sheryl WuDunn, authors of *Half the Sky*, have written a new book titled *A Path Appears*. The book begins with a quote from a Chinese essayist, Lu Xun: “Hope is like a path in the countryside. Originally, there is nothing — but as people walk this way again and again, a path appears.” My experience tells me that if we walk this path together with the children we care for, with their families and with our community, we arrive at a better place for everyone.

Have an idea for a Poverty and Pediatrics article, or want to write one yourself? Contact John O’Reilly, MD, at joreilly@mcaap.org. — **Audrey Guhn, MD**

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Treating Children with Cancer

continued from page 4

- Heart disease in survivors treated with anthracycline compounds
- Neurocognitive and neuroendocrine dysfunction in patients who received radiation for a brain tumor
- Male and female infertility, which may become a concern to survivors as they grow beyond their adolescent years

The Children's Oncology Group publishes web-based guidelines for survivors' follow-up care.¹ The primary care provider also has an active role to play. For instance, a child who received radiation to the brain might have difficulties with cognition that affect school performance. If problems arise, consider referring him or her for neurocognitive testing. Similarly, signs of growth delay, hypothyroidism, or early or late puberty could

indicate a treatment-related endocrine dysfunction that warrants referral to an endocrinologist.

4. Understand the new services available in cancer centers with pediatric oncology programs. With the growing number of survivors, most large pediatric cancer programs deliver specialized services for survivors. Many programs offer survivor clinics, which can provide multidisciplinary consultation and ongoing care, including parent/patient education; oncology assessment; mental health services; and medical subspecialty evaluations such as endocrinology, dermatology, neurology, and cardiology. In addition, many programs offer genetic counseling, fertility assessments, and support groups. Some programs even provide camp opportunities, scholarships, volunteer

opportunities, and team-building activities for eligible survivors.

5. Promote good eating, exercise, and health habits. Good nutrition, exercise, and tobacco avoidance are all part of good health and are just as important to childhood cancer survivors as they are to your other patients. Encouraging healthy lifestyles can help childhood survivors reduce later risks of chronic adult disease that may otherwise be elevated due to the treatment they received as children.

— *Lisa Diller, MD², and Peter Manley, MD³*

References

¹ www.childrensoncologygroup.org/index.php/survivorshipguidelines

² Chief Medical Officer of Dana-Farber/Boston Children's Cancer and Blood Disorders Center and Medical Director of the David B. Perini Jr. Quality of Life Clinic,

³ Dana-Farber/Boston Children's Neuro-Oncologist and Director of the Stop & Shop Family Pediatric Neuro-Oncology Outcomes Clinic

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BOOK CORNER

All Ears

When I was pregnant with my children, I tried to replicate a famous study of in utero “reading.” In the original study, infants who heard the book *Hop on Pop* nightly during the last trimester protested at two weeks of age when the words were changed and didn’t rhyme¹. My children unfortunately failed and just slept — but for that I was at least grateful. And I still believe in the power of voice both prenatally and in early infancy to impact how infants develop and understand language long before they can understand words.

In two recent studies in *Pediatrics*^{2,3}, Dr. Betty Vohr and colleagues studied the effects of early language exposure on babies at risk for language delays. The goal of the study was to test the association of early language exposure with Bayley Scales of Infant and Toddler Development later in life. The prospective cohort study included 33 preterm infants with a birth weight of < 1250g. Audio recordings were made in the NICU at 32 and 36 weeks and in the home at 44 weeks and 7 months. The recordings were analyzed for adult word count, infant vocalizations, and conversational exchanges. Home recordings were done only on days both parents were home. Bayley measures were assessed at 7 and 18 months.

The first study found that adult word counts for the 32-week recording in the

NICU were positively correlated with 7- and 18-month Bayley scores. When adjusted for birthweight, the adult word count accounted for 12% of the language variance scores and 20% of the variance in expressive communication scores at 18 months. Specifically, an increased amount of parent talk with preterm infants in the NICU was associated with higher 7- and 18-month corrected age Bayley-III language and cognitive scores.

In the second study they hoped to evaluate the verbal interactions of parents with their infants in the first months of life. They found that the majority of words infants heard, directed at them or in the background, came from mothers. They also found that about 25% of vocalizations from infants got an adult response. Those responses came from mothers alone more than 70% of the time, from both parents 18 to 23% of the time, and from fathers alone just 6 to 12% of the time. Infants preferentially responded to female adult speech compared with male adult speech. They also found that mothers responded more often to girls than boys. Fathers responded more often to boys, but the difference was so small that the researchers said it was not significant.

This study is small and included only families in which a male and female parent lived together, so it might not

represent all families and should be repeated on a larger scale. But these findings are notable. Babies are listening from the very beginning and the amount of language that they are exposed to seems to impact cognitive and language development seven and even 18 months later. While further studies are needed to understand early child development and the role language exposure plays in that development, why not start talking to our babies from the very beginning? For those fathers who may not be talking as much to their infants, let’s put a book in their hands and give them a useful tool to make the language happen. Our babies are listening, so we should be too. — **Marilyn Augustyn, MD, FAAP**

For more information about Reach Out and Read and early language development, email the Massachusetts Program Director Alison Corning-Clarke at alison.clarke@reachoutandread.org or the Massachusetts Coalition Medical Director Marilyn Augustyn at augustyn@bu.edu.

References

- DeCasper AJ, Spence MJ, “Prenatal maternal speech influences newborns’ perception of speech sounds”, *Infant Behavior and Development*, 9(2):133–156, 1986.
- Caskey M, Stephens B, Tucker R, Vohr B., “Adult talk in the NICU with preterm infants and developmental outcomes,” *Pediatrics*. 2014;133(3):e578–84.
- Johnson K, Caskey M, Rand K, Tucker R, Vohr B, “Gender Differences in Adult Infant Communication in the First Months of Life,” *Pediatrics*. 2014 Dec;134(6):e1603–10.

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Special Models of Care

continued from page 1

MA and 43% nationally) currently receive it. While these specific numbers may partly relate to medical home criteria and the nature of surveys, it's clear that *being* a medical home is difficult and that many children are left out.

Because the primary mission of MCAAP is to help our membership deliver better care, this year's Edward Penn Memorial CME Program and Annual Meeting (May 14 at the Massachusetts Medical Society headquarters in Waltham) will be devoted to building medical homes for children with special health care needs. Attendees will have the opportunity to hear from experts in Massachusetts and beyond about models of care that are in place today and are in development for the future. While the presentations themselves will be highly informative, we expect the workshops

and Q&A sessions to be even more so. Through activities such as these, the MCAAP hopes to help members build the awareness, connections, and collaborations necessary for integrating our systems of care.

Integrating systems of care for CSHCN is now an HRSA priority. State implementation grants have recently been awarded to increase the number of children with special health care needs who receive comprehensive, coordinated services in patient/family-centered medical homes. Our own Commonwealth has received one of these grants, so we can look forward to additional support in the coming years. MCAAP is committed to working closely with the state to bring tangible benefits to our members and patients. Please join us at this year's Annual Meeting, stay tuned for future developments, and let us know if you would like to help. — **Michael McManus, MD, MPD, FAAP**