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

MCAAP Ventures: From Tourist to Tour Guide

I have always been a believer in the philosophy: 'think globally and read locally.' When I was training in Baltimore, *The Accidental Tourist* by local author Anne Tyler was featured at my neighborhood bookstore. I have long forgotten the details of the book, but the title has stayed with me as a way to be open to the many unplanned adventures in my life. A car breakdown in Texas can turn into a honky-tonk tourist extravaganza, flight delays can turn into hours of learning about the worlds, and the worldviews, of stranded fellow passengers. Travel can be a great teacher if you let it. Tourists who truly experience their destinations can come home with a new appreciation of where they live because they can view their home through the lens of a fresh perspective.

I think of my work with the MCAAP as the latest example of my being "an accidental tourist." My journey started with a conversation over coffee before Grand Rounds, and a simple request to help out. There were no brochures about exotic places, not even promises of umbrella drinks. The drive to Boston would be annoying, and the conference rooms in Waltham corporate bland, but my fellow MCAAP Board members would create an inspiring vista. Their passionate visions of creating a society where the many needs of our pediatric patients can be met painted great vistas of the possible. After board meetings I would drive home on the dark Mass Pike, dodging tractor trailers and imagining that over the next rise will be the new dawn of pediatric care — ushered

continued on page 3

Table of Contents • Spring 2014 • Volume 15 No. 2

President's Message 1
Are Pediatric Provider Networks Too Narrow? 1
Editor's Note 2
Training Community-based Pediatricians in Palliative Care. .4
MSC Shoe Drive for Kids 6
The Policy Hub: A Recap of Official AAP Policy Changes 7
The Legislative Report: Notes from Beacon Hill. 7
ShotClock 8
From the Immunization Initiative Director: The Massachusetts Vaccine Trust Fund and Registry Bill is Now Law 8
Addressing Vaccine Hesitancy in Western Massachusetts 8
Vaccines: Victims of Their Own Success. 8
Science vs. Pseudoscience 9
HPV Vaccination Initiative — You are the Key to HPV Cancer Prevention Web Page 9
Tips and Time-Savers for Talking with Parents about HPV Vaccine 10
From the MDPH: Data Loggers 10
The 19th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference 10
Book Corner 11
Developmental Corner 12
Medical Student Committee Holds Annual MCAAP Mentoring Meeting 14

Are Pediatric Provider Networks Too Narrow?

Several MCAAP members have recently noted increasingly restrictive provider networks that interfere with the delivery of high-quality pediatric care. For example, some patients in Fall River must travel into Boston for routine audiology, while others face tiered networks with large co-pays for well child visits to any provider outside their small network[1].

The MCAAP leadership is very concerned about this trend and is eager to hear from our members. We are currently preparing to approach health plans, ACOs, insurance companies, state regulatory boards, and the legislature in order to advocate on behalf of patients across the state.

We welcome members to share their stories, and the stories of their patients, by contacting Cathleen Haggerty at chaggerty@mcaap.org or Anne Light, MD, at alight@mcaap.org.

Together, we can ensure that as our state undergoes dramatic changes in its care networks, our patients will continue to receive the high-quality care that they need.

— Anne H Light, MD, FAAP

Reference

[1]Rok W. Personal communication. March 4, 2014

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EDITOR'S NOTE

Announcing Three New *Forum* Columns

I am very excited to introduce three new *Forum* columns in this issue. Together, they will give you an overview of all AAP policy changes and practice guidelines, keep you informed about local legislation, and connect you to new resources that support early childhood development. You will find a brief description of each new column below. Then, dive into this Spring's *Forum* to read them all!

The Policy Hub: A Recap of Official AAP Policy Changes

The Policy Hub is a new column that highlights any and all changes to official AAP practice guidelines. With a glance, you can quickly review any new recommendations that will affect your patient care, and make sure you don't miss a thing. Presented in a brief, bullet-point format that is organized by recommendation type and patient age, this clearinghouse has short descriptions of each new policy. Should you want more information on any specific policy, the online, interactive PDF edition of *The Forum* can quickly take you from our page to the full guideline text with a click of the mouse. Citations and printed links are included for easy access to new policies in printed *Forum* issues as well.

The Legislative Report: Notes from Beacon Hill

So much of the MCAAP's value comes from our leaders' hard work at the state level. Our chapter advocates tirelessly for both our members and our patients on a staggering variety of levels. In any given month, our chapter might be soliciting member feedback on one issue, working with legislators on another, and helping a committee to create new policy for a third. We work extensively with other groups and governmental bodies to change both the Massachusetts statutes and the way they are interpreted and enforced.

Each quarter, the Legislative Report will summarize any new changes to Massachusetts Law that affect your practice or patient care, describe ongoing Chapter involvement with relevant bills, and provide a 'heads-up' for providers who might be interested in a specific topic. For example, we know that the gun safety legislation is likely to come to the House of Representatives in April, as this issue goes to print. If you have experience in this arena and would like to be involved in crafting or supporting the MCAAP's message, you can contact Michael McManus, MD, FAAP[1] or Karen McAlmon, MD, FAAP[2], the co-chairs of our Legislation Committee.

continued on page 5

MCAAP Ventures: From Tourist to Tour Guide

continued from page 1

in by the bright and dedicated pediatricians of the MCAAP.

I am not a "sit around the pool" type of tourist. If I'm not out exploring the outdoors, I'm usually touring the local museum or the local distillery (or both). Learning about the new places I'm visiting energizes me, spurring me to learn a new perspective, and use that experience to challenge my view of the world.

My time as an accidental tourist in the MCAAP was an opportunity to learn an amazing amount about the world beyond my office walls. The AAP works to educate pediatricians across the globe, and it makes sure its local leaders are on top of the latest research in order to effectively lead their Chapters. Leadership meetings were seminars where we would learn about cutting-edge research, discuss policy responses to the research, and plan how we would bring all of the information back to our members.

Before my time on the MCAAP board, I thought toxic stress was something that only happened around waste dumps. As part of our leadership training though, I went to meetings where top scientists in the fields of toxic stress and child development discussed the latest research. AAP leaders then review how to best revise the organization's policy to reflect our expanded knowledge of the issue. We determined how to translate the research into something our members can use to improve the care of their patients. The concept of toxic stress and its impact on early brain and child development will dramatically alter the way we deliver pediatric care, and the MCAAP and the AAP will be at the forefront of this paradigm shift.

I often try to include service in my tourist adventures. The MCAAP has given me many opportunities to provide service and promote a worthy cause. With my background as pediatric clerkship director at Baystate Health, mentoring the next generation of pediatricians has always been an interest of mine. The MCAAP has provided a great opportunity for the expansion of pediatric mentorship across the Commonwealth.

Working with Cathleen Haggerty and an amazing group of energetic medical students, we were able to organize the first annual mentoring conference at Boston University. I hope that all of our members will embrace the idea of mentoring the next generation of pediatricians and join our initiative.

As I finish my term as president, and my stint as an accidental tourist through the MCAAP and the AAP, I return to my practice with many new insights from my travels. My time working on the state level has changed the way that I work on the local level.

Working with our legislative committee has taught me the value of advocating with government officials. Watching years of hard work and dedication from Sean Palfrey and the Immunization Initiative culminate in the passing of a vaccine trust bill has been inspirational. I have never considered myself overtly political; I knew that Jim McGovern represented Northampton in Congress because his district office was next to a good Thai restaurant downtown, but I didn't know what a powerful voice he was for children's issues until I became involved in MCAAP advocacy and met with his staff about issues such as gun violence prevention and funding for the SNAP program. Although my stomach may argue otherwise, his office may become the new destination of choice on that block.

Toxic stress has filled the halls of the inner city resident clinic throughout the 24 years I have worked there, but it never had a name. As we all know in medicine, we often need a name for an entity before we can diagnose and treat it. I knew that the lead team chelated in hallway A, the child abuse team met their families in the Wesson conference room, and that the really psychiatrically impaired kids were sent downstairs to the partial hospitalization program. But I worked with that teeming multitude in the middle, the ones without a named diagnosis. Their morbid milieu of poverty, poor nutrition, inconsistent parenting, poor housing, and violent drug-infested neighborhoods had no ICD-10 code by which we could diagnose and treat. As Dr. John Snow taught us so long ago, the first thing you must do when a plague is destroying a community is to get a handle on the problem. It's not as easy as turning off a spigot, but at least we have some ideas about how to start. Advocacy, education, community action, and research will all be required for success. We can only make a difference by working together on local, state, and national levels. The MCAAP and the AAP can provide the organizational structure and support that is necessary to address the plague of toxic stress devastating our patients and families.

continued on page 6

Training Community-based Pediatricians in Palliative Care

A perspective that comes from continuity of care over many years. An awareness of local resources. A sense of who a family is. An appreciation of the things that give life meaning and value to a child and family. Isn't this care a lot to offer families of seriously ill children? What happens to all of this knowledge when a child becomes more ill and spends increasing amounts of time in the hospital? General pediatricians are uniquely poised to help children with serious illness and their families.

As a member of the Pediatric Advanced Care Team, a joint palliative care program of Dana-Farber Cancer Institute and Boston Children's Hospital, I've spent most of my career as a primary care pediatrician, practicing in Cambridge and Boston. I found great satisfaction in helping usher children and families through an incredible period in their lives as I treated the normal illnesses and injuries of childhood and helped to prepare my young patients for healthy adulthoods. Like virtually all pediatricians, I've also had some patients facing serious, life-limiting conditions. Some died. Although these children received important aspects of their treatment from specialists, I increasingly realized that I could — and should — have an ongoing role in their care.

Palliative care strives to improve the quality of life of patients facing life-threatening illnesses, as well as the quality of life of their families. It does so through the prevention and relief of suffering by early identification and treatment of pain and other problems, whether physical, psychosocial, or spiritual. It is a relationship-focused intervention, which dovetails with a core strength of primary care. Recent state requirements that physicians be trained in end-of-life care and pain management present a powerful opportunity to capitalize on this strength and integrate the primary care pediatrician into the team caring for seriously ill children.

The need is great. More children are living longer with conditions previously fatal at young ages. Even though more infants cared for in our neonatal intensive care units (NICUs) are surviving, some are burdened by ongoing illness. The large numbers of children with complex, chronic illnesses in our hospitals also spend much of their time at home with their families. It is there that their lives take shape and meaning.

Home includes community and the pediatricians whose practices encompass not only the seriously ill child but also healthy siblings, friends, and neighbors. Pediatricians know the families they serve and the resources in the communities in which they practice. They understand what animated previous decisions, what the families' goals are, and how the families confront risk. Children with "terminal" illnesses often lead meaningful lives for years. Indeed, 70 percent of patients consulting palliative care are alive after a year. Even with end-of-life care, primary care pediatricians can promote a life-centered approach that helps families clarify their priorities and helps ensure that their experience remains consistent with what the family wants for their child.

continued on page 5

Training Community-based Pediatricians in Palliative Care

continued from page 4

General pediatricians can also offer much to hospital-based medical teams, whose care improves when their understanding of a child goes beyond "the kid with a certain diagnosis in Room 4 who's on a ventilator." How do the choices being asked of the family align with their long-standing priorities? What will a tracheostomy mean, for instance, in terms of the local school system and community supports? Successful collaboration between the primary care physician and specialty team includes the timely sharing of information, mutual inclusion in clarifying goals of care and medical decision-making, coordinated designation of responsibilities, and explicit review of case management and social work needs.

General pediatricians are well positioned to handle basic issues of adjustment, behavior, and siblings. In collaboration with palliative care specialists, they can provide basic pain and symptom management. Pediatricians' ongoing relationships with patients and their families can inform discussions of prognosis, suffering, goals of care, and code status. Families appreciate their pediatrician's continued involvement. In conducting research on families that lost a child, I found that even when medical decisions were outside the realm of primary care, it mattered to them that the pediatrician remained informed. It mattered that they could come to the pediatrician for explanations and their perspective. It mattered that the pediatrician focused on their bereavement needs. The community-based pediatrician, after all, has a privileged role that will continue with the family and their surviving children.

Supporting community-based pediatricians to do much more for children with complex, life-limiting illness is a logical extension of what they already do and builds on their considerable strengths. Anything the medical system can do to promote this translates into better, more cost-effective care for these children and their families. ***— Richard Goldstein, MD***

Announcing Three New *Forum* Columns

continued from page 2

Investment in Early Childhood: Resources for Early Development

Investment in Early Childhood is a part of the MCAAP's core mission. In keeping with this mission, we advocate for early childhood support, co-sponsor an annual Early Childhood Summit, and provide members with emerging resources to benefit both their patients and their practice. *The Forum* is pleased to further this commitment with a new quarterly column on early childhood development. Topics will run the gamut from parent resources to screening tools and local legislation — and will change with every issue. What will remain constant is the input from our friends at Pathways.org, a nonprofit with expertise in and resources for both clinician assistance and parent support, as well as information from local experts in our Chapter. ***— Anne Light MD, FAAP***

References

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Beacon Assessment Center

Diagnostic and Neuropsychological Evaluations

North Dartmouth, North Andover
West Springfield, Milford

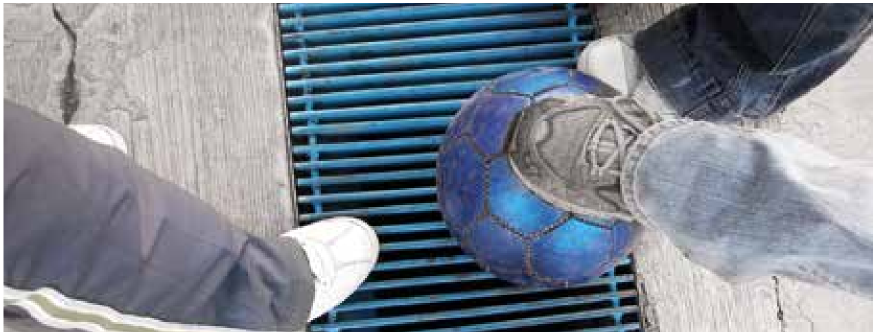
Referral Line: 508-478-0587
BeaconServices.org

Available Services:

- *Diagnostic Screenings, Neurodevelopmental Assessments and Neuropsychological Evaluations*
- *Specialization: Autism Spectrum Disorders, Learning Disorders, Developmental Disabilities and Challenging Behaviors, Ages one through sixteen years old.*
- *Appointments Scheduled within one month.*
- *Please call our referral line to schedule an appointment (508) 478-0587*
- *For more information please visit our website: beaconservices.org*
- *Most major health-insurance plans accepted*

MSC Shoe Drive for Kids

Did you know that there are many children, living just minutes away from you, without an adequate pair of sneakers to play outside? Physical activity is a key component of obesity prevention and management. An all-too-common barrier to physical activity among low-income children is a lack of proper footwear for exercise. The MCAAP Medical Student Committee is coordinating a shoe drive to benefit underserved children in Boston. The goal of this initiative is to encourage and empower kids to get on their feet and live active lifestyles. All four Massachusetts medical schools are uniting to raise funds at each medical school and in their respective communities. Later in the spring, medical students will distribute sneakers to children in the community. Each pair of shoes will include a note from donors with an idea for how children can be active in their new shoes. Every child deserves a good pair of sneakers that fit to get them excited about being active. We encourage all MCAAP members to donate at their medical schools or online at www.indiegogo.com/projects/mcaap-shoe-drive-for-kids. We appreciate any donation you can offer! ***— Michelle-Marie Peña, Harvard Medical School '14, HMS representative, MCAAP Medical Student Committee; and Kristin Schwarz, Boston University '14, co-chair, MCAAP Medical Student Committee***



American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Massachusetts Chapter

Medical Student Committee

Shoe Drive

Encouraging the Underserved Children of Boston to Take the Next Steps Toward an Active Lifestyle

MCAAP Ventures: From Tourist to Tour Guide

continued from page 3

Before I became MCAAP president I worked with medical students because it was my job as clerkship director. When I go back to being a regular primary care pediatrician, I will work with medical students because they are our future. Mentoring students and residents is a two-way street, where I can share the importance of compassionate care and the wisdom I have accumulated over the years, while they teach me the importance of computers. I believe my work in pediatrics will be more fun and rewarding if I share it with a student or resident.

Ending my term will not end my involvement with the MCAAP. There is a lot of work to do to be sure that high-quality pediatric care can be delivered and reimbursed for in our new era of ACOs and population-based medicine. The MCAAP needs all of its members to stay involved and engaged. Ending my term will end my President's Column, but it will not end my contributions to *The Forum*. My days as an "accidental tourist" in leadership may be ending, but there may be some "postcards from the edge" (of the state), as my adventures in trying to apply some of the national initiatives locally begin. I might even have to change my reading philosophy to 'read nationally, apply locally.'

As I step off the tour bus, there are a lot of seats open for anyone interested in becoming a purposeful tourist in the MCAAP. Your tour director Cathleen Haggerty has a range of tourist opportunities, and can create an experience that meets your interests and your time availability. I can guarantee that it will expand your horizons and enhance your practice. If you are as buried in flu, RSV, and the stomach bug as I am, perhaps working on a MCAAP project will be the break that brings you back to your clinical practice re-energized. I can also guarantee that whatever adventure you sign up for, the water will be safe, and fluorinated, thanks to the Oral Health Committee. Give Cathleen an email at chaggerty@mcaap.org, and let your adventure begin! ***— John O'Reilly, MD, FAAP***

THE POLICY HUB: A RECAP OF OFFICIAL AAP POLICY CHANGES

A Roundup of All Official AAP Policy Changes Since the Last *Forum* Issue

2014 Recommendations for Preventive Pediatric Health Care[1, 2].

A short summary of recommended changes:

Newborn

- Pulse oximetry in hospital

15–30 Months

- Hematocrit or hemoglobin risk assessment

9–11 Years

- Additional dyslipidemia screening

11–21 Years

- Depression screening
- Recommendations for specific screening tools
- Recommendations for CRAFFT-screening to assess alcohol and drug use

16–18 Years

- Screen for HIV

Under 21

- No routine cervical dysplasia screens
- Indications for pelvic exams remain as per 2010 guidelines

Other major recommendations released since January 2014

Guidelines for referral to pediatric surgical subspecialists[3]

Referral recommendations for pediatric surgeons, pediatric neurosurgeons, pediatric ophthalmologists, pediatric otolaryngologists, pediatric dentists, congenital heart surgeons, pediatric urologists, pediatric orthopedists, pediatric plastic surgeons, and endoscopy

Immediate CPAP followed by selective surfactant in preterm infants[4]

No raw milk or milk products[5]

All recommendations are from the AAP, published in the journal *Pediatrics*, and available both in print and online.

References

[1]www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx

[2]See more at www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx#sthash.raf4t1YD.dpuf

[3]http://pediatrics.aappublications.org/content/133/2/350.full.pdf+html

[4]http://pediatrics.aappublications.org/content/133/1/171.full.html

[5]http://pediatrics.aappublications.org/content/133/1/175.full.pdf+html

THE LEGISLATIVE REPORT: NOTES FROM BEACON HILL

Spring Full of Progress and Education

The Massachusetts Vaccine Trust Fund and Registry Bill Is Now Law

Thanks to the hard work and strong efforts of Sean Palfrey, MD, Ed Brennan, Esq., and our hardworking MCAAP colleagues and legistlative allies, the Massachusetts Vaccine Trust Fund and Registry Bill was signed into law in February 2014. For more information on the bill, see Sean's article on page 8.

Gun Safety Legislation

The state Legislature's Public Safety Committee is expected to issue a report on a gun safety bill before the end of March, with the House scheduled to take it up in early April.

A task force created by House Speaker Robert DeLeo has already issued a report on gun safety and the issue of mental illness, which may guide the Public Safety Committee in its efforts to develop legislation.

The MCAAP also submitted testimony in support of tightening Massachusetts gun control laws.

Electronic Medical Record (EMR) Use and State Licensure

As Chapter 224, the state's Health Care Payment Reform Law, currently stands, all physicians must demonstrate proficiency in EMR use by 2015 in order to renew their medical licenses.

This proficiency must be "at the level of the federal government's Meaningful Use standards."

Current provision in these Federal standards require that physicians need *both*:

- 20% of patients on Medicare or Medicaid
- 50% of patients with online portal accounts, and 5% patients contacting the physicians via said portal

Given the current wording, there is concern that many Massachusetts physicians will not qualify for license renewal.

The MCAAP is supporting efforts by the MMS to amend Chapter 224 to require physicians to either demonstrate Meaningful Use skills or familiarity with electronic health records (EHRs) for license renewal after January 1, 2015.

Our goal is to make sure that physicians demonstrate familiarity with EMR systems without onerous requirements to prove specifics in daily use.

Residents and Fellows Day at the State House (FDASH) — Save the Date

The annual FDASH will be held on Wednesday, June 11, at Massachusetts General Hospital and the Massachusetts State House. Visit the MCAAP website for more detailed information.

— Anne Light, MD, FAAP, and Edward J. Brennan Jr., Esq.

ShotClock

From the Immunization Initiative Director: The Massachusetts Vaccine Trust Fund and Registry Bill is Now Law

The bill itself took five years to work its way through the state Legislative process, but the concept of keeping Massachusetts a "universal distribution state" for *all* nationally recommended vaccines for *all* children has been central to the MCAAP mission as long as the state chapter has existed.

For a hundred years, the state funded the manufacture and distribution of vaccines for all its children. But when many new vaccines were developed and manufactured commercially outside of the state, the cost became prohibitive. Massachusetts could no longer afford to pay for them all, even with federal subsidies from the Vaccines for Children and 317 programs. So a coalition of MCAAP, MDPH, Ropes and Gray pro-bono lawyers, and several stalwart legislators (particularly Representative Alice Wolf and Senator Richard Moore) wrote a bill to create a public-private mechanism to fund the purchase of all these vaccines, create a state registry for data collection and management, and support the MDPH to continue to manage and distribute all vaccines.

The process of shepherding this bill from the writing stage to its signing by the governor in February 2014 was eye opening, educational, patience testing, infuriating — and sometimes exhilarating. It could not have been done without the inside knowledge and wise counsel of our lawyer-lobbyist, Ed Brennan, who monitored every slippery step in the process. There was opposition, but not from anti-vaccine groups. Nothing in the bill requires any child to receive any vaccine. It just makes all vaccines available to all children, free. The opposition came from insurance companies who are required to pay (at a 40 percent federal discount rate) for the vaccines given to all their covered children. The manufacturers were not all happy either because their vaccines are being bought at the federal discount, not open market rates.

Inevitably, compromises had to be made: not all vaccines fall under the payment mechanism of the bill, *yet*. Money for HPV and certain booster doses of recommended vaccines are not all contributed to the Trust Fund by the private insurers, *yet*. But provisions in the bill allow the MDPH, with the advice of a state committee (on which the MCAAP and other clinicians have solid membership), to steadily increase the coverage to 100 percent over a period of years. The registry is fully funded and will enable parents, clinicians, and essential partners (e.g., MDPH, schools, and WIC) to monitor all vaccines for all children, keep children up to date, and track them in emergencies. Most importantly, the bill is now law — essentially permanent — and immutable unless the Legislature votes to change the law.

— Sean Palfrey, MD, FAAP

Addressing Vaccine Hesitancy in Western Massachusetts

(Part 1 in a series on immunization challenges in western Massachusetts)

The summer 2013 issue of ShotClock addressed the alarming rise in school vaccine exemptions throughout the Commonwealth. Though the overall exemption rate for the 2012–2013 school year was only 1.5 percent, resembling the nationwide rate, that number hides the wide variability in vaccination rates due to local pockets of vaccine hesitancy. Franklin, Cape Cod, and Hampshire Counties reported exemption rates of 6.0, 4.5, and 4.2 percent respectively. These may not sound high, but the herd immunity threshold (the vaccination rate required to prevent disease outbreaks) is also quite high, and even a small dip in the vaccination rate can and does bring back disease. In several Massachusetts communities we are probably already at this threshold for some vaccine-preventable diseases. In other communities around the country the situation is even worse, and outbreaks of disease are already being seen. In Europe and the United Kingdom, where vaccine refusals are much more widespread, outbreaks of measles and other vaccine-preventable disease are becoming commonplace.

Vaccines: Victims of Their Own Success

Why are so many parents becoming fearful of vaccines? It's important to remember that parents who request an alternate vaccine schedule believe they are making the right decision for their child. One reason parents can be so easily swayed by vaccine misinformation is that most vaccine-preventable diseases are now a mere abstraction. Because vaccines have been so successful at reducing the incidence of these horrific diseases, few parents have ever seen or even heard of

them. That wasn't the case when they were an ever-present specter looming over every parent's head. Then, the thought of not vaccinating was inconceivable to most parents.

The fast-moving avalanche of vaccine misinformation propagated by social circles, social media, the mass media, and the Internet have further contributed to this climate of mistrust. Fortunately, most parents understand that vaccines are responsible for the dramatic decline in the incidence of horrible diseases and that they are generally safe. However, they may falsely conclude that because most vaccine-preventable diseases are now so rare, they no longer need to be as vigilant about vaccinating their children. This makes it easier for parents, who don't necessarily buy into the full anti-vaccine mythology, to take a 'play-it-safe' approach and accept some form of alternate vaccination strategy. It is difficult to explain to these parents that until the diseases are truly *eradicated*, we must keep vaccinating everyone; that everyone needs to be vaccinated to maintain herd immunity for those too young to be vaccinated, for those who cannot be vaccinated for health reasons, and for those for whom the vaccines do not work.

Science vs. Pseudoscience

Many parents report coming to their decisions about vaccines after doing their own "research." What this report usually means is that they have spoken with other vaccine-hesitant parents, have heard anecdotes about vaccine side effects, and have found anti-vaccine material on the Internet or in books. In the process, they resist or ignore scientific experts and science itself under the belief that they can be their own experts in areas far exceeding their capabilities. Unfortunately, the sources they rely upon typically cherry-pick data, misrepresent studies, and summarily ignore or explain away the weight of sound science to support an anti-vaccine agenda. What these parents don't realize is that, unlike science, this pseudoscientific perspective never changes or adapts to new evidence, whereas real science evolves and changes as new evidence emerges and is validated. In that regard, anti-vaccinationism and other pseudoscientific dogmas are closer to belief systems than to science. The inability of most people to distinguish science from pseudoscience lies at the heart of the current confusion regarding vaccine safety.

Unfortunately, this critically important public health issue has been largely ignored. Parents who are concerned may be hesitant to bring it up, as it tends to polarize individuals within communities. This lack of public discourse is glaringly evident when it comes to the issue of school vaccination rates. While much emphasis is placed on the safety of our children's environment, from the air they breathe and the water they drink, to the types of foods they eat and the way their fruits and vegetables are grown, few parents give any thought to whether their children are surrounded by the protective shield of community immunization. In fact, the Massachusetts school vaccination and vaccine exemption rates are not even publicly available. The situation is different in California, where any parent can look on that state's DPH website to find vaccination data for their child's school. While this information should be an important consideration when deciding where to send one's child to school, it isn't on the minds of most parents, nor is it even publicly available.

Getting the importance of this issue on the minds of more parents, legislators, and health care providers is the mission of the newly formed Coalition for Science in Health (CSH). This coalition is comprised of western Massachusetts parents, pediatric providers, and concerned citizens whose mission is to educate the community about the importance of vaccines, and to highlight the critical role of science in vaccination and other health care issues. To obtain more information about CSH, email coscihealth@yahoo.com.

— John Snyder, MD, FAAP

HPV Vaccination Initiative — You are the Key to HPV Cancer Prevention Web Page

The MCAAP has created a new web page dedicated to the Massachusetts HPV Vaccination Initiative, *You are the Key to HPV Cancer Prevention* (http://mcaap.org/immunization-hpv).

The web page contains news and resources about the Massachusetts HPV Vaccination Initiative, along with resources for providers, handouts for parents and patients, and professional education information.

Have you experienced a HPV vaccination challenge in your practice that you have been able to overcome and would be willing to share? If yes, please contact Cynthia McReynolds at cmcreynolds@mms.org.

Tips and Time-Savers for Talking with Parents about HPV Vaccine

As part of its initiative to improve HPV vaccination rates, the CDC has created a web page dedicated to HPV vaccine resources for providers — www.cdc.gov/vaccines/who/teens/for-hcp/hpv-resources.html.

Among the highlighted resources is Tips and Time-Savers for Talking with Parents about HPV Vaccine (http://www.cdc.gov/vaccines/who/teens/for-hcp-tipsheet-hpv.pdf). The tip sheet provides clinicians with straightforward messages for discussing the HPV vaccine with parents. These easy-to-deliver tips will address parents' potential concerns, provide effective responses to questions, and save time. Each question and answer pair is based upon research with both parents and providers to best understand parents' questions, share information, and offer clinicians the kinds of phrasing that helps make answers meaningful and relevant.

Additionally, the CDC has a wonderful Pre-Teens and Teens web page (http://www.cdc.gov/vaccines/who/teens/index.html) that includes immunization resources for providers, parents and pre-teens and teens. This page highlights the message that pre-teens and teens still need vaccines.

The CDC also publishes an Adolescent Immunization Campaign newsletter, #PreTeenVax. To subscribe to this newsletter, email PreteenVaccines@cdc.gov.

From the MDPH: Data Loggers

The CDC has issued new guidelines for monitoring vaccine storage refrigerators and freezers. These guidelines are intended to reduce the risk of a vaccine storage failure and administering vaccines that have been damaged. Continuous temperature monitoring with digital data loggers that meet specific criteria are now recommended for all vaccine storage units.

The Massachusetts Department of Public Health is pleased to announce the availability of Fridge-tag®2 data loggers manufactured by Berlinger & Company to measure and record the temperatures of your refrigerator and freezer vaccine storage units. A limited number of these data loggers were purchased with federal grant funds. They meet all CDC recommendations and require no special software. The data loggers have the ability to track temperatures 24 hours per day and record: 1) if there was a temperature excursion; 2) how long the excursion lasted; and 3) the warmest or coldest temperature the vaccine was exposed to.

Most pediatric sites in Massachusetts will be contacted and given the opportunity to receive one refrigerator and one freezer data logger which should be used for the primary vaccine storage unit at your practice. The MDPH anticipates that the current CDC recommendations will become requirements and therefore encourages all pediatric practices to take advantage of this program.

Please see the "Guidelines for Compliance with Federal and State Vaccine Administration Requirements," found at www.mass.gov/eohhs/docs/dph/cdc/immunization/guidelines-vaccine-compliance.pdf, for more information on recommendations and requirements for temperature monitoring devices for vaccine storage units.

— Robert Morrison, Vaccine Manager, MDPH Immunization Program

The 19th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference

Mark your calendar! The 19th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference will be held on **Thursday, October 23, 2014**, at the Best Western Royal Plaza Hotel, Marlborough, Massachusetts. MIAP is pleased to announce that this year's plenary speaker will be Alison Singer, co-founder and president of the Autism Science Foundation. Updated information will be posted as it becomes available on the MCAAP website, http://mcaap.org/immunization-cme.

BOOK CORNER

Better Living = Better Learning

Reducing inequalities in health and academic achievement are national priorities. In the era of Affordable Care, we strive to offer quality care equally for all. Yet we recognize that in many arenas, particularly in pediatrics, everything is sadly not equal right from the start. Perhaps nowhere is this inequality more evident than in the association between health and achievement. We all recognize that health and achievement are bidirectional: children with disabilities and chronic special health care needs may attain lower achievement and children with poor academic achievement are more likely as children and adults to have poorer health outcomes. In addition, confounders such as poverty, early school readiness, and family structure complicate the picture.

A recent study by a group affiliated with the Oxford Health Alliance, a community based study to prevent chronic diseases, attempted to tease out these factors.[1] The data were collected in 2009 at twelve K–8 public schools in New Haven, Connecticut. The final sample included 940 fifth and sixth grade students, representing 77% of eligible children who were 43.6% Hispanic, 40.4% African American, and 14% White. Researchers collected data from the school database for standardized test scores, physical fitness test scores, and number of days absent, as well as demographic variables. Survey questions were administered in the classrooms and measurements were obtained at the schools.

A health index was constructed to include 14 diverse, modifiable, and important health assets from four domains: physical health (e.g., healthy weight, physical fitness), health behaviors (e.g., meets recommended fruit and vegetable intake, less sugar sweetened beverage consumption, meets physical activity recommendations, meets school day screen time recommendations, never tried smoking), family environment (e.g., family meal > 5 days/week, less fast food consumption, food secure, no TV in the bedroom) and psychological well being (emotionally healthy, quality sleep, feel safe in your neighborhood) yielding a final health index of 0–14.

On average, students reported 7.1 health assets out of 14. Those with more health were 2.2 times more likely to achieve goals for standardized tests in reading, writing, and mathematics compared to students with the fewest health assets. In the discussion section the authors hypothesize that schools that used nontraditional instructional strategies to improve student health might also improve academic achievement. They advocate for the importance of a systems-oriented multilevel framework that emphasizes the importance of the context of schools, homes, and neighborhoods. But where is the pediatrician in that picture? We, as pediatric clinicians, may have the opportunity to innovate even earlier! In this study, not having a TV in the bedroom, being at a healthy weight and physically fit, being food secure and eating at fast food restaurants one time or less per week are the most important predictors of academic achievement. Many of these behaviors have their roots in early childhood and development when a pediatrician has the most opportunity to impact the course. One opportunity not to miss is the importance of talking about early literacy at every well child visit and reinforcing the message by giving the child a developmentally appropriate book. Can we ever hope to make the difference at 10 years if we haven't laid the groundwork from the beginning? 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 augustyn@bu.edu.

— Marilyn Augustyn, MD, FAAP

References

[1]Ickovics JR et al. Health and Academic Achievement: Cumulative Effects of Health Assets on Standardized Test Scores Among Urban Youth in the U.S. *Journal of School Health* 2014; 84(1):40–48

DEVELOPMENTAL CORNER

Communication Delays: Common Misconceptions

Popular misconceptions regarding communication delays in boys, bilingual children, and younger siblings may prevent these groups from getting the help they need. All children who show early warning signs of a delay should immediately be referred for a developmental screening by a speech-language pathologist. Developmental screenings are typically free and last approximately 15 minutes. Early detection and treatment give children with communication delays a greater chance of improving with speech therapy.

Misconception #1: It is normal for boys to show delays in speech and language. While boys tend to acquire communication skills at a slower rate than girls, they should still fall within the typical age range for major milestones. Any signs of a communication delay in both boys and girls should be addressed in a timely manner.

Misconception #2: Bilingual children talk later than monolingual children. Bilingual children will reach communication milestones at the same pace as their monolingual peers, with first words appearing around 11 to 14 months[1]. Complete vocabulary growth is typically the same between developing bilingual and monolingual children when every language is taken into account.

Misconception #3: Younger siblings talk later because their older siblings talk for them. Children are motivated to communicate their own needs and wants as soon as they can. Studies have shown that there are no differences in general communication development between first-born children and later-born children[2].

Communication delays, ranging from hearing and oral-motor issues to difficulties with language comprehension and production, can be detected within the first year. If an infant does not seem to respond to sounds or faces, or is not producing age-appropriate coos, babbles, or words, refer him or her for a screening. Pediatric therapy clinics usually offer free developmental screenings to help all children reach their fullest potential. For additional information on early communication development, please visit Pathways.org.

— Melissa Eichstead, Pathways.org

Pathways.org is a national not-for-profit organization dedicated to providing free resources and information for health professionals and families on children's motor, sensory, and communication development. The Pathways.org Baby Growth and Development Chart has been recognized and endorsed by the American Academy of Pediatrics. Additional educational materials are available online to download, copy, and share freely. For more information, please visit Pathways.org, email friends@pathways.org, or call our toll-free parent-answered hotline at 1-800-955-CHILD (2445).

References

[1]Petitto, L.A., Holowka, S. "Evaluating attributions of delay and confusion in young bilinguals: Special insights from infants acquiring a signed and spoken language." *Sign Language Studies*. 2002: 3(1);4-33.

[2]Oshima-Takane Y, Goodz E, Derevensky J. "Birth Order Effects on Early Language Development: Do Second Born Children Learn from Overheard Speech?" *Child Development*. 1996: 67(2); 621–634.

The Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) Annual Meeting and Edward Penn Memorial Lecture 2014

Thursday, May 1, 2014
9:30 AM to 4:00 PM
Massachusetts Medical Society
860 Winter Street, Waltham, MA

Jointly sponsored by the Massachusetts Chapter of the American Academy of Pediatrics and Baystate Health

Schedule

"Pediatrics and Health Care Reform"

9:30 AM **REGISTRATION**

9:55 AM **WELCOME**
John O'Reilly, MD, FAAP, MCAAP president

10:00–11:00 AM **"An Overview of Practice Transformation in Massachusetts including Patient-Centered Medical Home and ACO Certification"**
Carole Allen, MD, FAAP, commissioner, Health Policy Commission; District 1 chair, AAP; past president, MCAAP

11:00–11:15 AM **BREAK**

Edward Penn Memorial Lecture

11:15–12:15 PM **"On the Road to Accountability: The Role of the Medical Home in Achieving Optimal Outcomes in Romney/ObamaCare"**
Richard Antonelli, MD, FAAP, medical director, integrated care, Boston Children's Hospital

12:15–1:30 PM **ANNUAL BUSINESS MEETING AND LUNCH**

1:30–2:30 PM **"Pediatric Benchmarks: "A Review of Both Standard and Unique Pediatric-specific Benchmarks Gathered from Hundreds of Pediatricians Across the Country."**
Chip Hart, practice management consultant, Pediatric Solutions

2:30–3:30 PM **"Take the HPV Challenge: Improving Quality in Community Practice Settings"**
Rebecca Perkins, MD, MSc, assistant professor, OB/GYN, Boston University, Boston Medical Center; and Sean Palfrey, MD, FAAP, pediatrician, Boston Medical Center, director, MCAAP Immunization Initiative

3:30–4:15 PM **Panel: "Assessing Impact on Quality and Cost of Integrating Behavioral Health in Pediatric Primary Care"**
Rebecca Cronin, MD, FAAP, pediatrician, Chelsea Health Center; Greg Hagan, MD, FAAP, pediatrician, Cambridge Health Alliance, MCAAP past president; Michael Yogman, MD, FAAP, pediatrician, Yogman Pediatrics, chair, MCAAP Children's Mental Health Task Force

4:00 PM **ADJOURNMENT**

PHYSICIANS

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Baystate Health and the Massachusetts Chapter of the American Academy of Pediatrics. Baystate Health is accredited by the ACCME to provide continuing medical education for physicians.

Baystate Health designates this live activity for a maximum of 4.75 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NURSES

Baystate Health is an approved provider of continuing nursing education by the Massachusetts Association of Registered Nurses, Inc., an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. This activity carries a maximum of 4.75 contact hours.

For more information, please contact Cathleen Haggerty at chaggerty@mcaap.org.

Medical Student Committee Holds Annual MCAAP Mentoring Meeting

On Wednesday, February 26, the newly formed Medical Student Committee (MSC) of the MCAAP (http://mcaap.org/medical-student/) hosted the second annual mentoring meeting at the Liberty Hotel in Boston in conjunction with the MCAAP. The event was attended by over 60 medical students, residents, and attending physicians, including current AAP President Dr. James Perrin. Attendees had the opportunity to spend the evening meeting, talking, and networking with like-minded current and future pediatricians from around the state. The event, which began last year as a casual opportunity for residents and medical students to meet pediatricians from other institutions, has now become an annual gathering. It was continued this year with a more formal intent to facilitate the creation of mentor-mentee relationships between active members of the MCAAP. Attendees discussed interests ranging from residency selection to research, advocacy, and career planning, putting to great use the wealth of human resources we enjoy in this state as pediatricians and members of the MCAAP. There were brief addresses given by both faculty and students. A mentorship sign-up form was distributed after the meeting to facilitate the pairing of individuals interested in participating in mentor-mentee relationships according to areas of interest. If you are interested in being involved in a mentor-mentee relationship within MCAAP, please complete the survey at http://goo.gl/HTD3Ak. On behalf of all trainees in Massachusetts, we sincerely thank the MCAAP — especially the executive board and Cathleen Haggerty — for funding and planning the event. As future pediatricians and colleagues, we truly appreciate your continued efforts and support.

— Eli Freiman, UMass Medical School, School of Medicine '15; chair-elect, MCAAP Medical School Committee and Christian Pulcini, Tufts Medical School '15; chair, MCAAP Medical Student Committee

Photo © W.Rok 2014

Medical Student Committee members at the MCAAP Mentoring meeting.
Left to right: Aylin Sert, Alyssa Levin-Scherz, Walter Palmer, Eli Freiman, Michelle-Marie Peña, Mike Stratton, Kristin Schwarz, Lauren Sweetser, Anna Jo Smith, and Christian Pulcini

JOB CORNER

Full/Part Time Pediatrician

Looking for a BE/BC pediatrician to join our well established practice about five miles north of Boston. Rounding on newborns and night/weekend/holiday coverage to be shared amongst four providers. No delivery attendance or inpatient responsibilities. After hours calls are partly supported by night nurse. Please contact Carolyn at (781) 289-6581 or fax CV to (781) 289-3855.

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We would like to invite you and your organization to advertise your services in upcoming editions of *The Forum*. *The Forum* is mailed to 1,700 pediatricians and is available online at no charge. If you would like more information about rates and submissions, please contact Cathleen Haggerty at chaggerty@mcaap.org.

AD SIZE (ALL SIZES ARE BY WIDTH AND HEIGHT)
7" x 9.625" (full page)
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2.125" x 9.625" (1/3 page vertical)
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3.5" x 4.75" (1/4 page horizontal)
3.5" x 3.2" (1/6 page horizontal)

INK
Ads should be submitted as CMYK. As a convenience, we are able to convert your ad into CMYK if necessary.

BORDER
You do not need to include a border with your ad.

REVERSE TYPE
To reduce registration problems, type should be no smaller than 9 point.

SUBMISSION
All ads should be submitted as high resolution PDFs, sent via email to chaggerty@mcaap.org. Please include your name, company, phone, fax, and email address. Remember to label your PDF file with your company name (i.e., CompanyX.pdf). This will assist us in identifying your file.

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All submissions should be Acrobat PDF files, version 5.0 or higher, and should be sent at the exact size specified herein. Ads not submitted at the proper size will be returned.

Native files or other file formats will not be accepted. Fonts must be embedded and TrueType fonts should be avoided.

Please remember to double check that your ad is the correct size and contains the most up-to-date information.

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JOB CORNER

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Neighborhood Health Plan (NHP), located in Boston, is currently seeking an experienced, highly skilled Medical Director. As a senior medical leader, he/she will work closely with the medical leadership team to:

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- Collaborate with NHP's senior leadership to support the mission and values of NHP.

To apply, please visit www.nhp.org/jobs.

Looking to Hire or Be Hired?

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.*

To submit a listing, email alight@mcaap.org. Please include the following information:

- Contact information
- Practice name/residency program
- Position title
- Description (25-word limit)
- Availability (e.g., available now)

**Contact Cathleen Haggerty at chaggerty@mcaap.org for rate and payment information.*

Published by the **Massachusetts Chapter of the American Academy of Pediatrics, P.O. Box 549132, Waltham, MA 02454-9132.** Designed and printed by the Massachusetts Medical Society.

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JOB CORNER

Chairperson, Department of Pediatrics

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The Chairperson will have an established reputation of clinical excellence and innovation needed to lead a vibrant group of more than 90 exceptionally talented nurses and pediatric providers. Demonstrated leadership attributes with quality improvement, continuity of care and clinical growth are desired. Candidates must be board certified in their respective specialty and eligible based on education and experience for an academic appointment at Harvard Medical School. The successful candidate will have an exceptional track record of clinical and administrative success including a strong commitment to excellence in pediatrics, innovation and inquiry, and to sustaining and growing a culture of collaboration, teamwork, and achievement. All inquiries and applications will be held in the strictest confidence.

Mount Auburn Hospital and Harvard Medical School are equal opportunity employers and women and minority candidates are strongly encouraged to apply.

Written nominations, applications or expressions of interest should be submitted to:

Chairperson of the Department of Pediatrics, c/o Office of the President, Mount Auburn Hospital, 330 Mount Auburn Street, Cambridge, MA 02138