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

Pitching In

When I was a young baseball player, Roger Kahn published *The Boys of Summer.* The book told the story of players on the Brooklyn Dodgers, starting before their victory in the 1955 World Series and following their lives after baseball. Many years after I had hung up my mitt, David Halberstam wrote *The Teammates*, a similar story about a group of Red Sox players whose friendships, forged on a baseball diamond, lasted until death. Many things have changed since those classic teams of the 1950s. The "boys of summer" are now "the bearded boys of summer" and their high-priced free agency price tags make a lifetime career with one team the rare exception. But even with all the changes, many of the simple truths of baseball and teamwork remain.

I was in Florida at the AAP's National Convention and Exhibition (NCE) while I watched this latest group of Red Sox players battle to victory in the World Series. I was never the fastest base runner, but remembering tips from my old coach, I waited until the speakers at the evening leadership meetings looked away and then I made my move to steal away to the nearest TV. Feeling a little guilty about ditching our meetings, our small group of New Englanders led by Dr. Adams discussed pediatric issues in between innings rather than watching the commercials about beer and Cialis. It may have been the long days attending conferences, the late nights watching the Red Sox, or perhaps Dr. Sam's influence on our discussions, but I left the NCE thinking about how the Red Sox and the MCAAP are similar.

Like many players past their prime, the brainier aspects of a game became more interesting when my legs and arms could

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Generations Together for Child Health: Mentoring and More

On November 2, 2013, the MCAAP hosted its first annual conference for medical students, residents, and fellowship trainees, titled "Generations Together for Child Health: Mentoring and More." The event, which was held on campus at Boston University School of Medicine, welcomed medical trainees and a number of experienced child health advocates and leaders in pediatric medicine.

The keynote address, "A Life in Pediatrics: Advocacy, Adventures, and the AAP," was delivered by Dr. Judy Palfrey, AAP past-president and professor of pediatrics at Harvard Medical School. Dr. Palfrey highlighted one of the central beliefs that has guided her through her career: "Pediatrics would be stronger and more effective if community medicine and advocacy were core elements of training and practice."*

With the goal of inspiring medical trainees to get involved in advocacy and community outreach, seasoned child health advocates including Drs. Kitty

O'Hare, Sean Palfrey, Sarabeth Broder-Fingert, and Anna Rosenquist came together for a panel discussion on their experiences in legislative advocacy and

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EDITOR'S NOTE

New *Forum* Columns to Improve Your Practice

One of the things that I love most about working with the MCAAP is all of the advice and expertise that my fellow pediatricians bring to the table. Together, we have a formidable knowledge base and are experts on almost every aspect of pediatric care in Massachusetts. Learning from this wonderful group helps me to improve my own practice and allows me to help my patients more effectively.

In this issue you will find several features to help you care for your patients. But before I tell you more about them, I want to know how we can do more. For our New Year's resolution here at *The Forum*, we want to introduce some new articles and features to improve your practice. But we can only do that with your help.

What are you looking for in a quarterly publication? What other sections and articles would be most helpful to you? Below are a few ideas for recurring columns, or serials. Take a look, then send me an email at alight@mcaap.org and let me know what you would like to see in upcoming *Forum* issues. Have an idea that is not on the list or a need for information that isn't met? Email me and let me know what you want. I will do my best to get it to you. Want to write a serial yourself? We'd love to have you join us. Together, we can bring even more important information to all members of the MCAAP.

As for the gems of this issue, Dr. Abrams introduces us to the new Auvi-Q, a smaller, more portable auto-injector with voice instructions, on page 4. I have already prescribed it for several of my patients, and all were thrilled with the new device and excited to bring it to their child's school and other caregivers. Along different lines, Dr. Freidman shares a new tool for motivational interviewing (MI) training on page 7. Motivational interviewing is a skill that I have always admired, but practiced less often. Hopefully with this new program, I will find the expertise that I need to get me up to speed in the new year.

This issue also highlights some new resources for parents from Pathways.org on page 5 and ZipMilk on page 6. Pathways is a nonprofit whose website provides a whole host of developmental videos, worksheets, and information for families. I especially like their personalized baby calendar, which lets parents put in their baby's birthday and receive a customized date-based calendar with information on what to expect and what activities to try with their baby, week by week. Also useful for parents is an update to the ZipMilk site for breastfeeding support, which now contains even more providers and resources than before.

I hope the new year finds you fired up and ready to make some practice changes for the better. Please email me at alight@mcaap.org and let me know how *The Forum* can help.

— Anne Light, MD, FAAP

Possible Forum Serials

- **Key Developments in Child Health:** A short recap of the biggest pediatric news in the Commonwealth.
- **Legislative Updates:** Both local and national.
- **Practice Changes:** Updates on any new AAP recommendations released during the last quarter.
- **Subspecialty Consult, or Top 10 Things a Pediatric [Gastroenterologist] Wants You to Know:** Advice and up-to-date information from a different specialty each quarter. We would also be happy to take questions from members to print as part of the article.
- **Resident or Student article:** Highlighting their experiences and perspective.
- **Clinical Case:** Cases could be primary care focused, or new zebras to learn.
- **Ask the Pediatrician:** Life, practice, and ethical advice from a single pediatrician or a rotating group, depending upon questions received.

Submissions for the next issue of *The Forum* should be sent to alight@mcaap.org by March 3, 2014.

Pitching In

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no longer make the plays. I have spent many years coaching a range of sports, and now I much prefer the pure joy of coaching Special Olympic athletes. Watching the World Series, I loved to see the game unfold, matching the pitcher's strengths to the batter's weaknesses or the infield depth to the pitch count. Every player has a unique role, whether it is pitching for eight innings or for just one batter. The team succeeded because each player brought his own unique talent to the game. Sometimes it is not the biggest, strongest, or highest-paid player that makes a difference. I think we all love the unknown player whose enthusiasm and energy sparks the team and moves the group on to victory.

In my role as president of the MCAAP, I am like the coach of a team. I may not personally have the ability to hit the ball out of the park, but I have a talented roster of members who work together to win victories for our patients across the state. Like a baseball team, there are many roles that need to be filled, and we are always looking for talented players who can come up and make the clutch hit. We have no farm team system, and no scouts searching for prospects in newborn nurseries across the state, so I will have to appeal directly to our talented group of members to come out and join the team. I do not have a big budget for signing bonuses, but seeing your efforts improve the lives of our pediatric population can be priceless. Our team does not require that you wear a beard, not even those fake ones that filled the stands at Fenway. We do not require daily workouts, and will take any amount of time you can give us, even if that is only a few hours over the course of a month or a year.

So what is your talent that you can bring to our MCAAP team? What aspect of pediatrics are you passionate about? If you are passionate about immunizations and want to improve vaccination rates in our state, join Drs. Palfrey and Moriarty and Cynthia McReynolds, who head our Vaccine Initiative program. You don't need to be an ID specialist or an immunologist to join that team. Maybe you just have an approach in your practice that works for talking to parents who are refusing vaccines and you want to share it with other MCAAP members. Join the team and we can share your wisdom through articles, workshops, and webinars that the group will be creating.

Have you seen a social problem and want to propose a law to help fix it? Join Drs. McManus and McAlmon on the legislative committee. Do you want to learn how to advocate at the State House or testify before a hearing? The AAP has training sessions that make you feel comfortable advocating on that level. Perhaps you feel that you are too busy in clinical practice to be spending time on Beacon Hill. You can be like Anna Rosenquist, a busy primary care provider who only has a few spare hours a month available for advocacy. Anna focuses her efforts working as the MCAAP liaison to Act Fresh, a community-based advocacy group. What pediatric-related advocacy do you want to become involved in: Obesity work? Children in foster care? School health? Take a look at the Committee's page at mcaap.org and I am sure you will find a way that your interests can be used to help the MCAAP improve the lives of our patients across the state.

What if your talents lie on the business side of pediatrics? It is important that our patients receive the best care, and that pediatricians should be paid for their hard work. With the changes taking place in health care delivery, the MCAAP needs to advocate for the needs of our patients and for the needs of those providing that care. Medical home implementation in the real world, quality measures that matter, and creating appropriate referral patterns to meet the unique needs of pediatric patients across the state are some of the issues we are facing. The MCAAP needs the voices of both primary care pediatricians and pediatric subspecialists to be heard as our new systems of care are being designed.

How can you help? Perhaps you are interested in discussing these issues with representatives of the health plans. You can join the Pediatric Council and attend their quarterly meetings. Perhaps there is a specific area of care that needs to be addressed for your patients. If you don't have time to make the meeting, please let us know of your concerns and we will try to get them addressed through the Pediatric Council. Perhaps you have some "pearls" about practice that you want to share with your fellow MCAAP members. We are planning to increase our use of our website and social media to improve communication, and we will be looking for member input. The MCAAP is looking for bright and articulate pediatricians who can represent us as we all move into the new era of health care delivery systems.

On every team there are veteran players who become mentors and role models for younger players coming into the league. The veterans can give guidance to the younger players and get them through the transitions and slumps all young players go through. The same holds true for the MCAAP team. In early November we held a conference focusing on mentoring. We had a great group of medical students, residents, fellows, young physicians, and more seasoned pediatricians come together to discuss life in pediatrics. We had some great discussions ranging from how to choose a residency and later a practice setting, to how you can include advocacy

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New Auvi-Q Epinephrine Auto-Injector Easier to Use

Forty-six (46) million EpiPens have been prescribed to prevent anaphylactic reaction since their introduction 25 years ago.* While a huge step ahead of hospital-only care, they do have drawbacks, such as an exposed needle after use, a large size, and an inconvenient shape for carrying.

A new auto-injector, the Auvi-Q, was introduced last February. Unlike a traditional EpiPen, the Auvi-Q is small and flat. At 3 3/8" high, 2" wide, and 5/8" thick, it is about the size of a cellphone.† It also features a retractable needle and has voice instructions. *The Medical Letter*, which recently reviewed the Auvi-Q, found it to be both more portable and easier to use than a traditional EpiPen.‡

Currently, the Auvi-Q is under production by Sanofi, and the base cost is comparable to an EpiPen. Insurance coverage varies by carrier, with Massachusetts Medicaid and Tufts providing coverage, while Blue Cross Blue Shield prefers EpiPen prescriptions.**

— Robert Abrams, MD, FAAP

References

*Mylan Specialty L.P. Announces 25th Anniversary Celebration of EpiPen® (epinephrine) Auto-Injector, http://finance.yahoo.com/news/mylan-specialty-l-p-announces-131100241.html, April 25, 2013.

†www.auvi-q.com/epinephrine-auto-injector-size.

‡*The Medical Letter on Drugs and Therapeutics*, February 18, 2013.

** bluecrossma.com/pharmacy/formController?actionID=/en_US/main.jsp&repId=Repositories.MainContent.guest_medsNotCovered.xml and tuftshealthplan.com/providers/pdf/formulary_may_2013.pdf.

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offered valuable advice on how trainees can spearhead advocacy initiatives during their own careers.

In addition, several MCAAP committee leaders spoke about opportunities for involvement in committees such as the Committee on Legislation, the Committee on Disabilities, and the newly formed Medical Student Committee. Dr. James Perrin, president-elect of the American Academy of Pediatrics, gave an overview of the AAP's major initiatives for the upcoming year.

Medical students gained useful professional guidance in a discussion with Dr. Bob Vinci and Dr. Priya Garg, directors of the Boston Combined Residency Program in Pediatrics and the Pediatric Residency Program at the Floating Hospital for Children at Tufts Medical Center, respectively. Drs. Vinci and Garg shared advice on how to navigate the pediatric match and how to become a successful pediatric residency applicant. The day included a discussion of mentorship in pediatrics by Dr. Timothy Gibson, with a focus on the implementation of Learning Communities and Longitudinal Pediatric Experiences at UMass Memorial Children's Medical Center.

Altogether, this inaugural conference for the MCAAP's medical students, residents, and fellowship trainees was an invaluable opportunity for trainees to gain insights on child health advocacy, career planning, and mentorship opportunities from some of the MCAAP's most inspiring advocates and physician-teachers. The event helped this year's attendees to gain perspective on how we all can, as Dr. Palfrey stated, make advocacy and community medicine core elements of our training and practice. It will surely become an annual favorite for trainees and will continue to strengthen the MCAAP community by bringing generations together for child health.

— Kristin Schwarz, Boston University School of Medicine, M4

Reference

*Palfrey, J. "A Life in Pediatrics: Advocacy, Adventures, and the AAP." Speech, *Generations Together for Child Health: Mentoring and More,* Boston University School of Medicine, November 2, 2013.

Detecting Early Motor Delays at Well-Baby Visits

In the past 25 years, the number of children with early motor delays has dramatically increased. The American Academy of Pediatrics Council on Disabilities estimates that as many as 400,000 children are at risk for an early motor delay.* Suggested reasons for this sharp increase are varied and include: a rise in multiple and premature births, increased survival rate of children with cardiac, neurological and genetic disorders, and post-birth positioning.†

An early motor delay can refer to a variety of conditions ranging from low tone to cerebral palsy. Most severe motor irregularities are detected at birth and minor delays become apparent as early as 2 months of age. These delays can affect a child's ability to learn basic skills, such as grasping, crawling, standing, walking, and talking. Synapse development for motor skills, seeing, and hearing peaks at 3 months of age,‡ so the sooner a child with a suspected motor delay is referred for an evaluation, the better. The commonly used "wait and see" method can slow a child's developmental progress. Treatment and prevention for delays can be as simple as doing more tummy time while the baby is awake, while complex cases could require physical, occupational, or speech therapy.

When trying to detect early motor delays, it is helpful to know the signs of typical and atypical development. Pathways.org offers free videos and handouts that show typical and atypical development in infants at 2, 4, and 6 months of age. The videos show an infant assessment created by Dr. Elspeth Kong, a Swiss pediatrician, and demonstrate how the power of observation can be a physician's greatest tool in evaluating a child. The assessment encourages physicians to focus on the quality and symmetry of a movement rather than the existence of a movement.

Physicians should also regularly recommend tummy time to parents. When talking about "Back to Sleep" it is important to include "Tummy to Play." In 2008, a national survey of pediatric occupational and physical therapists was conducted. Sixty-six (66) percent observed an increase in motor delays in babies under 12 months of age, and a majority of these therapists suggested that lack of tummy time contributed to the increase. Seventy (70) percent of the therapists noted that most parents have little or no understanding of tummy time.** By increasing tummy time many children can avoid conditions like positional plagiocephaly, positional torticollis, and other conditions associated with early motor delays.

Tummy time can start as soon as a baby comes home from the hospital. Parents often struggle with tummy time when their baby cries; however, making tummy time a part of a baby's routine can help minimize the struggle. If a parent is unsure of how to begin tummy time, suggest the video "5 Essential Tummy Time Moves." This video can help give parents some tips and make tummy time easier.

If an early motor delay is suspected, the child can be referred to the state's Early Intervention Services. Early Intervention offers a number of services to children and their families, including physical, occupational, and speech therapy. Visit mass.gov/eohhs/gov/departments/dph/programs/family-health/early-intervention for information on Massachusetts's Early Intervention program or the tools and resources section of Pathways.org to find information on programs in other states.

Visit Pathways.org for additional free resources on children's motor, sensory, and communication development. Handouts, brochures, and videos are available for parents and health professionals to download, copy, and share freely.

— Melissa Eichstead, Pathways.org

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*Statistics compiled by the Pathways.org Medical Round Table from a variety of sources, including the March of Dimes, Pediatrics Annual Summary of Vital Statistics, and the Centers for Disease Control and Prevention.

†Mahnemer, A, Barr, RG. "Influence of Supine Sleep Positioning on Early Motor Milestone Acquisition," *Development Medicine and Child Neurology*, 2005; 47(6):370–6; discussion 364, and National Survey of Pediatric Experts Indicates Increase in Infant Delays (press release).

‡From *Neurons to Neighborhoods: The Science of Early Childhood Development*, 2000. Institute of Medicine (IOM).

**Survey conducted by Chicago-based marketing firm Hyde Park Group on behalf of Pathways.org.

Increased Breastfeeding Support from ZipMilk

Breastfeeding rates are on the rise in Massachusetts. According to the 2013 Breastfeeding Report Card from the CDC, 83 percent of Massachusetts women breastfeed their infants in the early days of life — a number that is greater than the U.S. rate as a whole and beyond the target set by the Healthy People 2020 goals. The number of women continuing to breastfeed in the weeks and months after birth is increasing as well.

With more women breastfeeding, the need for greater access to breastfeeding support is growing. ZipMilk.org, a project of the Massachusetts Breastfeeding Coalition, has been providing Massachusetts' families and professionals with breastfeeding resources sorted by ZIP code for more than seven years.

Recently, the Massachusetts Breastfeeding Coalition revamped the ZipMilk site and expanded its listings of breastfeeding service providers. With over 450 listings in Massachusetts alone, ZipMilk provides an abundance of resources that caters to the growing need for breastfeeding support. The online directory points users toward board-certified lactation consultants, breastfeeding counselors and educators, breastfeeding support groups, free community-based lactation resources such as WIC programs, and more.

Whether you are a new mom looking for breastfeeding advice or a health care provider wanting to link parents with knowledgeable lactation professionals, visit ZipMilk.org, where neighborhood breastfeeding help is a click away.

— Kara Ghiringhelli, RD, LDN, CLC

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in a busy practice. I can't decide whether I was more impressed with the amazing lives of pediatric advocacy being led by Sean and Judy Palfrey or the soon-to-be amazing future in pediatrics for all the bright and enthusiastic trainees who were in attendance.

Looking around that conference room, I was reminded of Erik Erikson's stages of development. Up to that point I had not considered myself at the older end of that pyramid, but a quick look at hairlines told me otherwise. My fellow gray-haired pediatricians and I are at the "generative" developmental stage, and the MCAAP was providing us with a way to meet our developmental milestones by mentoring the next generation. At one of the breaks I asked a pediatrician who has been out in practice for a number of years — but had a full head of dark hair — why he attended the conference. "I am the recruiting partner for our practice," he replied, "and I want to interest some of these young pediatricians to come out to my practice and shadow me. If they come and visit us they will see how attractive a life in primary care really is." If we don't connect with the trainees early in their careers they will be lured away by the sirens of subspecialties. An early connection to primary care will tie them to general pediatrics much like Odysseus to the mast, and they can safely sail past the sweet song of technology and procedure payments. There are many rewards that come from mentoring, and the MCAAP needs you to join us in welcoming our trainees to the MCAAP team.

Playing on the MCAAP will not require a lot of training. There are no complicated steal signs or barking snap counts. All you need to do is call or email Cathleen Haggerty, our general manager. Interested in joining a committee or a council? Call Cathleen. Want to get your voice heard in the health care reform discussions? Contact Cathleen. Want to star in a MCAAP podcast? Have your agent contact Cathleen. Want to mentor a trainee or have someone shadow you in your office? Cathleen is our matchmaker. It is easy to get involved in any way you are able, and for whatever amount of time you have to give. I will give you the same advice I give my obese teens: get off the couch (or perhaps if you are like me, off the EHR), get involved in some positive activity, and get moving.

I will end as all great movie coaches' speeches end, with a flurry of disconnected and disconcerting sports analogies. I need each of you to step up to the plate, give 110 percent, and get out there to win one for all the Gippers across the state. So join our MCAAP team, put your pants on one leg at a time, and get out there to play your hardest. ***— John O'Reilly, MD, FAAP***

Improve Your Motivational Interviewing Skills

Although the techniques of motivational interviewing (MI) are about 30 years old, most pediatricians have had no experience with this tool because it is rarely taught in medical school or residency.

Studies have shown MI can increase the use of seat belts, help with weight reduction, and reduce alcohol and drug abuse.* MI itself has very simple steps, but getting good at it takes practice. Learning this skill can be facilitated by role-playing, having a coach watch and give suggestions, and a critique.

For those of us who do not have the time or inclination to role-play in a group setting, a new pilot project at Boston University† allows you to learn this skill via computer. The training uses a computer avatar (a two-dimensional cartoon-like figure) that you control and speak through. Based on the avatar's performance, you get feedback from the instructor both in real time and after a critique of your avatar interview. After completing the course, you will be ready to begin practicing motivational interviewing with your patients. The more that you use this skill, the more effective you will be in motivating your patients and the more rewarding your practice.

For more information on motivational interviewing, visit samhsa.gov/co-occurring/topics/training/motivational.aspx or motivationalinterview.org.
— Mark Friedman, MD, FAAP

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*Rubak S, et al. "Motivational Interviewing: A Systematic Review and Meta-analysis," *British Journal of General Practice*, 2005 April; 55(513):305–12.

*Fernandez WG, et al. "Brief Motivational Intervention to Increase Self-reported Safety Belt Use among Emergency Department Patients," *Academic Emergency Medicine*, 2008 May; 15(5):419–25.

†Mitchell S, et al. "A Pilot Study of Motivational Interviewing Training in a Virtual World," *Journal of Medical Internet Research*, 2011, Vol. 3, e77. Contact Mark Friedman at markrichardfriedman@gmail.com for more details.

BOOK CORNER

Speak Up, Parents — Words Can Build A Child's Brain

Every once in a while a study comes out that truly changes the way we think and shapes how we practice every day. Such a study was published almost 20 years ago in a book by two investigators from Kansas, Betty Hart and Todd R. Risley (*Meaningful Differences in the Everyday Experiences of Young American Children*, 1995, Paul H. Brookes Publishing Co., Baltimore, MD). Their longitudinal study of parent-child talk in families in Kansas was conducted over a decade. A team of researchers recorded one full hour of every word spoken at home between parent and child in 42 families over a three-year period, with children from 7 months to 36 months of age. The team then spent six additional years typing, coding, and analyzing 30,000 pages of transcripts. They found that by age 3, children of higher socioeconomic status (SES) had heard on average 45 million words and children of lower SES heard only 13 million words. By age 9, there was a very tight link between the academic success of a child and the number of words the child's parents spoke to the child up to age 3.

Multiple follow-up investigations have come from this study, including most recently work that launched the Thirty Million Words Project in Chicago, an innovative parent-directed program designed to harness the power of parent language to build a child's brain and impact his or her future (tmw.org).

One recent study drove home the importance of parent-talk in both its simplicity and power. This research followed a cohort of 29 Spanish-learning infants tested at 19 and 24 months. (Weisleder A, Fernald A. "Talking to Children Matters: Early Language Experience Strengthens Processing and Builds Vocabulary," *Psychological Science*, September 2013.) Family income ranged from less than $25,000 to $75,000 per year with 79 percent of families reporting a yearly income below the federal poverty line. Most parents had not completed high school and had 4 to 16 years of education. All parents were native Spanish speakers and Spanish was the primary language in the homes of all these children.

Parents were asked to record their child during a typical day. A device in their clothing recorded all of the words the child uttered as well as all of the words they had spoken to them, both directly as well as "overheard." Families were recorded for an average of 11 hours over the course of one to six days, and a technology called LENA analyzed the words spoken and heard. (Xu D, Yapanel U, Gray S. Reliability of the LENA Language Environment Analysis System in Young Children's Natural Home Environment, 2009, lenafoundation.org/Techreport.aspx/Reliability/LTR-05-2). At 24 months they examined the children's communication development.

There was striking variability in the total amount of adult speech accessible to the child, which ranged from almost

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29,000 adult words to fewer than 2,000 words over the course of 10 hours. When talk only addressed directly to the child was considered, these differences were even more extreme. In one family, caregivers spoke more than 12,000 words to the infant, whereas in another family, the infant heard only 670 words of child-directed speech all day. Meaningful difference?

The outcomes were equally robust. Those children who heard more child-directed speech at 19 months had larger vocabularies at 24 months. In contrast, differences in exposure to "overheard speech" (language not directly spoken to the child) were not related to child vocabulary size, suggesting that language spoken directly is more supportive of communication development than merely "hearing the words."

What differentiates this study from the prior work by Hart and Risley is the homeogeneity of this group — all were Spanish-speaking and faced similar economic challenges — and yet the study revealed an 18-fold difference in caregiver talk to infants. Furthermore, the differences in parental engagement observed were not correlated to maternal education. What distinguishes families who "talk more" from those who don't will require further investigation. In the office we cannot predict which families may talk more to their children and which talk less, thus we must get this message out to ALL families we encounter: Talk to your children! It matters!

One concrete way that we can share this message is by talking to parents about the importance of reading aloud to their child — particularly in the United States where, sadly, data shows that less than half of children are read aloud to everyday.

— Marilyn Augustyn, MD, FAAP, medical director, Reach Out and Read Massachusetts

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

JOB CORNER

Partner-track Position in Berkshires

Exciting career opportunity in the beautiful Berkshires! Physician-owned pediatric group seeks one BC/BE pediatrician for a partner-track position. Competitive salary, four weeks vacation, 1:6 call schedule, excellent after-hours nurse triage, EMR (eCW), NHSC-designated site for loan repayment. Three or four days/week. Contact Childsy Art at childsyart@gmail.com or (413) 281-8339, or fax to (413) 662-2363.

Multispecialty Group Opportunity

Riverbend Medical Group, the premier multispecialty group in western Massachusetts, is looking for a pediatrician to work in our Agawam office, alongside two other pediatricians and a nurse practitioner. We offer a wide range of patient services, an electronic medical record (EPIC), and strong support for our physicians. Agawam is a growing community of 28,000 located across the river from Springfield near cultural and natural resources (and Six Flags amusement park).

For further information, please contact Suzanne Jones at (413) 523-0824. You can also email Alison Wondriska, MD, chief of pediatrics, at awondriska@riverbendmedical.com.

Cape Cod Pediatric Practice

Cape Cod Healthcare seeks a pediatrician for a busy pediatric practice on Cape Cod. The position includes both office pediatrics and hospitalist shifts at Cape Cod Hospital. Our patients are diverse, including a sizable Portuguese- and Spanish-speaking population. Cape Cod is a fun place to live and work, especially if you like outdoor pursuits such as water sports, biking, and golf, and there is a very active arts community. We are close enough to Boston for a "city fix."

Salary is competitive, with flexible hours and generous benefits. Please contact Sharon Fletcher Daley, MD, FAAP, chief of pediatrics, Cape Cod Hospital, at Seaside Pediatrics, (508) 771-8350 or sdaley@capecodhealth.org.

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.*

ShotClock

From the Immunization Initiative Director

Vaccine rates are determined by access, opportunity, and acceptance, and we in Massachusetts are some of the best at achieving all three. HPV vaccine still has the lowest rates of all universally recommended vaccines, but this month we were one of 11 states to receive a grant from the Centers for Disease Control and Prevention (CDC) to develop effective and innovative programs to increase coverage.

In this edition of ShotClock, Dr. Perkins gives us some excellent advice and convincing words to use when we see preteens due for their first HPV vaccinations. The first of them is *don't equivocate* — include HPV in your list of vaccinations due (discuss them even a year in advance of the 11-year-old visit, as I often do), and just as definitively as you list DTap or MMR for all infants. Our firm recommendation carries great weight. The second is to have strong, reassuring, and encouraging facts at hand about each of the vaccines. The third is to use personal, human stories to illustrate the importance of all vaccines.

We hope this will be an exciting upcoming year — with the passage of new legislation establishing a vaccine trust fund, new permanent funding for our vaccine registry, new opportunities afforded by the CDC grant, and monthly webinars on topics of importance. We are on a roll, but must stay energized and focused.

Thanks for your help, support, and spirit.
— Sean Palfrey, MD, FAAP

You are the Key to HPV Cancer Prevention

Because January is cervical cancer awareness month, this issue's ShotClock will focus on the HPV vaccine. Aside from the occasional genital wart, pediatricians do not see the severe consequences of HPV infection. However, HPV currently hurts and kills more Americans each year than all other vaccine-preventable diseases with the exception of influenza. The HPV vaccine prevents infection with HPV types 6, 11, 16, and 18 and is recommended for all girls and boys at ages 11–12, with vaccination permitted as young as 9 and catch-up recommended through age 26 for girls and age 21 for boys.

Did you know that 12,000 women in the United States get cervical cancer each year, and 4,000 die each year from their disease? Almost one-third of women who develop cervical cancer had normal Pap smears within three years of their diagnosis. When Pap testing does detect abnormal cells before they become cancer, it is necessary to surgically remove about 1 cm of the cervix to prevent cervical cancer (called LEEP, cone, or LOOP procedures). About 330,000 women in the United States undergo these procedures every year. This prevents cancer, but can cause pregnancy complications. HPV vaccination has the potential to prevent up to 70 percent of cervical cancers and their precursors.

Did you know that 11,000 men and women in the United States get a cancer of the head and neck caused by HPV? HPV causes 75 percent of head and neck cancers, and the incidence is rising. Studies estimate that the number of head and neck cancers caused by HPV will be higher than the number of cervical cancers by the year 2020. There is no screening test available for head and neck cancers, and the treatment causes permanent disfigurement and disability. A full 94 percent of oropharyngeal cancers are caused by HPV 16.

Did you know that 5,000 men and women in the United States get anal cancer each year? Two thirds of anal cancers occur in women. Routine screening is not currently available for anal cancer. Over 90 percent of anal cancers are caused by HPV 16.

YOU ARE THE KEY TO PREVENTING CANCER IN YOUR PATIENTS!

Substantial research has shown that a STRONG recommendation from a pediatric provider is the single most important determinant of HPV vaccination.

As stated by a parent: "If I'm unsure, I want someone to say to me, 'You need to do this for your daughter, you're doing the right thing.' Because people are unsure and they're afraid and they don't want to make a decision that's going to hurt their child."

What about safety? HPV vaccine safety has been widely studied, and it is very safe. Over 30,000 patients were vaccinated during clinical trials, and over 100 million doses have been distributed worldwide to date. The two largest studies, which included 200,000 girls in the United States and 1 million girls in Denmark and Sweden, found no increase in any of 200 categories of illness, including autoimmune diseases and venous thromboembolic disease. However, both girls and boys may faint after receiving vaccines, so observation for 15 minutes after each injection is recommended.

What about effectiveness? Population-wide studies show that the HPV vaccine works. In Australia, 80 percent of girls have received three doses of the vaccine. Genital warts have nearly disappeared among young women, and rates of cervical pre-cancer have declined by 80 percent. In the United States, rates of HPV 16/18 infection have decreased by 56 percent in teens, and rates of cervical cancer and pre-cancers have decreased in women under age 24.

Why vaccinate at ages 11–12? Girls and boys ages 11–13 produce more antibodies to the vaccine than those ages 16 and older. Preteens are also less likely than older teens to have started sexual experimentation that can lead to infection — but note that HPV is a skin virus spread by touching, and up to 46 percent of virgins have detectable HPV spread by genital touching that did not include intercourse. Also, several studies have shown that vaccinating against HPV does NOT promote unsafe sexual behavior — one study of high-risk teens found increased rates of safe sexual practices among vaccinated compared with unvaccinated girls.

How do you get patients to accept the vaccine when you recommend it?

Introduce the HPV vaccine along with the other recommended vaccines. Do say: "Today your child is due for three vaccines, the HPV vaccine, tetanus booster, and meningitis vaccine." When the vaccines are introduced together, the parent perceives them all as part of the normal schedule, and equally important.

Do not say: "Your child is due for two vaccines, tetanus and meningitis. There is also the HPV vaccine, which is optional." When you separate out the HPV vaccine, the parent will perceive it as less necessary than the other two. When you say "not required" or "optional" the parent thinks that the vaccine is not actually important to protect their child's health. Neither HPV nor the meningitis vaccine is required for middle or high school in Massachusetts, but they are both important.

Focus on cancer prevention. Research has shown that parents want to vaccinate their children to prevent cancer. This is the reason the vaccine was developed, and why the CDC and AAP are promoting its use.

An effective script for introducing HPV vaccination and addressing concerns:

Provider: Meghan is due for some shots today: HPV, meningococcal vaccine, and Tdap.

Parent: Why does she need an HPV vaccine? She's only 11!

Provider: The HPV vaccine will help protect Meghan from cancer caused by HPV infection. We know that HPV infection is dangerous — 33,000 people in the United States get cancer from HPV every year. And we know that the HPV vaccine is safe — over 100 million doses have been given and there haven't been any serious side effects.

Parent: But it just seems so young…

Provider: Vaccines only work if they're given before exposure — we never wait until a child is at risk to give any recommended vaccines. HPV vaccine is also given when kids are 11 or 12 years old because it produces a better immune response at that age. That's why it is so important to start the shots now and finish all three of them in the next six months.

— Rebecca Perkins, MD, MSc, assistant professor of obstetrics and gynecology, Boston University School of Medicine/ Boston Medical Center

For more information, including free resources for providers and patients, visit cdc.gov/vaccines/teens.

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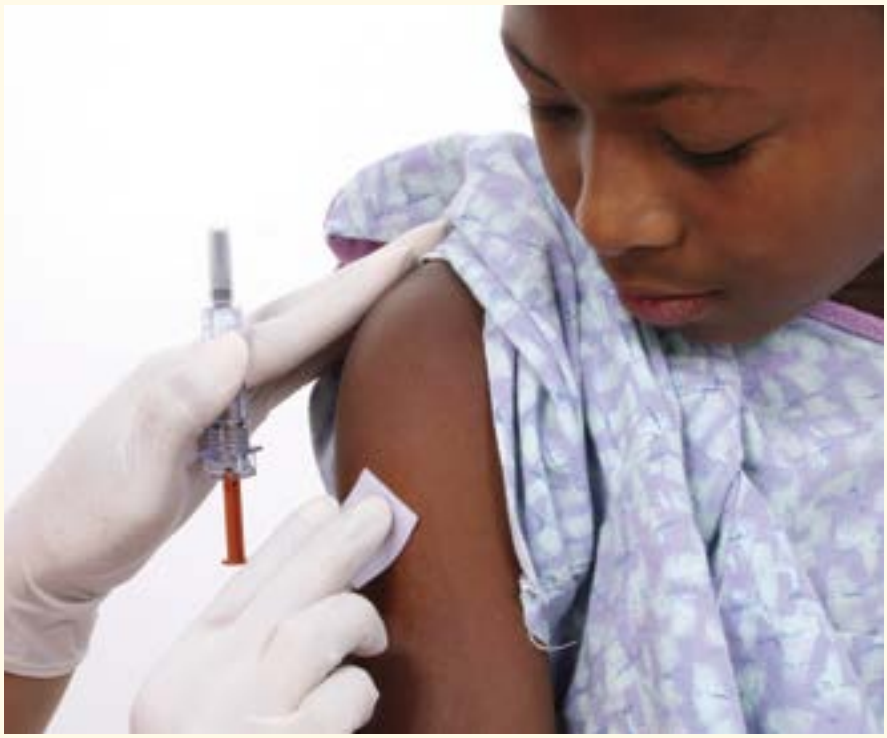

Tell, Don't Ask, When It Comes to Vaccinating Kids

Pediatricians who told parents their child needed a vaccination rather than asked if they wanted one met less parental resistance, researchers found.

Three-quarters of providers brought up the issue of vaccination by using a "presumptive" approach, which assumes parents will immunize their child, according to Douglas J. Opel, MD, MPH, of the University of Washington School of Medicine in Seattle, and colleagues.

Only 26 percent of parents were resistant to vaccine recommendations when providers used the presumptive approach. However, 83 percent resisted when providers used a "participatory" approach, which invites parental involvement, researchers noted in the study published online November 4, 2013, in *Pediatrics*.

Journal Article

pediatrics.aappublications.org/content/early/2013/10/30/peds.2013-2037.full.pdf+html.

Human Papillomavirus is Causing Head and Neck Cancer

A recent article published in *Nature** discussed the increase in head and neck cancers attributable to HPV in both men and women.

The number of oropharyngeal cancers has been growing over the past 30 years. There are now 10,000 cases in the United States each year, a number that is likely to climb to 16,000 by 2030. An overwhelming majority are caused by HPV. Worldwide, cancer centers have reported that the virus is responsible for between 45 percent and 90 percent of oropharyngeal cancers.

More than 90 percent of HPV-related oropharyngeal cancers are caused by HPV 16, a particularly dangerous strain and the main cause of cervical cancer. The two HPV vaccines approved to prevent cervical cancer, Merck's Gardasil and GlaxoSmithKline's Cervarix, both protect against HPV 16. In theory, therefore, protection against HPV-positive oropharyngeal cancer is already in doctors' cabinets. A clinical trial of 5,840 women, published this year by researchers at the United States National Cancer Institute, showed that Cervarix is 93 percent effective at preventing oral HPV infection in both women with pre-existing cervical infections and those without, none of whom had been previously vaccinated.

There are also hints that HPV is a risk factor for other more common types of cancer, including lung cancer.

There are currently no good screening methods available for HPV-caused cancer in the head and neck.

The complete article can be found online at nature.com/news/hpv-sex-cancer-and-a-virus-1.14194.

— MCAAP Immunization Initiative

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MDPH Massachusetts Immunization Information System (MIIS) Update

The Massachusetts Department of Public Health (MDPH) Immunization Program is pleased to announce continued success with the statewide rollout of the Massachusetts Immunization Information System (MIIS). The MIIS houses an Immunization Registry Module that aggregates data from health care provider sites across the state, as well as the newly implemented Vaccine Management Module for online ordering and inventory tracking for state-supplied vaccine.

Launched in June 2013, the Vaccine Management Module is an online system for vaccine ordering, inventory management, and annual provider enrollment. The MDPH Vaccine Unit is currently using this system as its primary tool for managing the distribution of state-supplied vaccine and to date has placed over 400 vaccine orders on behalf of provider sites. Additionally, over 170 provider offices across the state have placed their own vaccine orders online and have taken advantage of the ability to track their vaccine shipments.

As of November 2013, over 1,000 providers have registered with the MIIS, 370 of which are actively reporting data to the Immunization Registry, including pharmacies, boards of health, inpatient and outpatient health facilities, and provider offices. There have been approximately 1.8 million patient records consisting of over seven million immunizations reported to the MIIS. A new release of the MIIS system was deployed in mid-November, which included system upgrades and enhancements.

2014 Provider Re-Enrollment to be Done Online through the MIIS

Starting in January 2014, we are excited to announce that for the first time annual provider enrollment to receive state-supplied vaccine will be completed online through Vaccine Management Module of the MIIS. This online process will streamline re-enrollment for both your practice and the Vaccine Unit, facilitated by pre-population of your practice information and electronic signatures.

The Immunization Program is continuing to provide live webinar trainings on all aspects of the MIIS system, in addition to the self-paced training materials currently available online on the ContactMIIS Resource Center Training Library at contactmiis.info. The online webinars, training videos, and one-page guides describe how to access the MIIS and utilize functions and features of both the Immunization Registry and Vaccine Management Modules, including completion of online enrollment.

If your practice has not yet registered with the MIIS, please register today to be able to continue ordering vaccine from the MDPH and to complete your 2014 VFC enrollment online. The MIIS User Support team is happy to assist you with the registration process.

For questions regarding the MIIS or assistance with registration, please contact the MIIS Help Desk at (617) 983-4335 or miishelpdesk@state.ma.us. For questions regarding vaccine ordering, please contact the Vaccine Unit at (617) 983-6828.

Make a Difference in the War on Poverty

The recent anniversary of John F. Kennedy's assassination has been a time for reflection. The grief surrounding his death included the sense of tragedy of a life cut short, of promises unfulfilled. Although I felt that societal sadness over JFK's death, I did not experience the outrage and loss until his brother Bobby was gunned down a few years later. One of my teachers was an activist nun, and she told us stories of his fight against the Vietnam War and the societal evils of racism and poverty. I remember my view of the world was expanded when she brought in the photos of his travels highlighting poverty and racism. The pictures from Appalachia and Mississippi were so foreign to me that they might as well have been from the moon, but I knew that Brooklyn was only a 25-cent subway ride away from my Irish enclave. I understood that poverty was real, and that it was wrong, but I was not sure what a fifth-grader could do about it.

I have spent a lifetime trying to answer that question on a personal level, finding small everyday acts that make a difference. I started my career working in an inner city health center paying off my National Health Service obligation, and I currently work in an inner-city setting taking care of many poor patients and their families. But now I am confronted once again with that same question on a professional level. The AAP has made poverty one of its "planks," and it will be a focus of the organizational efforts over the next few years. Not much has changed since I wore that grade-school uniform: I know poverty is real, and that it is wrong, but I am not sure what I as a single pediatrician, or the MCAAP as an organization, should do about it. I need your help so that the MCAAP can answer that question.

Poverty is a complex issue, but we cannot let its complexity or its enormity stop us from trying to address the problem. Although poverty is obvious when I look around the waiting room in inner-city Springfield, it is a part of every pediatrician's practice. How you identify its manifestations and how you try to make a difference will depend on your individual circumstances, but we must all do our part.

I have asked many of my pediatric colleagues about how I should treat a patient's illness, but I don't think I have ever asked specifically about how we should treat the patient's poverty. Perhaps the AAP's making poverty a priority plank means we should start having those conversations. The MCAAP website can be a place where we can collect our ideas and our stories. Stories have been hard-wired into the human brain since the tales of brave Ulysses. Stories can educate, they can motivate, and they can inspire. Perhaps your story can help another pediatrician fight poverty in a way he or she never imagined before. Perhaps your story can influence a state legislator who is trying to decide on poverty-related issues such as welfare reform or minimum wage.

If you do not feel you can make a difference in overcoming the poverty that may be crushing your patients and their families, I would have you Google and read Teddy Kennedy's eulogy for his brother Bobby. He spoke eloquently about how we all can make a difference in the world, and he ended his speech with a quote from Bobby:

> *"Some men see things as they are and say why. I dream things that never were and say why not."*

You may not aspire to be a visionary like RFK, but we all could hope to be remembered as Teddy described his brother:

> *"To be remembered simply as a good and decent man, who saw wrong and tried to right it, saw suffering and tried to heal it, saw war and tried to stop it."*

In Bobby's honor, perhaps the MCAAP and its members could be described as: "Saw poverty as a societal scourge, and tried to alleviate it." Send your ideas and stories to Cathleen Haggerty to join the conversation, and perhaps even change the world. ***— John O'Reilly, MD, FAAP***

PROS Update

Meet the New PROS Associate Directors

PROS has two new associate directors, **Alex Fiks**, a general pediatrician and electronic health record researcher at Children's Hospital of Philadelphia, and **Laurel Leslie**, a developmental-behavioral pediatrician and translational and evidence dissemination researcher at Floating Hospital for Children/Tufts Medical Center.

Parent Engagement in PROS Research

Research funding agencies are increasingly encouraging or requiring patient/parent input into research. At a recent meeting, coordinators, steering committee members, and PROS directors discussed how we might begin to engage parents in the design and conduct of PROS studies, including the possibility of a standing family advisory board and/or eliciting parents' contributions for specific studies. Do you have a family advisory board in your practice? **Do you have any thoughts or suggestions about how to engage parents in PROS research? We'd love to hear from you!**

Teen Driving Study

Ten Massachusetts practitioners participated in a translational study of a proven, Web-based program to help parents make teen drivers safer with a parent-teen driving agreement. Data collection ended in August. **Preliminary results show that 140 practitioners delivered the intervention to over 3,400 families, resulting in 1,453 unique visitors to the Checkpoints website, 136 from Massachusetts.** Participants will receive feedback reports about visits to the Checkpoints website and use of the Parent-Teen Driving agreement.

State of the Network

PROS is comprised of 1,978 practitioners (53 percent are women) from 811 practices in every state in the nation, Washington, DC, Canada, and Puerto Rico. **Massachusetts is one of the largest PROS chapters, with 47 practices and over 150 practitioners.** With lots of exciting studies enrolling now and more being developed, PROS needs to grow! Tell your friends and colleagues in other practices about PROS.

Study Updates: Underway and Under Development

- **WECARE (Addressing Unmet Basic Social Needs)** is a collaboration between **PROS** and **CORNET**, **the residents' continuity clinic research network**, which will screen and refer to resources for problems like homelessness and food insecurity. At the meeting, the coordinators were excited about the study, especially a component that will facilitate compiling and maintaining a resource book for each practice. The principal investigator is **Arvin Garg** of Boston Medical Center.
- **Adolescent Health in Pediatric Practice (AHIPP): the first PROS study to give practitioners Maintenance of Certification (MOC) Part 4 credit.** Practices are randomized either to a smoking cessation or social media anticipatory guidance arm. Eight practices in our chapter are participating: **Gleason and Greenfield Pediatrics, Macony Pediatrics, Mill River Pediatrics, Northampton Area Pediatrics, RiverBend Medical Group-Springfield, Westfield Pediatrics, Tri-River Family Health Center, and Pediatric Care Associates. Many thanks! Welcome to the practices that are new to PROS, and extra kudos to the practitioners who are enrolling a second cohort of teens.**
- **ePROS is the PROS sub-network of practices using electronic health records for data collection. Currently 30 practices are enrolled in 20 states, and ePROS is actively seeking new practices.** An ePROS study of the prevalence of psychotropic medications in children 4 to 18 years of age showed a wide range, from 4 percent in some practices to 20 percent in others (preliminary data). A study of clinical decision support for ADHD prescribing is being developed.
- **DART (Dialogue around Respiratory Illness Treatment)**, a quality improvement intervention for antibiotic prescribing. The grant received an encouraging score and will be resubmitted in 2014. We hope that participants will be able to receive MOC Part 4 credit.
- **Social media** — lots of kids are using Facebook, Twitter, Snapchat, and Instagram. An intervention trial is being developed to use social media as a novel means of conveying health promotion messages to teenagers. Massachusetts PROS practitioner and PROS Steering Committee member **Jacques Benun** and former Massachusetts PROS practitioner **Chris Stille** are spearheading development of the study, which was originally proposed by PROS practitioners.
- **Brief Motivational Interviewing to Reduce BMI (BMI^2)**, a randomized controlled trial of motivational interviewing and dietitian visits to reduce BMI in overweight children. Over 670 parent/child pairs were followed for 2 years. All of the follow-up visits were completed in June, and an impressive 70 percent completed the study. Results are being analyzed and written up for publication.

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Advertise in *The Forum*

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.

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2014 MCAAP Call for Nominations

The MCAAP 2014 election will fill vacancies on the Executive Board for vice president, secretary, treasurer, and congressional district representatives in Districts 1, 2, 3, and 8. Individuals are eligible if they are voting members of the chapter and live or work in one of the vacant districts.

Please send names of nominees to Cathleen Haggerty via email at chaggerty@mcaap.org, or fax them to (781) 895-9855. You may mail nominations to 860 Winter Street, Waltham, MA 02451. Also, please contact Cathleen if you have any interest in serving on the MCAAP Nominating Committee. Nominations must be received by February 28, 2014.

Electronic ballots will be emailed and mailed in mid-March. Individual communities within each district can be found at house.gov/representatives/find. For new Massachusetts congressional district maps, go to malegislature.gov/district/proposeddistrictmaps.

PROS Update

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A follow-up study (BMI[3]) will attempt to increase the "dose" of dietitian counseling by using a centralized telephone service of study dietitians. Such telephonic disease management counseling has been studied in the treatment of hypertension, diabetes, and other chronic conditions, and has been very promising. Grant application was submitted in July.

- **OASIS (Objective Assessment of Signs to Improve Safety)** — Based on data from a previous PROS study **(CARES: Child Abuse Reporting Experience Study)**, OASIS is a study of evidence-based education and decision-support tools to improve the recognition and reporting of physical abuse in children under 3 years of age.
- **CHOMP (Children's Oral Health: Motivation for Prevention)**, a randomized controlled trial to improve pediatric practitioners' anticipatory guidance on oral health. Principal investigator is **Paul Geltman** of Boston University and Cambridge Hospital. Grant to be resubmitted in December.

Publications

Since our last newsletter, the Clinical Effort Against Secondhand Smoke (CEASE) study team (Principal Investigator MGH/Waltham-based pediatrician **Jonathan Winickoff**) published two more articles, and had two more manuscripts accepted for publication. Interested in manuscript preparation? All PROS members are welcome to get involved in writing up study findings. ***— Ben Scheindlin, MD, FAAP, and David Norton, MD, FAAP, PROS chapter co-coordinators***

If you would like to hear more or are interested in participating in any of the above studies, please contact Ben Scheindlin at (781) 272-2210 or bscheindlin@yahoo.com or David Norton at (413) 536-2393 or nortond@holypeds.com.