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

Trying to Connect

One night, I was sitting at my dining room table, sipping a cup of tea and staring at the "Connection Failed" message on my iPad, when an email popped up on my computer. It was a reminder that my final message to *The Forum* was due in two days. Besides my iPad, two other devices were arranged in front of me: a smart phone and a laptop. Their cyber bandwidth far exceeded my brain bandwidth at that moment, so I sat and reflected on my communication challenges as the Earl Grey woke up my gray matter.

One of these communication challenges involved my daughter Maureen, who is spending a semester abroad in Argentina. She wanted to have the experience of being immersed in a foreign culture. As Maureen works to communicate with her classmates and professors, I have been learning how to connect with her across the miles of cyberspace. I have learned that communication is difficult, often dependent on the fickle fate of a late bus, a random solar storm, or an unannounced power outage.

I tried to connect with Maureen with the iPad, but FaceTime was failing us. After some attempts using WhatsApp and Viber, we connected through Skype, thanks to a random café that had enough wi-fi to support it. During our brief conversation, Maureen complained that Marx's dense polemics, which were hard enough to understand in English, were nearly incomprehensible in the Spanish translation. The arcane world of biochemical compounds seemed simpler and more straightforward to her science-trained mind.

Maureen was not the only one who was trying to understand something that seemed incomprehensible. After the

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MCAAP Medical Student Committee's 1st Annual "Shoe Drive for Kids" Hits the Ground Running

The MCAAP Medical Student Committee (MSC) held its first annual "Shoe Drive for Kids" on Friday May 2, 2014, to provide athletic shoes to children who need them. This initiative was started as a way to promote healthy, active lifestyles, and combat childhood obesity. Besides distributing footwear, we also wanted to encourage outdoor activity and exercise. All four medical schools in Massachusetts united to support this meaningful cause.

Across the four campuses, we held spirited fundraising events and organized a successful online campaign using social media and our own fundraising website. In this pilot year, MSC members collectively raised over $1,200 of monetary donations and approximately $2,500 of donations-in-kind from generous local shoe stores, including Kids Footstop in Winchester and Michelson's Shoe Store in Lexington.

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EDITOR'S NOTE

New Tools for Patients

Well-child visits can be hectic. In addition to the questions that the parent and child bring to the table, pediatricians have to screen infants for delays in a vast array of domains. Previously, this screening required multiple different surveys or questions, each with its own paperwork and scoring system.

How many times I have wished that all of my screening could be done on one form and recorded in one place, without being too much of a burden to my staff or patients. Thankfully, Dr. Ellen Perrin at Tufts has heard my silent plea. In this issue, she introduces a new comprehensive screening tool for children ages called The Survey of Wellbeing of Young Children, or SWYC for short.

The SWYC is a complete screen of developmental domains (social, emotional, and behavioral) and family context, all pared down to around 40 questions tailored to each well-child visit. Parents usually take 10–15 minutes to complete the free form, which is currently available in English and Spanish at TheSWYC.org. The SWYC also has a Milestones Scoring Chart that allows practitioners to keep track of child development in each domain over time.

With this free comprehensive screening tool, you can streamline your practice to benefit both your patients and your staff. To learn more about the SWYC, please read the full article by Dr. Ellen C. Perrin on page 6 or visit TheSWYC.org.

And what of our older patients? Are those well visits a walk in park? Sadly, no. I often find myself advocating for a literal walk in the park as a strategy to combat one of the most common medical problems: obesity. With one in three children overweight or obese nationally, I know that I am not alone in my role as a weight-loss advocate, a position for which I was very poorly trained.

Luckily, the AAP knows that we need to develop these skills to help today's children and families, especially if we weren't trained in residency to promote behavioral change. To make learning effective counseling easier, the AAP Institute for Childhood Weight teamed up with the AAP Division of Quality and Kognito, a patient engagement company. Together, they created a new app called ChangeTalk.

With online, Apple and Droid versions, ChangeTalk is designed to help pediatricians hone their motivational interviewing tactics by providing a simulated environment to practice weight management counseling. In the app, a "pediatrician" user interviews a virtual mother and child. Users receive accelerated feedback from the parent/child team that teaches them which techniques are most effective to motivate behavioral change. Users also receive personalized feedback from a virtual coach. Last but certainly not least, ChangeTalk provides a pocket guide of motivational interviewing techniques for providers to use as a reference during practice. For more information, or to download the app, visit Kognito's homepage at kognito.com.

I am sure that my patient visits will still feel a bit hectic at times. But I hope with the new tools above, I can make good progress on these two critical parts of well childcare. Now, if anyone wants to create the perfect pediatric EMR, I'm ready.
— Anne H. Light, MD

Trying to Connect

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screen turned gray, I tried to reconnect; while I was waiting, I started to look over my MCAAP-related emails. One of them contained the details of the gun bill just released by the speaker of the house. After spending an hour trying to translate legalese into common parlance, I began to sympathize with Maureen and her Spanish translation of Marx. The bill did not meet all we wanted in our testimony. Should we push for more funding for mental health services, or should we just accept the tighter gun purchasing recommendations? Another email detailed the proposed postpartum depression regulations. Once again, I was trying to decipher dense legislation language. It appeared that pediatricians would be mandated to screen for PPD, but only OBs would be paid for the screenings. Supporting postpartum screening is important, but can we accept an unfunded mandate on pediatricians to get it done? That one would have to go to the legislative committee to review and see if my broken translation was true. Was this an issue that deserved an email blast to our members? The last member blast about narrow networks did not get a great response, so I wanted to be sure that we were not annoying our members.

In fact, another one of the communication challenges that a MCAAP president faces is determining the best way to use technology to respond to issues. Another email alerted me that the report on DCF had been released. How should the MCAAP respond? How do we best represent the children of the Commonwealth? In another email, I learned that comedian Jenny McCarthy, an outspoken critic of vaccines, posted a YouTube commercial promoting e-cigarettes. Once again, I had to think about what the most effective response should be. After all, I know my image on a YouTube video will not get as many hits as hers. The last email comes from our student group who wanted to me to Moodle Doodle about a meeting on Google. Hopefully, Dr. Seuss will be the meeting scribe.

Maureen returned to the screen, but the connection was choppy. Her image froze, but her ethereal voice could occasionally

be heard. It was getting late, so we scheduled a time to try again tomorrow. It can be frustrating to have so much to say, and so many possible ways to connect, but so little connection.

Heading up to bed, I started to muse about how my communication struggles with Maureen paralleled issues faced by the MCAAP. As an organization, we strive to represent our members and our patients. But how can we do this effectively in a world with a 24/7 news cycle and so many different communication platforms? Before we can effectively represent our members, we need to know what our members think, and what our members want. How do we have an effective dialogue with our members without clogging up their email inboxes and quickly becoming spam?

In fact, is sending an email the best way to communicate? Belonging to the generation that likes to hold a newspaper in my hand and read it with my morning coffee, I thought I was progressive when I pushed to upgrade the chapter's website. However, I was crestfallen when one of our younger, hipper executive board members told me he does not read anything that does not fit on his phone.

So how does the MCAAP evolve into an organization that communicates effectively with its members? How do we let members know the breaking news about issues of interest to them, whether they be local, state, or national? We need to connect with members who read papers and those who read phones. We need to communicate with those who make it through rambling presidential essays, and those who stop before the end of a 140-character tweet.

The MCAAP needs more engaged and involved members, and we can only do that with better communication. We need to let our members know what we are working on in a timely manner, and we need to hear from our members about what they believe our priorities and positions should be. There are many issues to address and many communication tools available to us. Would you join a committee if you could Skype into the meeting? Would you read and comment on a proposed bill or regulation if you could click a link to the bill off of our Twitter feed? Would you "like" us to have a stronger presence on Facebook, or would you show more interest if the MCAAP were on Pinterest? As I have learned from my communications with Maureen, there is not one perfect way to make a connection. The MCAAP needs to be flexible and connect with you in a way that works for you. Let us know, so we can meet you halfway in cyberspace.

My "pen and a pint" Irish writing style may have worked for James Joyce, but it is not well suited for the electronic age. Our new MCAAP president, Dr. Michael McManus, is already on Twitter, and he will bring presidential messaging into the twenty-first century. Mike has been a legislative committee co-chair for many years, and he can translate legislative machinations into advocacy action. Mike and the "Boston brain trust" that has helped guide me through my term will be able to guide us all through the brave new world of health care reform and ACOs. They will, however, need your input, so get your devices ready and text, email, or link in with them. As always, Cathleen Haggerty is ready to connect you to whatever you need at the MCAAP. And as they used to say on our old radio, or perhaps on that rabbit-eared black-and-white TV, "keep those cards and letters coming."

— John O'Reilly, MD, FAAP

DEVELOPMENTAL CORNER

Introducing Solid Food

Parents often rely on their child's health care provider for information and support regarding infant feeding practices and nutrition. The American Academy of Pediatrics recommends introducing solid food to an infant's diet around 6 months of age.[1] However, the results of a 2013 survey, which included 1,334 new mothers, indicated that 40 percent of respondents introduced solid foods to their infants much earlier — prior to 4 months of age.[2] Given the short-term and long-term risks associated with early solid food introduction, it is essential for health care providers to give clear and accurate feeding recommendations at early well-child visits.

Every infant develops at his or her own pace and parents should be instructed to watch for the following signs of solid-food readiness near 6 months of age:[3]

- Able to hold his or her head up when sitting
- Opens his or her mouth when food approaches
- Able to move food from a spoon or fork into throat

Infants can start their transition to solid food with thinly pureed fruits and vegetables, such as bananas, peaches, and squash, as well as single-grain cereals mixed with breast milk or formula. Particular foods should be avoided for the first year, including honey, cow's milk, salt, and artificial sweeteners. Honey contains spores that can cause infant botulism, and infants' digestive systems cannot process the protein present in cow's milk.[4]

Parents may be tempted to start solid foods early if their infant seems particularly fussy or hungry. They may also follow the common misconception that consuming solid foods before bedtime helps an infant sleep through the night; research shows that there is no evidence to support this claim.[5] Health care providers can encourage a healthy transition to solid food by communicating the risks associated with starting too soon. Introducing solid food too early may:

- Cause an infant to choke — in their first few months, infants cannot hold their heads up in a sitting position and have not yet developed the coordination needed to swallow food
- Result in stomach aches, gas, and constipation — an infant's digestive tract is not prepared to process solid foods until closer to 6 months of age
- Replace breast milk or formula with food that may not meet an infant's nutritional needs — breast milk or formula should remain an integral part of an infant's diet until the first birthday
- Increase the risk of obesity and diabetes[6,7]

— Virginia Li, Pathways.org

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

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[4]Shelov S, Altmann TR. *Caring for Your Baby and Young Child: Birth to Age 5.* 5th ed. New York, NY: Bantam Books; 2009.

[5]Macknin ML, Medendorp SV, Maier, MC. "Infant sleep and bedtime cereal." *American Journal of Diseases of Children* 1989; 143(9):1066–1068.

[6]Huh et al, "Timing of Solid Food Introduction and Risk of Obesity in Preschool-Aged Children." *Pediatrics* 2011; 127(3):544–551.

[7]Frederiksen et al, "Infant Exposures and Development of Type 1 Diabetes Mellitus." *JAMA Pediatrics* 2013; 167(9):808–815.

Fluoride Toothpaste: How Much Is Right?

Over time, recommendations and guidelines for pediatric dental care change. The same holds true for the use of fluoride toothpaste in young children. Topical fluoride through toothpaste can help prevent tooth demineralization and enhance remineralization, thereby decreasing the incidence of cavities. Due to the rise of childhood caries, the American Dental Association Council on Scientific Affairs recently made unified recommendations in the *Journal of the American Dental Association*.[1] These recommendations are also endorsed by the American Academy of Pediatric Dentistry.

The recommendations are as follows:

- All children 3 years and younger: as soon as teeth erupt, brush teeth with a smear (e.g., the size of a grain of rice) of fluoride toothpaste twice a day, in the morning and at night.
- Children 3–6 years of age: brush with a pea size amount of fluoride toothpaste twice a day, in the morning and at night.
- All brushing and dispensing of toothpaste should be monitored by an adult.

The use of further supplementation such as oral fluoride supplements and/or rinses should be determined by a caries-risk assessment to prevent overexpose of fluoride for patients. Dentists should be seeing children by 1 year of age to provide counseling on caries prevention, perform a caries-risk assessment, and establish a dental home. ***— Amy Regen, DMD, Chestnut Dental Associates***

References

[1]American Dental Association Council on Scientific Affairs, "Fluoride toothpaste use for young children," *The Journal of the American Dental Association* 2014; 145(2):190–191. (Accessed at http://jada.ada.org/content/145/2/190.full.)

THE POLICY HUB: A RECAP OF OFFICIAL AAP POLICY CHANGES

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

New recommendations and guidelines

- Iodine supplementation in pregnant and lactating women[1]
- Drug testing in children and adolescents[2]
- No body checking in boys' ice hockey unless both elite level and over 14 years of age[3]
- Recommendations for child life services in pediatric hospital-based care[4]
- Pediatric anthrax management[5]

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

References

[1]Council on Environmental Health, "Iodine Deficiency, Pollutant Chemicals, and the Thyroid: New Information on an Old Problem," *Pediatrics* 2014; 133(6):1163–1166.

[2]Levy et al, "Testing for Drugs of Abuse in Children and Adolescents," *Pediatrics* 2014: 133(6);e1798–e1807.

[3]Council on Sports Medicine and Fitness, "Reducing Injury Risk From Body Checking in Boys' Youth Ice Hockey," *Pediatrics* 2014;133(6); 1151–1157.

[4]Committee on Hospital Care and Child Life Council, "Child life services in pediatric hospital based care," published ahead of print on April 28, 2014, doi:10.1542/peds.2014-0556.

[5]Bradley et al, "Pediatric Anthrax Clinical Management: Executive Summary," *Pediatrics* 2014;133(5):e1471–e1478.

Legislative Report

The formal session of the Legislature ends on July 31, 2014, which means there will be a rush to enact bills over the next month before the legislators start their re-election campaigns.

The Chapter is following several bills, but we expect some action on the following legislation:

Gun Safety. House Speaker Robert DeLeo has filed a comprehensive bill (H.R.4121) to address gun violence, which is based on a task force he created last year.

- Massachusetts would be added to the national criminal background check database. Local police chiefs would have authority to deny a Firearm Identification Card (FID) for a rifle or shotgun, based on suitability standards developed by the State Office of Public Safety, similar to that for handguns.
- Gun purchasers would undergo background checks at gun shows; private sales of firearms must occur at the business of a licensed dealer so the sales can be tracked and the purchaser can undergo a background check.
- *School violence prevention:* School districts to develop plans to address the mental health of students and to provide suicide awareness and prevention.
- Increase penalties for violent acts using a firearm, for illegal possession and carrying of firearms, and improper storage of a firearm, rifle, or shotgun. **The MCAAP *supports* H.R.4121.**

Nurse Practitioner Independent Practice. The bills that would allow nurse practitioners (NPs) to practice independently without physician supervision, H.R.2009 and S.1079, were sent to a study by the Legislature's Public Health Committee. However, during Senate debate of the 2015 state budget in May, the nurses were able to get language similar to H.R.2009 and S.1079 adopted as an amendment to the budget. Because the House did not include language dealing with this issue in its budget, the Senate amendment (835) is now before a six-member House/Senate conference committee.

Senate Amendment 935 would allow NPs to provide advanced practice services that would include the ordering and *interpreting* of tests, the ordering of treatment and therapeutics, and prescribing medications without any physician supervision or oversight. Independent practice, in any setting, with any patient population, would be allowed after completing two years of clinical practice under a supervising physician or supervising nurse practitioner with independent practice authority. Also, regulations would be developed solely by the Nursing Board, without input or oversight by the Board of Registration in Medicine. Currently, NPs and certified registered nurse anesthetists (CRNAs) can order, but *not* interpret tests, order therapeutics and treatments, and prescribe medications under the supervision of a physician pursuant to regulations developed jointly by the Nursing and Medicine Boards. **The MCAAP *opposes* Senate Budget 935.**

E-cigarettes. H.R.3726 would treat nicotine vapor products, such as e-cigarettes, as tobacco products and ban the sale to children under 18. Use of the products on school premises would be banned, and the statute governing smoke-free work places would apply to these products. The bill is now before the Health Care Financing Committee. **The MCAAP *supports* H.3726.**

Massachusetts Child Psychiatry Access Project (MCPAP). The state budget now before a conference committee would increase funding for the MCPAP. The MCPAP is currently funded solely by state funds, but 60 percent of the care that the MCPAP provides is to children covered by commercial insurers. The House included language in the budget that requires health insurance companies to contribute their fair share to the operation of the MCPAP program. Without the insurers contributing their fair share, the MCPAP will continue to face cut backs in its needed services. **The MCAAP *supports* the House budget language.**

Residents and Fellows Day at the State House (RFDASH). RFDASH was held June 11, 2014. RFDASH participants lobbied in favor of H.R.4121, Gun Safety Legislation, and H.R.37221, Regulation of E-cigarettes.

A New Instrument for Developmental-Behavioral Screening: The Survey of Wellbeing of Young Children (The SWYC)

Overview

The Survey of Wellbeing of Young Children (SWYC) is a freely-available, parent-report screening instrument for children under 5 years of age. The SWYC was developed to provide first-level screening of a wide range of developmental-behavioral domains in a single instrument: cognitive, language, motor milestones; social-emotional/behavioral functioning; and autism and family risk factors. The entire instrument requires 15 minutes to complete and is straightforward to score and interpret.

There is an age-specific SWYC form for each age on the pediatric periodicity schedule through 5 years of age (2, 4, 6, 9, 12, 15, 18, 24, 30, 36, 48, and 60 months of age). Each of these 12 forms consists of questions appropriate for children in its designated age range. All forms are available without cost on the TheSWYC.org.

The SWYC is approved by MassHealth for screening in compliance with the Children's Behavioral Health Initiative program.

Developmental Domain

- At each age level, parents complete the Developmental Milestones checklist, consisting of 10 questions about the child's motor, language, and cognitive development. Each form includes items appropriate for a range of skills at that specific age.
- For children between 16 and 35 months of age, the forms include the Parent's Observations of Social Interactions (POSI), a seven-item autism-specific screener.

Social-Emotional/Behavioral Domain

- At each age level, parents complete a social-emotional/behavioral questionnaire, modeled after the well-validated and popular Pediatric Symptom Checklist (PSC):
  - The *Baby Pediatric Symptom Checklist (BPSC)* for children up to18 months (12 items)
  - The *Preschool Pediatric Symptom Checklist (PPSC)* for children 18–60 months (18 items)
- Each form also asks parents whether they have any concerns about their child's behavior, learning, or development (two items).

Family Context

- All forms include a set of screening questions addressing aspects of the child's family context, including parental discord, depression, substance abuse, and hunger (nine items).

What does the SWYC do?

The SWYC is designed to be a first-level screening instrument for routine use in regular well-child care. It combines traditional "developmental" screening with traditional "behavioral" screening, and it adds screening for autism, parental depression, and other family risk factors. It is designed to be used as a single package and to be used regularly over the course of health supervision. However, it is also acceptable to use individual parts of the SWYC separately to meet particular needs.

How can you obtain the SWYC forms?

All forms are available at no cost as pdfs on TheSWYC.org. An electronic form, suitable for incorporation into Electronic Health Records software, is in development.

Scoring guidelines for all parts of the SWYC are available on TheSWYC.org.

In what languages does the SWYC exist?

All components of the SWYC have been translated into Spanish. Some components of the SWYC have been translated into Burmese and Nepali. Non-English forms should be used with caution, as they have not yet been subjected to validation in the new language.

Additional information about the translation processes used for Spanish, Burmese, and Nepali is available at TheSWYC.org.

Implementation of the SWYC

The SWYC is a self-administered tool that can be given to families to complete at home or in the pediatric waiting room prior to their appointment. SWYC forms are age-specific. The appropriate form can be selected by referring to the age ranges printed at the top of each SWYC form.

Pediatricians should review the parent's completed form and inquire about areas of concern. The Developmental Milestones results can be recorded on a single copy of the SWYC Milestones Scoring Chart at every well-child visit. Physicians may refer to the results of the child's past screenings in order to monitor trends.

If a parent notes any area of concern, or if the score on any component of the SWYC is outside of the normal range, the next step is to observe the child, talk with the child and parent(s), and in some circumstances talk with the child's teacher or child care provider. The SWYC is a first-level screening test — not a diagnostic test — and its results should always be part of a comprehensive clinical evaluation.

Frequently Asked Questions

1. **How do I know which SWYC form to use?** There is a different SWYC form for each age on the pediatric periodicity schedule. There is an age band around the precise age on the periodicity schedule, which is indicated on the chart on the next

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The SWYC

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page. You can use the chart on the next page to find the appropriate form.

2. **How many items are on the SWYC?** Parents are asked to complete a two-page, age-specific form. For all children, the form includes three components: (1) cognitive, language and motor development; (2) social-emotional development; and (3) family risk factors, including parental depression, discord, substance abuse, and hunger. For children between 15 and 35 months, there is a fourth component: autism. The length of the SWYC forms varies slightly by age, but there are roughly 40 questions on each age-specific form.
3. **How long does the SWYC take to complete?** Different parents require different amounts of time to complete the SWYC. Most take about 10–15 minutes.
4. **How do I use the Milestones longitudinally?** Keep a Milestones scoring chart in a patient's file. At each visit, circle your patient's score on the same chart as used in previous visits. This chart will allow you to track your patient's development over time.
5. **For what ages has the POSI been validated?** We recommend the POSI for children between 16 and 35 months. It is included on the 18-, 24-, and 30-month SWYC forms.
6. **Why is the POSI not included on the 15- and 36-month SWYC forms?** There is a SWYC form for every age on the periodicity schedule. As depicted in the table, the age ranges for these SWYC forms do not correspond perfectly with the age range of the POSI. Thus, the 18-, 24-, and 30-month SWYC forms include the POSI, while the 15- and 36-month ones do not. The POSI is valid across the entire range of the former, but it is only valid for part of the age range for the latter.

Although the POSI may be valid for children at 15 months, at this time there is insufficient evidence to recommend the form for children of this age.

Which SWYC Form To Use

Form	Minimum Age	Maximum Age
2	1 month, 0 days	3 months, 31 days
4	4 months, 0 days	5 months, 31 days
6	6 months, 0 days	8 months, 31 days
9	9 months, 0 days	11 months, 31 days
12	12 months, 0 days	14 months, 31 days
15	15 months, 0 days	17 months, 31 days
18	18 months, 0 days	22 months, 31 days
24	23 months, 0 days	28 months, 31 days
30	29 months, 0 days	34 months, 31 days
36	35 months, 0 days	46 months, 31 days
48	47 months, 0 days	58 months, 31 days
60	59 months, 0 days	65 months, 31 days

Clinicians who wish to use the POSI for children older or younger than the suggested age range are free to do so, but we recommend additional caution when interpreting results.

7. **How do I purchase the SWYC?** No purchase is required. All of the age-specific SWYC forms are freely available at TheSWYC.org. You can find them by clicking on "Age-Specific Forms" in the left-hand navigation bar.
8. **Can I use only the social-emotional screener, or only the Milestones, or do all four sections of the SWYC have to be used together?** The SWYC is designed to be a comprehensive surveillance or first-level screening instrument for routine use in regular well-child care. It is designed to be used as a single package and to be used regularly over the course of health supervision up to 5 years of age. However, it is also acceptable to use individual parts of the SWYC separately to meet particular needs.
9. **Is the SWYC protected by copyright?** Yes. The SWYC is freely available, but it cannot be modified without expressed permission of the authors. If you are interested in translating the SWYC into a new language or administering it in a way for which the downloadable forms available at TheSWYC.org are not appropriate, please contact us at theswyc@gmail.com.
10. **Response to a positive screen** The SWYC is a first-level screening instrument and not a diagnostic tool. A positive score on the Developmental Milestones, BPSC, PPSC, or POSI indicate that a child may be at risk for a developmental or behavioral problem and may benefit from further assessment. Pediatricians should observe the child and discuss responses with parents to determine whether there is a need for evaluation. Should physicians feel that a child would benefit from additional evaluation, they may choose to administer standardized assessment measures, refer the child to a specialist, or contact MCPAP, which offers psychiatric consultation to primary care providers by phone.

Positive screens on the Family Questions or Parents' Concerns items should result in further conversation with parents.

Summary

The Survey of Wellbeing of Young Children (SWYC) is a new freely-available, parent-report screening instrument for children under 5 years of age. The SWYC is approved by MassHealth for compliance with the Children's Behavioral Health Initiative screening guidelines.

The SWYC was developed to provide first-level screening of a wide range of developmental-behavioral domains in a single instrument: cognitive, language, and motor milestones; social-emotional/behavioral functioning; and autism and family risk factors. We welcome feedback and questions at theswyc@gmail.com.

— Ellen C. Perrin, MD and R. Chris Sheldrick, PhD, Floating Hospital for Children, Tufts Medical Center

ShotClock

Improving Massachusetts HPV Vaccination Rates

As you probably are aware by now, the MCAAP is working with the MDPH and other organizations to improve HPV vaccination rates in Massachusetts. As pediatricians, we have a lot of individual (and group) work to do to massively boost the HPV vaccine rates in our practices and communities.

Even though I am known to vaccinate anything that moves, I admit I have been a little less than rigid about getting my teenage patients back for their second and third HPV shots on time. So I have turned over a new leaf. Now, in addition to making sure that I get the first shot into all my 11-year-olds (I prepare their parents for a couple of years before the visit to let the importance of it sink in), I also set up nurse visits for shots numbers two and three at the time of that first visit. Then our recall system can take over to remind parents to get in for these vaccines.

Please take the MA HPV Vaccine Challenge. Start your vaccine discussion with all 11- and 12-year-olds and their parents by saying, "Your child needs 3 vaccines today – HPV, Tdap, and meningococcal."

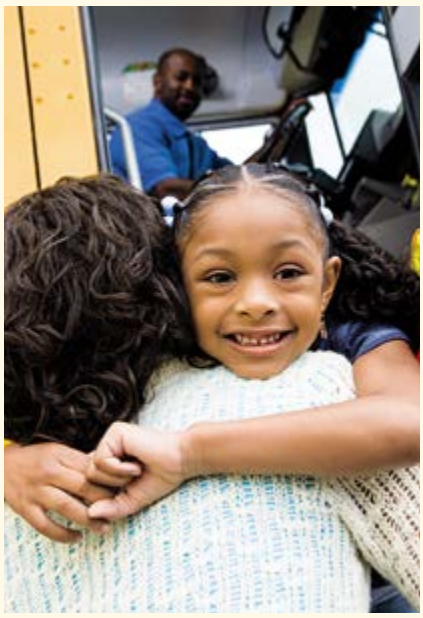
Your challenges and successes with HPV vaccination are welcome. Please submit them to Cynthia McReynolds at cmcreynolds@mms.org. ***— Sean Palfrey, MD, FAAP, director, MCAAP Immunization Initiative***

Public Access to Kindergarten Immunization and Exemption Data

My wife and I recently went through the process of deciding where to send our daughter to school. We weighed the pros and cons of several schools, taking into consideration curricular philosophies, student-teacher ratios, and facilities, among other things. What we didn't compare between these schools — and couldn't in the Commonwealth of Massachusetts — was the percentage of her classmates who would be appropriately vaccinated. We didn't consider or even have access to the information that would tell us the strength of the schools' protective shield of community immunity, so we would know how protected our daughter would be from contracting dangerous, vaccine-preventable diseases. In Massachusetts, as in most states, information about school vaccination and vaccine exemption rates is not publicly available. Fortunately, Massachusetts has just changed course and decided to publish these data.

Probably more than any other single issue, parents are concerned about their child's safety and the safety of their environment, whether it's the food they eat, the air they breathe, or the cars they ride in. Yet, the very serious and very real issue of how protected they will be by the shield of community immunity is not even on the radar for most parents when choosing where to send their child to school. The few states that publish this information (California, Oregon, Vermont, and Washington) have done so after experiencing dramatic increases in parental vaccine hesitancy. These states also have been at the forefront of tightening the laws that mandate school vaccinations. Wider availability of this information would not only provide parents with valuable knowledge about the potential safety of their children, but it would jump-start a national conversation about why vaccinations are such an important issue to begin with.

Overall, the United States does an excellent job of vaccinating children against a wide array of devastating diseases that were once common causes of childhood illness, disability, and death. The nationwide immunization rate for the key preschool vaccines has held relatively steady near the target rate of 90 percent. This number is misleading, however, as it hides vast regional differences in vaccination rates. Fueled by the rapid spread of vaccine misinformation and the increasing belief in a host of vaccine myths, a growing number of parents are rejecting the recommendations of science-based medicine, choosing to alter the recommended vaccine schedule or skip some or all vaccines completely. This rise in parental vaccine refusal and hesitancy has produced regional "hot zones" of underimmunization, placing all children at risk and leading to outbreaks of previously contained childhood disease across the country.



With the exceptions of Mississippi and West Virginia, every state has some provision allowing parents to claim a nonmedical exemption for their children from receiving the vaccines required for school entry. The ease with which such exemptions can be made varies by state, but it typically requires nothing more than signing a form.

Though the exemption rate for the United States as a whole has remained relatively stable at 1.5 percent, hot zones of parental vaccine refusal exist where the rates are much higher. In Massachusetts, these hot zones include Berkshire (3.2%), Hampshire (4.2%), Cape Cod (4.5%), and Franklin (6%) counties. These numbers are likely to be underestimates, as some schools are less strict than others in complying with collecting and reporting these data. This increasing trend in undervaccination has already brought with it outbreaks of dangerous, completely preventable diseases. Unless we reverse this trend, disease outbreaks will continue and grow in size and distribution. The universal availability of school vaccination and vaccine exemption rates is an important step in addressing this problem.

The Massachusetts Department of Health recently announced that it will soon join several other states by making these data available to the public on its website. These rates will give parents important information

about the safety of their child's school environment by shedding light on these otherwise hidden pockets of undervaccination. Equally important, open access to this information will increase the public dialogue about the importance of immunization and the danger of the spreading wave of parental vaccine refusal and denial of established science.

— John Snyder, MD, FAAP, assistant professor of pediatrics, Tufts University School of Medicine, pediatrician at Amherst Pediatrics, Amherst

School Immunization Updates from the MDPH

2013–14 Kindergarten Immunization and Exemption Data

The MDPH Immunization Program annually collects immunization and exemption data for all kindergarten students across Massachusetts. Last summer, ShotClock featured an article from MDPH regarding the increasing trend in exemption rates among this population. Fortunately, the exemption rate did not increase during the 2013–14 school year, remaining at 1.5 percent. However, this rate is still the highest total exemption rate Massachusetts has ever recorded for kindergarten students. There are also many counties throughout Massachusetts where exemption rates exceed 3 percent (Berkshire, Cape Cod Counties [Barnstable, Dukes and Nantucket], Franklin, and Hampshire counties), leaving large pockets of unimmunized or underimmunized children at risk for contracting vaccine-preventable diseases throughout the Commonwealth.

While exemption rates remain high in Massachusetts, so do the overall immunization rates. New immunization requirements were implemented in 2011 for two doses of MMR and two doses of varicella vaccine. These rates have been steadily increasing since the new requirement took effect. The rate of kindergarten students with two doses of MMR increased from 91.2 percent in 2010 to 95.2 percent in 2013.

Additionally, the rate of kindergarten students with two doses of varicella vaccine increased from 79.2 percent in 2010 to 94 percent in 2013. Please see the table for additional statewide immunization and exemption rates among kindergarten students for the 2013–14 school year.

Data Release Policy

In response to recent local, national, and international outbreaks of vaccine-preventable diseases, along with the slowly increasing exemption rates in Massachusetts, MDPH is implementing a new immunization data release policy. In the past, MDPH released annual school immunization data at the state and county levels. Beginning in June, MDPH will release immunization and total exemption (medical and religious combined) rates for child care centers, kindergartens and seventh grades at the individual school or child care level. Rates from schools or child care centers with ten or more students will be posted to the MDPH website; sites that did not respond to the survey will be indicated as such.

MDPH understands the public health importance of providing this information to providers throughout Massachusetts so that they can modify vaccine conversations with parents as necessary in order to increase immunization rates. This policy also provides an opportunity for parents to gain a better understanding of the immunization and exemption rates in their children's schools and local communities.

Immunization Requirement Phase-In Schedule for Upcoming School Year

September marks the fourth year of the phase-in schedule for new immunization requirements. For the 2014–15 school year, two doses of MMR and two doses of varicella will be required for all students in grades K–3 and 7–10. A dose of Tdap will be required for all students in grades 7–10. These requirements will continue to be phased-in through 2017. Visit mass.gov/eohhs/docs/dph/cdc/immunization/guidelines-ma-school-requirements.pdf for all school requirements by grade.

Massachusetts Kindergarten Immunization Rates, 2013–14

≥4 DTaP/DTP	≥3 Polio	2 MMR	3 Hep B	2 Varicella	5-4-2-3-2[1]	Total Exemption Rate[2]
98.4%	98.2%	95.2%	97.2%	94.0%	90.8%	1.5%

[1]5-4-2-3-2: Students with 5 DTaP/DTP, 4 polio, 2 MMR, 3 hepatitis B and 2 varicella
[2]Medical and religious exemptions combined

For any questions regarding school immunization rates in Massachusetts or immunization requirements, please call the MDPH Immunization Program at (617) 983-6800.

19th Annual MIAP Pediatric Immunization Skills Building Conference

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 in Marlborough.

Conference sessions include epidemiology of vaccine-preventable diseases, Massachusetts Immunization Information System (MIIS), vaccine storage and handling and VFC compliance training, immunization case studies, vaccine "101", adolescent vaccination, and more!

Conference registration will begin on August 1, 2014. Additional conference updates will be sent to MCAAP members as they become available.

2nd Annual HPV/Cervical Cancer Summit

The 2nd Annual HPV/Cervical Cancer Summit will be held on Friday, November 7, 2014, at the Dana Farber Cancer Institute in Boston.

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

Additional information will be sent as it becomes available. In the meantime, please contact Eileen Duffey-Lind at Dana Farber (eileen_duffey-lind@dfci.harvard.edu), if you have questions about the summit.

The Case for Fluoride Varnish

Over 75 private practices and community health centers in Massachusetts have been trained to apply fluoride varnish. The United States Preventative Services Task Force (USPTSF) recently made the recommendation that "primary care clinicians apply fluoride varnish to the primary teeth of **ALL** infants and children starting at the age of primary tooth eruption."[1] This recommendation is Grade B, which means the USPSTF recommends the service. According to the USPSTF recommendation, "there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial."[2] This evidence-based recommendation can substantially decrease the incidence of caries, the number one chronic disease of childhood. In studies, this reduction ranged from 18 percent to 59 percent as compared to placebo.

This simple procedure can significantly benefit our patients' lives both now and in the future.

Why Consider Fluoride Varnish in the Medical Setting?

Oral health is integral to a child's overall health and well-being. Although it is recommended that children visit a dentist at the eruption of the first tooth and no later than 12 months of age, the pediatrician is often the first clinician to examine a child's mouth. Each well-child visit should include an oral-health screening to assess the oral cavity. During this visit you can determine if a child is at moderate-to-high risk for dental caries disease, apply fluoride varnish as a preventive measure if necessary, and refer the child to a dentist for treatment. Fluoride varnish lowers caries-causing oral bacterial levels and repairs and strengthens teeth. It is the first weapon of defense against childhood caries disease.

Applying fluoride varnish in a medical setting is easy and takes less than two minutes. The varnish can be applied in any setting and does not require dental equipment. It is safe and well tolerated by infants and children, including children with special health care needs. Varnish is painted on the teeth with a brush and dries immediately upon contact with saliva. The child's teeth may appear yellow after the fluoride varnish application. This discoloration is normal and will disappear when the teeth are brushed the next day.

Health care professionals, including physicians, physician assistants, nurse practitioners, registered nurses, licensed practical nurses, and medical assistants can qualify to apply fluoride varnish after completing a MassHealth-approved training program. Web-based and office-based training programs for health care professionals, as well as CME credit, are available. The training can be taken at any time prior to providing services.

Physicians should bill the CDT code D1206 (topical application of fluoride varnish; therapeutic application for moderate-to-high caries risk patients) using either the 837P electronic submission form or the CMS 1500 form. Reimbursement for the code is for children ages 6 months to 21 years who are MassHealth-eligible. The current rate of $26 per application includes the materials and supplies used in the process.

For additional information, please visit mass.gov/masshealth/fluoridevarnish or contact Megan Mackin at (617) 886-1728 or megan.mackin@dentaquest.com or Gretchen Nakala at gretchen.ctaap@gmail.com.

Spotlight on Two Practices Who Have Successfully Incorporated Fluoride Varnish into Their Workflow

TLC Pediatrics

TLC Pediatrics is a three-physician practice that has served Revere, Winthrop, and the surrounding communities for more than 40 years.

While attending a conference on electronic medical records (EMR), TLC heard about pediatricians providing fluoride varnish.

According to Jamie Panagoplos, BSN, RN, who is TLC's oral health champion, "A lot of our patient population is not receiving dental care and [doesn't] have a dental home. We saw [fluoride varnish] as one way to help our patients. From the nursing perspective, you can't have good nutrition without good dentition. Once we found out how easy fluoride varnish was to do, it seemed like a no brainer."[3]

The physicians now have a prompt in their EMR to counsel their patients and determine their need for fluoride varnish. The physician decides on the need and the nurse or medical assistant provides the fluoride varnish when they give the immunizations. RNs and MAs do the varnish first and then the shots. They have found that varnishing takes less than a minute using the lap-to-lap approach. The parents have been extremely positive and not one parent has turned the service down. According to Panagoplos, "The parents are asking if they can get the fluoride varnish again. It is giving them an incentive to come in for the well-child visits and improving their compliance in keeping their well child

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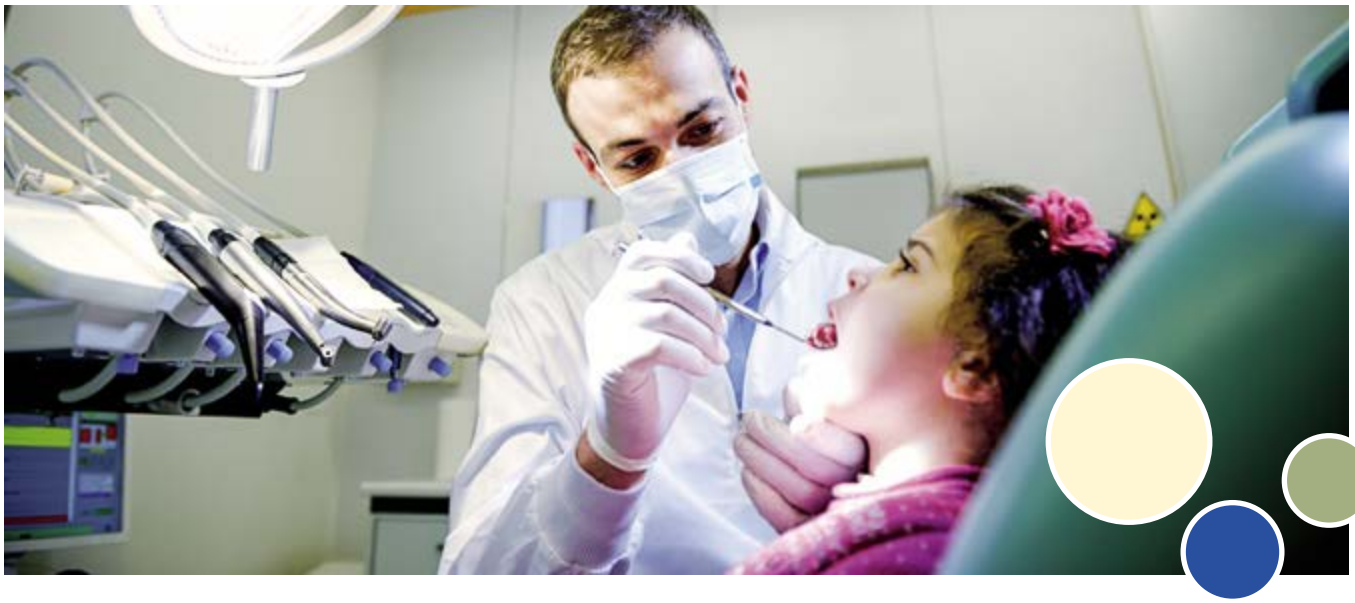

Fluoride Varnish

continued from page 10

visits."[4] Parents are also more aware of the importance of dental care and are seeking out more dental services.[5]

The practice offers the fluoride varnish to its non-Medicaid patients at a very low out-of-pocket cost. The staff members have posted information on their website and have gotten very positive feedback.

What does Panagoplos think has made the service so successful? Great buy-in from the staff and a great trainer, Gretchen Nahkala, who not only provided the training but follows up on TLC's progress; also, she is always available to answer any questions they have. According to Panagoplos, "It's been an easy, seamless transition."[6]

Southcoast Pediatrics, North Dartmouth

Southcoast Pediatrics opened over 25 years ago in North Dartmouth with one physician. Today, there are four physicians and two nurse practitioners serving a patient population of over 7,000. Fifty percent of the practice has state-provided insurance, such as MassHealth. Southcoast has been in practice long enough that the pediatricians are now treating the children of their former patients, who have grown up to have families of their own. Many of the staff members have been with the practice for over 25 years.

One of the newest physicians to join the practice recommended that the others should offer fluoride varnish for their patients, having provided it in her previous practice. Although the physicians always examined the teeth at well-child visits, they had not provided fluoride varnish. Aware of the significant oral health issues they were seeing with many of their patients and the perceived lack of dental providers who would treat their patients in their area, the other physicians were willing to try it. They recognized that it would be a helpful service for their patients.

Tracey Pereira, BSN, RN, who manages the nurses, agreed to implement the program. She sought out the training provided by From the First Tooth.[7] This training not only helped them to establish the program in their practice, but it also gave them an up-to-date list of local dental providers who would see their patients.

The nurses and medical assistants are responsible for providing the fluoride varnish to the practice's patients. Questions asked of the patients before seeing the physician indicate whether the patient meets the risk criteria for fluoride varnish. Given the flow of the physicians and patients in the practice at any given time, the child might receive the fluoride varnish before or after seeing the physician. The nurses and medical assistants do what works best for the patient. If the fluoride varnish is not applied before the physician sees the patient, then the staff will apply the varnish at the end of the visit. If varnish is given at the end of the visit and an immunization is also needed, the fluoride varnish is painted on the child's teeth before the immunization is given.

Parents have been very accepting of the service for their children, with the exception of those who just saw a dentist or who soon have an appointment with a dentist.

Pereira acknowledges that it is another step in the care of their patients. It adds very little time to the appointment and it is something that the patients really do need. At first they all thought it would be hard to do, but they have found that it really isn't. The nurses and medical assistants are all comfortable applying the fluoride varnish.

Pereira is proud that Southcoast Pediatrics added this much needed service for their patients, and wants to tell other practices that "I feel that this is an easy way to contribute to our patients overall health."[8] ***— Megan Mackin, outreach coordinator, DentaQuest/MassHealth, and Michelle Dalal, MD, chair, MCAAP Oral Health Committee***

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[1]Chou, et al, "Preventing Dental Caries in Children <5 Years: Systematic Review Updating USPSTF Recommendation," *Pediatrics* 2013; 132(2):332–350.

[2]Chou, et al, "Preventing Dental Caries in Children <5 Years: Systematic Review Updating USPSTF Recommendation," *Pediatrics* 2013; 132(2):332–350.

[3]Interviewed by Ellen Sachs Leicher on July 2013

[4]Interviewed by Ellen Sachs Leicher on July 2013

[5]Interviewed by Ellen Sachs Leicher on July 2013

[6]Interviewed by Ellen Sachs Leicher on July 2013

[7]From the First Tooth is a four-state collaborative that recruits, trains, and helps sustain the practice of oral health education and fluoride varnish application in primary care medical offices in Connecticut, Maine, Massachusetts, and Rhode Island.

[8]Interviewed by Ellen Sachs Leicher on May 13, 2014

BOOK CORNER

Let's Do It — Get the Books into Children's Hands

Amelia Earhart, pioneer in innovation and aviation, once said, "The most effective way to do it, is to do it."[1] Some things in pediatrics can become automatic: vaccinate your child, childproof your home, and keep discipline practices consistent. We don't question their evidence base, and they are a large part of the fabric of quality childcare that we all strive for. Recently the importance of reading aloud to children has joined that list. Almost a decade ago, research showed that parental reading was a normative behavior in many U.S. households and was reliably linked to school readiness and language outcomes, although many of the studies were associative.[2]

In 2004, a landmark study was done among 2,500 mothers of children less than 3 years of age; it showed that at 14 months the odds of being read aloud to increased if the child was firstborn or female. For English-speaking children, concurrent reading was associated with vocabulary and comprehension at 14 months, and vocabulary and cognitive development at 24 months. In this study, a pattern of daily reading over three points in the first three years for English-speaking children and at any one point for Spanish speaking children predicted children's language and cognition at 36 months. The pattern and power are evident, but how do we differentiate the role of book sharing in the highest risk children: those who speak another language at home or may be the children of immigrants?[3]

A recent study published in *Pediatrics* tackled just this question. The study examined the early developmental context of children in immigrant families as measured by the frequency with which parents shared books with their children. They used California Health Interview Survey data from 2005, 2007, and 2009. A total of 15,133 parents of children under the age of 6 years were sampled in respect to their book-sharing practices. The frequency of parents sharing books with their children was measured in two ways. The first was parental response to the standardized question: "In a usual week, about how many days do you or any other family members read stories or look at picture books with [a child younger than 5 years in the home]?" Frequency was recorded as "every day", "3 to 6 days per week," "1 to 2 days per week," or "never." The second measure dichotomized the outcome of book sharing, assessing whether parents read or look at picture books with children on a daily basis. Covariates in the analysis included parental education, household income, race and ethnicity, immigrant status of the family, language spoken in the home, and access to health care.[4]

This study found 57.5 percent of parents in immigrant families reported daily book sharing compared with 75.8 percent of native-born parents. The lowest percentage of daily book sharing was seen in Hispanic families with two foreign born parents (47.1 percent). When stratified by race and ethnicity, separate regressions revealed that being a child in an immigrant family was associated with lower odds for daily book sharing in Asian and Hispanic families. Most strikingly, this relationship held after controlling for variables thought to explain differences in literacy-related practices such as parental income and education.[5]

Thus we have our quest: reading aloud is important to early literacy and the highest risk children — children in immigrant families — receive the least daily book sharing. The evidence is there; the pattern is clarified. Now all we have to do is get the books into their hands and share the story of why it is so important. Let's do it. For more information about Reach Out and Read and early literacy, email the Massachusetts program director, Alison Corning-Clarke, at alison.clarke@reachoutandread.org or Marilyn Augustyn at augustyn@bu.edu.

— Marilyn Augustyn, MD, FAAP

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[1]http://womenshistory.about.com/od/quotes/a/amelia_earhart.htm

[2]www.reachoutandread.org/FileRepository/Research_Summary.pdf

[3]Raikes H, Pan BA, Luze G, et al, "Mother child bookreading in low-income families, correlates and outcomes during the first three years of life." *Child Development* 2006; 77(4):924–953.

[4]Festa N, Loftus PD, Cullen MR, Mendoza FS, "Disparities in Early Exposure to Book Sharing in Immigrant Families," *Pediatrics* 2014; 134(1):1–7.

[5]Festa N, Loftus PD, Cullen MR, Mendoza FS, "Disparities in Early Exposure to Book Sharing in Immigrant Families," *Pediatrics*, published online June 2, 2014, 134 (1):1–7.

Report of the Inaugural Year of the Medical Student Committee

It has truly been an honor for us to serve as co-chairs of the first year of the Medical Student Committee (MSC), and we look forward to hearing of the continued efforts of the MSC as interns next year. First, we would like to sincerely thank the Massachusetts Chapter of the American Academy of Pediatrics for its continued support of medical students' pursuit to improve the health and wellness of children in Massachusetts. We would like to specifically thank Dr. John O'Reilly (who was recently awarded the MSC's Mentor of the Year — an annual award to be given at the MCAAP annual meeting), Dr. Sean Palfrey, and Cathleen Haggerty for their guidance and mentorship throughout our first year. We would also like to thank the wonderful medical students, three from each institution in Massachusetts, for their collaborative efforts and participation over the course of the year.

The MSC was created last summer to involve enthusiastic and dedicated medical students from every institution in Massachusetts. Over the course of the year, the MSC hosted an annual fall advising and educational conference at Boston University School of Medicine for all pediatric trainees, hosted an annual networking event at the Liberty Hotel, established an ongoing charitable fund

MCAAP MSC members at MCAAP Annual Meeting Advertising Shoe Drive

Top, from left to right: Eli Freiman, UMass M'15, MSC Chair 2014–2015; Christian Pulcini, Tufts M'14 MSC Co-Chair 2013–2014. Bottom, from left to right: Michelle Marie-Pena, Harvard M'14; Kristin Schwarz, BU M'14, MSC Co-Chair 2013–2014.

to provide hundreds of shoes to children in Massachusetts to encourage them to be active, and actively participated in this year's Resident's and Fellow's Day at the State House (RFDASH). Future events for the coming year include a park beautification event at Franklin Park, coordination of volunteering at the Massachusetts Special Olympics, hosting MCAAP members at each medical school as speakers, and a formal mentoring program with a medical student and MCAAP member "mentorship match."

We have an exciting agenda for the coming year, and we are always looking for suggestions and collaborations with other MCAAP committees and members on projects that will benefit the health of children in Massachusetts. Please contact the new 2014–2015 MSC chair, Eli Freiman (eli.freiman@umassmed.edu), or Cathleen Haggerty (chaggerty@mcaap.org), if you have any ideas or would like to be put in touch with members of the MSC at a specific institution. Also, please view our website at mcaap.org/medical-student for more information. Thank you again for all your support and empowerment of medical students and future pediatricians in Massachusetts.

— Christian Pulcini, Tufts University School of Medicine M'14, MSC Co-Chair 2013–2014, rising intern in the Children's Hospital of Pittsburgh — Pediatric Residency Program; and Kristin Schwarz, Boston University School of Medicine M'14, MSC Co-Chair 2013–2014, rising intern in the Boston Combined Residency Program in Pediatrics

Shoe Drive

continued from page 1

After months of identifying families in need and measuring kids' shoe sizes, a whole fleet of colorful shoes were collected, purchased, and labeled in preparation for the official distribution day in Chelsea. As we set up the distribution center with festive sports balloons and a rainbow display of colorful shoes, excited families waited patiently for the shoes that had been specifically selected for their children. Families who benefitted from these efforts included those locally from Chelsea, along with refugee families from Somalia and Nepal. At any given moment, we could hear a multitude of languages spoken, yet the sentiments of hope and gratitude were universal.

While working with interpreters and social workers to distribute and fit the shoes, we learned that many of these children were from single-parent households or large families that find buying new shoes every year particularly challenging. Since children's feet grow so quickly, many of the children arrived wearing ill-fitting shoes or had bare feet. Therefore, it was especially rewarding to see the parent's look of relief as the children bounded around the room in their new shoes.

All in all, the event was a tremendous success. In just under two hours, about 80 pairs of sneakers were distributed, the children were thrilled, and the families were extremely appreciative. All MSC members thoroughly enjoyed the opportunity to meaningfully connect with the community, and we are excited to continue these efforts in the next academic year.

If you are interested in participating and/or supporting next year's "Shoe Drive for Kids," please contact Lauren Sweetser at Laurensw@bu.edu.

— Lauren Sweetser, MS (BUSM '17), and Michelle-Marie Peña, MD (HMS '14)

Introduction to the MCAAP Mentoring Initiative

The MCAAP has begun an effort to connect medical students, residents and fellows with the amazing reservoir of senior physicians in Massachusetts. There will be at least three arms to this initiative:

1. Increasing opportunities for young people — even undergraduates interested in medicine and medical science — to meet, talk, and even work with experienced pediatricians around the state
2. Providing experiences in clinical settings (e.g., internships, shadowing, research projects)
3. Offering discussions in print and in conferences about important facets of medicine and pediatric practice that clinicians feel are important to each other and to our profession.

As a start, here is a piece I wrote recently reflecting important lessons offered by seasoned clinicians, such as the late Dr. Joel Alpert, to us all.

Challenging Lessons from Old Giants in a New World

With the passing of Joel Alpert, MD, FAAP, we have lost an ardent, indomitable voice for child health in this country, but his legacy needs to live on in many spheres of health care practice and policy. Dr. Alpert pioneered primary care as a specialty and the disciplined training of primary care clinicians. He was a ferocious advocate who championed universal health care for children and the elimination of disparities. He pummeled his residents with a relentless emphasis on thorough and analytical history taking and physical examination, the use of time as a diagnostic tool, experience-based clinical judgment in decision making, and the idea that no intervention can often be the best approach. He was always emphatic and usually right.

Because science, technology, and the practice of medicine are all advancing so rapidly, students, residents, and attending physicians always feel pressured to use the most recent — and often undertested — tools in order to offer their patients the best care and show that they are up-to-date. However, many of us are learning, sometimes painfully, that integrating watchful waiting and use of clinical judgment with considered use of testing and treatment is often more effective and certainly less costly for our patients and our country's ability to offer health care to all. There are no such increments as "generations" any more. Every trainee needs to heed the wisdom of

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JOB CORNER

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.*

Mentoring

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their teachers and, together with them, carefully incorporate new discoveries into clinical practice.

Now, more than ever, we need to remember the basics: beware of hubris and ask each other's advice. There is a long road from bench to bedside. Dr. Alpert was not alone in demanding balance and emphasis on the long view, he was just one of our most perceptive clinicians and outspoken leaders. Some of the basic lessons he emphasized are:

1. Care of children and studies of child physiology, pharmacology, and behavior are different from those of adults, but understanding of and early prevention of pediatric illnesses have profound, massive, and cost-saving benefits over their lifetimes as children and adults. Prevention works wonders, and simply saying the word "children" when discussing policies, research, manpower, technology, and funding reinforces this central precept.
2. Universal access to basic health care is essential because in this increasingly connected society everyone's health and illness affects everyone else's. The United States has one of the poorest records in the developed world on access to care, and, as a result, on overall quality of care.
3. Building better, easier information-sharing practices and tools is essential to making health care coordinated, collaborative, comprehensive, and continuous. Fundamentals of the medical home must be extended to hospital and subspecialty care and enabled by improved communication systems and simpler EMRs.
4. Expanding opportunities, providing earlier and more flexible training, and making the best use of everyone's talents in the comprehensive care of our patients are crucial to our response to the explosion of knowledge and the lack of many types of health care providers. Professional territoriality has to disappear and clinical teamwork has to be firmly established or we will not be able to address the needs of our population.
5. Every physician must advocate for their patients. Advocacy can take many forms, but we must have the courage to speak out, sometimes on issues that may be unpopular but are right for the health and safety of our families, such as vaccinating all children, keeping guns out of homes, and eliminating smoking.
6. Think. Pause before you leap. Time is the foundation of clinical judgment. We must always take time to think, even in emergencies. Watch our patients' clinical course, ask them what they think is going on (they're sometimes right), what they're worried about, where they've been, what they've been exposed to, and what they've suffered before. Often no treatment is the right plan at one or many moments in the course of an illness.
7. Use data wisely. With thousands of articles coming out each week we need to be highly data-driven but extremely critical. Analyze study statistics carefully to make sure they apply to our specific case, and assume that tangential data could be dangerous.
8. Practice, teach, and learn in the communities and homes of our patients. Long gone are most of the remarkably valuable but time-consuming home visits. But if we cannot visit our patients' homes, at least we must meet them physically and personally in their own environments in order to understand the forces — the massively important social determinants — acting on our patients health so we can address them in parallel with the physical determinants of their health.

Case examples supporting these principles of twenty-first century medical care are legion, and Dr. Alpert was not alone in espousing them. But he was a remarkable advocate, leader, teacher, and articulate spokesperson, not just for children but also for the maintenance of high quality medical care in a rapidly changing world. We need to heed these principles. We ignore them at our peril and the peril of our patients and the U.S. health care system.
— Sean Palfrey, MD, FAAP

MCAAP Annual Meeting — May 1, 2014
Dr. Michael McManus, vice president, presents outgoing president, Dr. John O'Reilly, with a plaque of recognition for his service to the well-being of Massachusetts children and families over the past two years.

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