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

The Chapter's Vitality

Greetings and Happy Summer! It feels good to put that long winter behind us and get back to enjoying the many things we love about living in New England. Before you head off to Maine, New Hampshire, the Vineyard, the Cape, or wherever, let me catch you up on some Chapter developments.

This year's annual meeting was superb and exemplified the vitality of the Chapter. Under the leadership of Dr. Judy Palfrey and our Committee on Children and Youth with Special Healthcare Needs, we devoted the entire day to exploring models of care for our patients with the most complicated needs. We were joined by many of our friends from the Massachusetts Department of Health and Human Services, including Ron Benham, director of the Bureau of Family Health and Nutrition. We were extremely fortunate to hear from Dr. Robert Masters, our 17th Annual Edward Penn Memorial Lecturer, who outlined the structure and history of his Commonwealth Care Alliance. Commonwealth Care is a national model for creating sustainable medical homes that capably meets even the most difficult health care needs for children and adults. Dr. Master's insights were invaluable to us since many of his patients today were ours in their childhood. We also heard from Dr. Tisa Johnson-Hooper from Henry Ford Pediatrics in Detroit. Tisa shared many of her experiences and innovations in creating successful medical homes for complex children despite severely limited resources. The afternoon was densely populated with local experts offering workshops on and connections to cutting-edge work right here in Massachusetts. All in all, it was a day well spent. If you could

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DEVELOPMENTAL CORNER

Augmentative and Alternative Forms of Communication

For children with severe expressive communication disorders, augmentative and alternative communication (AAC) can improve their ability to interact with others in everyday settings. AAC promotes wider social interaction by offering different functions from supporting existing speech to providing an alternative for verbal communication. Individuals with autism, cerebral palsy, genetic syndromes, cognitive impairments, hearing impairments, and head injuries use AAC to enhance their communication abilities.[1]

Depending on a child's needs, AAC can be applied through the means of unaided or aided forms of communication. Unaided forms of ACC require children to use their bodies to communicate and include sign language, gestures, and facial expressions.[2] Aided forms of ACC involve the use of equipment and devices to communicate, and they are categorized by low-tech and high-tech options.[3]

Aided AAC was originally the last type of intervention recommended for children

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Massachusetts Chapter
American Academy of Pediatrics
P.O. Box 9132
Waltham, MA 02454-9132

Photo by Anne Light, MD, FAAP, 2015

Editor's Note

Almost 5 years ago, I eagerly accepted the role of *Forum* editor from the wonderful Dr. Lloyd Fisher. I went in excited to work closely with the many physicians and mentors at the MCAAP, and I was not let down. During my tenure our champions created a statewide immunization registry and a new psychiatric care paradigm with Massachusetts Child Psychiatry Access Project (MCPAP), started a Medical Student Committee, and began a series of early childhood summits. Tireless advocates worked in every facet of the health care system, from the government to private and nonprofit companies, to make sure that our patients' and clinicians' needs were front and center. Whether it was the new Massachusetts Department of Public Health (MDPH) regulations around concussion management, the funding of HPV vaccines, or the implementation of new EMR requirements, the MCAAP was there, shaping the discussion to best benefit the children of Massachusetts.

These amazing successes were possible because of tremendous leadership and deep passion. I have been honored and humbled by the drive and vision of each of our presidents, as well as by the savvy and pure sweat equity of the MCAAP Board and our members. I have been grateful to talk with and learn from each of our contributor's pieces, and thankful for the wonderful folks at the *New England Journal of Medicine* for turning each pile of word documents into a gorgeous publication. Last but most definitely not least, the tireless Cathleen Haggerty has helped me with too many questions to count, all while exuding kindness, calm, and grace. Every day, I learned new information and skills from these wonderful people, and I am so grateful to have worked with each and every one.

But as much as I love the MCAAP and *The Forum*, I must leave them behind. Since June 1, I have officially been a resident of Orange County, California. My new position as the Medical Director of the County Social Services Agency will give me the time and resources to create policies and collaborations that improve care for the more than 250,000 children served by our agency each year, and prevent others from ever needing our help. I wish all of my friends in the MCAAP the best of luck in your practices and your advocacy. I look forward to keeping in touch, and reading about your future MCAAP projects and victories in *The Forum*. ***— Anne Light, MD, FAAP***

The Chapter's Vitality

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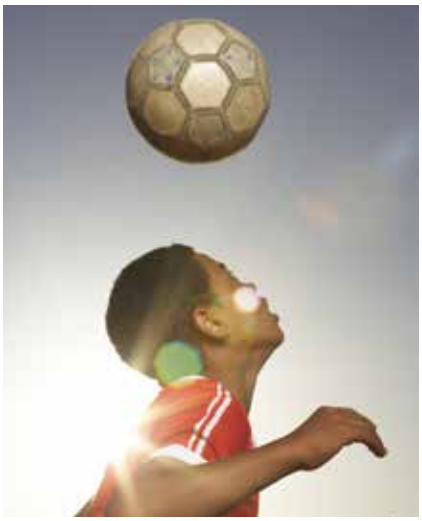
not make it, the accompanying PowerPoint slides are available on our website at www.MCAAP.org.

In our business meeting, Dr. Michael Yogman presented the Mental Health Task Force's successes in securing reimbursement for depression screening, continued funding for Massachusetts Child Psychiatry Access Project (MCPAP), and groundwork towards implementing a new sister program, MCPAP for Moms. Ed Brennan explained the upcoming legislative challenges, and we announced the award of a Friends of Children Healthy People 2020 grant to Dr. Julia Koehler. Julia's project, *Chelsea Wants to Dream*, is one of five in the nation and will begin to address the unmet mental health needs of immigrant children. The Medical Student and Resident Committees also had a lot of activity to report, including upcoming Plans for Residents and Fellows Day at the State House. Fittingly, they presented their 2015 Mentoring Award to Dr. Sean Palfrey. Annual Meeting presentations can be found at www.mcaap.org/cme.

In reviewing our national activities, we observed that MCAAP members now occupy close to 250 national AAP positions. The Chapter is exceptionally well represented across all of the many councils, sections, and special interests groups that help make the Academy what it is. Each year, the MCAAP identifies and recommends dozens of individuals for national positions, and each year we enjoy enviable success. A perfect recent example is MCAAP and MMS Past President Dr. Lynda Young, who is now candidate for national AAP president. As you've heard me say before, there is no more welcoming an organization than ours and even if you've never been involved before, we want to help you put your energies to good use.

Finally, as part of my report, I outlined some of the Chapter's progress in our new focus on poverty. Although our members have universally welcomed the initiative, many express difficulty in finding hands-on opportunities to get involved. To that end, let me close by asking for your help. This summer, send us your suggestions of places or programs where your fellow members might be able to lend a hand. These suggestions will be considered for



publication on our website. Please keep an eye out this summer and send us your suggestions of places or programs where your fellow members might be able to lend a hand. Send us the names and contact information as you think of them and, over the summer, we will collect your suggestions for publication on our website. Over time, perhaps we can build a useful clearinghouse that will help everyone get involved. Please direct your suggestions to mmcmanus@mcaap.org or chaggerty@mcaap.org. Have a great summer!

— Michael McManus, MD, MPH, FAAP

Wage Theft — A Major Etiology of Child Poverty

We visited the Chambi family home on a cool evening in mid-May 2015. They live on a quiet residential street in Milford, MA. The family's father, Cesar Chambi,[1] a gentleman in his 50s, welcomed us in heavily accented Spanish. His mother tongue is Quechua, the language of the Incas, and today the language of Ecuadorians in the high Andes who live in deeply impoverished communities. We spoke to Cesar, five of his sons, his wife, and his daughters-in-law, as well as his 8-year-old granddaughter and her baby sister, in the family's simple kitchen.

They told us that $25,000 was stolen from them by nonpayment of wages. In 2012, four of Cesar's sons were recruited by a subcontractor, Pereira,[1] who had won a bid from a large construction firm. The brothers worked full-time for two months doing carpentry, roofing, and siding for the houses. Pereira kept delaying wage payments until ultimately, he told the brothers that he would pay them after the job was complete. However, when the project was complete, Pereira disappeared. The brothers tried calling him but he did not answer. They even tried visiting his house but it was vacant.

"We were excited to get paid," said one of the brothers, Juan.[1] "Now, I feel really angry. It's so much money. All of us together [worked] on a hot roof under the strong sun for the entire summer."

The family's three children (ages 1, 8, and 11) had to do without school supplies and even food. When Pereira stole their wages, the family was not able to pay rent and was constantly afraid of eviction. "Not having money affects the entire family," said Juan's brother, Pedro.[1] "It creates tension and friction in the family."

The family struggled to recount how they were not able to purchase school photos. Their children could not participate in the school tradition where students give photos to each other as gifts. "The kids get teased because they don't have what other children have," said Juan. "They can't dress well and we can't pay for school activities."

Wage theft is a major driver of poverty across the United States. A study of 4,387 low-wage workers surveyed January through August of 2008 in Los Angeles, Chicago, and New York City found that 68% of the workers fell victim to at least one form of wage theft in the week preceding the interview.[2] Extrapolating from their sample, the authors estimated that approximately 1.1 million workers in Chicago, Los Angeles, and New York City lose more than $56.4 million per week, or $2.9 billion per year.[2] The Economic Policy Foundation estimates that companies

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Wage Theft — A Major Etiology of Child Poverty

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steal $19 billion in unpaid overtime annually.[3] And since unpaid overtime is only one of the tactics of wage theft, the amount of money that working families lose is staggering.[4] Were wage theft to be eliminated, child hunger, housing insecurity, and family scarcity of educational resources would immediately be greatly diminished.

Many workers do not pursue stolen wages, because they do not know where to turn, or because they succumb to employer threats of retaliation. But the Chambi family sought out the Metro West Workers' Center in Framingham to help them recover their $25,000 in unpaid wages. When contacted by Metro West Workers' Center, the owner of the large construction firm expressed his satisfaction with the quality of the brothers' work and stated that he would be willing to hire the brothers for future projects. However, he will not pay them for their past work as he claims that he has already paid Pereira for that project.

"Even though they can prove that wage theft has occurred," said Diego Low, coordinator of the MetroWest Workers Center, "it is very difficult to recover [wages] since the subcontractors don't have any assets. In an effort to fight wage theft, the [main] contractor needs to be liable for hiring a disreputable subcontractor. Employers use multiple layers of subcontractors to avoid accountability for wage theft. The proliferation of subcontracting in our economy is gutting society's ability to enforce labor standards across the board."

Wage theft is rampant in Massachusetts as it is across the country, with local media reports showing only the tip of an enormous iceberg.[5, 6, 7, 8] Legislation that would increase accountability for wage theft has been launched with significant support in our state legislature. Introduced by Senator Sal DiDomenico, S. 966, "An Act to prevent wage theft and promote employer accountability,"[9] aims to reduce the ability of large employers to participate in wage theft by hiding behind layers of subcontractors. We believe passage of this bill would do much to reduce child poverty in the state. Each of us can call our state senator to ask them to support this bill. Support by the Chapter as part of our focus on poverty would also show the legislators that the wider public has become aware of the harmful effects of wage theft on children.

We should also support Attorney General Maura Healey, who recently committed increased resources to fight wage theft because, as she stated, "it causes such great harm to not just the individuals but the families and their children."[10] Jocelyn Jones, deputy chief and special counsel of the attorney general's Fair Labor Division, has volunteered to partner with pediatricians to inform parents of the recourse they have when they fall victim to wage theft.

We can support the attorney general office's work by encouraging parents to come forward if they have experienced wage theft. We can provide them outreach materials and an anti-retaliation fact sheet (to inform workers of their rights when they face retaliation by their employer for a complaint) in our waiting areas. We can add a question about wage theft to our well-child screening repertoire. We can direct parents to the AG's office and other organizations like the Metro West Workers' Center[11] and the Immigrant Worker Center Collaborative.[12] Our Immigrant Health Committee will provide links to these materials and organizations on our web page (http://mcaap.org/immigrant-health). It should be noted that not only immigrant families need this support: wage theft is a common, harmful, determinant of child health among U.S.-born families as well.

In conclusion, to rescue our patients from child poverty, from the consequent food and housing insecurity, from the lack of educational resources and the daily humiliations, we believe that the most basic measure is to ensure that their parents get paid for their work. This issue goes far beyond immigrant health, because many native-born citizens are also affected. As pediatricians, we have a big impact when we decide to support our patients' families and speak out. In the privacy of a consultation room and the public space of the state legislature, we can make a difference. Please support our patients' families in their right to be paid for their work.

— Shabatun Islam, Boston University School of Medicine Class of 2016 , and Julia Koehler, MD, FAAP

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[1]Pseudonym: all names have been changed.

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[6]www.bostonglobe.com/news/nation/2015/05/09/the-human-cost-nice-nails-unprotected-and-underpaid-workers/8ATRNHXWXrJDh19LCwgaZO/story.html

[7]www.bostonglobe.com/business/2015/05/11/wage-theft-rampant-residential-construction-industry-workers-and-labor-groups-say/AS6oMO3EfZLr0sbMV4xNGN/story.html

[8]www.bostonglobe.com/business/2015/05/15/paramount-workers-sue-for-nonpayment-overtime/mNaakrsSQiOe90vW9yB2lL/story.html

[9]https://malegislature.gov/Bills/189/Senate/S966

[10]Attorney General Maura Healey, Interview, May 15, 2015, recording by Heloisa Galvao.

[11]Metrowest Worker Center — Casa, 116 Concord Street #5, Framingham MA 01702, tel (508) 532-0575, fax (508) 630-1642, diego@mwc-casa.org

[12]https://www.facebook.com/pages/Immigrant-Worker-Center-Collaborative/102548866465662?sk=timeline&ref=page_internal

From Dr. Mark Friedman: The Importance of Screening Patients

To members of the Massachusetts Chapter of the American Academy of Pediatrics,

I am writing this message to implore the pediatricians working in Massachusetts to increase their well-child screening of patients in two specific areas: a complete visual screening of young children (especially three- and four-year-olds) and the screening of older patients (10 years old and older) regarding alcohol and drug use.

Both areas have been included in the Early Periodic Screening and Diagnosis Treatment (EPSDT) documents for at least 35 years. Screening procedures have undergone small modifications in the academy's policy statements, and these modifications have aimed to make screening easier, yet too many children remain unscreened.

Each screening comes with its own difficulties, and I understand the time pressures in a well-child visit. However, there are new tools that make these screenings easier and more efficient. We cannot afford to continue to rely on other groups (i.e., school nurses or initiatives like Head Start) because if the screens are not done, the negative consequences can be significant for our patients.

Pediatricians should be engaged in conversations about screening and ensuring high-quality screening for our patients. The Massachusetts Chapter of the American Academy of Pediatrics can take a leadership role by convening a representative group to discuss how we can support pediatricians in meeting screening goals. Pediatricians have always been held up as the group that cares the most for their patients. This task of great worth will enhance the meaning of our lives. ***— Mark Friedman, MD***

Augmentative and Alternative Forms of Communication

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with communication disorders.[4] Older devices were limited in function because they exclusively helped children with their expressive communication to better convey their wants and needs. Today, there is an increased recognition that AAC devices can also be used to improve children's receptive communication abilities by helping them receive and understand messages from others.

Examples of AAC device features include the following:

- Speech output using text displays that allow two people to exchange information
- Picture board touch screens that use images and symbols
- Spelling and word detection
- Internet to access information
- Multimedia components for videos and photos
- Texting and cell phone features
- Social media to connect with others[5]

Mobile technology has made AAC more accessible to families with phones and tablets, because these devices are light and portable, less costly, and widely used. Although some of these technologies are easily accessible, it is more important than ever for children to receive a referral and formal evaluation for AAC software and devices. A speech and language pathologist will design a tailored program that uses the best language concepts, organization and layout, selection of target concepts, and support for each child's specific needs.

Obtaining a referral and arranging funding and training for an AAC program can be complicated for any family. Primary care providers can facilitate this process by doing the following:

- Identifying communication issues early and making timely referrals — pediatric clinics often offer free developmental screenings[6]
- Coordinating the AAC assessment with other therapeutic services the child is currently receiving
- Supporting funding of AAC devices and services by providing "medical necessity" letters to funding sources[7]
- Working with a team of educational and therapy professionals to monitor the effectiveness of the chosen AAC device
- Assisting parents in conversations with school staff and child care staff to ensure that AAC devices are being used effectively in both school and home settings

Children with suspected communication issues should always be referred for an additional evaluation. Early detection and treatment can help children reach their fullest potential. ***— Lisa Rubin, MA, CCC-SLP, and Emmy Lustig, Pathways.org***

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[3]"Assistive Devices for People with Hearing, Voice, Speech, or Language Disorders." National Institute on Deafness and Other Communication Disorders. NIDCD Homepage. www.NIDCD.nih.gov. Accessed 17 Dec 2014.

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ShotClock

Dr. Susan M. Lett Receives Commonwealth of Massachusetts Outstanding Performance Citation

On May 6, 2015, Dr. Susan M. Lett, medical director of the Massachusetts Department of Public Health (MDPH) Immunization Program, received a Commonwealth of Massachusetts Outstanding Performance Citation. The Commonwealth Outstanding Performance Citation recognizes state employees who have demonstrated exemplary work performance.

For 26 years, Dr. Lett has promoted immunization in Massachusetts, allowing the Commonwealth to consistently lead U.S. immunization rates. In the last several years specifically, Dr. Lett helped develop a legislative solution to stable funding for universal vaccination in Massachusetts and played a crucial role in establishing the Massachusetts Immunization Information System (MIIS).

Dr. Lett has been recognized locally, regionally, and nationally as a leader and expert in immunization, and she serves on the prestigious U.S. CDC Advisory Committee on Immunization Practices and National Vaccine Advisory Committee.

She has built partnerships with many organizations to promote vaccination and is the go-to expert at the MDPH.

Dr. Lett is a physician specializing in internal medicine and received a master's in public health from Harvard. A renowned expert on vaccine preventable disease, she has mentored many younger colleagues. She has been a tireless champion of immunization throughout her 26-year career and has earned the admiration and respect of her colleagues locally and nationally. Her recent efforts leading a coalition promoting cancer preventing vaccines has resulted in increased acceptance of HPV vaccine in Massachusetts. The Commonwealth has benefited by consistently ranking in the top tier (often number one) for immunization rates in the United States.

The Chapter and Immunization Initiative congratulate Dr. Lett for her tireless efforts to improve immunization rates in Massachusetts!

ACIP Recommendations for 9-Valent Human Papillomavirus (9vHPV) Vaccine

The recommendation of the Advisory Committee on Immunization Practices (ACIP) for the use of 9vHPV vaccine has been published in the *Morbidity and Mortality Weekly* (*MMWR* 2015; 64: 300–304). The Vaccine Information Statement for 9vHPV vaccine is now available on the CDC website.

In December 2014, 9vHPV vaccine (Gardasil-9) by Merck was licensed as a three-dose schedule at 0, 1–2, and 6 months. This vaccine targets five additional high-risk types of HPV: 31, 33, 45, 52, and 58, in addition to 6, 11, 16, and 18 covered by the 4vHPV vaccine.

The additional five strains are projected to prevent **an additional 10 percent of HPV-attributable cancers (14 percent for females and 4 percent for males).** See accompanying graphic below for distribution by sex and site.

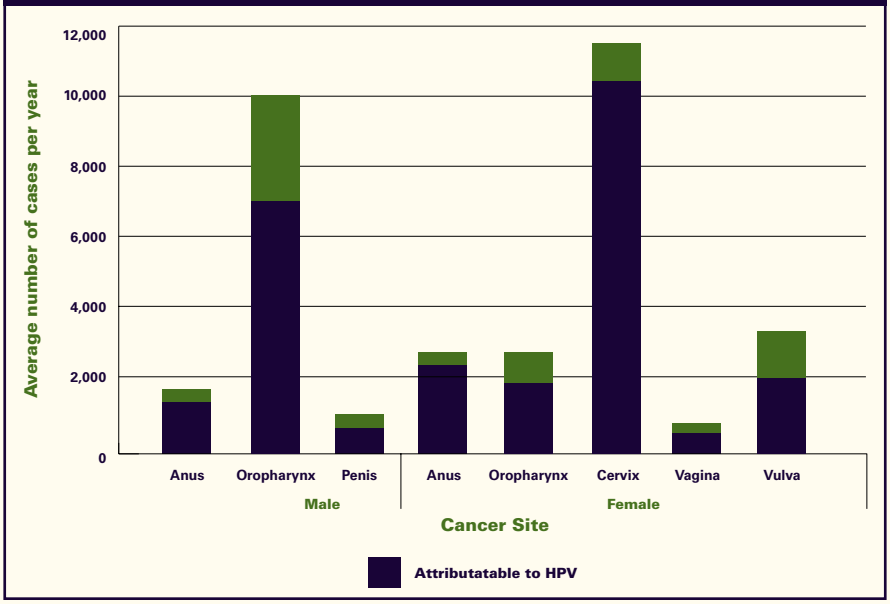
Summary of ACIP Recommendations

- The ACIP did **not** express a preference for 9vHPV (Gardasil 9) versus 2vHPV (Cervarix) or 4vHPV (Gardasil).
- CDC recommends that providers continue to use the HPV vaccine formulations they currently have in stock to vaccinate patients.
- If a provider does not know or have available the HPV product previously administered, or in a setting transitioning to 9vHPV, **any** product can be used to complete the series.
- The ACIP also recommended that 9vHPV can be used in both males and females through 26 years of age (see ACIP statement for additional guidance).

Questions

If you have a question about vaccine ordering, please call the MDPH Vaccine Unit at (617) 983-6828. If you have a question about vaccine recommendations or schedules, please call the MDPH Division of Epidemiology and Immunization at (617) 983-6800, and ask to speak with an immunization epidemiologist.

Estimated Number of HPV-attributable Cancer Cases per year, United States



NEW: Regulations Promulgated and MIIS Compliance Schedule Released

Regulations governing the MIIS, 105 CMR 222.000, have been promulgated by the Massachusetts Public Health Council and were effective as of January 2, 2015. The complete regulatory language can be found at www.mass.gov/courts/docs/lawlib/104-105cmr/105cmr222.pdf.

Immunization registries are an essential public health tool that provide access to consolidated patient immunization histories, improve clinical decision making, reduce vaccine waste, and improve accountability for publicly purchased vaccine. Additionally, these registries enhance **disaster preparedness** by providing an essential infrastructure for responding to natural disasters, bioterrorism events, influenza pandemics, and other emergencies.

As of May 13, 2015, 735 vaccine administration sites (including pediatric practices, multispecialty groups, provider networks, hospitals, pharmacies, and local health departments) have reported over 2.4 million patients and 15 million immunizations to the MIIS.

The Immunization Program's goal is to have all mandated users enrolled and using the system according to the following schedule:

9/1/2015	Providers who do not use electronic health record systems and will enter data directly into the web interface
12/1/2015	Providers who administer more than 1,000 doses of vaccine per year that use electronic health record technology and will report immunization information through electronic data exchange
6/1/2016	Providers who administer fewer than 1,000 doses of vaccine per year that use electronic health record technology and will report immunizations through electronic data exchange

The MIIS Team is available to provide technical assistance and facilitate health care provider onboarding and use of the system. In addition, there are many tools and materials available on the ContactMIIS Resource Center website (www.contactmiis.info) to assist with registration and training, as well as guidance and protocols related to informing patients and implementing data exchange with electronic health record systems. For further assistance, please contact the MIIS Help Desk at (617) 983-4335 or miishelpdesk@state.ma.us. — ***Massachusetts Department of Public Health***

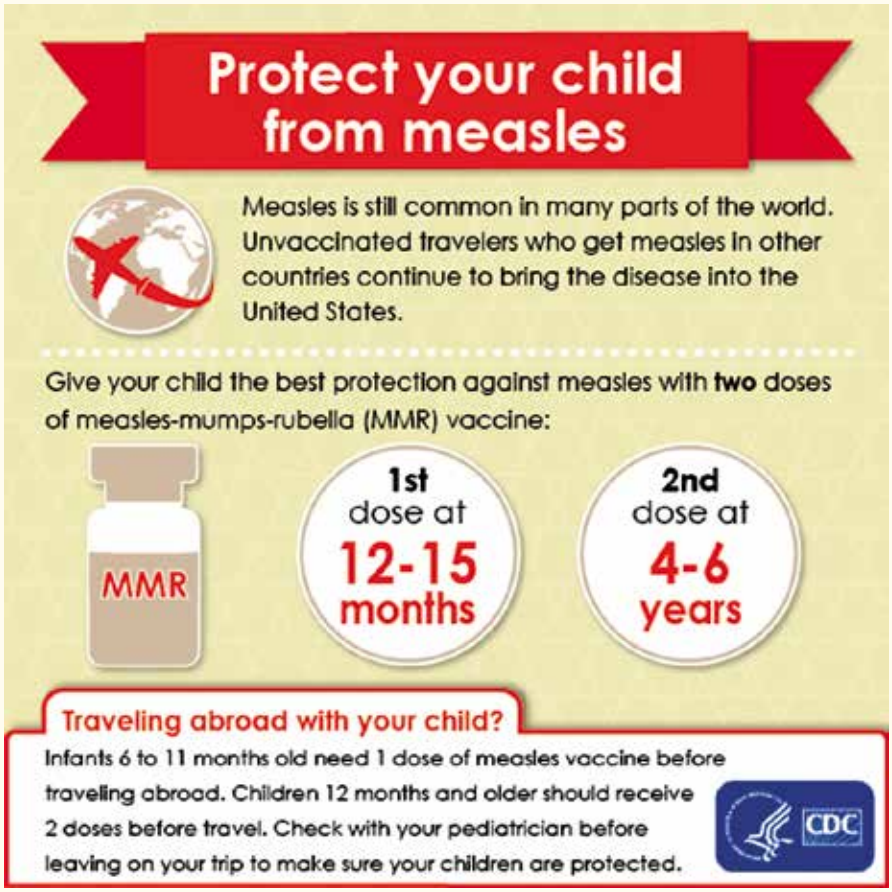
Measles 2015

All health care providers regardless of age should have written documentation of two doses of MMR, or laboratory evidence of immunity to measles, or laboratory evidence of disease.

The national picture: From January 1 to May 1, 2015, 169 people from 20 states and the District of Columbia were reported to have measles. Most of these cases (117 cases [70%]) were part of a large multi-state outbreak linked to the Disney amusement park in California. According to the CDC's National Center for Immunization and Respiratory Diseases (NCIRD), 2014 was a record-breaking year for measles in the United States, with 668 cases from 27 states. This was the greatest number of cases since measles elimination was documented in the United States in 2000. Also, 2014 was a big year for measles internationally, with more than 21,000 cases and 110 deaths in the Philippines (CDC, 2015, wwwnc.cdc.gov/travel/notices/watch/measles-philippines), and more than 58,000 cases worldwide. With constant international travel into and out of Boston and neighboring states, importation of measles (in a visitor or returning traveler) is an ongoing threat.

Massachusetts: In 2014, there were nine cases of measles in Massachusetts: eight in residents (six of which had recently travelled internationally) and one in a visitor. Two of the residents with measles were babies more than six months of age who could have received an MMR prior to international travel. There were more than 4,500 people exposed, and more than 500 received an MMR after exposure. Needless to say, when an exposure occurs in a medical practice or emergency room, there are numerous measles control steps that must be initiated immediately, to rapidly identify susceptibles among the exposed and provide MMR or immune globulin (IG) if necessary.

To date in 2015, there has been one confirmed case of measles in Massachusetts, in an unvaccinated exchange student from Western Europe. This individual should have been required to show evidence of immunity to measles prior to participation in a school-based education program. By the time he developed a rash and was diagnosed



www.cdc.gov/measles/travel-infographic.html

with measles, he had visited numerous tourist attractions in the Boston area and had made three visits to clinical settings while infectious. Over 700 were exposed. Approximately 15 were quarantined, with associated missed days of school, daycare, and work, along with missed public activities like holiday events, family gatherings, and end-of-school-year activities. MDPH issued a clinical measles alert to providers on April 30, 2015, urging clinicians to consider measles in patients who present with febrile rash illness and clinically compatible measles symptoms (cough, coryza [runny nose], or conjunctivitis); who recently traveled internationally or were exposed to someone who recently traveled; and who have not been vaccinated against measles (www.mass.gov/eohhs/docs/dph/cdc/advisories/mdph-clinical-measles-alert-4-30-2015.pdf).

Providers who suspect measles should do the following immediately:

1. **Promptly isolate patients** to minimize disease transmission.
2. **Immediately report** to your local board of health and to the MDPH Division of Epidemiology and Immunization at **(617) 983-6800**. Cases diagnosed in Boston should be reported to the Boston Public Health Commission at (617) 534-5611.
3. **Obtain specimens** for testing from patients with suspected measles, including serum, an NP swab or throat swab, and urine.

In addition, be sure to vaccinate patients lacking evidence of immunity prior to international travel, including infants more than six months of age. Infants who receive a dose of MMR prior to one year of age will need to have the dose repeated, following routine minimum age and minimum interval guidelines.

A more detailed list of initial measles control steps, suitable for printing and posting in your office, can be found on the last page of the April 2015 clinical alert. For questions about measles, please call (617) 983-6800 and ask to speak to an epidemiologist. CDC has many resources for providers at www.cdc.gov/measles/hcp/index.html.
— Massachusetts Department of Public Health

The Vaccine Handbook: A Practical Guide for Clinicians

The Immunization Action Coalition (IAC) is selling *The Vaccine Handbook: A Practical Guide for Clinicians* ("The Purple Book," 2015, 560 pages) by Gary S. Marshall, MD. "The Purple Book" is a uniquely comprehensive source of practical, up-to-date information for vaccine providers and educators. Dr. Marshall has drawn together the latest vaccine science and guidance into a concise, user-friendly, practical resource for the private office, public health clinic, academic medical center, and hospital.

IAC Executive Director Deborah Wexler, MD, notes, "During more than 20 years in the field of immunization education, I have not seen a book that is so brimming with state-of-the-science vaccine information. This book belongs in the hands of every medical student, physician-in-training, doctor, nursing student, and nurse who provide vaccines to patients."

The *Vaccine Handbook* includes the following:

- Information on every licensed vaccine in the United States
- Rationale behind authoritative vaccine recommendations
- Contingencies encountered in everyday practice
- A chapter dedicated to addressing vaccine concerns
- Background on how vaccine policy is made
- Standards and regulations
- Office logistics, including billing procedures, and much more

The *Vaccine Handbook* is now available on IAC's website at www.immunize.org/vaccine-handbook. The cost of the handbook is $29.95 (plus shipping).

About the Author

Gary Marshall, MD, is professor of pediatrics at the University of Louisville School of Medicine in Kentucky, where he serves as chief of the division of pediatric infectious diseases and director of the Pediatric Clinical Trials Unit. In addition to being a busy clinician, he is nationally known for his work in the areas of vaccine research, advocacy, and education. ***— Gary S. Marshall, MD***

Mark Your Calendar! 20th Annual MIAP Pediatric Immunization Skills Building Conference October 15, 2015

The Massachusetts Immunization Action Partnership (MIAP) is excited to announce the ***20th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference.*** The conference will be held on Thursday, October 15, 2015, at the Best Western Royal Plaza Hotel, Marlborough, Massachusetts.

This year's plenary speakers will be ***Cpt. Nancy Messonnier, MD,*** deputy director, National Center for Immunization and Respiratory Diseases (NCIRD), CDC; and ***JoEllen Wolicki, BSN, RN,*** nurse educator, CDC; as well as ***Susan Lett, MD, MPH,*** medical director, and ***Pejman Talebian, MA, MPH,*** director, Massachusetts Department of Public Health Immunization Program.

Additional conference sessions include vaccine preventable disease epidemiology, Massachusetts Immunization Information System, vaccine storage and handling and Vaccine for Children (VFC) compliance training, vaccine hesitancy and refusal, vaccine "101," vaccine "201," and more!

Conference registration will begin on **August 1, 2015**. Additional conference updates will be sent as they become available to MCAAP members.

Upcoming Immunization Initiative Advisory Committee Meeting

The next Immunization Initiative Advisory Committee meeting will be held on **Wednesday, September 30, 2015**, at the Massachusetts Medical Society in Waltham, MA. The meeting will begin at 6:30 p.m.

Chapter members are welcome to attend this meeting. If you would like to receive more information, or to attend the meeting, please contact Cynthia McReynolds at cmcreynolds@mms.org or (781) 895-9850.

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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BOOK CORNER

Better Literacy through Text Messages

According to the Researchers from the Center for Education Policy Analysis at Stanford, home-learning environments of children varied vastly across the country, yet nearly 90 percent of U.S. adults have cell phones and 98 percent of those can access texts. Based on this information, the researchers determined that texting was the "great equalizer" among these learning environments.[1] Perhaps more importantly, black and Hispanic adults, who often exhibit the highest dropout rates in parenting programs, send or receive texts more frequently than their white counterparts.[2]

So, by following the adage "If you can't beat 'em, join 'em," the researchers used text messaging as their intervention targeting parents of preschool children. Every week for eight months, the parents in the intervention group received three texts about a particular early literacy skill or set of skills: **1.** FACT designed to generate buy in from parents ("FACT: Bath time is great for teaching your child important skills for K[indergarden]. Start by asking your child: what are things we need for bath time? Why?"); **2.** TIP aimed to enhance parent's self-efficacy ("TIP: When you're bathing your child, point out letters on shampoo bottles. Ask your child to name them & tell you the sounds they make.") and **3.** GROWTH provided encouragement and reinforcement as well as a follow-up tip ("GROWTH: By teaching at bath time, you're preparing your child for K. Next time, ask questions about body parts. Where are your elbows? What do they do?"). About every two weeks, parents in the control group received a text pertaining to the district's kindergarten enrollment or vaccination policy.

The results were impressive. They found that the text intervention increased the frequency that parents told stories, pointed out rhyming words, or engaged in similar home activities by 0.22 to 0.34 standard deviations, as well as parental involvement at school by 0.13 to 0.19 standard deviations. As measured by required early literacy tests (lowercase alphabet knowledge and letter sounds), their kids performed better ranging from approximately 0.21 to 0.34 standard deviations.

What may have made it effective was that the intervention placed few demands on already busy families. Action was as simple as opening a text three times a week. Nonetheless, these texts seem to have impacted parenting behavior. Indeed, they have continued the intervention in a program titled READY4K! Further study is needed, but how intriguing is it for us as pediatric clinicians? If we can influence parenting practices by "speaking" to them through texts once they leave the office, we might truly be able to impact child development EVERY day and not just on the few days we actually SEE them. And even better, it's not very expensive. "For the entire school year," the researchers noted, "we spent less than one dollar per family to send text messages."

In all, texting is a promising idea that deserves further exploration as something we can add to literacy rich activities we are already engaged in like Reach Out and Read and Books Build Connections. Think (maybe text) about it. IMHO.

— Marilyn Augustyn, MD, FAAP

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 Marilyn.augustyn@bmc.org.

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[1]York BN, Loeb S. "One Step at a Time: The Effects of an Early Literacy Text Messaging Program for Parents of Preschoolers." http://cepa.stanford.edu/sites/default/files/York%20&%20Loeb%20(November%202014).pdf. Accessed 30 May 2015.

[2]Zickuhr K, Smith A. "Digital Differences." Pew Internet and American Life Project, 13, 2012.

A Conversation with Dr. Howard King by Eve Sullivan, Founder and President, Parents Forum

Pediatricians seldom have unhurried visits with parents of their young patients. If "the system" is not to blame for rushing parents and doctors, our all-too-human discomfort with the feelings that arise when we take time to reflect may keep us from discussing psychosocial issues.

Let me invite you to listen in on a reflective conversation I had over a period of days with Dr. Howard King, an MCAAP member and founder of Children's Emotional Health Link (www.cehl.org). Our conversation will, I hope, do two things: convince you of the powerful influence that family members' emotional well-being has on children, and persuade you to use your considerable influence to help parents better attend to both helpful and harmful psychosocial dynamics in their families.

Q: Tell me about your practice before you realized how issues in the extended family affect a child's emotional well-being?

H.K.: I spent two years in the military after my pediatric training and simply had no idea how to approach such issues. I did not consider the importance of spending time and learning to listen.

Q: What led you to incorporate questions on psychosocial issues into your practice?

H.K.: There were three important steps on my path:

1. The good fortune of taking time in one complicated family situation (see "A Psychosocial Assessment of the Terrible Twos," http://cehl.org/terribletwos.html) opened my ears to this element of my work as a doctor.
2. In situations with other parents I saw that opportunities for such interventions occur repeatedly if we are open to them.
3. These successes helped me achieve my primary goal of better care for my patients. At the same time, the work has had a ripple effect, transforming other care providers' experiences (see "On Becoming A Clinical Leader" elsewhere on the MCAAP website.)

Q: What is the concrete benefit from this practice, aside from the "feel good" effect you experience in developing a relationship of trust with the parent?

H.K.: Parents become empowered and more responsive in their day-to-day interactions with their children. They become more effective parents.

On May 1, Dr. King spoke to pediatricians in Maine. "Pediatricians cannot pick up emotional problems of children and families without the help of parents," he said. "We [can] help parents become better decision-makers."[1]

Q: Now I hear the hurried, harried pediatrician ask, "Who pays for the consultation time required for such extended conversations?"

H.K.: Many insurance systems do. Check http://cehl.org/roleofreimbursement.html to see how pediatricians who spend such time can be reimbursed. I was almost always reimbursed.

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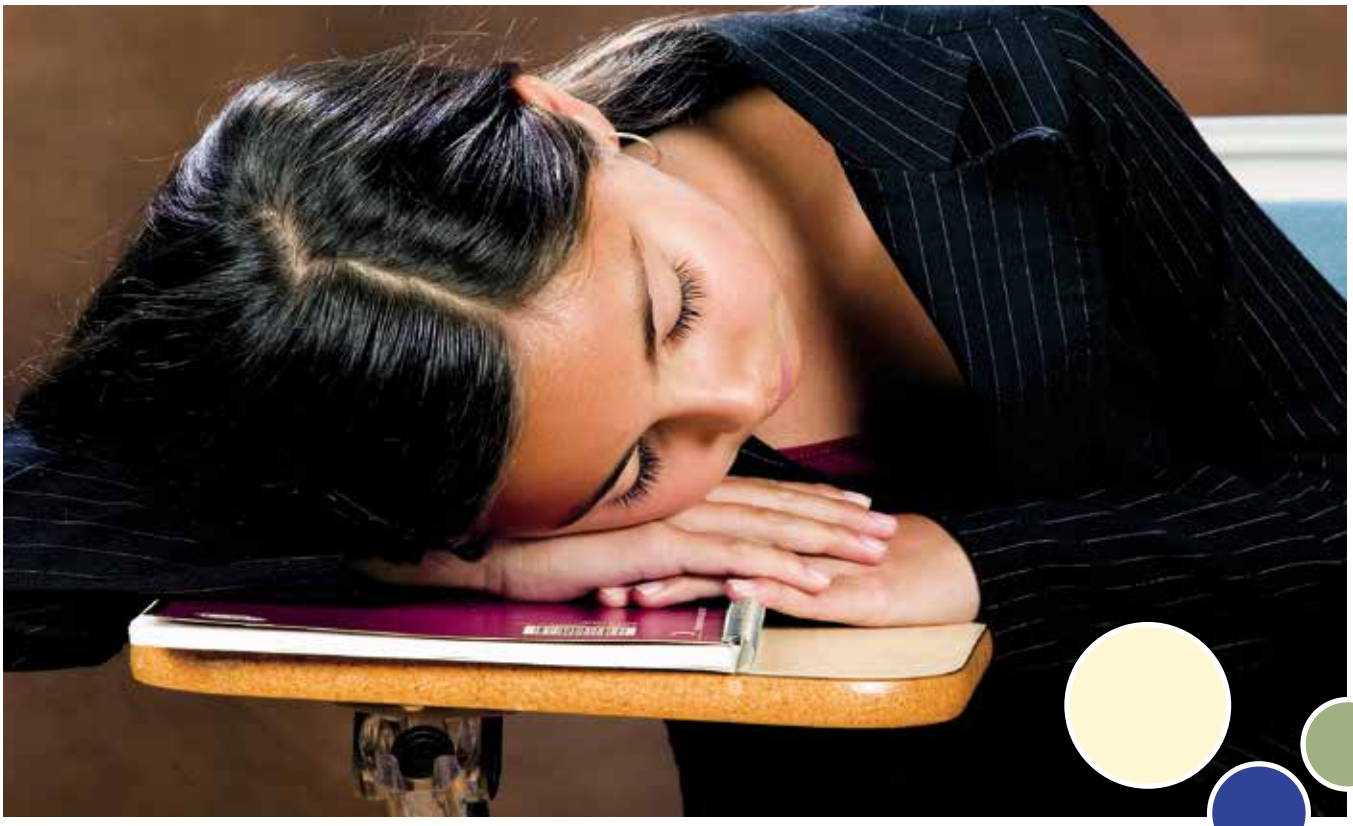

Sleep Deficiency — A Silent Epidemic Among Massachusetts Teens

Chronic sleep deprivation is one of the most important public health issues that affects adolescents. Start School Later is is a national organization that is working to address this problem. Pediatricians can help by advocating for later school start times and by educating patients and their families about the importance of getting 8½ to 9½ hours of sleep per night. Insufficient sleep has an adverse affect on cognitive functions, mood regulation, physical health and safety risks. The American Academy of Pediatrics recommends that teens start school no earlier than 8:30 a.m. The overwhelming evidence indicates that setting later school start times has dramatic benefits, such as improved academic performance, decreased car accident rates, reduced depression and suicidal ideation, increased attendance, reduced tardiness, fewer sport-related injuries — and increased sleep for students during the school week.

As a pediatrician, you've seen more than your share of children in good times and bad, and you care enough to do what it takes to help when you can. Right now, you have the ability to impact one of the most important public health issues that affects your adolescent patients: *long-term, serious sleep deprivation.*

As you may know, chronic sleep loss among teens is a silent epidemic that pediatricians, parents, and other health care professional groups, such as the AMA and AAP, are rallying to address. Scientific evidence has amply demonstrated that insufficient sleep adversely affects a whole host of both short-term and long-term outcomes ranging from *cognitive functions* (attention, decision making, and impulse control) to *mood regulation* (more depression symptoms, increased thoughts of suicide) to *medical consequence* (increased risk of obesity, hypertension, and type 2 diabetes), and *safety risks* (increased car accidents and athletic injuries).

Fortunately, there is something we can do right now. The Massachusetts chapter of the national organization Start School Later is working to address this public health problem, and there is much that pediatricians can do to help in this effort.

What Can Pediatricians Do to Help?

- Ask the MCAAP to **issue a public statement supporting the AAP's recommendation that middle and high schools start no earlier than 8:30 a.m**. Adoption of healthy school start times is one of the most important proven means to address teen sleep loss.
- As trusted advisors to your patients and their families, you have a vital role to play in educating people about the importance of sleep. Ask your patients about the timing and quality of their sleep. Let them know that most teens need eight-and-a-half to nine-and-a-half hours of sleep per night. Caution them against drowsy driving. Urge parents to pay attention to this fundamental pillar of good health and let them know that you support later school start times.
- Write letters in support of later school start times to local school boards and town newspapers.

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A Conversation with Dr. Howard King by Eve Sullivan, Founder and President, Parents Forum

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Q: When did you found Children's Emotional Health Link (CEHL) and how many practitioners have trained in the approach you advocate?

H.K.: CEHL was founded in 2004, and we have trained 60 health care professionals since that time. Evaluations done after each yearlong program are consistently positive.

Recognition of the group's work includes the National Academies of Practice (NAP) 2013 Interdisciplinary Group Recognition Award (www.napractice.org/eweb/DynamicPage.aspx?Site=NAP2&WebCode=NAPAwardsPrev) for enduring contributions to interdisciplinary practice and education. This award was presented to CEHL's leadership team: Howard S. King, MD, MPH; Elizabeth A. Rider MSW, MD; Julia Swartz, MSW, LICSW, CEIS; and David Robinson, EdD.

Q: When is the next training?

H.K.: We are planning our fifth training program for fall 2015. Interested health care professionals should contact me at howieking@aol.com to be notified about dates and the application process.

The ripple effect of the work is significant: since 2004, CEHL has influenced the lives of over 90,000 children and families in New England.

My friendship with Dr. King developed when we met through the National Parenting Education Network (www.npen.org). His confidence in my work and that of fellow parenting educators led me to attend your spring 2015 meeting in Waltham.

The bottom line is that our minds easily make the short hop from "I feel bad" to "feelings are bad," but doing so leads down a dead end street, to denial.

Like many of you, I grew up in an era when healthy psychosocial development was probably more the exception than the rule. Much has changed in childrearing, medical care, business practice, and social life since the 1950s. Mental health is now (at least officially) on a par with physical health, but it is awfully easy to fall back into denial. I very much appreciate the work Dr. King and his CEHL colleagues are doing. I hope you will want to become involved and help his legacy grow.

— Eve Sullivan, Cambridge, MA, Founder, Parents Forum, eve@parentsforum.org

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[1]http://mcaap.org/wp2013/wp-content/uploads/2013/07/Becoming-a-Clinical-Leader-by-Howard-King-MD1.pdf

MCAAP Committees and Administrative Appointments

AAP BREASTFEEDING COORDINATOR
Susan Browne
sbrowne@mcaap.org

CATCH CO-COORDINATORS
Anne Nugent
anugent@mcaap.org

Giusy Romano-Clarke
grclarke@mcaap.org

COMMITTEE ON ADOLESCENCE
Carl Rosenbloom
crosenbloom@mcaap.org

CHILDREN WITH SPECIAL HEALTH CARE NEEDS
Judy Palfrey
jpalfrey@mcaap.org

EMERGENCY PEDIATRIC SERVICES
Patricia O'Malley
pomalley@mcaap.org

ENVIRONMENTAL HAZARDS
Megan Sandel
msandel@mcaap.org

FETUS AND NEWBORN
Munish Gupta
mgupta@mcaap.org

FORUM EDITOR
Anne H. Light
alight@mcaap.org

FOSTER CARE
Linda Sagor
lsagor@mcaap.org

IMMIGRANT HEALTH COMMITTEE
Julia Koehler
Julia.Koehler@childrens.harvard.edu

IMMUNIZATION INITIATIVE
Cynthia McReynolds
cmcreynolds@mcaap.org

Sean Palfrey
spalfrey@mcaap.org

INFECTIOUS DISEASE
Sean Palfrey
spalfrey@mcaap.org

INJURY PREVENTION AND POISON CONTROL
Greg Parkinson
gparkinson@mcaap.org

INTERNATIONAL CHILD HEALTH
Sheila Morehouse
smorehouse@mcaap.org

David Norton
dnorton@mcaap.org

LEGISLATION
Karen McAlmon
kmcalmon@mcaap.org

MEDICAL STUDENT COMMITTEE
Michael Stratton
mstratton@mcaap.org

MEMBERSHIP
Chelsea Gordner
cgordner@mcaap.org

Walter Rok
wrok@mcaap.org

MENTAL HEALTH TASK FORCE
Barry Sarvet, M.D.
bsarvet@mcaap.org

Michael Yogman
myogman@mcaap.org

MMS DELEGATE/HOUSE OF DELEGATES
Lloyd Fisher
lfisher@mcaap.org

MMS INTERSPECIALITY COMMITTEE REPRESENTATIVE
Open

OBESITY COMMITTEE
Alan Meyers
ameyers@mcaap.org

Erinn Rhodes
erhodes@mcaap.org

ORAL HEALTH COMMITTEE
Michelle Dalal
mdalal@mcaap.org

PEDIATRIC COUNCIL
Peter Rappo
prappo@mcaap.org

PROS NETWORK COORDINATORS
David Norton
dnorton@mcaap.org

Ben Scheindlin
bscheindlin@mcaap.org

SCHOOL HEALTH
Lisa Dobberteen
ldobberteen@mcaap.org

Karen Sadler
ksadler@mcaap.org

SUSPECTED CHILD ABUSE AND NEGLECT
Stephen Boos
sboos@mcaap.org

Sleep Deficiency — A Silent Epidemic Among Massachusetts Teens

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- Join Start School Later Massachusetts and/or start a chapter in your town by visiting www.startschoollater.net/ma---statewide.html. Local advocacy efforts that include health care professionals are an essential part in raising awareness about teen sleep and in helping communities implement developmentally appropriate school hours.

Sleep Research Basics

The circadian rhythm shift that occurs in early adolescence makes it very difficult for the vast majority of teens to fall asleep before 11 p.m., even when following best practices such as restricting pre-bedtime screen usage. When school starts at 7:30 a.m., it is mathematically impossible for them to get the 8½–9½ hours of sleep they need. Moreover, waking kids up after less than eight hours of sleep disproportionately reduces the amount of Rapid Eye Movement (REM) sleep, which is critical for memory consolidation and learning, especially of new tasks. So-called "binge sleeping" on the weekend does not make up for the lack of sleep during the week, and in fact, may further disrupt circadian rhythms. The circadian rhythm "dysregulation" that occurs when human beings disregard their internal clocks (think night float) has its own set of consequences on virtually every physiologic function in the body, such as increased rates of obesity, GI problems, diabetes, and even some types of cancer.

What Is Start School Later Massachusetts Doing to Help?

Start School Later Massachusetts is a nonprofit organization working with local districts, as well as with statewide health and education leaders and lawmakers, to ensure safe, healthy school hours in all Massachusetts schools. The organization is supporting town-based chapters driving grassroots change, as well as working to create statewide change through legislation.

Last August, the American Academy of Pediatrics issued a recommendation that teens start school no earlier than 8:30 AM. Similar action is needed from Massachusetts pediatricians to underscore the importance of this issue locally.

Massachusetts public schools are lagging. On average, Massachusetts high schools start earlier than high schools in the rest of the country, with the earliest ones starting at 7:00 a.m. — a full 90 minutes earlier than what's recommended.

Because Massachusetts schools don't operate within large county systems as

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School Start Times Fact Sheet

Sleep in Teens

- Biological changes in sleep and in circadian rhythms occur during puberty, resulting in naturally-occurring delays in sleep and wake times. This means that it is difficult for many teens to fall asleep before 11 p.m.
- Scientific studies have shown that the average adolescent needs 8½–9½ hours of sleep per night. Based on an 11 p.m. bedtime, teens are biologically programmed to wake around 8 a.m.
- The average teen in the U.S. gets about seven hours of sleep per night, creating a chronic sleep "debt" of about 10 hours per week.
- Adolescents often "sleep in" on weekends in an attempt to make up for this sleep debt created during the week. However, this practice does not improve alertness during school and may actually worsen the circadian phase delay, pushing their biological bedtimes even later. For this reason, many adolescents exist in a chronic state of "jet lag" (like flying from DC to LA and back every weekend).

Consequences of Sleep Loss and Disruption of Circadian Rhythms in Teens

Impact on School Performance

- Shortened attention span, decreased higher-level cognitive skills, reduced ability to learn and remember new information, decreased efficiency in completing tasks, slowed reaction time
- Lower standardized test scores, decreased school achievement

Impact on Mood and Behavior

- Increased rates of depression and suicidal thoughts
- Difficulty regulating emotions
- Poor impulse control

Impact on Health and Safety

- Impaired immune function
- Increased use of caffeine and other stimulants, which is associated with increased rates of tobacco, alcohol and substance use
- Higher risk of automobile crashes due to "drowsy driving"
- Increased risk of sports-related injuries
- Increased long-term risk of obesity, metabolic dysfunction (diabetes) and cardiovascular problems (high blood pressure, stroke

Later School Start Times: The "Smart" Choice for Students

Middle and high school start times earlier than 8 a.m. are associated with:

- Chronic insufficient sleep and sleepiness
- Higher rates of tardiness and absenteeism, increased drop-out rates, more behavior problems in school, lower academic performance
- Higher rates of driving citations and car accidents in teens

Students in schools with later school start times (8 a.m. or later):

- Sleep more (i.e., they *do not* stay up later, and they *do* sleep later in the morning)
- Are less likely to be depressed or have thoughts of suicide
- Get better grades and perform better on standardized tests (like SATs)
- Since 1996, over 70 schools districts and thousands of schools across the U.S. have successfully delayed their school start times, with substantial benefits to students.
- In a 2011, the Brookings Institute reported that delaying school start times was one of the three top strategies for improving student achievement. The report estimated that higher test scores associated with delaying middle and high school start times by one hour changes translates to an increase of *$17,500 in additional lifetime earnings per student.*

Sleep Deficiency — A Silent Epidemic Among Massachusetts Teens

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they do elsewhere, it is much harder for individual towns to make this important schedule change, and they could benefit from cooperation across city and town lines. The creation of a Start School Later Massachusetts petition aims to bring the conversation to the state level and prompt lawmakers to take action (see the petition at tinyurl.com/sslma). One way the state could help is by developing a coordinated approach to intercommunity scheduling for academic, athletic, and other competitions and events. This type of planning would make it easier for public schools to shift to healthier hours.

Massachusetts Senator Cynthia Stone Creem of Newton introduced legislation S. 254, "An Act authorizing a study of student starting times and schedules." Start School Later is following this bill and is collaborating with Boston Children's Hospital, including Dr. Judith Owens, director of Sleep Medicine, and legislative affairs experts to identify additional educational and legislative solutions. Current federal and state legislation already sets limits on school lunch hours and nutritional requirements, mandates minimum exercise requirements, establishes school zone speed limits, and determines the number of days/hours per year that school must be held. Similar parameters are needed for school start times so that our children's health and well-being are protected.

Outside of Massachusetts, schools are planning to have or have already implemented later school start times. In October 2014, the Fairfax County, Virginia, school district, the 13th largest in the United States, announced that it was moving its high school start time later for its 57,000 students beginning in fall 2015. And in Europe, schools for high school-aged students rarely start before 9:00 a.m. Colleges have long recognized that sleepy students do not learn well, and they routinely do not start before 8:30 a.m.

It is inspiring to hear of the many ways that school districts across the country have used creative strategies to reconfigure bus routes and activity schedules to

align school start times with the AAP recommendation. The results have been dramatic for their teens' lives: improved academic performance, decreased car accident rates, reduced depression, increased attendance, reduced tardiness, fewer sport-related injuries, and increased sleep for students during the school week. The effect for disadvantaged students is even greater. Recently, for example, economist Finley Edwards found that moving start times from 7:30 to 8:30 a.m. in Wake County, North Carolina, significantly increased standardized test scores overall. Reading and math scores improved twice as much among students in the bottom third of the test-score distribution compared with students in the top third. Disadvantaged students benefited the most, with effects that persisted into high school, roughly twice as large as advantaged students.

Later start times make good financial sense as well. The Brookings Foundation concluded that there is at least a 9:1 benefit-to-cost ratio for later high school start times and 40:1 for later middle school start times. It is time for Massachusetts to study the issues at play and support policy decisions that will promote our children's welfare.

The overwhelming evidence indicates that setting later school start times is in the best interest of our children. Let's work together for our kids' health, safety, and academic performance. Find out more at startschoollater.net.

— Jenny Cooper Silberman, RN, MPH, co-founder of Wayland, MA chapter of Start School Later

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